Gray Matters: Autism, Impairment, and the End of Binaries

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GRAY MATTERS: AUTISM, IMPAIRMENT, AND THE END OF BINARIES

Kevin Barry

First diagnosed by psychiatrist Leo Kanner in 1943, Autism has exploded into the public consciousness in recent years. From science to science fiction, academia to popular culture, Autism has captured the world’s attention and imagination. Autism has also ignited a fierce debate among stakeholders who seek to define its essence. Many parents of Autistic children regard Autism as a scourge and press for a cure. The Neurodiversity Movement, comprised mostly of Autistic adults, regards Autism as a different way of being worthy of respect and even celebration. The Autism war is well underway and, given Autism’s swelling ranks and proposed changes to the American Psychiatric Association’s Diagnostic and Statistical Manual in 2013, this war shows no signs of abating.

Notwithstanding its rise to prominence in recent years as something both terrifying and terrific, Autism remains understudied in legal scholarship. This Article situates the Autism war within the larger theoretical debate over the social construction of disability and impairment. This Article accepts the “social model” of disability’s claim that disability is socially constructed and rejects the “medical model” as a theoretical model altogether. But “disability” – socially constructed or not – does not explain the Autism war. “Impairment” is where the action is.

This Article argues that while impairments like Autism may refer to some biological pathology, they are in part socially constructed. Autism is constructed not just by medical researchers and clinicians who name and diagnose it, but also by those who are so named – Autistic people, themselves, many of whom define Autism as a different way of being. Autism may be both a (still unknown) biological pathology and, according to Autism’s “Neurodiversity Movement,” an experience.

Autism has implications for disability rights law. The 2008 amendments to the ADA make clear that people discriminated against based on Autism are protected under the law. But the ADA’s exclusion of Gender Identity Disorder continues. Coverage of Autism, on the one hand, and exclusion of GID, on the other, is untenable. Both are largely a mystery to science, exist along a broad spectrum, and count among their ranks people who see their nonconformity as something to be proud of, not pathologized. Coherence in the law demands protection of those with Autism and GID – the “Impairmentqueer” who blur the line between “us” and “them.” It demands an “ADA Amendments Act Part 2” deleting GID from the ADA’s list of excluded impairments.

I. INTRODUCTION

There is a war raging over Autism. On one side are the parents of Autistic children who desperately want a cure for their children’s condition. On the other is the “Neurodiversity Movement” – Autistic adults who proclaim that they do not want to be cured because there is nothing wrong with them. While this war has been going on for some time, proposed changes

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2. For simplicity’s sake, this Article speaks of two sides in the Autism debate. One might reasonably argue that there are more. See Ian Hacking, Humans, Aliens & Autism in 138 DAEDULUS 44, 44-45 (2009) [hereinafter Aliens]
to the fourth edition of the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) have reinvigorated the debate. Under the proposed fifth edition (DSM V), there are no longer subtypes of Autism – no “Asperger’s Syndrome,” no “Pervasive Developmental Disorder Not Otherwise Specified (PPD NOS).” You are Autistic, or you are not.

The Autism debate is ground zero in a much larger and older debate over the meaning of “disability.” The word “disability” inhabits a world of binaries. It calls to mind a seemingly endless array of opposites that touch on nearly every aspect of our lives – one side good or desirable, and the other side bad or undesirable. How capable we are: “ability vs. inability.” How limited we are: “mild vs. severe.” How we fit into the world: “normal vs. abnormal.” How much we contribute: “asset vs. burden.” How free we are: “independence vs. dependence.” How fit we are: “strong vs. weak.” How attractive we are: “beautiful vs. ugly.” How happy we are: “joy vs. suffering.” How fortunate we are: “blessing vs. curse.” And, of course, how healthy we are: “health vs. sickness.” What all of these binaries have in common is that they are predicated on a view of disability as a personal deficit in bodily functioning, and personal deficits are always “bad.”

Beginning in the 1970’s, British scholars pioneered the “social model” of disability, which presented a new way of looking at disability. Specifically, they challenged the status quo, what they called the “medical model” of disability, which viewed disability as a personal deficit in bodily functioning. They advanced the idea of disability as a social construction, one that is synonymous with oppression or disadvantage imposed by society. While the social model of disability did wonders to illuminate disability’s troubling binaries, it did little to resolve them. In fact, it created new ones: “Love vs. hate.” “Acceptance vs. fear.” “Difference vs. defect.” “Gift vs. flaw.” “Equality vs. oppression.” “Culture vs. cure.” “Identity v. impairment.” “Pride vs. shame.” And above all: “social model” vs. “medical model.” Binaries remain.

("Autism is a highly contested field, and there are many collectives with quite distinct agendas.); see also Andrew Solomon, The Autism Rights Movement, N.Y. MAG., May 25, 2008, available at http://nymag.com/news/features/47225/ ("There are in reality three sides in this debate: those who believe autism is caused by environmental toxins (especially vaccines) and should be cured by addressing those pollutants; those who believe it is genetic and should be addressed through the genome; and the neurodiverse, who believe that it is genetic and should be left alone. These camps are blatantly hostile to one another.").


Bagenstos, supra note 4, at 18.

Id.

See, e.g., Tom Shakespeare & Nicholas Watson, The Social Model of Disability: An Outdated Ideology?, in RESEARCH IN SOCIAL SCIENCE AND DISABILITY, VOL. 2, EXPLORING THEORIES AND EXPANDING METHODOLOGIES: WHERE WE ARE AND WHERE WE NEED TO GO 11 (Sharon N. Barnartt & Barbara M. Altman eds., 2001) (“The social model could be used to view the world in black and white.”); MICHAEL OLIVER, UNDERSTANDING DISABILITY 45 (2d ed., 2009) (distinguishing “individual” (medical) from “social” model of disability).
Rarely are things “black” or “white”; there is often much gray. When it comes to disability, this is especially so. A model for understanding disability ought to help us understand that gray, but the tension between the social and medical models obscures. In many ways, this tension is a false dichotomy. And the Autism debate demonstrates why.

At a superficial level, the competing aims of parents and Autistic adults (the “Autism Rights” or “Neurodiversity” Movement) fit neatly into the medical-versus-social model binary. The former sees Autism as a disorder to be treated and possibly cured (medical model), while the Neurodiverse see it as an experience worthy of celebration or at least respect (social model). Parents are wrong and the Neurodiverse are right.

But delving deeper, there is a good deal of overlap between Autism’s factions and, importantly, between the medical and social models themselves. Both models seek to do away with disability (whether that disability is within the person or imposed by society), both models acknowledge the centrality of impairment and the functional limitations that may flow from it, and neither model demands a particular policy response. This leads to two conclusions about disability’s binaries. First, the medical model is “dead” – that is, it is not much of a model at all, or at least not a “model” in the same way that the social model is. Rather, the medical model is a way of describing a status quo that social constructionists don’t like, and so is always held out to be error. Second, the social model is far more moderate than is generally thought.

The medical-versus-social model binary is therefore a poor way of distinguishing between Autism’s factions. Parents who seek cures or treatment for Autism do not necessarily “disable.” In fact, they may be on the same side as Autistic adults.

The real fight within the Autism community has to do with Autism’s “essence,” but the hard-and-fast distinction between impairment’s11 biological core and people’s experience of impairment is also illusory. A recent “second wave” of disabilities studies suggests that “impairment,” like “disability,” is constructed by the social practices and institutions that name and diagnose it. This is true so far as it goes, but the Autism debate suggests another way that impairment is constructed: it is constructed not only by those who name it, but also by those who are “named” – Autistic people, themselves. The “Neurodiversity Movement,” which claims Autism as a way of being, is neither quaint nor quackery. It underscores that part of Autism is the experience of those who are classified as having Autism and who are changed by being so classified. For them, Autism is a part of their being, not – or not only – some (as of

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8 See infra note 71 and accompanying text.
9 See infra note 106 and accompanying text.
10 See infra note 107 and accompanying text.
11 The word “impairment” is not without ambiguity, and I will explore some of that ambiguity in Part V of this Article. Here I use the word consistent with disability theory and disability rights law to describe that subset of physical and mental traits (characteristics, differences, variations) that concern the medical profession – i.e., those that are named and diagnosed, such as cancer or depression.
12 See infra note 363 and accompanying text.
13 See infra note 278 and accompanying text.
14 See infra note 280 and accompanying text.
15 See infra notes 373-76 and accompanying text.
yet, unknown) biological pathology.\textsuperscript{16} Moreover, by adapting to, resisting, and transforming the social practices and institutions that classify them, Autistic people change Autism.\textsuperscript{17} Autism is therefore not fixed; it is on the move.

Autism has implications not only for disability theory, but also for disability rights law. Notwithstanding Autism’s vast spectrum – from those with severe functional limitations who view Autism as a pathology to be cured, to the Neurodiverse who view Autism as a difference to be respected and even celebrated – Autism is within the protection of disability rights law. The 2008 amendments to the ADA make this clear: if a person is discriminated against based on Autism, that person is protected.\textsuperscript{18} It does not matter if Autism’s features are mitigated by therapy, not functionally limiting, or even non-existent.\textsuperscript{19} From those well outside the norm to those who straddle the line between “us” and “them,” Autistic people are covered by the ADA.\textsuperscript{20}

But the ADA does not cover everyone. It explicitly excludes Gender Identity Disorder (GID), which, like Autism, is still largely a mystery to science, has a broad spectrum, and counts among its ranks a host of Transgender (or “Trans”) people\textsuperscript{21} who, like the Neurodiverse, see their nonconformity as something to be proud of, not pathologized.\textsuperscript{22} By excluding those with GID, the ADA sends a sobering message to those in the Transgender community: they have no civil rights worthy of respect under federal disability law.

While the social construction of disability does not demand a particular policy response, disability rights laws – once enacted – ought to provide coherent protection to those who are “disabled.” The ADA fails in this regard. As illuminated by the Neurodiversity and Trans communities, according disability rights protection to Autism, on the one hand, and excluding protection for GID, on the other, is untenable. The ADA “disables” people with GID. Coherence in the law demands legal protection for both. It demands an “ADA Amendments Act Part 2” that makes good on the ADA’s promise of (nearly) universal protection by covering everyone, including the “Impairmentqueer” – i.e., those who blur the line between “us” and

\begin{itemize}
  \item \textsuperscript{16} See infra note 192 and accompanying text. By “biological pathology,” I mean those “‘objectively’ ascertainable abnormalities of anatomy, physiology, or biochemistry” underlying various impairments. See Carol A. Bernstein, M.D., \textit{From the President: Meta-Structure in DSM-5 Process}, \textit{in 46 Psychiatric News No. 4}, March 4, 2011, at 7, available at \url{http://pn.psychiatryonline.org/content/46/5/7.full?sid=cf7bee48-b91b-4687-88f5-80b7bab5c07b}. Biological pathologies contrast with the DSM’s psychopathologies, the diagnosis of which is based “entirely on clinical description.” See id. (“[E]ven today objective tests and biomarkers for mental disorders remain research goals rather than clinical tools.”).
  \item \textsuperscript{17} See infra notes 376-79 and accompanying text.
  \item \textsuperscript{18} See infra notes and accompanying text; see also 29 C.F.R. § (j)(3)(iii) (“[A]utism substantially limits brain function.”).
  \item \textsuperscript{19} See 42 U.S.C. §§ 12102(3)(A) (prohibiting consideration of most mitigating measures), (4)(E) (stating that person is covered under “regarded as” prong of definition of disability even if impairment does not “substantially limit[]” or is “perceived,” not “actual”); see also 29 C.F.R. §§ 1630.2(g)(3) (discussing mitigating measures), (j)(1)(vi), (l) (discussing “regarded as” prong).
  \item \textsuperscript{20} See 42 U.S.C. § 12101(1); see also 29 C.F.R. § (j)(3)(iii).
  \item \textsuperscript{21} “Transgender” is an umbrella term that refers to those who are gender nonconforming. See infra note 431 and accompanying text. It therefore includes those diagnosed with GID as well as those without the diagnosis whose gender identity or expression does not conform to the social expectations for their assigned sex at birth. See infra notes 433-434 and accompanying text.
  \item \textsuperscript{22} See supra notes 437-38 and accompanying text.
\end{itemize}
“them” by claiming impairment as a different way of being and something worth celebrating, or at least supporting, under the law.

In Part II of this Article, I provide a brief overview of Autism and the dueling conceptions of Autism advanced by Autism’s Neurodiversity Movement and the parents of Autistic children. In Part III, I cover some familiar territory: disability’s medical and social models. According to the medical model, disability is an impairment that imposes profound functional limitations, while under the social model, disability is socially constructed by practices and institutions that disadvantage people on the basis of impairment. After examining similarities and differences between the two models, I chart a new course, suggesting that there are not two theoretical models of disability but rather only one: the social model. Applying philosopher Ian Hacking’s account of social construction theory, I argue that disability is socially constructed and the medical model is simply the name social constructionists give to the range of practices and institutions that disable. The medical model is dead; the social-versus-medical-model binary disappears as two models become one.

In Part IV, I analyze the positions staked out by Autism’s warring sides, and discuss why the social-versus-medical model binary does not explain the Autism debate. The Neurodiversity Movement’s conception of Autism as an experience entitled to respect is not disabling, but neither is parents’ conception of Autism as a pathology in need of cure. As far as disability is concerned, parents of Autistic children and the Neurodiversity Movement may well be on the same “side.”

Part V suggests that the real battle between the Neurodiverse and parents is not about disability at all – it is about impairment, about the meaning of “Autism.” Returning to Ian Hacking’s version of social construction, I argue that “impairment” is both an “idea” (which is socially constructed) and an “object” (which may or may not be). Impairments are socially constructed ideas because they are contingent upon the social practices and institutions that name and diagnose them, and that legislate, educate, entertain, and employ people with them. The idea of “Autism” never had to be: Autism could have remained childhood schizophrenia or MR (“mental retardation”), or never have been named at all; and schools, summer camps, laws, and other practices impacting Autistic children need never have been put in place.

Beyond the “idea” of impairment, I argue that impairment refers to two very different kinds of “objects”: pathologies and people. While pathologies are indifferent to social practices and institutions, people are not. Autistic people change in response to those practices and institutions – adapting to, resisting, and transforming them. In this way, the Neurodiverse change, or “construct,” Autism. Autism may be both a (undiscovered) pathology and, importantly, a different way of being.

Part VI examines Autism’s implications for disability rights law. While Autism’s vast spectrum is protected under the 2008 amendments to the ADA, GID remains explicitly excluded. I argue that protection of one and not the other is untenable – coherence demands coverage of the “Impairmentqueer.” I call for legislation amending the ADA to extend civil rights coverage to people with GID and touch on potential arguments from the Trans community against such coverage. In Part VII, I offer some concluding remarks.
II. AUTISM AND ITS DISCONTENTS

Autism is a way of being. It is not possible to separate the person from the autism. Therefore, when parents say, “I wish my child did not have autism,” what they’re really saying is, “I wish the autistic child I have did not exist, and I had a different (non-autistic) child instead.”

Read that again. This is what we hear when you mourn over our existence. This is what we hear when you pray for a cure. This is what we know, when you tell us of your fondest hopes and dreams for us: that your greatest wish is that one day we will cease to be, and strangers you can love will move in behind our faces.

You didn’t lose a child to autism. You lost a child because the child you waited for never came into existence. That isn’t the fault of the autistic child who does exist, and it shouldn’t be our burden. We need and deserve families who can see us and value us for ourselves, not families whose vision of us is obscured by the ghosts of children who never lived. Grieve if you must, for your own lost dreams. But don’t mourn for us. We are alive. We are real. And we’re here waiting for you.

-- Jim Sinclair, Don’t Mourn for Us

* * *

I love my children, but I do not love autism. My children are not part of a select group of superior beings named "autistics." They have autism, a neurological impairment devastating in its implications for their lives, if left untreated. I do not know the cause of autism, but research tells me the most likely possibility is that there is some kind of genetic anomaly, perhaps influenced by environmental factors. In other words, it is no more normal to be autistic than it is to have spina bifida. As with any other condition that would threaten their future and their happiness, I do as much as I can to help them be as functional and as normal as possible. And no, "normal" to me does not mean "a cookie-cutter robot-child, trained to do my will." It means: "able, like most people without autism, to lead an independent, purpose-filled life.” Able to speak, able to communicate, able to form and keep relationships. I have spent most of the last eight years poring over research on the treatment of autism. I have attended lectures and spent hours preparing materials for my children’s ABA therapy programs. I do all of this because I love my children and because this treatment has helped them develop language, cognitive, self-help and social skills, all things that they would not have acquired without this treatment.

-- Kit Weintraub, A Mother’s Perspective

There is much debate over what Autism is, and this Article will touch on that debate. As a starting point, most agree that Autism is a neurodevelopmental condition, that is, a condition that impacts brain development and functioning. There is no blood test or other definitive biological marker for Autism. "You cannot see Autism under a microscope or discover it through a lab." Instead, diagnoses of Autism are based on the recognition of certain core behavioral features, namely social communication/interaction differences and fixated interests and repetitive behaviors. For example, an Autistic person may have difficulty interpreting social cues and facial expressions, expressing emotions in conventionally recognizable ways, and developing and maintaining age-appropriate peer relationships. The Autistic person may also demonstrate unusual sensory behaviors (like hand- or finger-flapping), excessive adherence to routines, and inflexibility and discomfort with change.

Most also agree that Autism is highly variable: the intensity of Autism’s core features varies significantly from person to person, and these features may change throughout an individual’s lifetime. As Dr. Ami Klin, Professor of Child Psychology and Psychiatry at the Yale Child Study Center, has thoughtfully remarked:

The variability is immense. From individuals who are burdened by severe to profound intellectual disabilities to persons who are gifted and more competent than most in the community. From those who cannot speak to those who are loquacious. From those whose isolation is manifest by complete social withdrawal to those who cannot stop approaching others albeit at times awkwardly. From persons who are enchained by self-stimulating movements, rituals and self-injurious behaviors to those whose knowledge about circumscribed areas of knowledge or special skills are prodigious. These, at times, extreme characteristics notwithstanding, all are people with emotions who can love and can be hurt, who need to meet the demands of everyday life, and who are desirous of independence and meaningful relationships. Some are in need of intensive supports whereas others require little more than an equal opportunity community. All deserve a stab at happiness and a fulfilling life.

25 See infra notes 265-68 and accompanying text. The word “Autism” comes from the Greek autos, meaning “self,” and was first used by Swiss psychiatrist Paul Bleuler in 1912 “to describe the behavior of some people, then diagnosed with schizophrenia, who disengaged from everything except their internal world.” ROY RICHARD GRINKER, UNSTRANGE MINDS 44 (2007).
26 Baron-Cohen, supra note, at 137.
28 GRINKER, supra note, at 2.
30 Id.; see also Hacking, Aliens, supra note, at 52 (“[Autistic people have] notorious difficulty with eye contact. For whatever reason, autistic people, when they look at someone’s face at all, tend to focus on the lower part of the face (the mouth and chin) and not the eyes.”).
32 GRINKER, supra note, at 10.
Most can make contributions to society whereas some can in fact build on their specific strengths and reach unique achievements in science, art and technology.\(^{33}\)

Given the breadth of Autism’s variability, Autism is generally thought of as a “continuum” or “spectrum.”\(^{34}\) There is a saying in the world of Autism: “When you know a person on the [Autism] spectrum, you know one person on the spectrum.”\(^{35}\) Because the Autism spectrum “is broad enough to encompass both a severely mentally retarded autistic person without speech and a super-intelligent but socially awkward mathematician or physicist,”\(^{36}\) one might say that the world of Autism \textit{is} the world. Or nearly so. As a result, Autism resists easy definition.

