The Disabled: The Most Othered Others

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I found my way to thinking about otherness unexpectedly. I feel like it found me, actually. In this chapter I will discuss how that occurred and how my work with autistic patients raised my awareness of what it means to be disabled in our culture. I will discuss the main themes in the disability studies literature, suggest reasons for the absence of these ideas in the psychoanalytic literature, and offer a case that illustrates these themes. There is much to be gained when we add a disability studies sensibility to psychoanalytic theory and practice.

About fifteen years ago I was accruing hours toward licensure as a therapist and serendipitously ended up working in a special education school serving students with autism. This was the late 1990s, so Asperger’s disorder, having been added to the DSM in 1994, was a newly chic diagnosis. The huge and unprecedented increase in the prevalence of autism was just beginning at that time. The economy had not yet tanked so there was funding for treatment. The school I worked for couldn’t hire therapists and teachers fast enough to meet the increasing demand for services, so, for better or for worse, I had plenty of job security. And I became utterly fascinated with minds so different from mine, on the edges of society, with a view that those of us in the middle just don’t have.

However, I also didn’t know what I was doing. Most days as a psychoanalyst I still feel the same way, although I have come to appreciate that such epistemological wobbliness is a sought after state, as too much knowledge interferes with understanding my patients’ experiences in the world. So, because I knew nothing about how to work with an autistic person, and because the

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1In this article I will alternate between person-centered language (i.e., “person with autism”) and the more contemporary language that places the disabling condition first (i.e., autistic person, or autistic), recognizing that the disability is an integral aspect of the individual’s identity (Linton, 2010). This is consistent with language used in the disability studies literature.
training I received was really inadequate, I decided just to go full-Kohut, listening and understanding, as well as I could. Since then I’ve spent tens of thousands of hours with autistic people—mostly young adults these days—and their families, listening and understanding, first in the special education school and later in my private practice. People with autism have taught me what it is to be the ultimate other in a culture in which the dominant group is a highly social majority.

The autism experienced by these individuals, I’ve learned, has little to do with the autism we are asked to consume as a society, defined by the medical model, the idea that autistics cannot read social cues, and that they are always and only and permanently autistic. These mainstream approaches to autism dictate that autistics require lots and lots of expensive remediative treatment to cure their incurable, tragic, and miserable impairment and become more “normal.” I don’t mean to say that people with autism don’t need services or don’t have any relevant impairment. My critique has to do with how we think about this group, how we other them, and how some treatment providers exploit by over-pathologizing autism. And to the extent that I have profited from my work with this group of people, I’m part of this exploitative system too, something I feel I ought to disclose. My point here is that my autistic people have a *different* experience of their condition. Importantly, many individuals on the spectrum consider themselves to be disabled. And many do not. In either case, the notion of what it is to be disabled—to have a disability—was put on my radar by this group, something I personally hadn’t thought about much because I am not disabled, at least not yet.

Separately from my thinking about autism, seven years ago I found myself drawn to
contemporary psychoanalytic thought and entered psychoanalytic training. My institute, The Institute of Contemporary Psychoanalysis in Los Angeles, has a very significant commitment to diversity issues, supporting our community in examining our individual and collective minds for hidden biases, inevitable prejudices, and the tendency to totalize individuals in our overt actions and our more insidious microaggressions. This is how thinking about otherness found me at my psychoanalytic institute as well.

Perhaps naïve about politics in psychoanalytic institutes, a few years ago I requested to join my institute’s diversity committee because of my interest in disabilities. I was rebuffed and told, “Disability is not relevant to our institute. There is no one with a disability here.” Given that 20% of the population has a disability, either mild or more severe, at any one time (Brault, 2012), I was incredulous. And I was angry. My request to expand the diversity category to include disabilities was put to the bottom of the Board agenda, repeatedly tabled until next month, pushed out by more important or allegedly relevant issues such as budgets, curriculum, and programs.

