



# Neurodiversity with Nuance

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**Abstract** The neurodiversity movement grew out of the autism community but is now being applied to many neurological types, from dyslexia to schizophrenia. The resulting neurodiversity paradigm maintains that these neurological differences are normal variations in the human species, like race and sexual orientation, which should be valued and accommodated, not “fixed” or eliminated. Yet some clear-eyed individuals view their brain differences as deficits and would continue to seek treatment in the absence of discrimination or lack of accommodation. I argue that fully appreciating cognitive diversity requires more nuanced normative claims that respect individual differences and fluid circumstances. Although analogies to minority statuses can be useful, variations in personality traits provide a more flexible and inclusive model for neurodivergence. Despite ultimately rejecting the biodiversity metaphor, a more nuanced neurodiversity paradigm emphasizing our shared humanity can promote compassion, respect, and support for all.

**Keywords** Neurodivergence · Neurotypical · Mental health · Disability · Discrimination

## Introduction

Wandering the streets of Seattle in 2013, you might have seen a tactless ad for Seattle Children’s, a hospital and research center. Plastered on metro buses was a picture of an adorable smiling child with the charge, “Let’s wipe out cancer, diabetes and autism in his lifetime.” The ads were swiftly pulled after public outcry over the implication that autism, part of many people’s identity, should be exterminated (*Seattle* [1]).

The reaction to these ads illustrates the moral concerns of the neurodiversity movement. The term “neurodiversity” developed within the autism community to represent the idea that such variation in human brains is natural and valuable [2–9]. The frequent pathologizing of autism, as in the Seattle Children’s ad, is roundly rejected. Nick Walker, an autistic self-advocate and leading theorist in neurodiversity studies, writes: “Professionals who truly understand the neurodiversity paradigm would no sooner attempt to ‘treat’ a client’s autism than attempt to ‘treat’ a client’s homosexuality, or attempt to ‘treat’ a client’s ethnicity” ([10]: 117).

The term “neurodiversity” simply refers to the existence of many types of human brains—an uncontroversial phenomenon, not a thesis. But the term is meant to promote a new *paradigm*, a philosophical foundation for a social movement aimed at eliminating discriminatory attitudes and policies. Neurodiversity is often modeled on biodiversity, which recognizes not only the variety of organisms in an

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environment but also aims to value every one of them as part of a healthy ecosystem. The paradigm is now extended by many theorists and advocates to dyslexia, dyspraxia, and attention-deficit/hyperactivity disorder (ADHD), though some also include obsessive–compulsive disorder, substance use disorder, schizophrenia, and other categories found in diagnostic manuals for mental disorders [3, 11–13].

The concept of neurodiversity has undoubtedly enriched the dialog about mental health and social justice. Both the neurodiversity paradigm and the corresponding movement have helped raise awareness about problems with a rigid pathology paradigm and the importance of promoting greater acceptance and accommodation of neurodivergence. There remains debate, however, about when pathologizing of neurodivergence is problematic and how far the neurodiversity paradigm can be extended beyond conditions like autism and dyslexia to many other neurological differences [14–18].

The neurodiversity paradigm clearly makes normative claims about neurodivergences being mere differences not deficits, which require societal accommodation not treatment. Yet some clear-eyed individuals view their autism, ADHD, schizophrenia, or other brain differences as deficits and would continue to seek treatment in the absence of discrimination, stigma, or lack of accommodation. I will argue for a more nuanced approach that respects these individual differences. Recognizing a “cognitive continuity” among the neurotypical and atypical provides a philosophical foundation for a more nuanced approach to neurodiversity that applies well beyond autism to virtually all people. Although analogies to minority statuses and biodiversity can be useful, I’ll argue that variations in personality traits provide a more flexible and inclusive model for neurodiversity. By emphasizing our shared humanity amid neurological differences, we can still promote compassion, respect, and support for all.

This nuanced view is arguably a friendly amendment to the neurodiversity paradigm. However, discussions of neurodiversity are complicated and evolving. As Robert Chapman has put it: “Neurodiversity means a lot of different things to different people” ([3]: 218). Some theorists on both sides of the debate have gestured toward a more complex approach to neurodiversity [4, 14, 15, 17]. My aim is to explore a more nuanced neurodiversity paradigm while lacking

the space to completely develop its relationship to numerous moral and metaphysical issues about mental health, disease, and wellbeing. The resulting view is surely incomplete or otherwise flawed, but the exploration aims to further dialog on these important issues of social justice for neurodivergent people.

### Accommodation and Intervention

The *neurodiversity paradigm* brings together both empirical and normative claims. The empirical thesis states that there is such a wide range of individual differences in brain function that it makes little sense to talk of a “normal brain” or “normal mind.” The normative thesis adds that these differences are not defects that need to be cured. Just as we should value and preserve all species as part of a healthy ecosystem, we shouldn’t “wipe out” autism, dyslexia, and other neurological conditions. (Throughout I use “condition” in its normatively neutral sense, as in the “human condition” or when evaluative descriptors are necessary to describe an item as either in “good condition” or “bad condition.”).