While the DSM-IV tries to distinguish various “points” along the Autism spectrum by providing diagnostic categories for various subtypes of Autism, such as Asperger’s\(^{37}\) and PDD-NOS,\(^{38}\) the DSM-V is poised to dispatch with that effort. According to the DSM-V’s Neurodevelopmental Disorders Working Group, “a single spectrum disorder is a better reflection of the state of knowledge about pathology and clinical presentation.”\(^{39}\) Multiple diagnostic categories, the Group concedes, “were equivalent to trying to ‘cleave meatloaf at the joints,’” and were found to be “inconsistent over time, variable across sites, and often associated with severity, language level or intelligence rather than features of the disorder.”\(^{40}\)

Lastly, most agree that there are lots of people that have (and have had) Autism. According to the U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC), an average of 1 in 110 U.S. children have Autism, or about 1% of all U.S. children.\(^{41}\)

\(^{33}\) Ami Klin, \textit{Articles of Understanding: Introduction}, available at \url{http://www.grasp.org/new_art.htm}.

\(^{34}\) See DSM-5, “Proposed Revision,” supra note (proposing to rename “Autistic Disorder” “Autism Spectrum Disorder”); see also Grinker, supra note, at 10 (“‘Autism’ today is really an autism \textit{spectrum}.”) (emphasis in original).

\(^{35}\) Solomon, supra note.

\(^{36}\) Grinker, supra note, at 10.

\(^{37}\) DSM-IV, supra note, at 75-78. According to the DSM-IV, people with Asperger’s and people with “classic” Autism share limitations in social interaction and restricted interests and behaviors. \textit{Id.} The difference between the two is that people with Asperger’s have no clinically significant delay in speech or cognitive development (i.e., good IQ), whereas some people with Autism do. \textit{Id.}

\(^{38}\) DSM-IV, supra note, at 75-78. According to the DSM-IV, PDD-NOS is a catch-all condition encompassing those with \textit{either} limitations in social interaction \textit{or} restricted interests and behaviors. \textit{Id.}


\(^{40}\) Id.

\(^{41}\) What We’ve Learned About Autism Spectrum Disorder, \textit{Centers for Disease Control and Prevention}, \url{http://www.cdc.gov/Features/CountingAutism/}. Many people, including those in print, radio, and television media, have gone so far as to call Autism an “epidemic.” See, e.g., Grinker, supra note, at 143. While extended discussion of Autism’s prevalence is beyond the scope of this Article, “the increase in the rate of autism is more likely due to the result of new and improved science – more reliable [and broader] definitions of autism and more awareness among health-care professionals and educators. . . . The bottom line is that reported prevalence has increased, but the real prevalence has probably remained stable.” \textit{Id.} at 146, 170; see also Fitzpatrick, supra note, at 28 (noting that Grinker’s conclusions “echo[] the consensus of authorities in the field of autism”).
III. CONSTRUCTING DISABILITY: THE MEDICAL VS. SOCIAL MODELS

A. Social Construction Generally

The Autism debate appears to fit neatly within the broader debate between the medical and social models of disability. However, a closer look at these dueling models of disability reveals that the two models are not black and white but are instead shades of gray. To understand why, it is first necessary to look at the concept of “social construction.”

As philosopher Ian Hacking notes, the phrase “social construction” is both obscure and overused. . . [It] has become code. If you use it favorably, you deem yourself rather radical. If you trash the phrase, you declare that you are rational, reasonable, and respectable.42 Clearing away the underbrush, social construction accounts are, at bottom, about consciousness-raising, about unmasking assumptions, and, most of all, about hope.43 Things are not fixed or inevitable, but instead “are the product of historical events, social forces, and ideology”; they can be changed.44 And not only can things change, but we, as a society, can change them.

Social constructionist accounts are everywhere. Race and gender, rocks and genes – all are said to be socially constructed.45 According to Hacking, socially-constructed things tend to share two important features: (1) the thing that is said to be constructed is taken for granted – it “appears to be inevitable”; and (2) “the thing need not have existed, or need not be at all as it is.”46 It is “not determined by the nature of things; it is not inevitable.”47 Rather, it is contingent.48 Importantly, there are various grades of commitment to social construction, ranging from noncommittal (the thing is contingent, the upshot of historical events) to the rebellious and revolutionary (the contingent thing is bad and should be done away with).49

B. The Social and Medical Models of Disability

Disability scholarship identifies two primary models of disability: the social model and the medical model.50 Under both models, the word “disability” means some limitation on ability, some disadvantage.51 The primary distinction between the two models is the source of that disadvantage – i.e., the cause of disability.52

43 See id. at 6-7.
44 Id.
45 Id. at 1, 21-22.
46 Id. at 6, 12.
47 Id.
48 HACKING, supra note, at 12.
49 Id. at 19-20.
50 See, e.g., BAGENSTOS, supra note, at 18.
51 Barry, Toward Universalism: What the ADA Amendments Act of 2008 Can and Can’t Do for Disability Rights, 31 BERKELEY J. EMP. & LAB. L. 203, 210 (2010); see also Adam M. Samaha, What Good is the Social Model of Disability?, 74 U. CHI. L. REV. 1251, 1255-56 (2007) (“Striped down to basics, the [social] model moves causal responsibility for disadvantage from physically and mentally impaired individuals to their architectural, social, and economic environment. . . . [The “medical model”] focuses on the disadvantaging impact of physical or mental impairments rather than that of the environment in which they operate.”).
52 See Samaha, supra note, at 1255-56.
1. Medical Model

According to the medical model, disability is inevitable and is caused by an impairment that limits bodily functioning. Disability is not every impairment – just those that impose limitations that rise to a certain “disabling” level. The medical model may be expressed as follows:

\[
\text{Disability} = \text{impairment} + \text{profound functional limitations}
\]

Consider a man with depression. According to the medical model, he is disabled if his depression imposes profound functional limitations. Maybe there are days when he cannot stop crying, cannot bear the thought of getting out of bed, does not want to eat, feels worthless. If his depression is so severe that he cannot perform life functions, then he is “disabled”; he has a “disability.”

A person with psoriasis – a skin condition – has an impairment too. She is probably not disabled, though, unless that condition imposes functional limitations, such as psoriatic arthritis, which may limit her ability to bend or perform certain tasks with her hands. Otherwise, she goes about her day – working, sleeping, eating. Does she have an impairment? Yes. Does the impairment disable her? Of course not.

2. Social Model

Rather than taking disability for granted as an impairment that inevitably afflicts some people and limits their functioning, the social model holds that disability is socially constructed. While impairments may be inevitable, disability is contingent. Disability is the interaction between a person’s impairment and his or her environment – i.e., negative treatment that he or she experiences based on his or her impairment. This model may be expressed as follows:

\[
\text{Disability} = \text{impairment} + \text{environment (negative treatment)}
\]

There are several variations of the social model. One might say that any negative treatment based on impairment is disabling. This is the universal approach: we all have impairments, and those of us who are negatively treated because of those impairments are disabled.

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53 See, e.g., Bagenstos, supra note, at 18; see also OLIVER, POLITICS, supra note, at 58, 69 (discussing “the view of disability as an individual, medical problem and personal tragedy” which “load[s] responsibility for the restrictions that disabled people experience on to disabled people themselves, who are restricted because of the functional or psychological limitations imposed by their individual impairments rather than by the social restrictions imposed by society”).

54 See DSM-IV, supra note, at 327 (listing criteria for Major Depressive Episode).

55 See Bagenstos, supra note, at 19 (stating that social model “treats human differences as constructed by, and residing in, social relationships”).

56 See id. at 18; see also OLIVER, POLITICS, supra note, at 70 (noting that while “impairment is ‘real,’” disadvantage based on impairment is “neither natural nor inevitable”).

57 Id.

58 Barry, supra note, at 217-18.
A narrower approach to the social model says that the negative treatment cannot be an occasional affair – it must result in systematic disadvantage. Since systematic disadvantage generally applies only to those impairments that are stigmatized (i.e., those considered not normal), only people with stigmatized impairments are disabled. This is the “minority group approach” to the social model.

No matter what the approach, under the social model, it is society’s negative treatment of individuals based on their impairments – not the impairments themselves – that “disable.” In fact, one need not even have an actual impairment to be disabled – one may be disabled as a result of a perceived impairment (e.g., a person who is perceived as having HIV and discriminated against on that basis). Under the social model, the impairment is not the “problem” that results in disadvantage – we are.

Consider again the man with depression. He has an impairment, and the social model acknowledges that. He may also have functional limitations associated with the impairment, and the social model acknowledges that too. But under the social model, those functional limitations do not “disable” him. He is only “disabled” if society treats him negatively based on his impairment. And society often does – he may not get hired for a job if the employer finds out about his depression. His friends and family may think of his depression as a liability – something that may rub off on them – and decide to limit the time they spend with him. On the other hand, he may not be disabled by his depression. Maybe he has an employer who understands that he may need to work remotely from home some days. Maybe he has friends and family who support him through those hard times. In this way, even a person whose depression imposes clinically significant functional limitations may not be “disabled” under the social model.

59 See Barry, supra note, at 213-14; see also Shakespeare, supra note, at 25 (“[W]hile all living beings are impaired – that is, frail, limited, vulnerable, mortals – we are not all oppressed on the basis of this impairment and illness. Only a proportion of people experience the additional disabling processes of society. Put another way, societies have evolved to minimize the problems of the majority of people with impairment, but have failed to deal effectively with the problems of a minority of people with impairment.”).
60 Barry, supra note, at 214.
61 See Barry, supra note, at 212-13.
63 Barry, supra note, at 212.
64 See Barry, supra note, 212-13.
67 While this example is useful for purposes of comparison between the medical and social models, it assumes that the person with depression does not experience negative treatment in any other aspect of their lives. This is probably not the case. Notwithstanding supportive employers, family, and friends, the person with depression is probably still “disabled” by negative treatment elsewhere in their lives. See generally Emens, supra note, at 401 (discussing widespread discrimination against people with mental illness).
The converse is also true. Take the person with psoriasis. She may have no functional limitations. But if she is denied a job because someone spots an odd rash along her hairline, she is disabled – regardless of the lack of any functional limitation.

C. Two Models Become One

Beyond their causation stories, the social and medical models have much in common. First, both models regard disability as a limitation on ability – a disadvantage – and, therefore, something to be gotten rid of. Second, as a general matter, both models acknowledge the centrality of impairment to disability. Under the medical model of disability, only impairments that limit functioning give rise to disabilities. Under the social model, only impairments that are negatively treated give rise to disability (whether or not they limit functioning).

Third, and perhaps most importantly, neither model requires a particular remedy. The social model, which conceives of disability as being “brought into existence or shaped by social events, forces, history,” is generally understood as favoring civil rights interventions over medical ones. If society is causing the problem, the argument goes, then society ought to remedy it through accommodations, antidiscrimination, and so on. Removing disability, the reasoning goes, lay not in cures, charity, and social welfare interventions, but rather in access.

While civil rights remedies are certainly consistent with the social model, they are not necessitated by it. The social model – at least, a more non-committal version of it – does not demand a particular policy response. The social model might acknowledge that society’s neglect of people with various impairments is to blame for disability, but that the remedy – at

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69 See, e.g., Bagenstos, CONTRADICTIONS, supra note, at 7 (contrasting those who seek to eliminate disability “through the medical means of eliminating impairments” and those who seek to “eliminate the social and physical structures that create ‘disability’ by denying opportunities to people with some impairments”).
70 See, e.g., Samaha, supra note, at 1257-58 (discussing medical model’s focus on “the disadvantaging impact of physical or mental impairments” and the social model’s focus on the “disadvantage caused by the confluence of (1) personal impairment and (2) a social setting . . . .”); BAGENSTOS, CONTRADICTIONS, at 19 (contrasting social model’s treatment of disability “as the interaction between societal barriers . . . and the impairment” and medical model’s treatment of disability “as an inherent personal characteristic”).
71 See Samaha, supra note, at 1275 (arguing that while social model explains cause of disability (i.e., combination of impairment and social setting), it does not determine appropriate policy response, which is instead “a matter of contested norms”).
72 See HACKING, supra note, at 7.
73 BAGENSTOS, CONTRADICTIONS, supra note, at 18.
74 Id. at 20 (“Most disability rights activists insist that society as a whole has a responsibility to eliminate the social and physical structures that deny people with ‘disabilities’ access to opportunities – the structures that, in a significant way, create ‘disability.’”).
75 Samaha, supra note, at 1308 (arguing that “[t]he social model of disability is not a justification for any policy goal,” be it social restructuring or individualized medical care).
76 Id.; see also HACKING, supra note, at 20 (tracing grades of commitment of social constructionists, from those who believe that something is contingent, to those “who move beyond the world of ideas and tr[y] to change the world”).
least for now – should include continued cash benefits and charity.\textsuperscript{77} It might also acknowledge that rehabilitation and research into cures are not antithetical to eliminating disability, so long as they minimize stigma and maximize independence.\textsuperscript{78} After all, if there is no underlying impairment, one might argue, there will be no negative treatment. Favoring policy responses outside the realm of civil rights is not abandonment of the social model – it may be of a piece with it.

Similarly, medical treatment and social welfare interventions are not proprietary to the medical model. One who views disability as a personal problem of solely medical origin may favor accommodation over cure because the former is a surer bet. Schizophrenia has been around for a century and there is still no cure,\textsuperscript{79} one might argue, so why not support laws that take aim at stigma?

Given these similarities, the dividing line between the medical and social models is not as clear as it is often made out to be. Sure the medical model supports research into cures for certain impairments – but the social model does not necessarily forbid the same.\textsuperscript{80} And both models acknowledge that medical impairments may impact life functioning and that the world would be a better place without “disability.”\textsuperscript{81} What differences remain, then, lay in the models’ causation stories – the medical model’s emphasis on impairment as the locus of disability versus the social model’s acknowledgement of society’s role in constructing disability\textsuperscript{82} – but even this boundary is blurred.

The fundamental claim of the medical model is that: (1) impairments are real, and (2) some impairments limit bodily functioning in profound ways.\textsuperscript{83} Those whose bodily functioning is profoundly limited by impairments are “disabled.” Their functional limitations disadvantage them and that disadvantage is inevitable.

The social model, on the other hand, already recognizes that: (1) impairments are real, and (2) some of them limit bodily functioning in profound ways.\textsuperscript{84} But it does not dwell on it; it goes further. This model realizes that (3) impairments result in disadvantage that is not inevitable, but is instead the product of negative treatment of people with those impairments.\textsuperscript{85} While the social

\textsuperscript{77} See BAGENSTOS, CONTRADICTIONS, supra note, at 25, 149 (stating that social welfare remedies like cash and in-kind benefits are not necessarily at odds with disability rights activists’ goal of independence, and noting that civil rights remedies like the ADA’s reasonable accommodation mandate “might readily [be] characterize[d] . . . as a request for charity”).
\textsuperscript{78} See OLIVER, POLITICS, supra note, at 48 (“Some [medical] involvements are, of course, entirely appropriate, as in the diagnosis of impairment, the stabilization of medical condition after trauma, the treatment of illness occurring independent of disability and the provision of physical rehabilitation.”); see also Samaha, supra note, at 1277 (arguing that, with respect to deafness, social model would not prohibit policy responses ranging from do-nothing, to subsidized access to cochlear implants and genetic screening, to expansion of ASL instruction and sign language communities”).
\textsuperscript{79} See GRINKER, supra note, at 120.
\textsuperscript{80} See supra note 78 and accompanying text.
\textsuperscript{81} See supra notes 69, 70 and accompanying text.
\textsuperscript{82} See supra note 51 and accompanying text.
\textsuperscript{83} See supra note 53 and accompanying text.
\textsuperscript{84} See supra note 56 and accompanying text.
\textsuperscript{85} See supra note 57 and accompanying text.
model does not deny that impairments (and the functional limitations that may or may not flow from impairments) play a role in the causation of disability, it says that environment also plays a role, and a major one.

1. “The Medical Model is Dead and the Social Model Has Killed It?”

Rather than two opposing models of disability, the medical and social models appear to exist on a continuum, with the social model further along that continuum. The medical model is not “flat-out wrong,” one might argue, “it just does not go far enough.” If that is the case, then what is left of the medical-vs.-social model binary: are the two models really at odds, or is the medical model “dead,” rendered useless by the more expansive social model?

The answer is that the medical model of disability is not dead, but it is far less a “model” than often portrayed. To understand why, it is necessary to understand a significant bone of contention between the medical and social models: the theme of subordination. The social model does not say that the medical model does not go far enough. The social model says much more – that the medical model’s excessive focus on impairment is, itself, “disabling.” By failing to look beyond individual impairments to society’s role in causing disability, the social model argues, the medical model subordinates people with impairments.

Stigma is perpetuated as “the disabled individual is viewed as innately, biologically different and inferior,” and independence is undermined as the medical profession is granted “cognitive authority to identify and treat disabled persons.”

Given the social model’s focus on impairment plus environment, it is not surprising that it finds nothing redeeming in the medical model’s focus on impairment only and consistently holds out the medical model as error. What is surprising, though, is that the medical model has no retort. The medical model does not say people should look only at impairment. In fact, it does not say people should do anything. There is virtually no support for the medical model as a theoretical position.

This is because the enemy of the social model is not a competing theoretical position at all – i.e., a normative model about the way things should be. As with all other social constructs, the enemy of the social model is the status quo – our unraised consciousness, the way things are. For the social model of disability, that status quo has a name: “the medical model.” Disability means “oppression” and “medical model” is the label for that oppression. The medical model is therefore not a normative model that is espoused, but is instead a descriptive device that is used by social constructionists to explain what is wrong with our current institutions and practices.

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86 See Samaha, supra note, at 1256 and accompanying text.
87 See BAGENSTOS, CONTRADICTIONS, supra note, at 18-19 (“[T]he view of disability as a personal tragedy obscures the social practices that exclude ‘the disabled’ from the opportunity to participate fully in society.”).
89 See Samaha, supra note, at 1257.
90 See id. at 1257 (“It is difficult to find scholars who promote any such model of disability.”).
91 See supra notes 43-44 and accompanying text.
92 See Crossley, supra note, at (discussing ways in which medical model permeates healthcare, benefits law, and popular culture); see also Bradley A. Areheart, When Disability Isn’t “Just Right”: The Entrenchment of the
The medical model is a story of inevitability in which disability is taken for granted: “Of course people are disabled – they are unfortunate, they cannot work, they cannot care for themselves.” The social model, on the other hand, is a reaction to that story, and a liberating one: “Oh, I see now – disability is not inevitable but is instead the result of how we treat people with certain impairments. Disability can be changed.”

The social model is about hope, and hope is always “good.”93 The medical model, in turn, is the social model’s description of the attitudes and institutions that need to be changed – those that “disable” people by stigmatizing their impairments, undermining their independence, and ignoring society’s contribution to their disadvantage.94 It is everything wrong with the status quo, and so it is always “bad.” Comparing the two models, therefore, is like comparing apples and oranges. The former is a normative model for how disability “should” be understood, while the latter is a way of calling the present state of things wrong. Two models of disability thus become one (the “social model”), plus a description of how society disables (the “medical model”). There is no binary here. There is only disability, which is socially constructed, and many shades of gray as to what “disables.”