Motivated by my irritation and my curiosity, I started reading the disability studies literature. I owe a debt of gratitude to one of my patients for introducing me to this discourse, as I likely would never have known to look for it. Disability studies comprises a very considerable body of scholarship, but most people have never even heard of it, even those of us sensitive to and aware of identity politics. Conferences and journals are loaded with papers taking up the experience of the other in terms of race, class, gender, and religion, including those marginalized through political oppression, trauma of all sorts, and postcolonialism. But where is there mention of those
with disabilities? I have never seen a presentation on this topic and have found scant reference to it in the psychoanalytic literature. To the extent that individuals with disabilities—particularly mental disabilities—have been excluded from our discourse, they comprise a group of most othered others. Lennard Davis (1995), one of the most important figures in the disability studies world, notes the “strange and really unaccountable silence when the issue of disability is raised (or, more to the point, never raised)” (p. 5) in academic and intellectual circles. He continues:

The silence is stranger, too, since so much of left criticism has devoted itself to the issue of the body, of the social construction of sexuality and gender. Alternative bodies people this discourse…But lurking behind these images of transgression and deviance is a much more transgressive and deviant figure: the disabled body. (5)

Disability Studies

Disability studies as an academic discipline developed parallel to the disability rights movement, that in turn following on the heels of the civil rights and women’s rights movements in the US and abroad. The first wave of the disability rights movement began in the 1960s and 1970s, with activism and passage of the landmark Rehabilitation Act of 1973, prohibiting discrimination against individuals receiving federal aid on the basis of handicap. The disability rights movement in the US gained greater visibility in the 1980s, culminating in 1990 with passage of the Americans with Disabilities Act, or ADA, and the Individuals with Disabilities Education Act, or IDEA, sweeping legislation guaranteeing accessibility and civil rights protection for people with disabilities, as well as free and appropriate public education for children with disabilities. Interestingly, these were both enthusiastically—and with broad bipartisan support—signed into law by George H.W. Bush. Modeled after the provisions of the ADA, The United Nations
Convention on the Rights of Persons with Disabilities came into force in 2008. Perhaps a sign of our shifting political climate, the US, ironically, is one of very few UN member states that has voted against ratification of the Convention, with many on the right objecting to its provisions, the same ones they supported when creating the ADA.

Now well into its second wave (Davis, 2010b), disability studies has three key ideas. The first is to point out the ubiquity of ableism in our culture, that is, discrimination against individuals with disabilities (Linton, 2010; Watermeyer, 2013; Davis, 1995), that continues despite the legislation I mentioned above. In some parts of the world the term used is disablism (Watermeyer, 2013), and which term is preferable is debatable. The second key idea notes the transition from a medical model of disability to the social model. This reflects a shift in thinking about disabilities not as pathology experienced in individual bodies with the goal of cure or, if that is not possible, sequestration (Straus, 2010, p. 537), but rather as “a social creation—a relationship between people with impairment and a disabling society” (Shakespeare, 2010, p. 266). The aim of social model thinking is to remove barriers to accessibility and to view all bodies as acceptable, with no one body type privileged (Shakespeare, 2010; Longmore, 2003; Goodley, 2011; Watermeyer, 2013). Interestingly, the revolution in the disability studies discourse from the medical model to the social model has parallels in the contemporary psychoanalytic literature, in our relational turn, the move from a one-person medical model approach to a two-person psychology, the emphasis on social construction, context, and culture.

The third key insight is the idea that “normal” is a construction (Davis, 1995; 2010a). Normalcy—the idea of measurable norms—was a creation of pioneers of statistics in 19th
century Europe. They created the famous bell curve, its mean and standard deviations
categorizing people along lines of normal vs. deviant. Prior to these ways of categorizing people,
no culture had the concept of “normal” as we use it now; instead, the prevailing trend had been
to compare a human ideal against everyone else, with no one reaching the ideal. This was a
remarkable shift that coincided with the development of Darwin’s ideas of fittedness. I was both
surprised and not to discover that these statisticians were actually eugenicists, interested in
identifying and eradicating deviance. We use the term “normal” all the time without realizing its
sinister implications (Davis, 1995, 2010a; Longmore, 2003). Few people would say now that a
particular race, gender role, or sexual orientation is “normal” but this loaded term is frequently
used with impunity in discussions about disability (Davis, 2013).