Although neurodivergent people can have limitations or disabilities, it doesn’t follow that we should pathologize neurodivergence. One could regard an individual with an atypical brain or body as being disabled but believe that *society* is the primary cause of the limitations, not the individual [7, 10, 16]. As the psychologist and autistic activist Jacqueline Den Houting contends: “Even for those autistic people with the highest support needs, disability often can be minimised or avoided through environmental change and the provision of appropriate assistive tools” (2019: 271). The idea is that neurodivergent people deserve accommodation, not intervention.

Discussions of disability traditionally focus on physical impairments, such as paraplegia or blindness, but we can extend these discussions to cognitive differences as well. The standard *medical model* pathologizes disability as undesirable itself and regards the individual as the primary target of treatment [19]. In contrast, the *social model* holds that any disadvantages from one’s disability arise solely or primarily from “society’s failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation” [20]: 32). The

target of treatment is society, not the individual. Consider that many societies around the world now mandate wheelchair accessible ramps and audible crosswalk beacons. Once these accommodations are in place, the relevant class of citizens are no longer impaired with regard to that activity—they can wander the streets and enter public buildings, just like everyone else. With sufficient support, accommodations, and time to adjust to their condition, many disabled individuals report relatively high life satisfaction (see e.g. [21]).

Another set of obstacles is negative attitudes in others: the stigma, bias, and pity directed toward those who are disabled. The offices of a tech company might allow physical access for individuals who use wheelchairs, but prejudice against the disabled can prevent them from being hired or from climbing the corporate ladder within. Similarly, a sensory-friendly concert might allow autistic individuals to enjoy the show without sudden drastic changes in the volume or lighting. But a bias in favor of “normal” behavior—such as “the expectation of eye contact in job interviews” [10]: 55)—can prevent an autistic employee from becoming the theater’s operations manager. Such limitations on disabled people’s acceptance in the community, and economic mobility, can impair quality of life, but these limitations appear to lie in prejudice, not disabled people.

Unlike impairments in mobility, barriers for the neurodivergent are most often the prejudice built into societal norms. Compare homosexuality, which was categorized as a mental disorder until the 1970 s. Gay people have certainly experienced many psychological problems—including stress, trauma, and suicidal ideation—but because of harassment, assault, and stigma, not brain dysfunction. Some autism advocates accordingly argue for accommodation via *acceptance*. One way involves “preserving autistic ways of being” ([22]: 272), such as highly restricted interests and repetitive bodily movements (stimming) that help autistic individuals cope with over-stimulation. Often clinicians and parents seek to eliminate these traits and behaviors, but that’s regarded by many in the neurodiversity movement as an overbearing attempt to “correct” the individual, merely to conform to present social expectations. It’s often both more compassionate and productive to simply accept an autistic person’s unusual hand flapping or fixation on presidential birth dates.

But is it ever appropriate to correct, rather than accept, one’s neurodivergence? Consider Jack Ori [23] who has written about how masking his autism is sometimes an authentic decision to adapt rather than to conform to unreasonable expectations of a neurotypical world. In some situations, Ori happily adopts neurotypical behaviors, such as making a point to thank a coworker for feedback. In other cases, he chooses not to conform. After being told for years that attending office parties and engaging in small talk were part of the job, he decided to work for himself by becoming a freelance writer. The suggestion is not that acceptance is never appropriate, as Ori himself emphasizes, but rather that it’s appropriate in some circumstances but not others. (Indeed, there may be no bright line between acceptance and intervention.)

We can see this mixture of intervention and acceptance in other neurotypes as well, including schizophrenia. In her memoir, *The Center Cannot Hold*, Elyn Saks [24] describes psychotic episodes in which she experiences a “shattered” mind, rife with delusions, hallucinations, incoherent thoughts, and speech that she describes as “word salad.” Such episodes do impair her agency and diminish her wellbeing, but most other times she manages her symptoms well, which allows her to hold a distinguished professorship at the University of Southern California. Saks attributes her flourishing to a mixture of treatment and acceptance: medication and therapy but also loving friends and an accommodating work environment.

Saks’s case also illustrates how diagnostic categories aren’t monolithic. A diagnosis then is not enough to draw an inference about the patient’s experience, agency, or wellbeing—either in general or at any particular time. Psychiatric symptoms can come in short episodes and often only locally disrupt aspects of one’s psychological capacities [25–27]. As with autism, schizophrenia and other neurological conditions lie on a spectrum, depending on individual differences in brain function and circumstances, including cultural context [28].

The mixing of elements from the medical and social models of disability seems to resonate with many neurodivergent people. One qualitative study found that this mixture of models is prominent among individuals experiencing a variety of mental health conditions, from bipolar disorder to OCD [11]. Similarly, a group of researchers who surveyed hundreds in the autism community found that “autistic people’s

apparent acknowledgment of their deficits and acceptance of means to ameliorate them challenge a purely social model of disability in which oppression alone creates disability” [29]: 68).

A mixed model makes sense partly because neurological differences vary *across* individuals as well as across time *within* the same individual. We saw that Saks only sometimes experiences symptoms of schizophrenia, just as neurotypicals only sometimes experience distorted cognition, anxiety, or loss of self-control. For neurotypical and atypical individuals alike, such experiences are *fluid* over time. They fluctuate depending on one’s circumstances, particularly stressors, such as financial hardship, isolation, and exhaustion. Thus, it would be a mistake to think only that there are different types of autism, schizophrenia, dyslexia, and so forth. Rather, all neurotypes—even relatively homogenous categories—can impact one’s mental life differently depending on the circumstances.