So is the medical model dead? If by “model” one means a theoretical position competing with the social model then, yes, the medical model is dead because it was never alive to begin with. The medical model was created by social constructionists to raise consciousness about a status quo that they do not like.95 It is therefore always wrong. This does not mean, however, that the medical model is merely a straw man. The medical model describes conditions that permeate our society and produce (socially-constructed) disability.96 As a descriptor of the status quo, the medical model is alive and well. One can reasonably argue that the present state of things does disable people with certain impairments, and that disability is taken for granted as something inevitable, something that afflicts.97 One can further argue that there is an overemphasis on the functional limitations of impairment, which breeds stigma by depicting people with various impairments as damaged goods in need of cures and charity; cedes too much control over people’s lives to the medical establishment; and ignores the role of society in creating disability.98

So long as this status quo remains, then there is a medical model. It is just not everything it has been made out to be. It is far less didactic: it has nothing to do with consciousness-raising and commands no moral weight. The medical model does not say that it is right to focus solely on impairment – it just does not know any better.

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93 See supra notes 43-44 and accompanying text.
94 See BAGENSTOS, CONTRADICTIONS, at 18-19.
95 See supra note 93 and accompanying text.
96 Id.
97 Id.
98 See supra 95 note and accompanying text.
2. A Moderate Social Model

The medical-versus-social model binary turns out to be illusory. There is disability, which is socially constructed, and a range of practices and institutions that may or may not disable. Acknowledging that disability is a social construct is not controversial for two reasons.

First, the social model does not deny the inevitability of impairment or the functional limitations associated with some impairments. On the contrary, it leaves the concept of impairment undisturbed, safe and sound in the annals of science, and focuses instead on the contingency of disability. By leaving the concept of impairment undisturbed, the social model of disability’s central claim of contingency is not radical. In fact, it is more of a punt. After all, if disability is negative treatment based on impairment, then of course it is contingent (and therefore socially constructed). So is racism (negative treatment based on race). And sexism (negative treatment based on sex). And homophobia (negative treatment based on sexual orientation). There is nothing inevitable about people being treated badly because of these characteristics — people should not be treated that way. By assuming the inevitability of “impairment,” the social model of disability sidesteps a crucial question: are impairments, themselves, inevitable, or are they, too, socially constructed? (Part V will address this difficult question.)

Second, the social model does not require a particular policy response. While the social model suggests that disability should be gotten rid of, it does not suggest how. So long as the policy response is not itself disabling — that is, so long it does not perpetuate disadvantage — anything goes. Cures and treatments, for example, are not necessarily “disabling” under the social model. They may, after all, help people overcome certain functional limitations and increase access. Cures and treatments at the expense of everything else, however, may be a different story. There is, of course, no bright-line test — no clear dividing line between “non-disabling” and “disabling” policy responses. Two helpful flashpoints are stigma and dependence: policy responses are likely disabling when their purported benefits are outweighed by the stigma they cause or the autonomy they deprive.

99 See Bradley Areheart, Trouble, Yale Law & Policy Review at 5 (2011) (“[T]he social model – by relying on a binary division between social disablement and physiological impairment – unwittingly underscores the notion that disability has a biological essence... Although the social model was formulated to indicate disability’s constructed nature, it inadvertently reifies the idea that disability is built upon non-social, biological, and essential facts.”).
100 See id. at 5.
101 See id. at 11-12
102 See supra note 71 and accompanying text.
103 See supra note 69 and accompanying text. A more non-committal version of the social model might hold that, while disability is a bad thing, we cannot do anything about it. See HACKING, supra note, at 20 (discussing “ironic” social constructionism).
104 See supra note 78 and accompanying text.
105 See BAGENSTOS, CONTRADICTIONS, supra note, at 18-19 (discussing dependency and stigmatization under social model).
IV. AUTISM AND DISABILITY

Under the social-vs.-medical model binary, one can make easy work of the Autism debate. By celebrating Autistic strengths and rejecting cures and treatments, one might say, the Neurodiversity Movement advances a social model of disability and is therefore “right.” Conversely, the parents of Autistic children who regard Autism as tragedy and seek cures and treatments advance a medical model of disability and are therefore “wrong.”

But this strong binary between the medical and social models is too facile. The medical model of disability is far weaker than often portrayed: it is a descriptive device used by social constructionists to describe what disables; it is not an opposing theoretical model for understanding disability. The social model of disability, on the other hand, is far more moderate than often portrayed: it not only acknowledges the reality of impairment but also permits a host of different policy responses (from civil rights interventions to medical ones) or no response at all. There is no binary: disability is a social construction, it turns out, and the “medical model” is just the name we give to those practices and institutions that disable.

At issue in the Autism war is whether parents’ pursuit of cures and treatment for their Autistic children perpetuates (socially-constructed) disability. Making this determination is no easy feat – there is much gray here. A closer look at Autism’s warring sides reveals why parents who seek to defeat Autism through cures and treatment do not necessarily “disable” their children, and why they may in fact be on the same side of “disability” as Autistic adults.

A. Defeating Autism

For many families, particularly those whose Autistic children have profound functional limitations, the challenges of Autism can be overwhelming. For them, “the search for cures, or at least, for more effective treatments, is a clear consensus.” Many choose the path of conventional medicine, while others pursue an alternative course. Because both paths seek to treat and, ultimately, defeat Autism, one might say they are per se disabling (“medical model”). The reality is more complicated.

1. “Autism as Puzzle”: Mainstream Medicine and Autism Research

For parents who subscribe to conventional medicine, Autism is a puzzle, its cause(s) and cure unknown. As a result, research is a top priority. While Autism research still has a very long way to go, it has made some headway in recent years. For example, research in genetics, namely, family and twin studies and the recognition of the coexistence of Autism with a number
of genetic disorders, points to a substantial genetic contribution to Autism.\textsuperscript{112} Research in neuroscience, including post-mortem studies and brain imaging, has “attempted to identify distinctive anatomical, physiological and biochemical features of the ‘autistic brain,’”\textsuperscript{113} while psychological research has “clarified some of the distinctive characteristics of autistic thought and behaviour.”\textsuperscript{114} Many in the medical mainstream believe that “it is only a matter of time before the key links in the causal chain extending from genes through the brain to autistic mind are identified – and therapeutic interventions discovered.”\textsuperscript{115}

Medical research into Autism raises a multitude of ethical concerns that may or may not give rise to disability.\textsuperscript{116} This subpart will discuss the ethical concerns that arise with respect to one of the uses to which medical research is put (prenatal testing an embryo selection) and some of the methods used to fund it (Autism Speaks’ fundraising tactics).

\textit{(a) Prenatal Testing and Embryo Selection}

Mainstream science points to “a strong and unambiguous genetic component [to Autism] that may explain as much as 80%-90% of the risk for autism.”\textsuperscript{117} It also suggests that a number of different genes may be at work, with estimates ranging from 10 to 100.\textsuperscript{118} “Notwithstanding the slow and, at times, frustrating progress in characterizing the genetic factors contributing to autism, many scientific experts in the field are optimistic that clinically useful genetic markers of autism have been, or will soon be, identified as a result of new genetic technologies and increased funding of research.”\textsuperscript{119}

While cure and treatment of Autism are among the goals of genetic research, another goal will inevitably be prevention, that is, “prenatal tests and embryo selection techniques that inform prospective parents about future children.”\textsuperscript{120} Although some prospective parents “will seek out information yielded by the tests even if they intend to continue a pregnancy regardless of the finding,” many more will use this information “to decide whether to carry a particular fetus to term.”\textsuperscript{121} Down Syndrome is a case in point: about ninety percent of pregnancies testing positive for the condition are terminated.\textsuperscript{122}

\textsuperscript{112} See FITZPATRICK, supra note, at 78 (stating that 10% of Autism cases coexist with other known genetic conditions, such as Down’s Syndrome, and that in 90% of cases involving identical twins, both have Autism, as opposed to only 5% of cases involving non-identical twins).
\textsuperscript{113} Id. at 8; see also SIMON BARON-COHEN, THE ESSENTIAL DIFFERENCE: THE TRUTH ABOUT THE FEMALE AND MALE BRAIN 137 (“There is evidence of brain dysfunction (such as epilepsy) in a proportion of cases. There is also evidence of structural and functional differences in regions of the brain (such as the amygdala being abnormal in size, and less responsive to emotional cues.”).
\textsuperscript{114} FITZPATRICK, supra note, at 9.
\textsuperscript{115} FITZPATRICK, supra note, at 9.
\textsuperscript{117} Marchant & Robert, supra note, at 204-05.
\textsuperscript{118} Id. at 213.
\textsuperscript{119} Id. at 215.
\textsuperscript{121} Id. at 336.
This raises several ethical concerns, some common to conditions with a genetic component, others unique to Autism. First, having the gene or genes at issue does not mean having Autism – susceptibility is not the same as certainty.\textsuperscript{123} “Not every child carrying an autism predisposing gene will develop autism . . . Like many complex diseases, autism appears to result from an interaction of environmental and genetic factors.”\textsuperscript{124} But “[p]eople often misunderstand the nature of their genetic data, believing that a genetic predisposition necessarily results in the development of their illness.”\textsuperscript{125} Given these difficulties in comprehension, how informed should parental consent be? Should doctors and other medical professionals be required to counsel parents in the myriad ways that the life of an Autistic child may resemble those of his or her peers, “focusing on capacities for education, stimulation, play, and relationships,” or in the ways that Autistic life may be different but nevertheless fulfilling?\textsuperscript{126} Furthermore, “[a]s with any genetic test, some level of false positives are to be expected.”\textsuperscript{127} Does the risk of having a child with Autism outweigh the risk of terminating a non-Autistic pregnancy or not proceeding with the implantation of a non-Autistic embryo?

Second, when it comes to Autism, parents’ uncertainty is compounded because Autism is not a single, uniform condition – it is extremely variable.\textsuperscript{128} Even if parents know that their unborn child will have a substantial likelihood of developing Autism because of this or that gene, doctors may not be able to tell them what form that Autism may take.\textsuperscript{129} Is it the non-verbal child they do not wish to bear, or the verbal but socially awkward one? And if research progresses to a point where doctors do know, are they obligated to tell parents everything they know, or will mainstream medicine draw a line, informing parents of only certain kinds of Autism?\textsuperscript{130}

Lastly, even assuming that consent is informed and the form of Autism susceptibility is reasonably certain, what impact will prenatal testing and embryo selection have on Autistic people’s and others’ views of their inherent worth as human beings?\textsuperscript{131} Can these genetic procedures “comfortably coexist with society’s professed goals of promoting inclusion and equality for people with disabilities”\textsuperscript{132} As Professor Adrienne Asch explains, singling out particular impairments, or certain variants of those impairments, for testing is tricky business because it inevitably stigmatizes those on the “list”:

\begin{quote}
[C]reating an official list of conditions that parents should worry about will have an undesirable effect on the societal acceptance and self-esteem of those with the
\end{quote}

\begin{footnotes}
\item \textsuperscript{123} See Marchant & Robert, \emph{supra} note, at 220.
\item \textsuperscript{124} \emph{Id.} at 229.
\item \textsuperscript{125} \emph{Id.} at 220.
\item \textsuperscript{126} Asch, \emph{supra} note, at 334.
\item \textsuperscript{127} Marchant & Robert, \emph{supra} note, at 229.
\item \textsuperscript{128} See \emph{supra} note 33 and accompanying text.
\item \textsuperscript{129} Marchant & Robert, \emph{supra} note, at 220, 233 (discussing “infeasibility of an accurate prenatal test given the genetic heterogeneity and variable expression of autistic disorders”).
\item \textsuperscript{130} See \emph{id.} at 220; see also Asch, \emph{supra} note, at 338-39 (discussing ethical concerns with clinicians’ decision to inform prospective parents of susceptibility to some impairments but not others).
\item \textsuperscript{131} See Marchant & Robert, \emph{supra} note, at 232.
\item \textsuperscript{132} Asch, \emph{supra} note, at 315.
\end{footnotes}
listed conditions. Why should it be acceptable to avoid some characteristics and not others? How can the society make lists of acceptable and unacceptable tests and still maintain that only disabling traits, and not people who live with those traits, are to be avoided? If it is legitimate to be a person with a disability, or to parent a child with such a disabling condition, should the society make a list of “serious” and “trivial” characteristics?¹³³

Many in the Autism community argue against genetic research, or at least suggest that such research proceed with caution.¹³⁴ Ari Ne’eman, a member of the President’s National Council on Disability and Founding President of the Autism Self-Advocacy Network (ASAN), a “non-profit organization run by and for Autistic people,”¹³⁵ sees “serious problems with taxpayer and well-meaning charitable funds going toward [genetic] research” and stresses that “not every dollar given toward autism causes is helpful to autistic people.”¹³⁶ Professor Simon Baron-Cohen, director of Cambridge University’s Autism Research Centre, likewise warns of genetic research’s unintended consequences: “[c]aution is needed before scientists embrace prenatal testing so that we do not inadvertently repeat the history of eugenics or inadvertently ‘cure’ not just autism but the associated talents that are not in need of treatment.”¹³⁷

(b) “You are Scared, and You Should be”: Fundraising for Autism Research

Autism Speaks, founded in 2005, is the nation’s “largest autism science and advocacy organization.”¹³⁸ Like many advocacy organizations, Autism Speaks raises funds by raising public awareness: from lobbying for federal monies on Capitol Hill to soliciting major gifts from corporate and private donors; from organizing local fundraising events like Walk Now for Autism Speaks across the country to establishing the United Nations-sanctioned World Autism Awareness Day on April 2; and from launching national media campaigns about Autism to recruiting celebrity spokespeople.¹³⁹ Autism Speaks has something to show for all of this. In 2005, only $15 million in privately raised funds went to Autism. Since that time, Autism Speaks has committed “over $142.5 million to research through 2014.”¹⁴⁰

Autism Speaks’ advocacy efforts have also helped to expand federal funding of Autism research. Following on the heels of the Children’s Health Act of 2000, which, among other things,

¹³³ Id. at 339.
¹³⁶ Solomon, supra note.
required the National Institutes of Health to “expand, intensify, and coordinate” research on Autism:\footnote{141}:

\begin{quote}
[t]he 2006 Combating Autism Act (CAA) . . . provided for approximately $950 million in spending on autism over five years among research and other programs, and was subsequently funded accordingly. . . . In President Obama’s 2011 budget proposal, overall federal research and development funding is set to decline slightly from 2010 levels, but funding for autism research is actually set to increase.\footnote{142}
\end{quote}

In raising awareness about Autism, Autism Speaks emphasizes the need to find a cure for Autism. This goal, of course, carries with it the implicit, but nevertheless powerful, message that Autism “is unacceptable; a cure must be found,” and that anyone living with Autism “should not be content with her current condition.”\footnote{143} But Autism Speaks’ awareness campaigns are not always so subtle. Time-tested pity and fear tactics are hallmarks of its advocacy,\footnote{144} and have drawn the ire of many in the Autism and broader disability community.

In 2009, Autism Speaks unveiled its “I am Autism” video at the second annual United Nations World Focus on Autism.\footnote{145} The video features black-and-white footage of Autistic children alone, and the sinister-sounding,\footnote{146} anthropomorphized voice of Autism, stating:

\begin{quote}
I am autism. I’m visible in your children, but if I can help it, I am invisible to you until it’s too late. I know where you live, and guess what? I live there too. I hover around all of you. I know no color barrier, no religion, no morality, no currency. I speak your language fluently, and with every voice I take away, I acquire yet another language. I work very quickly. I work faster than pediatric AIDS, cancer, and diabetes combined. And if you are happily married, I will make sure that your marriage fails. Your money will fall into my hands, and I will bankrupt you for my own self-gain. I don’t sleep, so I make sure you don’t either. I will make it virtually impossible for your family to easily attend a temple, a birthday party, a public park, without a struggle, without embarrassment, without pain. You have no cure for me. Your scientists don’t have the resources, and I relish their desperation. Your neighbors are happier to pretend that I don’t exist, of course, until it’s their child. I am autism. I have no interest in right or wrong. I derive great pleasure out of your loneliness. I will
\end{quote}

\footnote{141}{42 U.S.C. § 284g.}
\footnote{142}{Caruso, \textit{supra} note, at 493 (emphasis added).}
\footnote{143}{Areheart, \textit{Goldilocks, supra} note, at 204 (discussing cures generally).
\footnote{144}{\textit{See} OLIVER, \textit{POLITICS, supra} note, at 93 (stating that the “prime objective” of many disability advocacy organizations “is to maximize income, regardless of the image presented,” and that many organizations “are quite shameless in the way they reinforce the image” of disabled people as “burdens of charity . . . through their fund-raising campaigns.”).
\footnote{146}{The video was created by Academy Award-nominated director Alfonso Cuarón, director of the third Harry Potter installment. \textit{Id.}; Biography for Alfonso Cuarón, THE INTERNET MOVIE DATABASE (IMDb), http://www.imdb.com/name/nm0190859/bio.}
fight to take away your hope. I will plot to rob you of your children and your dreams. I will make sure that every day you wake up, you will cry, wondering ‘who will take care of my child after I die?’ And the truth is, I am still winning, and you are scared, and you should be. I am autism. You ignored me. That was a mistake.\textsuperscript{147}

The second half of the video features color footage of the parents of Autistic children speaking out against Autism:

We will spend every waking hour trying to weaken you. . . . We search with technology . . . and voodoo . . . prayer and . . . herbs . . . genetic studies . . . We speak the only language that matters: Love for our children. Autism is naive. You are alone. You think that because some of our children cannot speak, we cannot hear them? That is autism’s weakness. You think that because my child lives behind a wall, I am afraid to knock it down with my bare hands? Autism, if you are not scared, you should be. When you came for my child, you forgot: You came for me.\textsuperscript{148}

The video ends with footage of Autistic children smiling with their families (but not speaking).