Interestingly, the disability studies literature is in conversation with scholars in the areas of
feminist theory, queer theory, studies of race and class, postcolonialism—in short, they talk to all
the other identity politics scholars, the same ones with whom the psychoanalytic literature talks.
Even more, many of the disability studies theorists engage psychoanalytic theory (e.g., Goodley,
2011; Marks, 1999a, 1999b; Watermeyer, 2001, 2013. Most of this writing about psychoanalysis
takes up Lacanian theory, exploring the symbolic foundations of ableism (Goodley, 2011), the
extent to which the sense of bodily wholeness is an illusion (Watermeyer, 2013), and the idea of
“disability’s role as messenger from the real” (Watermeyer, p. 2013, p. 90). Theses writers also
take up how our culture engages in defense mechanisms to disavow our feelings of vulnerability
when considering the disabled body (e.g., Watermeyer, 2013). As Tom Shakespeare (1994) puts
it, people with disabilities are “dustbins for disavowal” (p. 283).
Psychoanalysis and Disability Studies

The contemporary psychoanalytic canon, however, very specifically excludes the disability studies literature, a curious oversight. For example, Lew Aron and Karen Starr (2013), argue that “psychoanalysis is situated in the midst of a hierarchical division of binaries into male/female, heterosexual/homosexual, white/black, and gentile/Jew. This is why we find racism, misogyny, anti-Semitism, and homophobia to be surprisingly relevant to the fundamentals of psychoanalysis” (p. 5). When discussing these and other binaries, though, Aron and Starr leave out the disabled/non-disabled binary, even as they make a strong case for enacting Freud’s ideal, that we should be “a psychotherapy for the people,” (Aron & Starr, 2013, p. xiii; Freud, 1918), which I presume includes all people, not just the non-disabled. Freud was writing in Europe at the height of the eugenics movement, so surely the notions of normalcy and deviance, disability and non-disability, were on his radar, making the absence of this binary in Aron and Starr’s writing that much more curious.

This is an oversight shared by myriad psychoanalytic writers, including those writing about embodied subjectivity (Aron & Anderson, 1998; Anderson, 2008). Much is written about how our body sense is constructed relationally, how embodied experience is brought into the analytic dyad (Aron and Anderson, 1998), how our subjectivity is inextricably linked to our “bodily grounding” (Anderson, 2008, p. x), how we use our bodies to register subtle aspects of intersubjective relating (Anderson, 2008), and how our bodies are an irreducible aspect of our vulnerability (Anderson, 2008). These writers discuss how bodies are raced, sexed, and gendered, though across the board they leave out that our bodies are also “abled.” There is no
mention of our status as disabled or non-disabled subjects anywhere in this writing, and our participation in the system of non-disabled privilege is left not theorized. There is mention of the analyst’s body when she experiences an illness (e.g., Gerson, 2001), but that writing never takes it as far as discussing disability and the politics therein.

When our literature does take up disability the medical model is privileged. This is ironic, given the supreme value we place on contextuality, social construction, and embodied subjectivity, as well as our rejection of a medical model of psychology (Watermeyer, 2013). We see this in the ableist tone and language in this writing and in the lack of reference to society’s role in a disabled person’s experience; instead, we locate the so-called tragic pathology in the individual and end our thinking there. These writers refer, for example, to patients’ deficits, the experience of being abnormal, and one autistic individual’s “unmanageable” and “alienating” behaviors (Gould, 2011). As a patient of mine recently commented, if we were to use words like these—“deficit,” “abnormal,” “unmanageable,” “alienating”—to describe an African American person we would be considered racist, but in the context of a person with a disability this language is not questioned. The tone of much psychoanalytic writing about disabilities is often unintentionally condescending and patronizing too, such as one writer suggesting the importance of helping these patients set “realistic goals,” to find “occupation[s]…suited to [their] talents and abilities,” (Dasteel, 2012, p. 252), and for the therapist to “feel pleasure with small gains and minimal changes” (Dasteel, 2012, p. 259).