The call to accommodate, then, mustn’t be too sweeping or lack nuance. The complexities are compounded when we imagine applying blanket acceptance to characteristics of other neurological conditions. Should people accept their crippling anxiety, debilitating depression, or substance abuse? Walker writes that whether a neurodivergence is something to accept or correct “all depends on what sort of neurodivergence one is talking about” ([10]: 32). But cognitive variation cautions against such categorical thinking. Whether a neurotype should be treated doesn’t depend primarily on the diagnostic category. All conditions present quite differently among distinct people and across time. Obsessions and compulsions about doing the right thing might be admirable, particularly to highly religious individuals [30]. Mild addiction to an illicit drug might be acceptable if it enhances an artist’s career without harming others [31]. Even anxiety, when it doesn’t go off the rails, serves the important function of alerting us to something that isn’t right [32]. Considerations like these suggest we ought to avoid asserting that quite general categories should always be accommodated and are only disabling in the absence of acceptance and other forms of accommodation.

We’ve seen that it’s difficult to apply a strict version of the social model to a heterogenous classes of individuals and experiences over time. A more nuanced approach is needed. The medical and social models

don’t necessarily exhaust the possible approaches to disability. As Elizabeth Barnes writes of physical disabilities: they can be “bad *for some people* even in the absence of ableism” although “that doesn’t mean they are bad simpliciter” ([33]: 98). We could similarly adopt a nuanced approach that accounts for how cognitive disabilities can accrue either costs or benefits depending on the particular individual’s brain differences and social conditions. Rather than jettison the social model altogether, it can be blended with elements of the medical model, which can still fit the spirit of the neurodiversity movement [7]: 2 [4]).

However, proponents of the neurodiversity paradigm typically reject any elements of a medical model because it still pathologizes neurodivergence. Should neurodivergence ever be viewed as a deficit?

### Difference and Deficit

The neurodiversity paradigm is meant to provide a framework for viewing neurotypes as mere differences. Walker writes: “Those who have embraced the neurodiversity paradigm, and who truly understand it, do not use pathologizing terms like ‘disorder’ to describe neurocognitive variants like autism” (2021: 13). Instead of focusing on the ways autistic people might struggle to navigate social events, self-advocates often detail advantages, such as pattern recognition, mathematical acuity, and empathic connections with nonhuman animals [34, 35].

To illustrate this perspective, consider a description of neurotypicality from the fictional Institute for the Study of the Neurologically Typical:

*Neurotypical syndrome* is a neurobiological disorder characterized by preoccupation with social concerns, delusions of superiority, and obsession with conformity... Neurotypical individuals often assume that their experience of the world is either the only one, or the only correct one. (quoted in [36]: 250).

This satirical description shines a light on how autism is typically pathologized by clinicians and family members as a deficit to be fixed. Proponents of neurodiversity often call for wholesale rejection of the pathologizing of autism, even for those who cannot live independently. As Chapman and Carel document, there are “many instances of autistic persons,

*all along the spectrum*, publicly stressing that they are fully capable of living good and happy lives” ([37]: 619). To dismiss this testimony is an epistemic injustice arising from prejudice and paternalism.

Similar rejections of pathology are present within the Deaf community. Many Deaf people do not view their inability to hear as something inferior that needs to be fixed with cochlear implants, but rather as an essential part of their identity and community [38]. Consider Sharon Duchesneau and Candy McCullough, a Deaf couple who chose to use a sperm donor who was also congenitally deaf [39]. There was some chance of giving birth to a hearing child, which they would have welcomed with love, but they were delighted to have two children, born 5 years apart, both of whom are Deaf.

Of course, the Deaf community is not a monolith. Some Deaf people view cochlear implants as a tool for providing other auditory experiences. Partly for this reason the National Association for the Deaf no longer opposes cochlear implants. The association now “recognizes the rights of parents” and “respects their choice to use cochlear implants and all other assistive devices” (quoted in [40]: 47). Like the debate about cochlear implants, we can avoid false dichotomies that force a choice between whether deafness is a deficit or a mere difference.

Similarly, although some autistic individuals do see their neurological condition as part of their identity, that does not preclude a desire to seek treatment as a tool for modifying their present mode of thought. Indeed, many autistic individuals do not regard these attitudes as mutually exclusive. The group of researchers who surveyed autistic people found that “self-identification as autistic and awareness of neurodiversity reduce neither acknowledgment of deficits associated with autism nor support for ameliorative interventions” [29]: 66). Perhaps precisely because autism presents along a wide spectrum, it is only regarded as a mere difference sometimes or in some respects.

Similar sets of mixed attitudes are present among other neurodivergent populations as well. Many people grappling with major depression, anxiety, or personality disorders adamantly seek cures, even when they view their condition as a central part of who they are. Many schizophrenics would gladly take a magic pill, free of side effects, that effectively eliminated visions and silenced disembodied voices.

Yet others embrace their “nonconsensus realities.” Chacku Mathai says of his hallucinations, “My experience is so rich. I wouldn’t trade it for anything” (quoted in [41]).