The “I am Autism” video sparked an immediate outcry from many in the Autism and broader disability communities. In an open letter to the sponsors, donors, and supporters of Autism Speaks, then-ASAN President Ari Ne’eman and over 30 international, national, and local disability advocacy groups, called for an end to support for Autism Speaks.\textsuperscript{149} Specifically, ASAN charged Autism Speaks with “us[ing] damaging and offensive fundraising tactics which rely on fear [and] stereotypes,” thereby “devaluing the lives” of the very people for whom they purport to speak.\textsuperscript{150} According to ASAN,

Contrary to the ‘I am Autism’ video, which equates autism with AIDS and Cancer, autism is not a terminal disease. It is a disability, one that comes with significant challenges in a wide variety of realms. Yet the answer to those challenges is not to create a world in which people are afraid of people on the autism spectrum. . . . It is to work to create a society that recognizes the civil rights of Autistic people and others with disabilities. It is to work to create a world in which people with disabilities can benefit from the supports, the services and the educational tools necessary to empower them to be full citizens in society.\textsuperscript{151}

\begin{footnotesize}
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\item \textsuperscript{147} Horrific Autism Speaks “I am Autism” Ad Transcript, THE AUTISTIC SELF ADVOCACY NETWORK (ASAN) (Sept. 23, 2009), http://www.autisticadvocacy.org/modules/smartsection/item.php?itemid=58. While the video is no longer available on Youtube, several Autistic parodies are. E.g., ooohprettycolors, I Am Autism, YOUTUBE (Sept. 27, 2009), http://www.youtube.com/watch?v=a4IKKlOnx_I.
\item \textsuperscript{148} Horrific Autism Speaks “I am Autism” Ad Transcript, supra note.
\item Id.
\item Id.
\end{enumerate}
\end{footnotesize}
ASAN called the video the most recent offense in a “pattern of unethical behavior” that uses the theme of “fear, pity and prejudice” to advance a misguided agenda.152 A prior series of Autism Speaks Public Service Announcements compared “having a child on the autism spectrum to having a child caught in a fatal car accident or struck by lightning,”153 and in a 2005 Autism Speaks fundraising film, the then-senior Vice President of Autism Speaks told of how she once contemplated placing her Autistic daughter “in the car and driving off the George Washington Bridge.”154

The ASAN letter also charged Autism Speaks with undermining the autonomy of Autistic people by failing to prioritize social services and change its governance structure.155 The letter noted that Autism Speaks devotes only a small amount of its budget (4%) toward researching and providing social and educational supports for Autistic people, while spending the bulk of its budget (65%) on genetic and biomedical research, “including the prospect of prenatal testing.”156 Autism Speaks’ ‘refus[al] to include any individual with the disability they purport to serve on their board of directors or at any point in their leadership and decision-making processes,” the letter further stated, is “deeply unrepresentative and out of step with the mainstream of the disability non-profit community.”157

Echoing the sentiments raised in ASAN’s letter, many in the Autism community lamented Autism Speaks’ depiction of Autism as “devil personified,”158 and warned against conflating Autistic children’s’ actual experience with parents’ despairing perceptions of that experience.159 Others noted that Autism Speaks’ video was particularly objectionable given its close similarities to New York University Child Study Center’s 2006 Autism Ransom Note ad campaign, which was widely denounced by the Autism community and was withdrawn just three weeks after it began.160 That campaign featured advertisements in the form of ransom notes, one of which read, “We have your son. We will make sure he will not be able to care for himself or interact socially as long as he lives. This is only the beginning.” It was signed, “Autism.”161 Another

152 Id.
153 FITZPATRICK, supra note, at 47.
155 ASAN Letter, supra note.
156 Id.
157 Id.
160 See When Will They Listen?, CLUB 166 (Sept. 23, 2009 4:06 AM), http://club166.blogspot.com/2009/09/when-will-they-listen.html; see also Solomon, supra note (discussing NYU 2006 ransom note campaign).
161 Solomon, supra note.
read, “We have your son. We are destroying his ability for social interaction and driving him into a life of complete isolation. It’s up to you now.” It was signed, “Asperger Syndrome.”

2. “Autism as Toxic”: Alternative Medicine and Chelation

All of the research in the world is of little comfort to overwhelmed parents who want help for their children now. With no cure in sight, many parents attempt to modify their children’s undesirable behavior through a variety of therapeutic interventions. Some of these interventions are conventional, like the prescription of stimulants such as Ritalin, antidepressants such as Prozac, and anti-anxiety agents such as Buspar, while others fall into the alternative or “biomedical” camp.

For many parents who turn to biomedical interventions, Autism is an epidemic and time is of the essence. Some blog about “hating Autism” and convey their level of disdain through metaphor, comparing Autism to a “beast’s shadow” under which they live, a stealer of souls, an alien abductor, and a condition that “relentlessly sucks life’s marrow out of the family members one by one.”

Because mainstream medicine offers few answers and little hope in the short-term, parents who pursue biomedical interventions are oftentimes distrustful of, and even openly hostile toward, mainstream medicine. In particular, these parents are dismissive of mainstream medicine’s focus on the role that genetics plays in Autism. For them, it is our toxic environment – not some unidentified, genetic defect, perhaps conferring susceptibility to some unknown environmental agent – that is to blame for Autism. And that means hope, for if we can identify the environmental factor or factors that cause Autism, we can prevent Autism, treat it, and maybe even cure it.

For these parents, potential environmental culprits are everywhere: in the food we eat (e.g., pesticides, MSG); in the medication we take and medical procedures we undergo (e.g., vaccines, antibiotics, reproductive and hormonal drugs, prenatal ultrasounds, early clamping.

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162 Id.
163 NADESAN, supra note, at 194.
164 Id.
165 FITZPATRICK, supra note, at 11.
166 Id. at 15.
167 Foresam (John Best), HATING AUTISM BLOG, http://hatingautism.blogspot.com/?zx=3bae7ade4c48a8be.
168 FITZPATRICK, supra note, at 43-44; see also Hacking, Aliens, at 50 (“‘I want my grandson back!’ The metaphor of abduction feels overpowering to some families; a baby that was a lovely human being has disappeared.”) (quoting the CEO of NBC Universal and grandfather of Autistic child).
169 See NADESAN, supra note, at 194.
170 FITZPATRICK, supra note, at 11.
171 See id. at 9, 19-22, 84-87; see also Caruso, supra note, at 496 (discussing biomedical movement).
172 See FITZPATRICK, supra note, at xv.
173 “Autistic symptoms often become visible at age 18 months, exactly when children are routinely vaccinated against measles mumps, and rubella.” Caruso, supra note, at 501-02. According to anti-vaccine advocates, the measles-mumps-rubella (MMR) vaccine, in combination with several vaccines containing the mercury-based preservative thimerosol, can damage a “child’s immune system, resulting in an immune deficiency that prevent[s] her from being able to clear from her body the measles virus contained in the MMR.” John Thomas, Paranoia Strikes Deep: MMR Vaccine and Autism, PSYCHIATRIC TIMES, Mar. 5, 2010,
of the umbilical cord); in the technology we use for work and play (Television, WiFi); in the sounds we hear (e.g., mechanically-generated noise); and in the air we breathe, the water we drink, the ground we walk on, and the energy we produce (e.g., electromagnetic and nuclear radiation, chemical waste, heavy metal residues).

All have been blamed for causing Autism. Given the breadth of potential causes, potential remedies run the gamut: from special diets (e.g., wheat-free/dairy-free), supplements (e.g., vitamins, amino acids), and medication (antibiotics, anti-fungals, anti-inflammatories); to medical procedures aimed at extracting toxic metals from the blood (chelation), stimulating blood-vessel formation (stem cell therapy), and improving blood circulation (hyperbaric oxygen therapy); to much-publicized anti-vaccine campaigns.

The efficacy of biomedical interventions is debatable. While many supporters of biomedical interventions claim that Autism is not only treatable but also curable by this or that intervention, the studies upon which they rely generally have numerous “methodological defects that render their conclusions unreliable.” These defects, together with Autism’s variability among individuals, Autism’s evolution over the lifetime of each individual, and “the difficulty in isolating the effects of any particular intervention from the range of other” interventions that a child may be receiving, make it difficult to draw solid conclusions about which interventions work.

The safety of biomedical interventions is also debatable. While “biomedical diets and supplements, though not without some risks, do not raise major concerns about safety,” the same is not true for medications, which “are no safer in the hands of biomedical practitioners than they are in those of mainstream doctors,” and for certain medical procedures advocated by the biomedical movement. Chelation is a case in point.

On July 22, 2005, Marwa Nadama, the mother of a five-year-old Autistic boy named Abubakar Tariq, took her son to Advance Integrative Medicine, Inc. in Pennsylvania for biomedical treatment. Dr. Roy Kerry determined that Tariq’s treatment would include the use of chelation therapy, which involves the “administration of a synthetic chemical solution which is designed to extract certain heavy metals from the body, the theory being that such heavy metals contribute to a variety of illnesses including autism.”

First used during the First World War to treat victims of poison gas, chelation therapy has achieved prominence among alternative health practitioners in recent decades as a treatment for medical and psychiatric disorders attributed to environmental toxins, as well as for coronary heart disease.

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174 See FITZPATRICK, supra note, at 19-22, 84-87; see also Marchant, supra note, at 216 (discussing suspected environmental causes of Autism).
175 FITZPATRICK, supra note, at 115, 131.
176 Id. at 131 (stating that “[m]ost interventions are endorsed by small studies, carried out by sympathetic researchers in collaboration with supportive parents, using biased methods of selection, subjective measures of outcome, lacking in control groups and ‘blinding’ procedures . . .”).
177 FITZPATRICK, supra note, at 131-32.
178 Id. at 132.
180 FITZPATRICK, supra note, at 5.
is caused by vaccines containing mercury has become increasingly popular, practitioners have begun to offer chelation as a treatment for autistic children, using a wide variety of agents, in oral, injectable or even transdermal forms. 181

Dr. Kerry prescribed a series of treatments involving the IV administration of disodium EDTA, the chelator agent commonly used to treat heart disease and known to carry a risk of irregular heart rhythms, seizures, and even death. 182 The first and second administrations occurred in July and early August, respectively, without incident – although Tariq had to be restrained by four adults using a “papoose board,” which is “a flat wooden board with attached straps which are wrapped around the child’s body and limbs to prevent struggling during treatment.” 183 On August 23, 2005, shortly after the administration of the third treatment, “Tariq Nadama went into cardiac arrest. CPR and chest compression were given, but the child could not be revived... [and] was pronounced dead shortly after arriving at the hospital.” 184

News of Tariq Nadama’s death ignited a firestorm of debate in the world of Autism. Biomedical advocates defended the safety and efficacy of chelation therapy and asserted that “the boy’s death resulted, quite simply, from a drug error” – Dr. Kerry had used the wrong drug. 185 Many adult Autistics blasted back, calling Tariq’s death “tragic, needless,” and the consequence of “the whole ‘cure’ mentality. It creates a dynamic in which nearly any risk is acceptable in fighting autism, because living with autism, as they see it, is a fate even worse than death.” 186

And the war goes on. “In 2008, a study evaluating the quality of research on various autism treatments gave chelation the lowest possible grade, saying there are no controlled trials on the safety and effectiveness of chelation as an autism treatment. That same year, the National Institutes of Health canceled plans to run a clinical trial on chelation for the treatment of autism in children, saying the risks outweighed any potential benefit.” 187 And in October 2010, the Food and Drug Administration issued letters warning several companies that it is a violation of the law to market over-the-counter chelation products. 188 In those letters, the FDA noted that chelation’s efficacy in treating autism and other conditions is “unsubstantiated,” and that there are “serious safety issues associated with chelation products, which can alter the levels of certain substances in the blood... [and] cause serious harm, including dehydration, kidney failure, and

181 Id.
182 Id.
183 Id. at 3.
184 Nadama Complaint, supra note, at para. 18.
185 Dr. Bernard Rimland, Chelation: The Story Behind the Headlines, 19 AUTISM RES. REV. INT’L, no. 3, 2005 at 3.
186 FITZPATRICK, supra note, at 8 (quoting Autistic blogger, Joe Klein).
Nevertheless, many children each year continue to receive chelation therapy as biomedical advocates champion its safety and efficacy.

B. “Autism as Way of Being”: Neurodiversity and Applied Behavioral Analysis

The Neurodiversity (or “Autism Rights”) Movement originated in the 1990’s in response to the dominant conception of Autism as a disorder, and consists primarily of (generally high-functioning) Autistic adults and their families. As epitomized by Jim Sinclair’s “Don’t Mourn for Us,” the Neurodiversity Movement’s central claim is that Autism is not a disorder but a way of being or, more specifically, a “different” way of being, of thinking, of behaving. As such, the Neurodiversity Movement focuses on “acceptance and even admiration for autism’s most appealing traits, which range from savant-like musicality to a philosophical detachment from most mundane matters.”

With the Internet as their “sign language” or “prosthetic limb,” Autistic people “are beginning to see themselves not as blighted individuals, but as a different ethnicity. In a sense, autistics are constituting themselves as a new immigrant group online, sailing to strange neurological shores on the Internet.” Autistic websites proclaim Bill Gates, Albert Einstein, and Andy Warhol as “closet aspies” (i.e., they have or had, as the case may be, undiagnosed Asperger’s Syndrome), and have even coined a term for non-Autistics: NTs (“neurotypicals”). Beyond the blogosphere, Hollywood, television, radio, literature, and outspoken Autistic people like Temple Grandin have popularized Autistic people’s contributions to math, science, and

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189 Id.
190 See The Safety and Efficacy of Chelation Therapy in Autism, AUTISM RESEARCH INSTITUTE (Mar., 2006), http://www.autism.com/pro_chelationsafety.asp (“Tens of thousands of children and hundreds of thousands of adults have been treated safely with chelation therapy for many decades.”).
191 See Solomon, supra note; see also Caruso, supra note, at 495 (discussing Neurodiversity Movement). The Neurodiversity Movement does not represent the experience of all Autistic adults, of course. See Baron-Cohen, supra note, at 145-46 (“Do I wish I hadn’t been born with [Asperger’s]? Yes, I hate my [Asperger’s], and if I could be rid of it I would. . . . Every day is like climbing Mount Everest in lead boots, covered in molasses. Every step in every part of my life is a struggle.”) (quoting Autistic adults). Interestingly, the Neurodiversity Movement is not limited to those who communicate verbally. See Sanjay Gupta, Behind the Veil of Autism, CNN.COM, http://www.cnn.com/HEALTH/blogs/paging.dr.gupta/2007/02/behind-veil-of-autism.html (interviewing Autism rights activist, Amanda Baggs, who communicates through computer and voice synthesizer).
193 Caruso, supra note, at 495.
194 Judy Singer, “Why Can’t You be Normal for Once in Your Life?” From a “Problem with No Name” to the Emergence of a New Category of Difference, in DISABILITY DISCOURSE 59, 67 (Mairian Corker & Sally French eds., 1999) (quoting Harvey Blume).
195 Solomon, supra note.
196 Singer, supra note, at 67 (quoting Harvey Blume); see also Hacking, Aliens, supra note, at 56 (“In retrospect, we shall almost certainly see today’s Internet as making possible a form of life in which autistic people can thrive. It is precisely the medium that does not depend on body language or eye contact. . . .”)
197 See NADESAN, supra note, at 199; see also Hacking, Aliens, supra note, at 46 (“Members of [the Neurodiversity Movement] . . . agree that autism is a neurological condition, but so, after all, is the state of what they call neurotypicals. . . . The Neurodiversity movement rejects the idea that there is a neuro-normality.”).
Magazines like Wired and Time have called Asperger’s the “Geek Syndrome” and credited Autistic people with being the “dreamers and architects of our technological future.” And academia has also weighed in, with anthropologists, psychologists, philosophers, sociologists, historians, and others pointing to Autistic features as “a different kind of intelligence” or “essence,” an expression of the glory of the human brain, in itself an unimaginably complex symphony, “an overexpression of the very traits that make our species unique,” a “ray of light,” and even “a unique, masculine cognitive style.”

While celebrating Autistic differences, the Neurodiversity Movement does not deny Autism’s genetic roots, biological components, and sometimes troublesome features (e.g., self-injurious behavior). Instead, the Neurodiversity Movement points to these biogenetic differences as “qualitatively different, rather than deficient, from typical minds,” and characterizes Autism’s troubling features as “defense strategies mounted by the autistic mind” to cope with a non-Autistic world. Both the Autism Self-Advocacy Network (ASAN) and Autism Network International (ANI), for example, are dedicated to providing support services to Autistic people to help them “compensate, navigate, and function in the world,” but are respectful of “characteristically autistic styles of relating to others” and eschew “changing [Autistic people] into non-autistic people.”

The Neurodiversity Movement’s distinction between difference and disorder is a somewhat vague one, but talk of cures and therapy for Autism brings the distinction into focus. Generally speaking, the Neurodiversity Movement opposes research that seeks to eradicate Autism and therapies that “normalize” children at the expense of valued Autistic traits. Nowhere is this opposition more pronounced than in the area of intensive behavioral therapy.

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198 See NADESAN, supra note, at 205.
199 Steve Silberman, The Geek Syndrome, WIRED, Dec. 2001, available at http://www.wired.com/wired/archive/9.12/aspergers_pr.html; see also Andrew Watts, Traits, Diagnosis, and Social Aspects of Asperger Syndrome (April 1999), http://srl2.tripod.com/andrew/asperger.htm (“An interesting and positive trait that people with Asperger Syndrome have is that they develop unique interests and become highly intelligent especially in their main area of interest[,] . . . may include topics in astronomy, classification of plants and animals, memorization of train schedules and other obscure but intriguing topics.”).
200 Baron-Cohen, supra note, at 149 (echoing findings of Austrian psychiatrist Hans Asperger, who called “[t]he autistic personality . . . an extreme variant of male intelligence”). “Autism spectrum conditions . . . appear to affect males far more often than females. In people diagnosed with high-functioning autism or [Asperger’s], the sex ratio is at least ten males to every female.” Id. at 137.
201 NADESAN, supra note, at 207.
202 GRINKER, supra note, at 280.
203 Paul Collins, NOT EVEN WRONG: ADVENTURES IN AUTISM _ (2011). According to Collins, “autism . . . is as much about what is abundant as what is missing . . . Other animals are social, but only humans are capable of abstract logic. The autistic outhuman the humans, and we can scarcely recognize the result.” Id.
204 Hacking, Aliens, supra note, at 45.
205 NADESAN, supra note, at 200.
206 NADESAN, supra note, at 207.
207 Id. at 206
208 Id. (quoting ANI).
209 See NADESAN, supra note, at 208-09.
210 NADESAN, supra note, at 206-08; see also Burgdorf, supra note, at 327 (“Because of such positive aspects, many people with Asperger's live satisfying lives and would not choose to give up the advantages for the disadvantages if they had the choice.”). The Neurodiversity Movement’s objections to cures and therapy closely parallel those of the
While behavioral therapy has been used for decades to modify undesirable behaviors, Dr. O. Ivar Lovaas is widely credited with having pioneered its use on children with Autism. In 1987, Dr. Lovaas published a report on the use of “Applied Behavioral Analysis (ABA)” therapy on children with Autism, showing improved outcomes in the areas of “compliance, imitation, receptive and expressive language, and peer integration.” Generally speaking, ABA “requires children to engage in very specific responses to one-to-one demands,” and uses “positive reinforcement in the form of rewards (candy, toys, etc.) . . . as the child’s primary motivator. . . .” Because autistic children often resist ABA’s highly structured and disciplined demands, the program tends to be quite intensive in terms of the efforts exerted by autistic children and therapists. Given its purported effectiveness, ABA is now one of the most favored therapies for children with Autism.

Those in the Neurodiversity Movement object to ABA on a number of grounds. These objections were perhaps best articulated by an Autistic woman named Michelle Dawson in a 2004 case before the Supreme Court of Canada, British Columbia v. Auton. At issue in that case was whether Canadian law guaranteed funding for “medically necessary” services and, if so, whether British Columbia’s failure to provide funding for ABA violated Canadian law. In her Intervenor’s Factum, Ms. Dawson argued against medically-required ABA. The court held that Canadian law only guarantees funding for services provided by physicians, and therefore British Columbia’s decision not to fund ABA (which is performed by non-physicians) was within its discretion. Citing Ms. Dawson’s Factum, the Court also noted that ABA “is not uncontroversial,” with objections “ranging from its reliance in its early years on crude and arguably painful stimuli, to its goal of changing the child's mind and personality.”