Cathy Hannabach (2007) writes that “many disability, queer, transgender, postcolonial, and feminist theorists have been understandably suspicious of psychoanalysis for its complicities
with a medical model that constructs a normative body and pathologizes all of the embodiments, identifications, and desires that exceed such a norm” (p.256). This is highlighted in a case described by Lynne Jacobs² (2008). She announces her patient: he was “born with an obvious deformity” (p. 410). She then—apparently unwittingly—continues to use ableist language, stating that her patient feels “paralyzed” when required to consider others’ feelings, and referring to his “blindness to the otherness of the analyst” (p. 421). Disability studies scholars strenuously object to language linking physical impairments to negative human tendencies (Kleege, 2010), such as describing people as metaphorically lame, paralyzed, or blind. When talking about metaphorical blindness, Simi Linton (2006) asks, “how can the culture get away with attaching such an absurd proliferation of meanings to a condition that affects, simply, visual acuity?” (p. 213).

Jacobs draws us into her difficult experience with her patient. Her writing is beautiful, vulnerable, and intimate. She writes,

My desire to be recognized and affirmed surged like waves on our relationship.

The more he ignored my subjectivity, the stronger my desire surged. My work with him was messy, continually being infiltrated by my reactions to feeling disregarded and negated. (411)

Although recognition is a tall order in any case, I’m wondering, how much of Jacobs’ specific struggle has to do with unrecognized ableism being enacted in the dyad? To what extent is she enacting her own disavowed non-disabled privilege? Knowing how sensitive she is to structures of power and privilege—indeed, she is a leading theorist in the areas of social location and white

² The author wishes to express gratitude to Lynne Jacobs, both for her helpful comments in writing this chapter and for her permission to discuss her writing.
privilege--I know Jacobs would never consciously overlook this aspect of the work.

Psychoanalysis is interested the hidden meanings in things (Watermeyer, 2013). Although I am gratified to have found our non-disabled bias hidden in what seems like plain sight, I remain perplexed: if we really care about these types of ideas, how did we miss this one? I will briefly highlight a few possible explanations for our oversight. First, the language of ableism is insidious and slippery, the narratives ubiquitous yet very well hidden in both our psychoanalytic culture and the culture at large. A recent short film, popular on social media websites such as Facebook, shows a poor little boy with tattered clothes and shoes who covets the nice clothes and shoes of another boy he sees sitting on a bench nearby (Page, 2012). Then we discover that the little boy on the bench uses a wheelchair. The explicit message in the video is: be happy with what you’ve got! The grass isn’t always greener! But the hidden ableist message is loud and clear too: being disabled is worse than being poor; being disabled is most definitely something tragic that you don’t want.

This leads to my second observation, the extent to which we may unconsciously rank individuals with disabilities against those in other marginalized groups. A patient of mine, a young white man with cerebral palsy and mild intellectual disability, states unequivocally, “society treats me worse than a black person.” This is a provocative comment that says as much about the perceived ranking of marginalized groups as it does about how the black man has become the quintessential other. Even within the disability population there is a hierarchy of disabilities, with the physically and sensory impaired at the top, and those with mental disability at the bottom (Docherty, 2010, p. 438). Perhaps even more telling is another patient who recently fell, broke
her hip, and is struggling to take care of herself. She stated, “if I don’t take better care of myself I could die—or worse!—I could become permanently disabled.” Being disabled is apparently even worse than being dead, and you can’t get much more marginalized than dead.