Similarly, many people with ADHD seek treatment, such as medications, in addition to accommodations at school or work. These practices seem compatible with pathologizing their neurotype to some degree. Yet others don’t take medications and view their ADHD as part of who they are, even if something to keep in check. A person in this group might have coworkers, friends, and family who simply know them as someone who tends to get easily distracted, forget details, and rambles. Still others might find themselves somewhere in the middle. The journalist Matilda Boseley [42] has tried to explain this “interwoven web of my identity and my disorder” when she writes: “We aren’t saying it’s incorrect to call ADHD a ‘disorder’, just that it might be a touch too narrow.”

Respecting the great variation within categories might require us to avoid talk of what “autistic people prefer” or what “Deaf people want.” That holds even if the implicit quantifier isn’t *all* people within the category but *most*. Of course there is some commonality among people who are part of a community. At the same time, we mustn’t overgeneralize. To adopt a phrase from Mel Baggs [34], we must navigate “the twin oblivions” of “But we’re not all like that!” and “Thank you for showing me The Autistic Experience™.” Ultimately, a nuanced approach to neurodiversity requires that we examine experiences as they arise in particular circumstances, not broad medical or psychiatric categories. Some experiences cause individuals distress, but not always and not for everyone. So “difference, not deficit” and even “difference *as* deficit” are too rigid.

The need for nuance is appreciated by some commentators, but they only go part way. Regarding autism, some argue that we should distinguish between levels of autism and only apply the neurodiversity paradigm to some individuals, such as those with “high functioning” autism (e.g., [6, 18, 43, 44]). However, even this approach involves categorical thinking, with problematic categories like “high functioning” which implicitly rank individuals along a spectrum. Although there may be useful diagnostic divisions to be made, there are no bright lines that cleave deficits from mere differences. For some autistic people who cannot live independently, it could be

appropriate to conceptualize their condition as more of a difference than a deficit, especially given the right environment and social support. Some autistic individuals with relatively low support needs, such as Temple Grandin ([45]: 50), identify with their diagnosis, but others do not. Author Jonathan Mitchell says of his autism, “I hate it” and “I wish there were a cure” (quoted in [46]). Donna Williams, an Australian author and artist, expressed a similar pro-cure view in her memoir *Somebody Somewhere*:

The most important thing I have learned is that AUTISM IS NOT ME. Autism is just an information-processing problem that controls who I appear to be. Autism tries to stop me from being free to be myself. ([47]: 238)

To capture the variety of cases, we can embrace a nuanced paradigm that rejects categorical thinking or sweeping claims about which kinds of neurological conditions are mere differences in human brain function.

### Minority vs. Personality

Many proponents of the neurodiversity paradigm would reject a nuanced approach because neurodivergence is viewed as analogous to diversity in categories like race, gender, and sexual orientation, which should never be considered deficits (e.g., [9, 10, 16]: 16). John Marble, an autistic self-advocate who has worked for the Obama administration, once expressed this forcefully on social media:

“THERE IS NO SUCH THING AS SEVERE AUTISM, just as there no such thing as ‘severe homosexuality’ or ‘severe blackness’” (quoted in [43]).

The analogy to ethnicity and homosexuality is most plausible if we don’t define autism and other neurodivergence as inherently problematic. Some autistic people do injure themselves (and others) and experience debilitating seizures, but these are regarded by some theorists as co-occurring conditions not inherent to autism itself. Non-autistic people can have seizures and self-injurious behavior too, after all. Chapman gives the example of smoking as a form of self-injury taken up by neurotypical people, and yet we don’t “thereby think of neurotypicality itself as

a disease” ([3]: 381). Even if self-injury is more common among autistics than smoking is among neurotypicals, neither defines the class.

Of course, other traits are arguably inherent to autism while being deficits for some people some of the time. Candidates include sensory sensitivity and communication difficulties [15]: 58). Perhaps these too could be regarded as co-occurring, but the dispute becomes merely terminological and perhaps a kind of “nosological gerrymandering” [18]: 507). Similar difficulties arise for other neurotypes, such as ADHD and schizophrenia. Inattention, impulsivity, delusions, and hallucinations are arguably inherent to these conditions and perceived by some patients as deficits. Rather than attempt to cast these as extraneous, we can embrace nuance by regarding some of these experiences as deficits for some people some of the time. Whether one’s sensory sensitivity, distractibility, or voices are a problem depends partly on the person’s values and circumstances.

If neurodivergence is like race, we cannot account for this variability. On that model, we shouldn’t even pathologize autistic people who are nonverbal and cannot live independently. Pro-cure autistics like Mitchell and Williams are as mistaken as a man who regards his sexual attraction to other men as mental disorder. This is a form of adaptive preference driven by internalized oppression or other false consciousness, like women in deeply patriarchal societies who are happy with arranged marriages, polygamy, or honor killings.

However, we should be cautious about dismissing the testimony of those who construe their neurodivergence as a deficit. As Barnes [33] has argued in the case of physical impairment, we should err on the side of believing what people say about how their own disability affects their wellbeing. Barnes is concerned to counter-act the prevailing tendency to disbelieve those who value their disability, such as the writer Rebecca Atkinson who is blind or Ben Mattlin, an editor and public radio correspondent who has spinal muscular atrophy. But the deference cuts both ways. Testimonial injustice should be avoided regardless of whether the testimony is positive or negative [33]: 78). In either case we should resist “the imposition of a single story,” as Chapman [14] puts it.