Ms. Dawson’s Factum begins with the proposition that Autism is a difference to be accepted and even celebrated, not a disorder to be eradicated:
It must be underlined that autism is not a disease . . . [nor is it] a mental illness. . . . Autistic people, like non-autistics, sometimes develop serious physical diseases, and sometimes suffer from mental illness.

... 

No allowance is made by either the parties[1] or the Courts below that “untreated” autistic traits, which result in atypical learning and intelligence, have great benefit both to autistics and to society. The inherent strengths of autistics, based on measurable differences in cognition (perception, attention, memory; and kind, not level, of intelligence) are unavailable to non-autistics, and according to the principles of ABA as well as its practice, are unavailable to treated autistics.

... 

In contrast to the doom painted by the parties for all untreated autistics, autistics are in the workforce, they are in academe, they are parents (often of autistic children), they are artists, architects, engineers, physicists, musicians, and writers. Many have, through the brilliance, innovation, impartiality, persistence, and courage with which they are gifted, disproportionately contributed to the progress and enlightenment of society. \[221\]

Having articulated Autism as a different way of being, Ms. Dawson proceeds to challenge ABA treatment on four primary grounds. First, she argues that it is unethical. \[222\] Like homosexuality and left-handedness, Autism brings with it behaviors considered “odd” or “inappropriate” by many, but they are variations integral to the person. \[223\] By forcing individuals “to lose their autistic nature and traits, and become, or appear to become, indistinguishable from non-autistic [people],” \[224\] ABA seeks to extinguish these variations. Attempting to “treat” Autism through ABA is therefore as wrongheaded as trying to prevent or cure homosexuality (a feat that Dr. Lovaas, himself, attempted to do years earlier through ABA) or left-handedness. \[225\] Even if it were possible to disentangle certain especially troublesome characteristics from exceptional Autistic abilities for purposes of treatment, Dawson questions whether the purported benefits would outweigh the burdens to the child. \[226\] “Many ‘normal’ behaviours may be painful, frightening, or useless to an autistic (i.e. eye contact),” Dawson argues, while “engaging in repetitive behaviour such as arranging objects into neat rows or flapping their hands in front of their eyes” \[227\] may be comforting – a coping strategy mounted by the Autistic mind. \[228\]
Second, Dawson argues that ABA reinforces stigma by depicting Autistic people as non-productive and in need of cure. Quoting the decision of the lower court, Dawson states that, “[t]he basic premise of the parties is that without ‘effective treatment,’ . . . ‘almost all autistic children are doomed to a life of physical, emotional, social, and intellectual isolation and eventual institutionalization – a tragic outcome for the children, their families, and society.’” Dawson counters that successful “untreated” Autistic people are not “freakish oddities,” but are everywhere – living lives filled with “learning, intelligence, achievement, innovation, and autonomy, however atypically,” and “contribut[ing] greatly to society.” By seeking to make Autistic children indistinguishable from the normal majority, ABA is a constant reminder that “an autistic individual’s behaviour, interests and concerns are unacceptable to the majority,” and that “autistic individuals can only be fulfilled (and in fact can only be ‘human’) if they are moulded to meet society’s expectation of what is ‘normal’.”

Third, Dawson stresses the lack of autonomy implicit in the provision of ABA. Because children do not have the capacity to consent to ABA, the decision to receive the therapy falls to parents and their “all too human mixture of emotions and motives,” often in consultation with advocacy organizations that consistently deny the participation of autistics in their governance structures.

Lastly, Dawson argues that by envisioning Autism as a disorder to be eradicated rather than a difference to be accommodated, ABA ignores society’s obligation to fine-tune its structures and assumptions to allow for the meaningful participation of Autistic people. According to Dawson, society does not require Deaf people to obtain treatment (e.g., cochlear implants) to make them non-Deaf; “train them to act like non-Deaf persons”; or tell them that if they do not strive to become non-Deaf, they cannot participate in society. Rather, society accommodates them (for example, through sign-language interpreters). According to Dawson, ABA does not accommodate Autistic differences – it disregards them, “teach[ing] autistics to be ‘normal’ such that they can participate in society by passing as non-autistic.”

C. Autism and Disability

The medical-versus-social model binary, which generally pits medical and social welfare interventions against civil rights interventions, does not hold up. Disability is socially constructed, but it does not deny the inevitability of impairment nor does it dictate policy.
While parents’ focus on cures and treatments can disable (indeed, it can kill), it does not have to.242 The flashpoints are stigma and dependence and, as demonstrated by the Autism war, they are often far from clear.243

For example, notwithstanding fervent opposition from various corners of the Neurodiversity Movement, mainstream medicine’s genetic research into Autism is not necessarily disabling. Even the Neurodiverse acknowledge that Autism presents a host of challenges for Autistic children and their families,244 and genetic research may help meet some of these challenges. Because Autism is currently diagnosed based on behavioral criteria, parents are often unaware that their child is Autistic until the child is 2 or 3 years old.245 Genetic testing may give parents a few months or even a few years’ head start – watching for Autism’s features in a child with a genetic predisposition toward Autism and getting services for their child (and getting themselves educated) sooner rather than later.246 It may also lead to better pharmacological treatments, which are likewise not necessarily disabling.247 With more tailored and effective drugs, an Autistic child might be better able to cope with the stresses of an NT world and, therefore, less likely to be “disabled” by it.

Of course, genetic research also brings with it the prospect of prenatal testing and embryo selection, which is far more problematic.248 While minimizing the number of Autistic people who experience disability is perfectly consistent with the social model, doing so by minimizing the number of Autistic people born may not be. Terminating pregnancies because of a predisposition toward Autism, one might reasonably argue, is itself disabling and therefore out of step with the social model because it sends a message that Autistic lives may not be worth living or may be too great an imposition for families and the rest of society to bear.249

Autism Speaks’ ad campaigns, which paint Autism as a curse and something to be defeated at all costs, present a clearer case of stigmatizing attitudes at odds with the social model.250 While raising money and Autism’s profile is not disabling, doing so at the expense of Autistic people’s dignity is.251 Similarly, while special diets and supplements for “treating” Autism are arguably harmless and not disabling, the same cannot be said for many biomedical interventions.252 Try-anything, kitchen-sink approaches to curing Autism through dubious and even deadly therapeutic

242 See supra notes re: above section
243 See supra note 105 and accompanying text.
244 See ASAN Letter (stating that “[Autism] comes with significant challenges in a wide variety of realms”).
245 Centers for Disease Control and Prevention, Autism Spectrum Disorders (ASDs), Screening and Diagnosis, at (“By age 2, a diagnosis [of Autism] by an experienced professional can be considered very reliable. However, many children do not receive a final diagnosis until much older.”).
248 See supra note 133-38 and accompanying text.
249 See Asch, supra note, at 315 (“As currently practiced and justified, prenatal testing and embryo selection cannot comfortably coexist with society’s professed goals of promoting inclusion and equality for people with disabilities.”). Prenatal testing gives rise to some of disability’s most vexing questions. For a good introduction to some of these questions, see Bagenstos, CONTRADICTIONS, supra note, at 102-04.
250 See supra notes 141-45 and accompanying text.
251 See supra notes 146-59 and accompanying text.
252 See supra notes 176-84 and accompanying text.

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regimes breed stigma and defy Autistic autonomy. After all, Autism did not kill Tariq Nadama – chelation did. And whether it was the wrong medicine or a wrongheaded treatment, Tariq Nadama did not assume the risk – his parents did. Desperate medical interventions, no matter how well-intended, are inherently “disabling” because they create disadvantage of the highest order: risk of harm to the Autistic person.

ABA is a much closer call. Unlike genetic testing, ABA does not threaten Autistic children’s being, but it may prevent them from “being Autistic” by seeking to erase some of Autism’s unique behavioral features. This may not be such a bad thing. Eliminating self-injurious behaviors, for example, does not seem “disabling” – it helps Autistic people find healthier, self-affirming ways of coping with their world and maximizing their autonomy. Ceding some independence to behavioral therapists in the short-term may be a way of winning back greater independence in the long run. The same may not be true of efforts to curb stimming and other unfiltered expressions of interest and joy that are the mark of Autistic “style.” By suggesting – or, in the case of Auton, requiring – that these behaviors be modified, ABA may stigmatize those who choose to hold onto them.

Furthermore, because the choice to initiate ABA belongs to parents, not Autistic children, autonomy is also an issue. As one ABA advocate said of her verbally-limited Autistic daughter:

If she decides to communicate without speech, that will be her choice, and I would love for her to be capable of such choices. It’s my fantasy that someday my daughter will go to her therapist to say what a terrible mother I was [for] forcing her to do all this ABA. When that happens, I’ll know I succeeded.

But, by that time, it may be too late. According to the Neurodiversity Movement’s critique, ABA disables Autistic people by confusing what is good for parents with what is good for Autistics, undermining the very attributes that society should strive to keep.

V. CONSTRUCTING IMPAIRMENT: PATHOLOGY VS. EXPERIENCE

Disability does not explain the Autism war. Neither side denies the real-life challenges that Autism brings, and both sides advocate policy responses that are not, in and of themselves, disabling. While prenatal testing, embryo selection, and dangerous biomedical interventions may disable, parents’ quest for cures and certain other treatments for Autism (including ABA) might lead to greater independence, and less disability, in the long run. Autistic adults’

253 See supra notes 180-82 and accompanying text.
254 See id.
255 See supra notes 218-36 and accompanying text.
256 See GRINKER, supra note, at 177 (discussing purported benefits of ABA).
257 See NADESAN, supra note, at 192 (discussing ABA’s “tendency to pathologize many characteristically ‘autistic’ behaviors (such as ‘stimming’ and ‘hand-flapping . . . ’)).
258 See supra notes 230-32 and accompanying text.
259 Solomon, supra notes 242-45, 253-54.
260 See Dawson Factum, supra note, at paras. 43-45.
261 See supra notes 242-45, 253-54 and accompanying text.
262 See id.
celebration of Autistic strengths and challenges to social practices that stigmatize or undermine Autistic autonomy is, of course, not disabling either.\textsuperscript{263} As far as disability is concerned, then, the parents of Autistic children and the Neurodiversity Movement may, in fact, be on the same side. Neither side necessarily “disables.” But if disability does not distinguish the two sides in the debate, then what are they fighting about? The answer is that they are not fighting about \textit{disability} at all – they are fighting about impairment. They are fighting about Autism.

According to many parents of Autistic children, Autism is a (as of yet, undiscovered) biological pathology.\textsuperscript{264} The Neurodiversity Movement says, “No, that’s not what Autism is, or that’s not all that Autism is. There is something else – there is the \textit{experience} of having Autism, of being Autistic.”\textsuperscript{265} Here, the debate shifts from the social construction of \textit{disability}, which recognizes impairment as inevitable, to the construction of \textit{impairment}.\textsuperscript{266} According to the Neurodiversity Movement, Autism is itself socially constructed and therefore contingent, not inevitable.\textsuperscript{267} Now this is radical.

\textbf{A. Beyond Diagnosis}

Recent work in disability studies has chronicled how impairment is socially constructed.\textsuperscript{268} As several commentators have noted, impairment is principally identified and described through the practice of medical diagnosis.\textsuperscript{269} Medical diagnosis, they rightly argue, is a social concept in at least two ways.\textsuperscript{270} The first involves the creation of the diagnosis itself – i.e., the historical and political factors leading to the existence or “naming” of an impairment.\textsuperscript{271} For example, protests by gay activists and “the shifting fortunes of various powerful factions within the American Psychiatric Association” led to the elimination of homosexuality as a mental impairment.\textsuperscript{272} Likewise, the naming of deafness, blindness, and mental retardation are social judgments

\begin{itemize}
  \item \textsuperscript{263} See supra notes 192-210 and accompanying text.
  \item \textsuperscript{264} See supra note 24 and accompanying text.
  \item \textsuperscript{265} See supra note 23 and accompanying text.
  \item \textsuperscript{266} See supra notes 100-02 and accompanying text.
  \item \textsuperscript{267} See supra note 23 and accompanying text (describing Autism as “a way of being”).
  \item \textsuperscript{268} See Areheart, \textit{Trouble}, supra note, at 2 (arguing that “impairment – though theorized as biologically asocial – is a social concept”); see also Susan Wendell, \textit{Toward a Feminist Theory of Disability}, in \textbf{THE DISABILITY STUDIES READER} 243 (2003) (arguing that “[t]he idea that there is some universal, perhaps biologically or medically describable paradigm of human physical ability is an illusion”).
  \item \textsuperscript{269} Areheart, \textit{Trouble}, supra note at 12-13; see also \textsc{Herb} Kutchins \& \textsc{Stuart A. Kirk}, \textit{Making Us Crazy: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS} 27 (1997) (discussing DSM’s role in defining mental disorders).
  \item \textsuperscript{270} Areheart, \textit{Trouble}, supra note, at 14; see also Kutchins \& Kirk, supra note, at 27-28, 52-53 (discussing arbitrariness inherent in DSM’s definition of mental disorders, and inability of clinicians to reliably diagnose mental disorders).
  \item \textsuperscript{271} Areheart, \textit{Trouble}, supra note, at 13-14.
  \item \textsuperscript{272} Kutchins \& Kirk, supra note, at 37, 55-56 (“The dispute over the inclusion of homosexuality in DSM was not about research findings. It was a 20-year debate about beliefs and values. Although the professionals who formulated diagnoses couched their arguments in the language of science, the actual influence of empirical data was negligible. More often than not, the issues were settled by political compromises that promoted personal interests.”).
\end{itemize}
The creation (or deletion) of these impairments was not inevitable — it was the product of clinicians, advocates, and others deciding what is “normal” and what is named.  

The second involves the act of diagnosis — i.e., the process by which a person is determined to have an impairment.  

For example, a diagnosis of depression relies on a person’s self-assessment, “which will almost necessarily be informed by social meanings,” together with a clinician’s interpretation of these subjective phenomena to yield a diagnosis.  

Because the naming and act of diagnosis is fraught with contingency, impairment may be said to be socially constructed.  

The social model’s anchor of “impairment,” one might say, is not a “raw, unadulterated biological core.”  

It is contingent.  

This is true so far as it goes, but what about the closer cases where impairment is diagnosed not through a collection of subjective features pathologized by clinicians, but rather through our blood, our genes, our brains, our immune system?  In these types of cases, it seems more difficult to say that impairment is contingent.  Results of blood tests, genetic testing, brain imaging, and CT scans seem awfully inevitable, unaffected by social institutions and practices.  

I want to suggest another way in which impairment is constructed, one with implications for all impairments, including the closer cases.  Drawing on the work of philosopher Ian Hacking, I argue that impairments are constructed, in part, by those classified as having the impairments.  

This argument takes us well beyond the semantics of construction — i.e., how impairment is constructed through naming and diagnosis.  This argument focuses instead on the dynamics of construction — i.e., how impairments (once named and diagnosed) affect, and in turn are affected by, those who are named.  

As Professor Hacking states, “One of the defects of social construction talk is that it suggests a one-way street: society (or some fragment of it) constructs the [impairment] (and that is a bad thing because the [impairment] does not really exist as described, or would not really exist unless

273 See Areheart, Trouble, supra note, at 16-18; see also Lane, supra note, at 177 (1995) (“Research has shown that some children characterized as profoundly hearing impaired can understand words and sentences whereas others do not even detect sound. . . . Likewise . . . the official definition of blindness is based upon a meaningless demarcation among those with severely impaired vision.”) (internal quotation marks omitted).

274 See KUTCHINS & KIRK, supra note, at 37 (“[T]he construction of DSM involved much more than the assembling of scientific conclusions and the making of technical decisions.  It involved negotiating among contending interest groups of theoreticians, researchers, clinicians, hospitals, clinics, and drug companies – and, at times, potential patients.”).

275 See Areheart, Trouble, supra note, at 19.

276 Id.; see also Bernstein, supra note, at http://pn.psychiatryonline.org/content/46/5/7.full?sid=cf7bee48-b91b-4687-88f5-80b7bab5c07b (contrasting diagnosis of mental disorders with “scientifically more mature (some would say less difficult) areas of medicine where diseases are identified by more ‘objectively’ ascertainable abnormalities of anatomy, physiology, or biochemistry and where genetic and environmental etiologies are increasingly certain”).

277 See Areheart, Trouble, supra note, at 13.

278 Id. at 14.

279 See HACKING, supra note, at 121.

280 Id. at 123.
so described)." 281 My argument “suggests a two-way street” by which the meaning of impairment changes, and is changed by, those classified. 282

B. Ideas and Objects

In arguing that impairment is socially constructed by those classified by it, an important distinction must be made. When we say that something is socially constructed (contingent), it is not always clear what that “something” is. According to Professor Hacking, things that are said to be socially constructed include both “objects” in the world, broadly speaking (like people or material things) and “ideas” about those objects (like classifications, kinds, categories, concepts, beliefs, and attitudes). 283 This distinction matters; the answer to the question of whether something – such as “impairment” – is constructed depends on it. Therefore, it is necessary to distinguish between the “idea” of impairment and its referent, the “object” to which that idea refers.

1. Ideas

First consider ideas about objects. These ideas – take classifications (ideas) of people (objects), for instance – do not exist in a vacuum, in solely the “empty space of language.” 284 Instead, they are formed within a social setting, a “matrix” of institutions and practices. 285 This matrix in which ideas are formed is a mosaic; it is a complex of everything from laws, lawyers, court decisions, social workers, advocates, and newspaper articles, to doctors’ offices, schools, health insurance, and fundraisers. 286 Ideas are not inevitable – they are the product of social practices and institutions, and are therefore socially constructed.

As noted above, the classification “disability” (or “disabled person”) is socially constructed – it came about as a result of the disadvantage experienced by people with certain physical or mental impairments. 287 It encompasses the physical and social barriers that exclude people with certain impairments, as well as the laws that arguably contribute to disadvantage and those aimed at remedying it. 288 As Professor Hacking notes, the classification “woman refugee” is likewise constructed – it came about as a result of social events that led women to leave their homes under threat of violence, and includes the laws that recognize these events as grounds for not returning women to their homelands. 289 Similarly, the idea of “the child TV viewer” came about as a result of concerns expressed by researchers over the ills of obesity, poor socialization, and violence attributed to children watching television. 290 And the idea of “child abuse” emerged in the 1950’s when radiologists and pediatricians “decried the evidence they were seeing of parents beating their children,” and when society responded by passing laws forbidding it, hiring social

281 Id. at 116.
282 See id.
283 Id. at 22.
284 Id. at 10, 31.
285 Id. at 10.
286 See id., at 10, 31.
287 See supra notes 55-63 and accompanying text.
288 See infra notes 385-86 and accompanying text.
289 Id. at 10-11.
290 Id. at 26.
workers to investigate it, requiring schoolteachers to report it, and appropriating funds to study and raise awareness about it.\footnote{Lane, supra note, at 172.}

None of these classifications was inevitable. As for “disability,” sidewalks never had to be built without curb cuts; schools never had to deem certain children uneducable; employers never had to refuse to hire certain people based on medical histories; and the medical establishment never had to institutionalize certain people. For “women refugees,” countries could have made any person crossing their borders a citizen with no questions asked, could have found some other way to protect women fleeing their homelands, or could have immediately returned them to their country of origin.\footnote{See HACKING, supra note, at 11.} With respect to “child TV viewers,” researchers could have overlooked TV as a potential culprit for obesity, poor socialization, and violence, or parents could have ignored the purported threat to their children altogether.\footnote{See id. at 26-27.} And as for “child abuse,” pediatricians need never have called attention to unreported healed fractures in the legs and arms of children, and society could have continued to focus on other children’s issues, such as child poverty, infant mortality, child labor, and juvenile delinquency.\footnote{See id. at 134-36.} The ideas of “disability,” “women refugees,” “the child TV viewer,” and “child abuse,” and the matrix of institutions and social practices surrounding them, never had to be, or never had to be quite as they are. In this way, these classifications of people (these ideas about objects) can be said to be socially constructed.