Perhaps more relevant is the role of our own vulnerability. I am never going to be a Latina woman or a gay man, for example, but there’s a really good chance that at some point I am going to become disabled. The literature makes frequent reference to our status as “Temporarily Able Bodied” (Davis, 1995). This scares us, because on some level we know how society feels about people with disabilities. For the other categories of identity we can safely say that each represents a “me” or “not-me” attribute, but for disability that does not apply. The neoliberal trend (Layton, 2009) to disavow both our own vulnerability and our interdependence with others’ vulnerabilities might be at play here (K. Gentile, personal communication, 11/13), and in turn ableist attitudes may solidify neoliberal ones as well.

We can gain further insight from such writers as Steven Botticelli (2004) who demonstrates that as psychoanalysts we do have political concerns, though we often do not act on them outside the consulting room, unwitting participants in a system of “ameliorative projects” (p. 635) rather than true social transformation. He cites Philip Cushman’s (1995, p. 337) insistence that we not overlook the extent to which political structures may cause psychological suffering in our patients. Whereas we may be aware of this when it comes to race, gender, and so on, we have been slow to include the experience of being disabled.
I would also say that, despite our oversight, our collective psychoanalytic heart is in the right place. There are many examples of how we theorize other areas of identity extraordinarily well, and we can borrow some of these themes as we begin to theorize disability. For example, Lynne Layton’s (2006) seminal idea of normative unconscious processes (2006), as demonstrated in racial identity and racial enactments in the consulting room, is a natural fit with the disability studies theme of constructing normalcy. “Normative unconscious processes refer to that aspect of the unconscious that pulls to repeat affect/behavior/cognition patterns that uphold the very social norms that cause psychic distress in the first place,” (p. 242) she explains. And writers such as Adrienne Harris (2009) frame questions about, in her case, gender, that could be asked of disability as well, such as: can we question psychoanalytic accounts of disability? To what extent is disability a stable category? And how does a person come to participate in the disability/ability system? She implicitly asks us to take up the able-normative body that inhabits our theories and practices.

In any case, much is to be gained if we add a disability studies sensibility to our discourse. First, we can recognize the irreducibly political aspect of our work, understanding our own implicit ableism, how we co-construct the system of non-disabled privilege in which we participate. Harris (2009) writes, “we cure with contaminated tools. We are embedded in structures of money, hierarchy, and power, and we must keep a double vision in play. Psychoanalysts practice subversion and hegemony in every hour” (p. 16). Thinking about ableism—keeping this “double vision in play”—allows us better to understand our patients when they experience disabilities, particularly the mental disabilities that we as mental health clinicians are very likely to encounter. We can analyze the extent to which we may subtly discourage people with disabilities
from coming to our practices. And we can appreciate how in our professional ranks we exclude people with disabilities, either by implicitly requiring them to pass or hide their disabilities or by just not making our institutes accessible or truly inclusive.

**Medical Model Autism**

In the specific case of mental disability, Foucault (1964) notes that madness was considered special—a mad person was a wise person—prior to the age of reason, after which the warehousing of these others began. This was followed by construction of categories for “normal” and “deviant” bodies, as theorized by Davis (1995, 2010a). In our contemporary world we can see how a disability studies sensibility shines a light our construction of diagnostic labels too, particularly the diagnosis that fills me with endless fascination: autism. I will identify several trends.

First, when we apply the medical model to autism we mistakenly conceive of this condition as a cluster of allegedly measureable behaviors comprising the DSM criteria, rather than considering it in terms of an individual’s subjective experience in the context of the social environment (Emanuel, 2015). Behaviors fail to capture what is essential about autism. By way of example, if I were to take a Tylenol and then put my hand on my forehead you might imagine that I have a headache, but those behaviors would not be the headache. The same is true for autism—the behaviors are not the autism. Part of medical model autism consists of the metaphor of an autism spectrum (Solomon, 2012) “that fades into normality at one end” (p. 257). A
spectrum implies that someone’s behaviors can be measured and the person’s condition located somewhere along the spectrum of normal to deviant.