To avoid yet another exclusive single story, we could follow Barnes on physical disability and construe neurodivergence as neither good nor bad as

such, even if it can be good or bad for some individuals. A neurodiversity paradigm allows for this nuance. The primary claim is that there's no one right neurological type, not that there are no pathological ones [14]. Even when it comes to sexuality, we can deny that there is one right sexual orientation while understanding pedophilia as pathological. Chapman helpfully views the neurodiversity paradigm as not pathologizing neurodivergence *by default*. When individuals seek treatment for their neurotype, Chapman [48] recommends describing this as “neurotype dysphoria,” which is meant to avoid pre-judging whether this is something to respect or reject as internalized oppression. Yet we should avoid putting this in categorical terms. If pathologizing is said to be appropriate for epilepsy and psychopathy, but not autism or dyslexia, then we can't respect the identities and testimony of both Temple Grandin and Donna Williams. We need a different model for neurodiversity.

Personality types might do the trick. Consider the “Big Five” traits: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. These were intended by personality psychologists to be normatively neutral descriptions of traits that lie on a continuum and together form personality types. Although some of these traits, such as “neurotic,” have developed negative connotations, personality types aren't pathologized by default. They are mere differences in general, although they can be bad for some people in certain circumstances. Some introverts accept that their social batteries have limited capacity and accordingly limit socializing to reduce stress. Others find that their introversion goes too far by letting valued relationships languish in the long term. These introverts might deliberately seek a “cure” or at least treatment through psychotherapy and self-help books. Although personality traits are relatively stable, some research suggests that people can deliberately change their personalities over time and thereby improve life satisfaction [49, 50].

Similar variability can be found with other personality traits. You might embrace your high conscientiousness, identifying as someone who pays attention to detail and respects the rules. Yet I might reasonably regard my high conscientiousness as making me a stick in the mud who values rules more than relationships. Neither of us needs to be wrong. You might sensibly embrace your identity as a “worrywart” while I yearn for more tranquility when faced

with the same level of neuroticism. Similarly, many people value being open to new experiences, such as exotic foods and counter-culture lifestyles. Others might regard these tendencies as barriers to enjoying stability, laying down roots, and building long-lasting relationships. Even agreeableness, despite its positive connotations, can make for push-overs and people-pleasers.

These examples show that personality can serve as a model for regarding traits as mere differences in general while recognizing they can be deficits for some, not due merely to lack of accommodation. Many aspects of modern society are structured better for extraverts. Introverts who skip the litany of office parties and other social events can miss out on opportunities for career advancement, for example. Yet some introverts can reasonably view their predicament as primarily caused by a deficit in themselves rather than discrimination, stigma, or unaccommodating circumstances. In contrast with minority statuses, personality types can be reasonably construed as individual deficits for some people but not others.

### Dimensions of Demarcation

So when is it appropriate in a particular case to treat a personality type or neurotype as a deficit or a mere difference? We can only partially answer this question here. Whether one's autism or schizophrenia is a deficit depends partly on the individual's conception of their own life and identity [3]: 384), but self-identification as merely neurodivergent isn't enough. A person with antisocial personality disorder might value their unsympathetic, no-nonsense character without fully appreciating how it's damaging their relationships. Whether antisocial personality disorder is a deficit, rather than mere difference, probably depends on more than the individual's values and preferences.

Compare how similar complexities arise for physical conditions, such as infertility [33]: 18). Is the inability to reproduce a disorder? It depends, and not only on the patient but in some cases the joint values of a couple or community. Other examples blur the line between physical and psychological conditions, such as low sexual desire. One person can embrace a low libido and adapt, while others are happy to take medication to restore a source of pleasure and bonding that has been lost to stress and aging.

Negotiating the difference/deficit divide doesn't depend only on community values or consensus either. Chong-Ming Lim ([16]:570) has us imagine a hypothetical community of pedophiles who complain about being historically disadvantaged and urge society to accommodate their neurocognitive differences. This community sentiment alone isn't enough to undermine the pathologizing of pedophilia.

It would be ideal to have a complete theory of when a trait is a mere difference versus a deficit, but we shouldn't hold our breaths while we wait. Like the storied distinction between treatment and enhancement, the search for a clear and principled demarcation may be in vain. Fortunately, we needn't have a complete theory to know that neurodivergent identity will require nuance. The truth in the mere-difference claim is that it is possible for someone to fall within a diagnostic category while accepting it as part of their valued identity (sometimes described by psychiatrists as "ego-syntonic"). In such cases, it may be appropriate to avoid pathologizing the individual's identity. In other cases, it's appropriate to regard the individual as having a deficit for which they reasonably seek treatment.

None of this makes sense if we treat neurodivergence like homosexuality or race. Drawing on minority status as a model, one prominent version of the neurodiversity paradigm rejects pathologizing of any "innate or largely innate neurodivergence" that gives rise to "intrinsic and pervasive factors in an individual's psyche, personality, and fundamental way of relating to the world" [10]: 31). However, as Chapman points out, anencephaly seems to meet these criteria despite being quite clearly a deficit for the infants who live tragically short lives with little cortical development [3]: 377). Such infants may not be fully conscious, so a better counterexample might be heritable forms of epilepsy, which are largely innate and certainly have pervasive effects on a person's fundamental way of relating to the world.