The same might even be said (albeit with more difficulty) of classifications of things other than people. Consider the quark (a fundamental particle of matter). Professor Hacking suggests that a social construction account of the classification “quark” need not deny the existence of fundamental particles of matter.\footnote{See HACKING, supra note, at 70.} Instead, it would argue that the idea or concept of the quark was not inevitable – that “the evolution of physics, including the quark idea, is thoroughly contingent and could have evolved in other ways.”\footnote{See id. at 31.} An equally successful physics could have proceeded in a “non-quarky way” with “different successes evolving in other ways that do not converge on the route that was in fact taken.”\footnote{Id. at 32-33, 70.} The same might also be said for ponies and plutonium: the former might have been classified as a “horse” and the latter, an artificial element, might never have been created at all.

Impairments can be thought of in much the same way. When commentators say that impairments are constructed, they are arguing that classifications like MR (“mental retardation”) and “learning disability” (call them “impairment X”) never had to be.\footnote{See supra notes 266-76 and accompanying text.} The classification “impairment X” was formed within a social setting where certain characteristics were pathologized (named) and applied to people (diagnosed).\footnote{See id.} Clinicians need not have named certain characteristics; or they need not have diagnosed people as they did. As commentators have noted, “social forces effect the conceptualization, recognition and visibility of disorders. A
disorder in one place and at one time is not seen in another . . .”\(^{300}\) The classification “impairment X” is therefore not immune to social events but is instead the upshot of those events – the convergence of clinicians, advocates, health insurance, drug makers, and others who decide what “impairment X” is.\(^{301}\)

The classification “Asperger’s Syndrome” is a good example of the contingency of ideas. According to the proposed DSM-V, Asperger’s will disappear as a diagnosis due to the inexactitude of its current criteria, which have been “used loosely with little agreement” among clinicians.\(^{302}\) But inevitable things do not just disappear – Asperger’s is disappearing because it is contingent.

The classification “Autism” is also contingent. It need never have been named: its higher-functioning manifestations could have remained mere oddities, while its lower-functioning manifestations could have continued to be lumped under “childhood schizophrenia” or MR.\(^{303}\) Furthermore, far from disappearing like Asperger’s, Autism is expanding under the DSM-V and swallowing a number of formerly-named Autistic subtypes along the way.\(^{304}\) Autism’s appearance on the scene and proposed metamorphosis under the DSM-V are contingent.

Importantly, the contingency of “impairment X” does not stop there. The matrix in which “impairment X” derives meaning includes not only those contingent practices and institutions that name and diagnose “impairment X,” but all of those other practices and institutions in the matrix that affect people classified as having “impairment X.”\(^{305}\) It includes those social elements that not only treat people with “impairment X,” but also those that educate, legislate, employ, and entertain them. Therapists and advocates, laws and lawyers, summer camps, job coaches, and popular media – all give “impairment X” its meaning.\(^{306}\) None of these institutions and practices was inevitable.

2. Objects

So classifications of people, and even classifications of things in the natural world, might be said to be socially constructed. This is not that controversial. After all, such classifications are embedded within matrices that include many obvious social elements.\(^{307}\) Through social practices and institutions, these classifications are “debated, assessed, applied, and developed . . .[,] proposed, criticized, entertained, and rejected.”\(^{308}\) In a word, they are contingent.

\(^{300}\) OLIVER, POLITICS, supra note, at 13 (internal quotation marks omitted).

\(^{301}\) See supra note 272 and accompanying text.


\(^{303}\) See GRINKER, supra note, at 157-59.


\(^{305}\) See supra note 282-84 and accompanying text.

\(^{306}\) The ADA, for example, provides antidiscrimination protection only to those with an actual or perceived “impairment.” See 42 U.S.C. § 12102(1); 29 C.F.R. § 1630.2(h) (defining “impairment”).

\(^{307}\) See supra notes 282-284 and accompanying text.

\(^{308}\) HACKING, supra note, at 10, 125.
But now to the root of the matter. What about the things so classified – the things to which the classification refers? The people, the ponies, the pathologies, themselves. Might the point be extended – might the people or the material objects so classified, themselves, also be socially constructed? Or have we at last reached bedrock – those things that are inevitable, that are fixed? According to Professor Hacking, the answer depends on the thing so classified.\[309\]

(a) “Interactive Kinds”: Classifications of People

Classifications of people are “interactive” kinds of classifications.\[310\] These classifications interact with – and influence – the people they classify.\[311\] This is so because people are self-conscious – they are aware of what is said about them, thought about them, and done to them.\[312\] As they move through the matrix of social practices and institutions affecting them, “[p]eople become aware of how they are classified and modify their behavior accordingly.”\[313\] The classification, and the matrix within which that classification gets communicated, “changes how some people feel about themselves, their experiences, and their actions.”\[314\] A person may think of herself as fitting within that classification, may transform the meaning of that classification, or may reject that classification altogether.\[315\] Because she is indirectly affected by that classification, “the individual herself is socially constructed into a certain kind of person.”\[316\] For interactive kinds of classifications, then, it “makes sense to say that the very individuals and their experiences are constructed within the matrix surrounding the classification.”\[317\]

Take the example of an individual “disabled” person. He may internalize the stigma directed toward him and believe himself incapable of doing certain things.\[318\] He may not apply for a job or go to a grocery store because he does not want to “burden” others. Or he may react differently – he may challenge that stigma. He may embrace the term disability. If he uses a wheelchair, he may chain his wheelchair to a bus that is not accessible to him and yell – “Access now!”\[319\] In either case, the classification “disabled” affects him. He has become a “disabled” person.

Consider also an individual woman refugee. Rather than go into hiding, the woman responds to questions and submits paperwork to government officials who literally hold her life in the balance.\[320\] She takes her children to holiday camps for refugee children.\[321\] She works with an

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\[309\] See Hacking, supra note, at 32, 103-05 (distinguishing between indifferent and interactive kinds of classifications).
\[310\] Id. at 103-04.
\[311\] Id.
\[312\] Id. at 31-32, 102-103.
\[313\] Id. at 32 (While “[t]he awareness may be personal, [it] more commonly is an awareness shared and developed within a group of people, embedded in practices and institutions to which they are assigned in virtue of the way in which they are classified”).
\[314\] Id. at 11.
\[315\] Id. at 31.
\[316\] Id. at 11.
\[317\] Id.
\[319\] Cf. To Ride the Public’s Buses: The Fight that Built a Movement _ (Mary Johnson & Barrett Shaw, eds., 2001).
\[320\] See Hacking, supra note, at 10-11.
\[321\] See id.
immigrant advocacy group that helps usher refugees through the residence process. This matrix of institutions and practices affects her, and the classification (embedded in that matrix) affects her. As she interacts with the matrix surrounding the classification “woman refugee,” she is changed by being so classified. She acquires the characteristics of a woman refugee. “By living that life, she evolves, becomes a certain kind of person (a woman refugee).”

The same is also true of the child TV viewer. Reacting to the reported ills of TV watching, parents “begin to interact, on occasion, with their children regarded not as their children but as child viewers.” Parents curtail television-watching and embed parental guidance chips in their TVs. As a result, children may come to see themselves as child viewers and may watch less TV or, in defiance, find ways to watch more. Similarly, after receiving counseling from social workers and even new (foster) parents and homes, children who are abused may come to see themselves not as ordinary children but rather as child abuse survivors. And as for child abusers, they are mentally ill, perpetrators of “the worst possible vice,” and possibly the victims of child abuse themselves.

Importantly, this interaction between idea and object is a two-way street. Just as interactive kinds of classifications may cause people to change how they feel or behave, changes in people may cause classifications to be modified or replaced. What was known about a certain classification of people, for instance, “may become false because people of that kind have changed in virtue of how they have been classified, what they believe about themselves, or because of how they have been treated as so classified. There is a looping effect.” As a result, classifications of people are not static – they are on the move. “Disabled” may come to mean “activist”; “woman refugee” may come to mean “patriot.”

(b) “Indifferent Kinds”: Classifications of Material Things

Classifications of people are “interactive kinds” of classifications: they interact with the people they classify. But what about those classifications that do not involve interactions with the thing so classified, like classifications of things in the natural world, such as fundamental particles? According to Professor Hacking, these classifications are “indifferent kinds” of

322 See id.
323 See id.
324 See id.
325 See id. at 11.
326 Id. at 17.
327 Id. at 26.
328 See id. at 27.
329 See id. at 142, 162 (explaining that child abuse “has changed the past of many people, and so changed their very sense of who they are and how they have come to be”).
330 See id. at 125-26, 135, 137.
331 Id. at 103.
332 Id. at 104.
333 See id. at 108.
334 See supra notes 308-09 and accompanying text.
classifications. They do not interact with the thing so classified because the thing is not aware of how it is classified.

Take “quarks,” for example. “Quarks are not aware that they are quarks and are not altered simply by being classified as quarks.” As a result, “[t]he classification ‘quark’ is indifferent in the sense that calling a quark a quark makes no difference to the quark.” The same can be said for plutonium, water, tigers, lemons, and the color yellow. And because these things are not aware of how they are classified, and do not change accordingly, it makes little sense to say that they are socially constructed. At the very least, these things seem far more inevitable, far more determined by the nature of things, than “disability,” a “woman refugee,” a “child TV viewer,” or “child abuse.”

(c) Impairment X: Classifications of People and Material Things

To summarize, classifications of people (such as a “woman refugee”) are interactive kinds of classifications. These classifications affect people who are aware of how they are classified and, in turn, are affected by how people react to being classified (looping effect). In this way, both the classification (“woman refugee”), and the thing classified (the individual woman), may be said to be socially constructed. They change. They are contingent.

Classifications of things other than people – things that are not aware of and therefore not affected by their classification – are “indifferent” kinds of classifications. While the classification plutonium may be said to be socially constructed (e.g., the idea of plutonium was not inevitable), the thing so classified (plutonium itself) is not socially constructed. It is very much with us, and it is not going anywhere. The thing is inevitable.

Fair enough. But what happens if a classification is both interactive and indifferent – i.e., one that refers to both people and, say, the natural world? Impairment is such a classification. As seen above, the classification “impairment X” (or disorder X, dysfunction X, deficit X, defect X, condition X, or what have you) is socially constructed – it exists within a matrix of socially contingent institutions and practices that name and diagnose, educate and entertain, accommodate and legislate. But what about the thing to which “impairment X” refers?

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335 See HACKING, supra note, at 104.
336 See id. at 32, 105.
337 Id. at 32.
338 Id. at 105.
339 Id. at 107.
340 See id. at 30 (“[Q]uarks, the objects themselves, are not constructs, are not social, and are not historical.”); see also id. at 119-20 (distinguishing between indifferent, biological kinds and interactive, socially-constructed kinds).
341 See supra note 308 and accompanying text.
342 See supra notes 329-31 and accompanying text.
343 See HACKING, supra note, at 11.
344 See supra notes 333-34 and accompanying text.
345 See HACKING, supra note, at 105.
346 See id. at 108.
347 See supra notes 282-84 and accompanying text.
On the one hand, the “object” to which the classification “impairment X” refers is some biological pathology that is indifferent, unaffected by its classification. You can see it under a microscope. You can test for it. The pathology does not change because researchers have named it or clinicians have applied it to people. Pathologies are not aware of how they are classified, and are therefore not constructed. They are inevitable.

But pathology is not impairment X’s only referent. The classification “impairment X” also refers to people. Now, to head off an obvious objection at the outset, one could say that the classification “impairment X” refers only to pathology – it does not refer to people who share that pathology. “While people may experience and even embrace impairment X,” one might say, “the impairment does not refer to them.” This seems wrong for two reasons.

First, recall that the vast matrix surrounding the classification “impairment X” includes not only those practices and institutions that name and diagnose the impairment. It also includes those practices and institutions that act upon the impairment or, more particularly, on people classified as having the impairment. These practices and institutions “change the ways in which individuals experience themselves – and may even lead people to evolve their feelings and behavior in part because they are so classified.” As people interact with this matrix of practices and institutions, they may also change how “impairment X” is understood (looping effect). Therefore, the classification “impairment X” refers to both a pathology and the people whose lives shape – and are shaped by – the classification.

Consider again the example of Asperger’s. In 2013, Asperger’s will disappear from the lexicon of the American Psychiatric Association and will be replaced by the DSM-V’s umbrella diagnosis, “Autism Spectrum Disorder.” But Asperger’s will most likely not disappear from autobiographies, blogs, and elsewhere. Notwithstanding the lack of coherent diagnostic criteria, the classification “Asperger’s” will probably remain. Why? Because people currently classified as having Asperger’s want it to. For them, it is a shared experience, a way of being.

So there must be more to “impairment X” than pathology.

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348 See HACKING, supra note, at 117.
349 See id.
350 See id.
351 See id. at 119.
352 See supra notes 303-04 and accompanying text.
353 See id.
354 HACKING, supra note, at 104.
355 See supra notes 329-31 and accompanying text.
358 See, e.g., Dave Angel, Aspergers Diagnosis and the DSM 5 Proposed Changes, THE PARENTING ASPERGERS BLOG, http://parentingaspergers.com/blog/other/aspergers-diagnosis-and-the-dsm-5-proposed-changes/ (objecting to DSM-5’s removal of Asperger’s on grounds that, for people with Asperger’s, “the diagnosis is part of who they are, and changing that to Autism may be extreme and cause anxiety”).
Consider also Deafness. While Deafness refers to a pathology in the sense of hearing loss,\(^{359}\) it is also refers to an experience, a way of being in the world.\(^{360}\) Resisting the institutions and practices that pathologize Deafness (e.g., school administrators, social workers, therapists, surgeons, otologists, hearing aid specialists), the Deaf have redefined the classification, constituting themselves as a new ethnicity, a “linguistic minority” with its own “distinct manual language [ASL], culture, and social organization.”\(^{361}\)

Second, and more fundamentally, one might argue that “impairment X” presumes at least some connection to the person. Pathologies, after all, do not exist outside of the person – they reside in the person, in their blood, in their brains. But for people, “impairment X” disappears.

C. Autism and Impairment

Because of the social setting in which “impairment X” derives its meaning, “impairment X” might be said to refer not only to a pathology but also to the experience of people classified as having the impairment.\(^ {362}\) Pathology = Impairment X = Experience of people so classified.

This is important for three reasons. First, it suggests that “impairment X” has as much to do with people’s experience – how they are conceived of and how they conceive of themselves – as it does their bodies.\(^ {363}\) It does not matter to a pathology if we say we wish it never existed or was less pathological. But people are different. People are aware of how they are classified (either literally, or because they interact with the matrix of social practices and institutions through which the classification gets communicated).\(^ {364}\) It matters very much to people when we say that we wish they were not born, or were different than they are.

Second, it means that “impairment X” is in part contingent on the people it classifies.\(^ {365}\) As people experience and change in response to their classification, the social institutions and practices surrounding the classification “impairment X” may need to be changed.\(^ {366}\) In this way, “impairment X” is constructed in part by those to whom it refers. It is a moving target that changes as people change.\(^ {367}\)

Lastly, the social construction of impairment complicates disability, which is itself a social construction.\(^ {368}\) Disability refers to negative treatment based on impairment, and impairment refers both to some bedrock biological pathology and to the experience of people so classified.\(^ {369}\)


\(^{360}\) See Lane, supra note, at 173 (construing “deaf” as “designating a member of a linguistic minority”).

\(^{361}\) See Lane, supra note, at 174; see id. at 180 (“[W]e’re more of an ethnic group because we speak a different language. . . . [D]eafness is a difference, not a deficiency.”).

\(^{362}\) See supra note 353 and accompanying text.

\(^{363}\) See Areheart, Trouble, supra note, at 26 (“[I]mpairment, rightly understood, is complicated – and far more than just biology.”).

\(^{364}\) See supra notes 314-15 and accompanying text.

\(^{365}\) See supra notes 354-57 and accompanying text.

\(^{366}\) See supra notes 333-34, 357 and accompanying text.

\(^{367}\) See supra notes 334-35 and accompanying text.

\(^{368}\) See supra notes 55, 350-53 and accompanying text.

\(^{369}\) See supra notes 57, and accompanying text.
While both disability and impairment have a social component, and while these waters are murky, there is a fundamental distinction between the two that offers some clarity. Disability is synonymous with disadvantage, and so the experience of being “disabled” is always a negative one. Disability is something to be gotten rid of. Being classified as having an impairment, on the other hand, is not always a bad thing. On the contrary, for those so classified, it may be a good thing. The classification may be something to be celebrated.

Autism is a case in point. The war raging over Autism is not a war about disability. It is a war between those who believe that Autism is a (still unidentified) biological pathology and inevitable (“I love my children, but I do not love Autism”), and those who believe that it is an experience and therefore contingent (“Autism is a way of being”). They may both be right. Autistic people share differences in social communication and behavior, and research may one day locate the source of those differences in a shared pathology. But alongside these behavioral features, Autistic people share something else – an experience of being “different” from the norm.

As demonstrated by the Neurodiversity Movement, Autistic people are shaped by, and are shaping, Autism – resisting, embracing, and transforming it. Under their stewardship, Autism has become something mysteriously beautiful (a window into the wonders of the human brain), wonderfully liberating (not tethered to social niceties), and even radically transformative (defying social norms). Through their art, writing, and other modes of communication, the Neurodiverse are challenging the conception of Autism as some undiscovered pathology, and pointing instead toward an understanding of Autism as something akin to homosexuality, blue eyes, tallness, or shyness – a characteristic with its own brand of gifts and weaknesses. And if Autism turns out to be a biological pathology, then, the Neurodiverse might reasonably argue, it is a pathology only in the sense that a mole or hearing loss is a pathology – not necessarily bad, and possibly quite good.

With the Internet as their bricks and mortar, the Neurodiversity Movement has built a vibrant culture that prides itself on pushing the bounds of normality. Neurodiversity is Autism. Pathology may be too.