Furthermore, there is also no one-to-one correspondence between these behavioral criteria and the diagnosis of autism. Lots of things look like autism behaviors but are not (e.g., schizoid phenomena, some aspects of narcissism, certain presentations of fetal alcohol spectrum disorders, and the behaviors of some highly gifted individuals), and autism itself can have many different behavioral manifestations. My patient Lexi puts it best: “I could have two of these diagnostic criteria and you could have the other three criteria that I don’t have, and we’d still be given the same diagnosis and treatment. How absurd is that?!?” Furthermore, professionals frequently conflate autism with the other diagnoses that often accompany it.

The behavioral criteria also fail to consider that autistics are sometimes not autistic, and I, to the extent that I may not read someone correctly, am sometimes autistic. Even the best readers of others do so far less than 100% of the time. For example, when building Legos with my autistic patient Ryan a few years ago, I noticed that I wished I could find Lego wheels to buy, just the wheels, for the vehicles my patients liked to make. I kept this wish to myself, though the very next week Ryan came in with an entire box of Lego wheels he had bought for me. “How did you do know I wanted these?” I asked. He responded, “I just knew.” This led to my conviction that autism is a state, not an always/only/forever trait. The medical-model literature, though, treats it as an all-or-nothing phenomenon, even when it offers data suggesting otherwise. For example, when describing one of his studies Hobson (2002) writes, “Ten of the thirteen children with autism never referred to emotional states, whether correctly or incorrectly” (p. 56). He makes no
comment, though, about the three of thirteen autistic children who did refer to emotional states.

Medical model autism also does not include the role of context in making the diagnosis. This is extremely ironic, given that autism is an impairment of poor social engagement. In the right environment, autism is not an issue, with autistic minds highly valued in many circumstances. Autism is not like the chickenpox or a broken arm, where no matter the context you’d still have a legitimate impairment.

So, medical model autism has too many moving parts and too many undecidable, equivocal cases, and even too many undecidable moments in an individual who has legitimate autism. At best we can think of autism as a metaphor that applies to some people some of the time, depending upon the situation. A social model autism shifts the focus from the impairment to the context, and the case I will present below illustrates that. Aron & Starr (2013) use Derrida’s concept of “undecidables” (p. 47) to bust the binaries—the artificially sharp distinctions—that plague psychoanalysis. We can use this concept as well to deconstruct the medical model of autism. Instead, we can see that autism is an unstable category (see Davis, 2010b), with more variation within groups than between, that is only problematic to the extent that the context considers it to be such. Stuart Murray (2012) emphasizes, and I agree, that we cannot assume that autism always represents an illness (p. 37).

Lexi, A Human Subject

Lexi, a Japanese-American young woman I see, was diagnosed with autism during her early elementary school years when her teachers noted that she had no friends and tended to drift off
into her own world, replaying scenes from Star Wars and the anime Sailor Moon verbally and in her imagination over and over again. She would flap her hands and spin, also known as “stimming,” when excited. She did not pay attention in school. Lexi was excluded by peers and bullied. It was assumed that she was intellectually disabled.

Her parents were stunned to learn, when she was evaluated at UCLA, that she was both autistic and highly gifted. She was reading at an 11th grade level even as her peers were just beginning to sound out words. The evaluators also noted her extreme sensory sensitivity, something I consider to be at the core of autism. Lexi subsequently received an IEP—an Individualized Education Program—in which she was sequestered in special education programs. This involved her being pulled out of the regular classroom for speech therapy and other services. All the children knew where she was going, causing Lexi to feel even weirder than she already did. Lexi was placed in social skills groups where she learned that there was something wrong with how she communicated with other kids. She was instructed to adopt the social skills of the highly social, extroverted majority, who sat in clusters of desks at school and were expected to complete collaborative group projects.