We can't avoid these issues by adding the criterion that to be a mere difference the individual must regard the neurodivergence as unproblematic (ego-syntonic). Again, self-identification as merely neurodivergent isn't enough for the neurodiversity paradigm to apply. Many cases of personality disorder involve deficits of impulsivity, paranoia, and grandiosity that often lead to broken relationships, self-harm, unemployment, and prison time [51]. These are arguably deficits in

many cases, even when patients beg to differ. Similarly, sociopathic traits are largely innate brain differences that give rise to pervasive features of an individual's psyche, yet these individuals often (problematically) value their callous and unemotional character [52]. Some personality disorders might be mere differences when the patients find ways to value their traits and flourish [48]. Patric Gagne [53] identifies with being a sociopath and has managed to channel her "callousness" into objective assessment for her therapy patients. She has even found her version of love with her husband and keeps at bay her tendencies toward theft and manipulation. Gagne's situation, however, doesn't generalize to all cases.

It's ultimately doubtful that a neurodiversity paradigm applies only to largely innate or pervasive features of a person's psyche. Dyslexia may be largely genetic, but it impacts a rather specific area of life: reading words. Autism looks to be partly genetic, but its causes are still under investigation. The empirical facts matter less here than the counterfactuals. Even if it turned out that autism and dyslexia were largely caused by environmental factors, such as exposure to mercury or lead, these conditions are not thereby deficits. Compare clear cases of mere differences, such as savant syndrome. The ability to perform rapid mental arithmetic, for instance, affects a rather small part of one's mental life and can be either congenital or acquired after traumatic brain injury. So a neurodiversity paradigm still seems appropriate, regardless of whether a neurological difference is innate or impacts much of one's mental life.

Personality provides a better model for neurodivergences than homosexuality or ethnicity, because it avoids these problems. We treat some forms of conscientiousness as mere differences, even when this trait is acquired later in life and affects a relatively small portion of one's experience. And whether a personality trait is a mere difference is determined by more than self-identification. It's possible for an introvert—or extravert—to fail to recognize or appreciate the ways in which their personality type is detrimental. Perhaps the harms are only seen by an insightful therapist, a sympathetic family member, or a friend who feels the pangs of a withering relationship. We can still make sense of oppression and disadvantage, as when extraversion becomes overly valued in society such that introverts miss out on social events that are key

opportunities for career advancement. Accommodation and social acceptance of differences is possible while at the same time acknowledging that some individuals can rationally seek treatment for their personality or neurotype. Of course, many neurological conditions, like deafness and dyslexia, aren't best thought of as personality types. The point is rather that personality serves as a model for more nuanced normative claims about neurodivergence. There is room for cases in which neurodivergence is sometimes a mere difference, sometimes a deficit—and the demarcation depends only partly on one's own values.

We can even embrace this nuance while retaining categories. Compare how introversion remains a category even though it comes in degrees and can be a liability. For those who do identify with a category, bonding with others who have similar experiences can be profoundly meaningful and therapeutic. As one woman with schizophrenia put it: “when people talked about feeling like they're Jesus Christ, I was like, ‘Oh, my God, I'm not the only one?’ In group, I don't feel alone, and feeling alone is like something crushing my chest” (quoted in [41]). Indeed, unlike most personality types, many neurodivergent people are marginalized, stigmatized, and downright oppressed. Autistic and schizophrenic people, for instance, are frequently pitied, ignored, underemployed, and forced to undergo therapies that teach conformity to neurotypical demeanor. This is what may justify labeling such neurodivergent individuals as “neurominorities” [10]. Yet being marginalized needn't be essential for application of a neurodiversity paradigm.

A nuanced approach to neurodiversity is compatible with identities that can provide individuals with self-understanding, community, and solace. The key is to embrace neurocognitive identities while avoiding neurotribalism. Neurotypical people find it tempting to “other” those diagnosed with neurological conditions: *they* experience distortions in perception and thought, unlike *us*. If there is a parallel with racial identity, it might be what Tommie Shelby [54] calls *interracial unity*. Shelby envisions “a society in which the members of different racial groups have a sense of goodwill toward one another and think of themselves as collectively constituting one people,” which is to be “founded on mutual respect and understanding” (265). Similarly, we can adopt an integrationist ethos

in which the neurotypical and atypical alike maintain a pervasive sense of neurological unity.

Consider some parallels in how acceptance and accommodation are sometimes appropriate for the neurotypical. All parents are partly in the business of teaching their children, which includes sometimes correcting their behavior. Yet parents of neurotypical children often do, and should, balance correction with acceptance. When a young child can't sit still in a restaurant, a wise and compassionate parent will in some circumstances accommodate more than correct. She might dine at more kid-friendly restaurants, ensure adequate sleep and exercise prior to the event, or avoid giving the child loads of sugar. Or the parent might just accept that the child will need a break from sitting still and occasionally run around the restaurant—judgmental looks be damned. If the child's behavior becomes too disruptive, harmful, or disrespectful, then correction might be in order, even if the behavior results from features of the child's personality or identity. It depends on the context.