As Professor Daniela Caruso notes:

370 See supra note 51 and accompanying text.
371 See supra note 69 and accompanying text.
372 See supra notes 23-24 and accompanying text.
373 See HACKING, supra note, at 116.
374 See NADESAN, supra note, at 204-05.
375 See supra notes 194-206 and accompanying text.
376 See Jim Sinclair, Why I Dislike “Person First” Language, available at http://www.autcom.org/articles/defeated.html (1999) (likening Autism to traits such as blue eyes and left-handedness); cf. KUTCHINS & KIRK, supra note, at 90 & n. 66 (calling “homosexuality . . . a normal variant [of sexual behavior]; the nearest analogy is that of left-handedness.”) (quoting memo from Harold Lief, member of DSM-III-R Advisory Committee on Sexual Disorders, to Robert Spitzer, Chair of Work Group to Revise DSM-III (Jan. 15, 1986)).
377 See supra note 364 and accompanying text.
378 See NADESAN, supra note, at 209-10.
autism can be credited with a veritable advancement in the understanding of difference. Since the spectrum of autistic disorders is ample enough to include persons of high accomplishment, the line between the ill other and the healthy self is blurred. The very concept of cognitive impairment dissipates, leaving in its place a vision of a more advanced society, where human beings are allowed to flourish for who they are and are helped to reach their potential without preconceptions. The post-modern concept of neuro-diversity, with its promise of inclusion and its philosophical acceptance of variation, may find in autism a perfect home.379

VI. “IMPAIRMENTQUEER”: AUTISM’S LEGAL IMPLICATIONS

Autism has implications not only for disability theory but also for disability rights law. As one of the institutions through which ideas are communicated, law plays an important role in the social construction of disability.380 Over the years, some laws have “disabled” people by disadvantaging them based on their impairments. Laws enacted during the “eugenics” period of the early twentieth century to control the reproduction of people with intellectual impairments (through forced sterilization) and to institutionalize them for posing dangers to society are notorious example of this.381 To have an intellectual impairment thus meant having no rights – to marry, to procreate, or even to be free.382

Disability civil rights laws like the Individuals with Disabilities Education Act and the Americans with Disabilities Act, on the other hand, attempt to do just the opposite.383 These laws attempt to redress “disability” by providing special education services and antidiscrimination protection, respectively, to those who experience disadvantage (e.g., exclusion from education; termination from a job or denial of goods and services) based on their impairments.384 The 2008 amendments to the ADA, in particular, demonstrate the law’s power to take aim at disability and make impairments like Autism something worthy of respect.385 At the same time, Congress’ continued exclusion of GID from protection under the ADA demonstrates the law’s power to entrench stigma and perpetuate disability.386

A. Autism and the ADA Amendments Act of 2008

For nearly twenty years, the ADA has been widely understood by courts and society at large to protect a narrow class of people – “those” people with impairments that impose severe functional

380 Cf. Hacking, supra note, at 10 (discussing law’s place in the matrix of social institutions that give meaning to “woman refugee”).
382 Id. at 8-10, 20 (quoting City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985)) (Marshall, J., joined by Brennan & Blackmun, JJ., concurring in part and dissenting in part).
384 See, e.g., 20 U.S.C. § 1415 (ensuring “that children with disabilities and their parents are guaranteed procedural safeguards with respect to the provision of a free appropriate public education”); 42 U.S.C. § 12101 (prohibiting “discriminat[ion] against a qualified individual on the basis of disability in regard to” employment).
385 See infra notes 400-05 and accompanying text.
386 See infra notes 427-28 and accompanying text.
According to the ADA, a person is protected from discrimination if he or she has a “disability,” that is, a “physical or mental impairment that substantially limits one or more major life activities.” Although the ADA’s implementing regulations define “physical or mental impairment” broadly to include virtually any physical or mental disorder, the Supreme Court held that, in order to qualify as a “disability,” the impairment must “prevent or severely restrict” life functions. This strict interpretation effectively gutted the ADA, depriving antidiscrimination protection to all but those with the most severe functional limitations.

By passing the ADA Amendments Act of 2008, however, Congress clarified that, with a few exceptions, anyone discriminated against based on an impairment is protected by the ADA. It does not matter if the person’s impairment is episodic, mitigated by medication, not functionally limiting, or even non-existent. In each case, that person is covered so long as an impairment (whether real or perceived) was the reason for the discrimination. Because everyone has an impairment of one sort or another (or may be perceived as having one), this means that everyone, with only a few exceptions, is entitled to legal protection. ADA protection is now nearly universal.

Take Autism, for example. All that an Autistic person need show in order to be protected under the ADA is that he or she was discriminated against based on Autism. If the person is denied a reasonable accommodation based on Autism, the requisite showing is slightly different, but straightforward. In that case, the person must show that Autism substantially limits a major bodily function (like neurological or brain function) or a major life activity (like thinking, concentrating, or social interaction). According to Congress, this should not be difficult to do. In fact, according to the EEOC, the agency which enforces the ADA’s employment

387 See Barry, supra note, at 250.
388 42 U.S.C. § 12102(1).
389 See 29 C.F.R. § 1630.2(h).
391 See Barry, supra note, at 221-22.
392 See 42 U.S.C. §§ 12102(3)(A) (covering those who are “subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity”), 12102(4)(A)-(B) (broadly construing definition of disability and “substantially limits”); Barry, supra note, at 264-65 (discussing exception for “transitory and minor” impairments, 42 U.S.C. § 12102(3)(B), and requirement that, in failure-to-accommodate cases, impairment must substantially limit a major life activity, 42 U.S.C. § 12201(h)).
393 See 42 U.S.C. §§ 12102(3)(A) (stating that person is covered under “regarded as” prong of definition of disability even if impairment does not “substantially limit[]” or is “perceived,” not “actual”), (4)(D) (requiring that episodic impairments and impairments in remission be considered in their active states), (4)(E) (prohibiting consideration of most mitigating measures); see also 29 C.F.R. §§ 1630.2(j)(1)(vi), (l) (discussing “regarded as” prong).
395 See Barry, supra note, at 272-74.
396 See id.
398 See id. § 12201(h).
399 See id. §§ 12102(2) (defining “Major life activities”); 29 C.F.R. § 1630.2(i)(1) (2011) (stating that “[m]ajor life activities include, but are not limited to . . . interacting with others . . .”).
400 ADAAA § 2(b)(1) (“[T]he question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.”).
provisions, Autism is now presumptively covered. To be “Autistic,” therefore, is to have civil rights protection.

Given Autism’s wide spectrum, the EEOC’s presumptive protection of Autism underscores the ADA’s broad scope of coverage. So far as the EEOC is concerned, the ADA now covers not only the non-verbal eighteen-year-old who exhibits self-injurious behavior, but also the socially awkward professor not hired for a job. It covers the person who views Autism as a pathology in need of cure as well as the person who views Autism as a difference to be celebrated. By presumptively protecting Autism, the EEOC acknowledges that “impairment” is broad indeed—broad enough to encompass both the Neurodiversity Movement’s conception of impairment and that of many parents of Autistic children as well.

As one scholar has noted, Autism has “warped the law as we know it.” From those well outside the norm to those who straddle the line between “us” and “them,” Autistic people are within the protection of disability rights law. This is a good thing for the parents of Autistic children as well as for Autistic adults because these laws help Autistic people access the benefits, services, employment opportunities, and public accommodations they need to lead fulfilling lives. Despite the vast differences between parents of children with Autism and the Neurodiverse over the meaning of Autism, no one on either side of the aisle argues that Autism should not be protected by the law.

B. Gender Identity Disorder and the “ADA Amendments Act Part 2”

Notwithstanding the ADA’s nearly universal coverage and presumptive protection of Autism’s broad spectrum, the ADA does not protect everyone. Since 1990, the ADA has explicitly excluded from coverage the following list of impairments:

1. transvestism, transsexualism, pedophilia, exhibitionism, voyeurism, gender identity disorders not resulting from physical impairments, or other sexual behavior disorders;
2. compulsive gambling, kleptomania, or pyromania; or
3. psychoactive substance use disorders resulting from current illegal use of drugs.

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401 See 29 C.F.R. § 1630.2(j)(3)(iii) (“[I]t should easily be concluded that the following types of impairments will, at a minimum, substantially limit the major life activities indicated: . . . autism substantially limits brain function. . .”). ADA coverage, however, does not necessarily mean winning one’s case in court. See infra note 459 and accompanying text.
403 See id.
404 See supra note 33 and accompanying text (discussing Autism’s variability); cf. Simon Baron-Cohen, supra note, at 163-64 (discussing award-winning professor of mathematics who is Autistic).
405 See 29 C.F.R. § 1630.2(j)(3)(iii).
406 Caruso, supra note, at 486; see id. at 512 (“[I]t may be hard to see why a[n Autistic] person endowed with average or high intelligence is entitled to protection under the ADA.”).
1. GID and the ADA Exclusion

While subparagraph (A) purports to exclude all “sexual behavior disorders,” it notably includes Gender Identity Disorder (GID) (and Transsexualism, which was folded into the definition of GID in 1994 and is no longer used by the DSM) – which is not a sexual behavior disorder. Unlike the sexual disorders listed in subparagraph (A), all of which are characterized by “recurrent, intense sexual urges, fantasies, or behaviors that involve unusual objects, activities, or situations,” GID is, as its name suggests, a gender identity disorder.

According to the DSM-IV, GID is characterized by a “strong desire” to be the other gender and “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” As with Autism, the diagnostic criteria for GID are in a state of flux. Under the proposed DSM-V, GID will be renamed “Gender Dysphoria,” which is less “stigmatizing” and “better reflects the core of the problem: an incongruence between, on the one hand, what identity one experiences and/or expresses and, on the other hand, how one is expected to live based on one’s assigned gender (usually at birth).” Rather than “presuppose the existence of acute or inherent distress” associated with GID, the DSM-V modifies the requirement of “clinically significant distress or impairment” to include “a significantly increased risk of

408 The DSM-III-R, in effect at the time of the ADA’s passage in 1990, distinguished between “Transsexualism” and “Gender Identity Disorder of Adolescence or Adulthood, Non-Transsexual Type” – the primary difference being that the former involved a “persistent preoccupation for at least two years with getting rid of one’s primary and secondary sex characteristics and acquiring the sex characteristics of the other sex,” while the latter did not). See DSM – IIIR: Transsexualism, ALL MIXED UP: PERSPECTIVES ON TRANSGENDERISM AND “GENDER IDENTITY DISORDER,” http://www.genderpsychology.org/transsexual/dsm_iiir.html (quoting DSM-III-R). “In 1994, the DSM-IV committee replaced the diagnosis of Transsexualism with Gender Identity Disorder.” See The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, Sixth Version, TRANSGENDER LONDON, http://transgenderlondon.com/HBSOC.htm. Despite its removal from the DSM-IV, the word “transsexual” continues to be used colloquially to refer to those “who seek to live in a gender different from the one assigned at birth and who may seek or want medical intervention (through hormones and/or surgery) for them to live comfortably in that gender.” Trans/gender 101 Terms and Explanations, CT EQUALITY, http://www.ctequality.com/storage/trans-101-materials/Transgender%20101%2010-20-10.pdf.

409 See DSM-IV, supra note, at 532.

410 DSM-IV, supra note, at 493, 532. By adding the words “not resulting from physical impairments” after “gender identity disorders,” the ADA presumably covers those whose GID is attributable to intersex conditions (formerly known as “Hermaphroditism” and increasingly referred to by the medical community as “Disorders of Sex Development” (DSD)), which affect the sexual and reproductive anatomy. See 42 U.S.C. § 12211(b)(1). For a good discussion of intersex conditions, see Yamuna Menon, Note, The Intersex Community and the Americans with Disabilities Act, 43 CONN. L. REV. 1221, 1227-32 (2011), and Types of Intersex Conditions, TRANSFAITHONLINE, http://www.transfaithonline.org/intersections/intersex/types/.

411 DSM-IV, supra note, at 537-38.


413 Id.

414 AMERICAN PSYCHIATRIC ASSOCIATION, DSM-5 Development, Gender Dysphoria in Adolescents or Adults, “Rationale,” http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=482# [hereinafter DSM-5, GID Rationale] (stating that DSM-V Neurodevelopmental Disorders Working Group “received many favorable comments about the proposed name change, particularly with regard to the removal of the ‘Disorder’ label from the name of the diagnosis”).

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411 DSM-IV, supra note, at 537-38.


413 Id.

414 AMERICAN PSYCHIATRIC ASSOCIATION, DSM-5 Development, Gender Dysphoria in Adolescents or Adults, “Rationale,” http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=482# [hereinafter DSM-5, GID Rationale] (stating that DSM-V Neurodevelopmental Disorders Working Group “received many favorable comments about the proposed name change, particularly with regard to the removal of the ‘Disorder’ label from the name of the diagnosis”).
suffering death, pain, disability, or an important loss of freedom.” According to the DSM-V’s Working Group on Sexual and Gender Identity Disorders, not all people with GID are distressed and, according to some studies, they “generally function psychologically in the non-clinical range.” The Working Group further suggests that it is “stigma” that causes distress, not GID, and that the desire “to be rid of body parts that do not fit one’s identity is, in the absence of data,” not “inherent[ly] distress[ing].” According to the proposed DSM-V, the “desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender” may not only not be distressing – it may well be liberating.

Given the unlikely company in which GID (and Transsexualism) finds itself, one might guess that this list was not the result of careful Congressional deliberation. And one would be right. This list was a slapdash collection of mental impairments drawn from the DSM-III-R (the precursor to the DSM-IV), and was grafted onto the ADA by amendment to ensure passage in the Senate.

What is perhaps more remarkable is that, when given the chance, Congress did nothing to modify this list in the 2008 amendments to the ADA. The reason for this is straightforward, albeit unsatisfying. Political support for the ADAAA (originally, the “ADA Restoration Act”) depended on the bill’s restoring – not expanding – congressional intent. Because Congress clearly intended to exclude GID (and Transsexualism) from protection when it passed the ADA in 1990, it would not have been a “restoration” to include those conditions in 2008 – it would have been an expansion. Disability rights advocates therefore made the strategic decision to leave for another day the ADA’s exclusion of these impairments (and several other problems with the ADA).

Notwithstanding these political realities, Congress’ refusal to address the ADA’s blanket exclusion of those with GID is deeply troubling. The continued exclusion of GID flies in the face of the ADAAA’s primary purpose, which is to “reinstate a broad scope of protection” for people discriminated against based on impairment. The newly amended ADA extends antidiscrimination protection to any individual discriminated against based on any impairment unless the impairment is “transitory and minor” or is one of those listed alongside GID. While it arguably made sense for Congress to continue to exclude certain impairments that necessarily involve harm to oneself or others (such as exhibitionism, compulsive gambling, pyromania, and kleptomania), and for Congress to guard against frivolous claims by excluding “transitory and minor” impairments, the continued exclusion of GID is nonsensical, offensive, and ultimately

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416 DSM-5, GID Rationale, supra note.
417 Id.
419 Kevin Barry, Personal Notes on ADA Amendments Act Advocacy Effort.
420 Id.
421 See id.; see also Barry, supra note, at 251 n.292.
422 ADAAA § 2(b)(1).
423 See supra note 395 accompanying text.
424 See Barry, supra note, at 273 & n.410.
“disabling.” GID has as little to do with pedophilia, for example, as it does the common cold, and should be covered by the ADA.

By refusing to cover GID, the ADA’s message to people with GID has never been more clear: nearly twenty years after the passage of the ADA, they still have no civil rights worthy of respect. In the eyes of federal disability law, people with GID are despicable and even dangerous, and therefore undeserving of legal protection. The ADA should be righted again through passage of a modest bill, the “ADA Amendments Act Amendments Act Part 2,” which deletes the words “gender identity disorders not resulting from physical impairments” and “transsexualism” from the ADA’s list of excluded impairments.

An “ADA Amendments Act Part 2” would no doubt face objections for political reasons (e.g., lack of political will, given the 2008 amendments to the ADA) and for religious or moral ones (e.g., people with GID do not deserve protection). But the most salient objections would likely come from those with a personal stake in a GID diagnosis, from members of the Transgender community, “whose gender identity or expression does not conform to the social expectations for their assigned sex at birth.”

Like the Autism community, the Trans community is not a monolith. It includes “transsexual” people who have undergone hormonal treatment or surgery in order to align their anatomy and gender identity; people “who undergo no medical treatment but also take steps to conform their

425 See Colker, supra note, at 50 (noting that ADA’s exclusion is “deeply insulting” in part because “many individuals who are transgendered do not consider themselves to have a ‘sexual behavior disorder’”).

426 Jennifer L. Levi & Bennett H. Klein. Pursuing Protection for Transgender Through Disability, in TRANSGENDER RIGHTS 75 (2006) (“At the heart of the federal exclusion of transgender people from the ADA lies bias, bigotry, and misunderstanding of transgender people.”).

427 This Article does not argue that “transvestism” should be deleted from the ADA’s list of excluded impairments. As discussed above, the impairments excluded from the ADA derive from the DSM. See supra note 420 and accompanying text. According to the DSM, “Transvestism” (renamed “Transvestic Fetishism” under the DSM-III-R (1987) and, under the proposed DSM-5, now called “Transvestic Disorder”) is highly specific – it refers to sexual arousal from cross-dressing that results in significant distress or impairment. See AMERICAN PSYCHIATRIC ASSOCIATION, DSM-5 Development, Transvestic Disorder, “Proposed Revision,” at


http://www.dsm5.org/Documents/Sex%20and%20GID%20Lit%20Reviews/Paraphilias/DSMV_TF.pdf (discussing changes to “Transvestism” in successive versions of DSM). Importantly, “Transvestism” does not refer more broadly to cross-dressing absent sexual arousal and distress, nor does it refer to GID. Therefore, while those with Transvestic Fetishism would continue to be excluded under the ADA, the “ADA Amendments Act Part 2” would likely protect cross-dressers (under the “regarded-as” prong, 42 U.S.C. § 12102(3)(A)) and, of course, people with GID.


http://democrats.edworkforce.house.gov/documents/111/pdf/testimony/20090923CraigParshallTestimony.pdf (“Neither the Congress nor the courts have jurisdiction over the religious beliefs of people of faith. . . . Christian ministries that object to those sexual preferences which are in clear violation of the standards of the Bible are standing on a long and well-worn road.”).

429 Paisley Currah et al., Introduction to TRANSGENDER RIGHTS, supra note, at xiv.

430 See supra notes 23-24 and accompanying text.
gender expressions to meet their gender identities”; and the “Genderqueer” – i.e., those who “redefine[] or play[] with gender, or who refuse[] gender altogether. . . . A person whose gender identity is neither male nor female, is between or beyond genders, or identifies as some combination of genders.”

Given the diversity of the Trans community, Trans attitudes toward GID are wide-ranging. Some Trans people, for example, regard the misalignment of their anatomy and gender identity as a mental impairment and accept the GID diagnosis. Others attribute this misalignment to differences in the brain or central nervous system and therefore believe it to be a physical impairment. Still others reject the notion of “impairment” altogether and argue instead for an understanding of gender nonconformity as “a practice of self-determination, an exercise of autonomy. . . . one among many human possibilities of determining one’s gender for oneself.”

Echoing the Neurodiversity Movement, this thread of the Trans community acknowledges the discomfort experienced by Trans people, but attributes the discomfort to “something caused purely by cultural prejudices rooted in gender stereotypes” – not pathology. Some have even called for elimination of the GID diagnosis altogether.

For this thread of the Trans community, the ADA Amendments Act Part 2 may be particularly controversial for a number of reasons. While this is difficult terrain, the Autism debate demonstrates why disability rights coverage for GID makes sense.

2. Potential Objections to the “ADA Amendments Act Part 2”

One argument against disability rights protection for GID is that GID is a social construction, not an impairment. The problem with this argument is that all impairments – both physical and mental – are, to a certain extent, socially constructed. All impairments are named and diagnosed, and the process of naming and diagnosis are social, and therefore contingent, exercises. Autism, for example, need never have been named and diagnosed. Children exhibiting the subjective behavioral features we now call Autism could have been diagnosed with “childhood schizophrenia” or need never have been diagnosed at all. These same contingencies apply to GID, which has been named and renamed over the years (from “Transsexualism” in the DSM-III-R to “Gender Identity Disorder” in the DSM-IV to “Gender Dysphoria” in the proposed DSM-V), and which is diagnosed based on subjective behavioral criteria. The fact that impairments are socially constructed, by itself, does not justify withholding legal protection.