Her parents were ashamed of Lexi, wanting desperately for her to be normal. Filled with anxiety from the pressure at home and at school, Lexi would stim frequently. Her parents punished her for that, attempting to extinguish this so-called inappropriate behavior. Lexi later described to me that her chronic anxiety was, at times, terrifying.

Lexi’s parents took her to psychiatrists beginning in her 3rd grade year, where she was given
medication to help her focus, though it was not clear that she actually had ADD. When she was older, she was prescribed medication for the mood symptoms that were often made worse by the ADD meds. These interfered with her sleep and so Lexi was given medication for sleep. Groggy in the mornings, her ADD meds were increased. This went on for years, a sort of pharmaceutical death spiral, culminating in a series of excruciatingly traumatic hospitalizations where Lexi was restrained and forcibly medicated. Stripped of her dignity, Lexi was grossly misunderstood to be a cluster of maladaptive behaviors rather than a human subject.

The most important factor in Lexi’s recovery has been the realization that the dominant, highly social majority culture has been unfairly imputing to her the requirement to adopt its social skills and be “normal,” rather than giving her the choice whether and how to join the social environment. I didn’t try to change anything, but rather she helped me see—and I then helped her see—how she was being misunderstood. More than anyone I’ve worked with, Lexi exemplifies that the culture’s response to her autism has been much worse than the autism itself. She was assumed to be more impaired than she really was, over-medicated, and taken advantage of by care providers who gave the impression that they were more expert in the area of autism than was truly the case.

Lexi, who knows I am writing about her in this chapter, would like you to know how angry she is to have been repeatedly harmed by the medical-model system, othered by the very system designed to help her. She would also like you to know the advantages that autism offers while at the same time emphasizing that it represents, for her, an impairment and a disability. She has told me many times, “Just because I’m not reading as many social cues as you are doesn’t mean I’m
reading *nothing*.” Lexi has shown me that the view from the margins can be interesting. She takes great comfort in organizations such as the Autism Self Advocacy Network (ASAN), a community supporting a neurodiversity agenda, very much in line with disability studies thinking, and madinamerica.com, an online forum for mental health advocacy that is stridently anti-psychiatry.

There are many treatments that are extremely helpful, if not essential, for autistic people, including psychiatry for some. I want to make it very clear that I don’t question that. Rather, it is the ableist tone and attitude toward autism, seen in both the mainstream and the psychoanalytic literature, that troubles me to no end. Lexi once told me, “You want the missing part of the culture and so do I.” When we add a disability studies sensibility we do construct a better autism, one that captures what is essential about this condition while at the same time appreciating the extent to which it is constructed.

A disability studies sensibility helps me think about the exquisite care and thoughtfulness we should take when applying normative data to an individual person in the service of cure. It also helps me think of diagnostic labels such as autism as potentially helpful starting points when understanding individual people, though not good endpoints. It helps me realize how, in treating individuals with disabilities, the psychoanalytic profession may inadvertently harm these patients with our ableist biases, our normative unconscious processes. And it helps me unhinge autism and other disabilities from categories of normalcy and deviance.

I don’t want to end without acknowledging how controversial it is for me, a non-disabled person, to be writing about disability. I experience the unearned privilege that comes from being non-
disabled, and, in the case of autism, neurotypical. I’m part of the disability/ability system, as I construct it and am constructed by it. This chapter is a call better to theorize the body that shows up in psychoanalytic discourse. But beyond that, there are significant limits to my position (Linton, 2006, p. 138). Therefore, with deep respect I call on disabled persons to speak with more authority about their experience than I can, as I attempt to honor their important slogan: “nothing about us without us” (Linton, 2006).
References


Media Arts Production. (Available at http://www.youtube.com/watch?v=SolGBZ2f6L0).


*Disability and Society, 9*(3): 283-299.