Accommodation via acceptance is also present in self-improvement among neurotypical adults. Imagine a friend who becomes frustrated by her tardiness and her propensity to dominate conversations while incessantly tapping out rhythms on the table. Sometimes it will be appropriate for her to expect more punctuality of herself or to let others get a word in, even if her friends, family, and coworkers don't mind. Other times attempting to change oneself is morally and prudentially questionable. It's often best to accept yourself for who you are and to let friendships fizzle if it's all too intolerable for them. The right approach depends on the circumstances. General rules are possible, but they're beyond the scope of this discussion to provide them.

We should perhaps envision a “great continuum” of human agency and mental health [55]: 268), such that the neurodivergent and neurotypical are “different only in degree” (266). However, even this statement might involve categorical thinking by presuming two well-defined and importantly distinct groups: the neurodivergent and the neurotypical. We should resist such categorical thinking, except when necessary for practical purposes. For example, cognitive continuity is compatible with only permitting someone diagnosed with schizophrenia a prescription for haloperidol. There are no doubt extreme cases. Some patients with schizophrenia, substance use disorder,

depression, and so on experience symptoms that are quite powerful, frequent, and treatment resistant. These cases look rather different from those rare neurotypical individuals who enjoy great mental stability and tranquility, even in the face of adversity. Differences of degree might be large enough to warrant distinct categories. However, it is crucial to recognize that the extremes within broad categories do not represent the norm.

### Oppression and Pathology

The neurodiversity paradigm nobly calls for an end to the stigmatization and oppression of people with atypical brains. One might worry that, without a strict social model of disability or an unqualified avowal of “difference not deficit,” neurodivergent individuals will be unjustly oppressed by being pathologized. Walker writes that “framing autism as a pathology fosters a societal mindset in which autistic modes of embodiment, expression, and communication are stigmatized as pathological symptoms rather than accommodated” ([10]: 55).

The predominant pathology paradigm certainly has presumed a singular and overly narrow standard of what is neurologically normal. Stigma, even pity, can particularly harm individuals through social marginalization. People regarded as mentally ill become increasingly cut off from many of the interactions with others that humans so often crave and need to thrive, such as love, friendship, and community. As David Shoemaker puts it, “when people find out that someone has a ‘mental illness,’ they tend to recoil, fearful, and tend to avoid socializing with, falling in love with, or hiring that person as a babysitter, for example” ([56]: 36). Some employers have even used personality tests to screen job applicants, which can be used to discriminate against autistic people [57]. Such social exclusion can exacerbate one’s stress and depression, which promotes further exclusion, forming a vicious loop [58].

However, stigma and oppression are importantly distinct from claims about mere-difference and accommodation. One could even adopt the pathology paradigm while raising awareness about neurodiversity, seeking to create inclusive environments, and chastising those who disregard, disrespect, or dismiss neurodivergent people. This is common ground

between the neurodiversity paradigm and its opponents [3, 17, 18]: 343,[15]: 60). Many researchers, health professionals, and disability advocates have sought, for example, to reduce prejudice against blind people, to empower their independence and integration into society, and to increase societal accommodations—all while continuing to classify blindness generally as a neurological deficit. Against this backdrop, blind people can, like Jeffrey Ricker [59], declare: “I wear my blind identity proudly.”

A nuanced approach to neurodiversity promotes compassion and respect in part because it forces us to recognize our shared humanity. We often treat mental disorders as rare and categorical—something *others* suffer from. The more we see mental health as lying on a fluctuating continuum, the more it can be seen as similar to other conditions that impact everyone, not just those who have an extremely atypical body or mind. A recent meta-analysis of experimental research backs this up, suggesting that thinking of mental health on a continuum reduces stigma toward those with mental disorders [60].

We can see the benefits of emphasizing continuity and personality in Zanzibar. On this island off the coast of Tanzania, people with schizophrenia who experience hallucinations are regarded as being taken over by spirits, which is unfortunate, but it happens to everyone from time to time, even if to a lesser degree among the neurotypical [61]. Rather than being stigmatized and ostracized, individuals with schizophrenia are integrated into the community and appear to enjoy better overall health. These positive outcomes seem to arise from social integration and emphasizing continuity, not a belief that spiritual possession is never problematic or entirely due to lack of accommodations. Cultural beliefs in Zanzibar do reduce prejudice, which the social model of disability targets, but the point is that reduced stigma can result precisely from a focus on continuity and a diversity of personality types, rather than categories modeled on racial identity or sexuality.

Variation *within* neurotypes does suggest continuity *between* such groups and among everyone else. Psychiatric research consistently finds that diagnostic categories overlap and exhibit fuzzy boundaries that are often arbitrary [62]. Indeed, few individuals considered “neurotypical” experience perfect mental health. Far from a calm, rational, restrained font of joy, the neurotypical mind is rife with distorted

thoughts, from cognitive biases like wishful thinking and denial to false and selective memory (e.g., [63–66]). Neurotypical minds also regularly experience negative feelings, such as guilt, sadness, anxiety, impulsivity, and stress about family, finances, health, and appearance (e.g., [67, 68]). So placing a person in a diagnostic category does not necessarily imply that their mental life is categorically different from neurotypical individuals.