431 Levi & Klein, supra note, at 80.
432 Trans/gender 101 Terms and Explanations, CTEQUALITY, supra note.
433 See Levi & Klein, supra note, at 80-81.
434 See id. at 81, 84-85.
435 Judith Butler, Undiagnosing Gender, in TRANSGENDER RIGHTS, supra note, at 275.
436 See Levi & Klein, supra note, at 81.
437 See Discrimination, NATIONAL CENTER FOR TRANSGENDER EQUALITY, http://transequality.org/Issues/discrimination.html (“In order to make federal law consistent with the Employment Non-Discrimination Act [bill], Congress should alter or remove problematic language regarding transgender individuals in the Americans with Disabilities Act and related federal agency regulations.”).
438 See supra notes 270-80, 300-03 and accompanying text.
439 See supra note 305 and accompanying text.
440 See id.
441 See supra note 410.
“No,” some might further argue, “Autism is ‘real,’ while ‘Gender Identity Disorder’ is not.” What they mean is that GID does not refer to some objectively-measurable biological pathology and, therefore, it is not an impairment but rather the pathologizing of a perfectly healthy way of being. According to this reasoning, however, Autism is not an “impairment” either. While the discovery of some biological pathology underlying Autism appears likely, there is none yet. And there are plenty of Autistic people (i.e., the Neurodiversity Movement) who, like those in the Trans community, resist the pathologizing of Autism and instead recast Autism as a different way of thinking and being that should not be cured or normalized.

Given that both Autism and GID lack an objectively-measurable pathology, and given that many members of both communities regard these “impairments” as different ways of being, why should the law treat them differently?

“Fine, then,” some might argue, “the ADA should exclude both Autism and GID because neither is an impairment.” But this argument misses its mark for a couple of reasons. First, Autism and GID do not cease being “impairments” because they are considered to be experiences or different ways of being. Experience, one can reasonably argue, is not antithetical to impairment – it is a part of it. Pathology is too. Autism and GID may refer to both (unknown) pathologies that concern clinicians, and the lived experiences of those classified as having the impairments.

Second, the experience of impairment is not universal. While the Neurodiverse may resist the pathologizing of Autism, forego medical “treatment” such as ABA, and advocate against “cures,” many parents of Autistic children may do just the opposite. Likewise, while many Trans people resist the GID diagnosis and forego hormonal treatment and surgery to align their anatomy with their gender identity, many others seek out the diagnosis and treatment for it. Claiming GID as a different way of being (or rejecting the diagnosis altogether) is therefore not a principled reason for withholding legal protection for GID – it merely favors one side’s experience over another’s.

Another argument against disability rights protection for GID is that it is bound to be underinclusive because it does not include Trans people who do not have the diagnosis (because they do not want it, because they do not meet the diagnostic criteria, or because they lack access to the medical system that provides such a diagnosis). This argument ignores the 2008 amendments to the ADA’s “regarded as” prong, which clarify that a person treated adversely because of an impairment – whether that impairment is real or perceived, and whether it actually

442 See Butler, supra note, at 275.
443 See supra notes 27-28 and accompanying text.
444 See supra notes 194-95 and accompanying text.
445 See supra note 364 and accompanying text.
446 See supra notes 110-11 and accompanying text.
447 See Butler, supra note, at 274-75.
448 See id.
449 Franklin H. Romeo, Beyond a Medical Model: Advocating for a New Conception of Gender Identity in the Law, 36 COLUM. HUM. RTS. L. REV. 713, 730 (2005) (stating that “[l]ow-income transgender people who are unable to afford trans-friendly healthcare . . . are unlikely to be able to avail themselves of legal protections that have emerged” from courts’ reliance on diagnosis of GID).
limits life functions or not – is protected under the law.\textsuperscript{450} A Transgender man who does not seek out a GID diagnosis or otherwise avail himself of medical interventions (and would not qualify for a GID diagnosis even if he did), and who is not functionally limited in any way, but who dresses in traditionally male clothing and is discriminated against as a result, is most likely “regarded as” having GID.\textsuperscript{451} The “ADA Amendments Act Part 2” would cover him.

As other commentators have noted, this argument also ignores “a truism of a limitation of disability antidiscrimination laws generally,” which is that not all people will be found “disabled.”\textsuperscript{452} While the 2008 amendments drastically lower the bar for legal protection, this truism remains. As other commentators have noted, “[t]his is not a reason, however, to forego pursuing critical nondiscrimination protections for those transgender people who can meet the definition of disability.”\textsuperscript{453} Consider Autism’s vast spectrum, where some Autistic people are profoundly limited in their life functioning (e.g., self-care, speaking), and others are not.\textsuperscript{454} Consider also the Neurodiversity Movement’s outer-rim, the so-called “Autistic cousins” (i.e., non-Autistic people with significant social and communication abnormalities that render them significantly “Autistic-like”).\textsuperscript{455} While “cousins” and even some high-functioning Autistic people will inevitably be denied accommodations under the amended ADA,\textsuperscript{456} the Neurodiversity Movement does not – and should not – suggest that Autism should not be protected under the law. The same reasoning applies to the Trans community and GID.

Another argument against GID coverage is that it stigmatizes Trans people by both legitimating the GID diagnosis and labeling people with GID as “disabled.”\textsuperscript{457} The second concern can be dealt with rather easily. As discussed above, the 2008 amendments make clear that the ADA covers anyone who is “disabled” (i.e., adversely treated) based on an impairment, whether that impairment is limiting, non-limiting, or even-nonexistent.\textsuperscript{458} “No-one’s body works perfectly, or consistently, or eternally. We are all in some way impaired.”\textsuperscript{459} Since all of us have impairments of one sort or another,\textsuperscript{460} and since any of us can be regarded as having an impairment of one sort or another, the ADA covers all of us.\textsuperscript{461} ADA coverage is therefore not stigmatizing – at long last, it is something broadly shared.\textsuperscript{462}

\begin{itemize}
\item \textsuperscript{450} See supra notes 394-98 and accompanying text.
\item \textsuperscript{451} See 42 U.S.C. § 12102(3)(A).
\item \textsuperscript{452} Levi & Klein, supra note, at 87.
\item \textsuperscript{453} Id.
\item \textsuperscript{454} See supra note 33 and accompanying text.
\item \textsuperscript{455} See Jim Sinclair, Autism Network International: The Development of a Community and its Culture, AUTISM NETWORK INTERNATIONAL (Jan. 2005), \url{http://www.autreat.com/History_of_ANI.html}. Mirroring the breadth of the Neurodiverse and Trans communities, the Deaf community includes those without hearing impairments. See Lane, supra note, at 179 (“The claim that one is in the DEAF-WORLD, or that someone else is, is not a claim about hearing status at all. . . . All degrees of hearing can be found among Deaf people . . . and most people who are hearing-impaired are not members of the DEAF-WORLD.”).
\item \textsuperscript{456} See Caruso, supra note, at 513 (citing cases where courts denied relief to Autistic plaintiffs under (unamended) ADA).
\item \textsuperscript{457} See Levi, Clothes Don’t Make the Man (or Woman), But Gender Might, 15 COLUMBIA J. GENDER & L. 90, 105-06 (2006).
\item \textsuperscript{458} See supra note 451 and accompanying text.
\item \textsuperscript{459} Shakespeare & Watson, supra note, at 24.
\item \textsuperscript{460} See id. at 24-25.
\item \textsuperscript{461} Barry, supra note, at 272-74.
\item \textsuperscript{462} See id.
\end{itemize}
But does the ADA Amendments Act Part 2 stigmatize Trans people by legitimating the GID diagnosis? This is a harder question. As many commentators have noted, “[b]eing transgender is a quintessentially stigmatic condition.” People who do not adhere to gender norms are considered the epitome of “abnormal”: neglect, prejudice, and stereotypes are hallmarks of their experience; murder, suicide, homeless, joblessness, and poverty are tragically common in their community. The GID diagnosis plays a paradoxical role in the creation of stigma. On the one hand, it alleviates suffering by “facilitat[ing] access to medical and technological means for transitioning . . . [I]t makes life livable.” But the diagnosis also comes at a price. As Professor Judith Butler writes,

[GID] subscribes to forms of psychological assessment that assume that the diagnosed person is affected by forces he or she does not understand; it assumes the there is delusion or dysphoria in such people; it assumes that certain gender norms have not been properly embodied and that an error and a failure have taken place; it makes assumptions about fathers and mothers, and what normal family life is and should have been; it assumes the language of correction, adaptation, and normalization; it seeks to uphold the gender norms of the world as it is currently constituted and tends to pathologize any effort to produce gender in ways that fail to conform to existing norms. . . .

As a result, the diagnosis “takes on a life of its own, . . . mak[ing] life harder for those who suffer by being pathologized and who lose certain rights and liberties, including child custody, employment, and housing, by virtue of the stigma attached to the diagnosis . . .” According to Professor Butler, the “pathologizing force” of the GID diagnosis can disable – and even kill – trans people by “mak[ing] them feel in a stigmatized position and, in some cases, contribut[ing] to a suicidal conclusion.” With good reason, many in the Trans community have sought to eliminate GID as a DSM diagnosis altogether, just as the gay community successfully did with homosexuality years ago.

The stigma surrounding a GID diagnosis should not be underestimated, and the stakes are high. While the GID diagnosis no doubt plays a role in the stigmatization of Trans people,

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463 Levi & Klein, supra note, at 88.
465 Butler, supra note, at 274, 285
466 Id. at 276.
467 Id. at 285.
468 Id. at 276; see id. 295 (“[O]ne has to ask whether the diagnosis of transgendered youth does not act precisely as peer pressure, as an elevated form of teasing, as a euphemized form of social violence.”).
469 Compare id. at 275 (stating that “some activist psychiatrists and trans people have argued that [GID] should be eliminated altogether. . .”), with KUTCHINS & KIRK, supra note, at 71-72 (explaining history of gay liberation movement’s successful efforts to delete homosexuality from DSM in early 1970’s).
470 See Butler, supra note, at 276; cf. KUTCHINS & KIRK, supra note, at 77 (“If homosexuality were still considered a mental illness, business and insurance companies would not be offering health coverage for domestic partners, the
ADA coverage of GID would do nothing to further its legitimacy – at least nothing more than the ADA does at present. Unlike homosexuality and bisexuality, which the ADA states “are not impairments and as such are not disabilities,” the ADA states only that GID is not a covered “disability.” Implicitly, the ADA therefore already states that GID is an impairment, but refuses to cover GID by stating that it is not a “disability” (only “disabilities” are covered under the ADA – not impairments). The only change made by the ADA Amendments Act Part 2 would be to allow GID to be considered a covered “disability.”

But this textual argument aside, the risk of stigmatizing Trans people by covering them under the law seems far outweighed by the stigma that attaches to their continued exclusion under the law. While it is possible that GID coverage might stigmatize Trans people by somehow strengthening the “status” of the GID diagnosis, it is much more likely that the ADA’s exclusion of GID currently stigmatizes Trans people by marking them as undeserving of legal protection. Having the law on one’s side seems far less stigmatizing than having a law that groups GID with pyromania and pedophilia and permits discrimination with impunity. In fact, it is these very prejudices and stereotypes that the ADA is designed to remedy. As Professor Levi notes, “To avoid relying on disability law for protections because of stigma would exacerbate the problem the laws seek to redress.”

One might also argue that the rejection of ADA coverage does not leave Trans people without any antidiscrimination protection. In the wake of the Supreme Court’s decision in Price Waterhouse v. Hopkins, which held that Title VII’s prohibition on “sex” discrimination in the workplace extends to discrimination based on sex stereotypes, a growing number of federal circuit and district courts have held that Title VII protects Trans people who do not adhere to the stereotypes associated with their assigned sex at birth. Furthermore, fifteen states plus the District of Columbia have passed laws prohibiting discrimination based on gender identity. And proposed federal legislation awaits. Since 2007, the Employment Nondiscrimination Act (ENDA), a bill intended to prohibit employment discrimination based on “sexual orientation” and “gender identity,” has been introduced in Congress. Given these channels of existing and potential legal protection, one might argue, the Trans community does not need disability rights law.

army would still be using psychiatry to screen suspected homosexuals for discharge, and many of the other advances in gay rights would not be part of our culture.”).

472 Id. § 12211(b).
473 See id.
474 Levi, supra note, at 106.
The response to this objection is straightforward. Current antidiscrimination protection for Trans people is precarious at best. While many courts have interpreted *Price Waterhouse* to prohibit discrimination against Trans people under Title VII,478 successfully making out a case of gender stereotyping is no easy feat, especially where the case involves restroom usage or dressing and grooming standards.479 And in any event, Title VII protection does not extend beyond the workplace (to education or housing, for example).480 State law, moreover, is a patchwork quilt, with some states extending broad protection to Trans people, others extending narrow protection, and most extending no protection.481 And even if ENDA were to pass,482 it would provide, as its name suggests, only employment discrimination protection.483 The ADA is far more comprehensive, covering, among other things, public accommodations and government services, and defining discrimination to include the failure to provide reasonable accommodations.484 ADA coverage would fill important gaps and provide another, and surer, layer of needed protection.

C. Impairment

Autism and GID are still largely a mystery to science – no biological pathology exists for either, and instead they are defined through behavioral features deemed “abnormal.”485 Both have wide spectrums, with many of those diagnosed functioning at high levels.486 And both count among their ranks a strong contingent of people who are (loudly) critical of their respective diagnoses – those who claim “impairment” as a different way of experiencing the world, as something to be proud of.487

478 See supra notes 477-78 and accompanying text.
479 See Mcginley, supra note, at 750, 757-61 (stating that while “transgender persons may enjoy partial coverage [under Title VII] . . . their method of proof is difficult and their efforts are often unsuccessful,” and noting cases in which courts ruled against Transgender plaintiffs); see also Angela Clements, *Sexual Orientation, Gender Nonconformity, and Trait-Based Discrimination: Cautionary Tales from Title VII & An Argument for Inclusion*, 24 BERKELEY J. GENDER L. & JUST. 166, 179 (2009) (”The dress and grooming codes cases are the clearest example of narrow protection for gender nonconformity under Title VII.”).
482 While passage of ENDA is probably inevitable, it will take some time. In 2007, the “last-minute jitters [of] some Democrats” over ENDA’s trans-inclusive language prompted Members of Congress to introduce a “compromise” bill that stripped out “gender identity,” fracturing the coalition of trans and gay rights organizations in the process. *A Non-Transgender-Inclusive ENDA? No Way!, NATIONAL GAY AND LESBIAN TASK FORCE* (Sept. 27, 2007), http://www.thetaskforce.org/press/releases/prMF_092707. Neither the trans-inclusive nor the sexual-orientation-only bill passed.
484 See 42 U.S.C. §§ 12112(b)(5) (prohibiting failure to reasonably accommodate), 12131(1) (defining “Public entity”), 12181(7) (defining “Public accommodation”).
485 See supra notes 444-45 and accompanying text.
486 Compare supra note 33 and accompanying text (discussing Autism’s variability), with Levi, supra note, at 106 (”For many transgender people, of course, the condition of being transgender has no impact on their lives. For others, however, the identity or condition, without any medical intervention or care, is seriously limiting.”).
487 See supra notes 437-38 and accompanying text.
The Neurodiversity community and members of the Trans community are, one might say, “Impairmentqueer.” They are classified as having impairments, but the ambiguity in their diagnoses, the variable nature of their functional limitations, the richness of their experience, and the vigor of their self-advocacy point to “impairment” as something more than pathology. 488 By resisting and redefining what “Autism” and “GID” mean, the Impairmentqueer challenge what “normal” means. They blur the line between “us” and “them.” To paraphrase Michelle Dawson, Autistics and Trans people are in the workforce, they are in academe, they are parents, they are artists, architects, engineers, physicists, musicians, writers, doctors, professors, and lawyers. 489 Neither doomed nor dangerous, they “contribute[] to the progress and enlightenment of society.” 490

Are Autism and GID atypical? Yes. But abnormal? That turns out to be a much harder question. Fortunately, disability rights law need not wrestle with this question because the newly amended ADA protects anyone discriminated against based on virtually any impairment – whether conceived of as a limiting pathology or as just another way of being. 491 This means that under the ADA, the Neurodiversity Movement can have its cake (claiming Autism as experience) and eat it too (claiming protection under the ADA). It is time that the Trans community enjoyed the same.

While the social construction of disability does not demand a particular policy response, disability rights laws – once enacted – ought to provide coherent protection to those who are “disabled.” Given the similarities between Autism and GID, as illuminated by the Neurodiversity and Trans communities, according disability rights protection to one and not the other is untenable. By excluding GID from coverage, the ADA “disables” those with GID. Coherence in the law demands legal protection for those with GID; it demands an “ADA Amendments Act Part 2” that removes GID (and Transsexualism) from the ADA’s list of excepted impairments. Regardless of whether Autism and GID derive from some biological pathology, they are nevertheless a “ray of light” and something worth celebrating – or at least supporting – under the law and elsewhere in the matrix.

VII. CONCLUSION

The binaries surrounding disability and impairment are not what they seem. As Autism teaches, there is much gray here. Three conclusions emerge.

First, the social-vs.-medical model binary is illusory. As the social model of disability makes clear, disability is a social construction – it is the negative treatment of people based on impairment. That treatment is contingent and can be changed. The medical model of disability, according to which disability consists of functionally limiting impairments, is not a theoretical model of disability at all – it is merely a way of describing a world that social constructionists, for good reason, don’t like.

488 See id.
489 See Dawson Factum, supra note, at para. 29.
490 Id.
491 See supra notes 397-98 and accompanying text.
Concluding that disability is socially constructed and that the medical model is dead is not radical. After all, the social model does not deny the centrality of impairment and the functional limitations that may flow from it, nor does it demand a particular policy response (or any response at all). Thus, while the parents of Autistic children and the Neurodiversity Movement may respond to Autism in very different ways, with the former often supporting and the latter often opposing treatment and medical research into cures, neither side necessarily “disables” Autistic people. Quite the contrary, both seek an end to (socially-constructed) disability, albeit through different means.

Second, impairment is not pathology or people’s experience. It is both. While impairment refers to pathology, it is also constructed by those classified as having the impairment. Again, the Autism debate is instructive. Medical research strongly suggests that Autism is a biological pathology – some unidentified genetic defect conferring susceptibility on some unknown environmental agent. But the Neurodiversity Movement shows that Autism is also an experience, and a rich one. Through activism, the Internet, and art, Autistic people are adapting to, resisting, and transforming the social practices and institutions that classify them. Autistic people are constructing Autism.

Third, while the social construction of disability does not demand a particular policy response, disability rights laws – once enacted – ought to provide coherent protection to those who are “disabled.” The ADA currently fails in this regard. The ADA protects people with Autism while at the same time excluding people with GID, an impairment that, like Autism, is still largely a mystery to science, has a broad spectrum, and counts among its ranks those who see their nonconformity as something to be proud of, not pathologized. Coherence demands an “ADA Amendments Act Part 2” that makes good on the ADA’s promise of nearly universal protection by covering nearly everyone, including the “Impairmentqueer” who blur the line between “us” and “them.”