If a personality model needn't stigmatize neurodivergence, it certainly needn't medicalize it either. Even if introversion can be legitimately conceptualized as a deficit for one person, that doesn't mean it should be labeled a disease or disorder and listed in diagnostic manuals. Some personality flaws, such as impulsivity and callousness, are medicalized to some degree in diagnostic manuals, but others are not, such as greed and cowardice. Whether to label a condition a disease (or disorder) is a distinct question partly because doing so puts it under the purview of the institution of medicine, and there are various legitimate reasons for or against doing so. The disease or disorder labels can be useful for understanding the causes of a condition, for getting insurance coverage for treatment, for reducing blame for individuals with the condition, and more [69].

To be clear, diagnostic categories do exist and are important. Often a diagnosis becomes appropriate because the symptoms are more severe, persistent, or disruptive to one's performance at school or work. Such differences in degree can be stark enough to warrant a distinct category [70]. Like the age of eligibility to vote in elections, some cutoff is necessary. We can embrace a strict voting age of 18 while recognizing that some 16-year-olds are more mature than some 20-year-olds, that the "over 18 category" includes sages in their golden years, and that the "under 18" category includes infants. We likewise need psychiatric categories for purposes of treatment and insurance reimbursement, but we should recognize that the divisions are somewhat arbitrary and mask great variation [71–73]. For these reasons, a large consortium of psychiatrists has developed and propounded a dimensional, rather than categorical, taxonomy of mental disorder [62].

Our primary concern, however, has not been with legal or medical labels. We've been asking prior ethical questions about whether neurotypes should be considered deficits, as well as when and how to

treat others with respect and increase accommodations. Although these questions are related to concerns about medicalizing and insurance coverage, they are distinct and beyond the scope of the present analysis. It might be that autism is a mere difference for some—making a neurodiversity paradigm apt in those cases—and yet for practical purposes we should keep it in diagnostic manuals (as arguably with schizophrenia) or remove it completely (as with homosexuality). Some neurotypes, such as ADHD, might instead occupy the uncomfortable zone of inconsistency, similar to infertility and low sexual desire, which are regarded in some contexts as health conditions but not in others. Limitations on time, money, and attention might require positing categories for the purposes of research, diagnosis, and insurance coverage. But we should recognize that what counts as a disease or disorder—where we draw the line—is partly scientific, partly moral, and partly arbitrary. A nuanced conception of neurodiversity is compatible with diagnostic categories but provides a conceptual and moral framework for cautioning against our propensity to reify them, to give them more reality than they warrant [71].

A nuanced approach would recognize that we can respect the humanity and rights of individuals regardless of whether their neurotype is sometimes pathologized or medicalized. Some individuals can reasonably regard their neurotype as a mere difference, not a deficit, while others with the same neurotype pathologize it. Such apparent inconsistencies are reconciled by acknowledging that, like personality types, there is great variation in neurological types including whether one reasonably regards a neurological difference as a valued identity.

## Conclusion

The neurodiversity movement has made important strides in understanding neurological differences, empowering individuals to value those differences, and urging more ethical treatment of the neurodivergent. More people now are being accepted, valued, and accommodated in ways that promote their flourishing and a more just society. Further progress may require a more nuanced paradigm.

A nuanced approach avoids two extremes. The pathology paradigm pathologizes neurodivergence

by default, from autism to schizophrenia. A common approach to neurodiversity instead counts autism and other forms of neurodivergence as always and everywhere mere differences, never appropriate targets of treatment. The pathology paradigm insists that Temple Grandin and Chacku Mathai are simply mistaken in thinking that their neurodivergence is a mere difference, while the standard neurodiversity paradigm insists that Donna Williams and Elyn Saks are simply mistaken in thinking that their own neurodivergence is an appropriate target of treatment. A nuanced paradigm instead takes cognitive continuity seriously and suggests that each approach errs in making absolute, categorical, universal claims about all instances of autism, ADHD, schizophrenia, and other neurodivergence. Instead, we should promote more inclusive and nuanced normative claims akin to how we regard personality. One in the same neurotype can sometimes and in some respects be a mere difference hampered only by lack of accommodation, while at other times and in other respects it's a deficit that would persist even in the absence of ableism.

A nuanced paradigm also cautions against analogies to ethnicity and biodiversity. Unlike lions, tigers, and bears, human beings really are of the same species. Individual differences in brain function are quite unlike the phenotypic differences between a beetle and a Bengal tiger. It's tempting to break humans up into categories, but it can mislead us into positing deep differences between groups and homogeneity within them. Although cognitive variation is the norm, we are more alike psychologically than we are unlike. We all lie on a continuum of neurotypes, akin to personality types that are sometimes mere differences, sometimes deficits.

The approach defended in this article, though surely incomplete, attempts to sketch a view that is largely absent in discussions of neurodivergence. Some theorists might happily regard the nuanced approach as a version of the neurodiversity paradigm that allows for variability and pathologizing of some neurotypes (compare [14]). Others will regard this as no better than the pathology paradigm. Any attempt to view cases of neurodivergence as even sometimes appropriate targets of treatment might seem "illegitimate and harmful in the same sort of ways as racism, misogyny, and other forms of bigotry" [10]: 107). These are complicated and justly sensitive issues.

My aim is not to settle the matter, but rather to offer another paradigm in good faith and with good will.

## Declarations

**Competing interests** No competing interests to disclose.

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