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21 Models of helping and coping with autism

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Introduction

Better understanding parents' and autistic people's different approaches to addressing the problems they face may help to shed light on the ethical and practical issues raised by tensions among and between these primary stakeholders in the autism community (Pellicano & Stears, 2011). Empirical evidence suggests key differences and overlap between autism's cure movement (led by parents and supported by academics and practitioners) and the neurodiversity movement (led by self-advocates: Gillespie-Lynch, Kapp, Brooks, Pickens, & Schwartzman, 2017; Kapp, Gillespie-Lynch, Sherman, & Hutman, 2013), although a growing number of non-autistic parents have joined the movement as allies (Langan, 2011). This chapter traces the history of autism from the perspective of parents and autistic people, applying Brickman et al.'s (1982) models of helping and coping to paradigms of autism not limited to but culminating in the medical model and neurodiversity movement. In the process, like Brickman et al. (1982), this analysis provides evaluations of which views and actions promote subjective well-being, recognising the importance of toxic stress to development (Singh, 2012) and happiness to quality of life (Ne'eman, 2010).

Brickman et al. (1982) take care to distinguish between attribution of responsibility for problems and solutions, a distinction with critical implications for helping and coping. They argue that in terms of the origin of problems, it is most beneficial not to blame people, because then people will be more willing to seek help and be perceived as deserving it. With regard to finding solutions, they present strong evidence that it is more effective to hold people, and view oneself as, responsible, because attributing solutions to oneself increases motivation and competence. People have the most power to get help and cope when not blamed for problems but given credit for solutions, because they are more likely to have the respect and opportunity to get help and can more actively control help towards solutions.

Parents and autistic people have made or been subjected to attributions of responsibility for all combinations of onset and offset of problems related to autism. Professionals and society have unjustly blamed parents for causing autism, isolating and judging their family. As scientific progress absolved parents of blame, parents organised a dominant movement to cure autism, viewing it as separate from their innocent children. Instead of leaving families on their own or breaking them up as before, now autistic people often receive too much and inappropriate help, suffering mistreatment and becoming dependent, as others do for them what they could do for themselves. Autistic people also often develop learned helplessness from other experiences, such as trying to fit

in but getting rejected, feeling ashamed and lonely. When offered help for their disability, many try to avoid it, not wanting that which could mark them as different. Yet, increasingly, autistic people come to embrace their differences through the neurodiversity movement, which attributes disability mostly to systemic factors that problematise those outside the norm. As self-advocates, autistic people must take control over our lives with the support needed for full participation in society.

Models

Moral model: refrigerator mother theory and parent-blaming

Under the moral model, people are held responsible for problems (which they supposedly create because of personal failings) and for solutions to them (Brickman et al., 1982). Over the course of autism's history, the most prominent example (as applied to the parents' perspective) is the refrigerator mother theory of autism, which harmfully blamed mothers (and fathers to a lesser degree) for causing autism (Sarrett, 2011).

The refrigerator mother theory damaged parents and their autistic children. Amid a clinical climate in which psychoanalysis and mother-blaming dominated, a psychiatrist who recognised autism as a distinct condition, Leo Kanner (1949), blamed what he considered parents' coldness and obsessiveness for their child's withdrawal into autism. While the moral model tries to encourage people to gain motivation for self-improvement, including from peers (Brickman et al., 1982), this professional orientation caused parents to feel guilty and shunned by society. This is consistent with the weaknesses of the moral model stated by Brickman et al. (1982), especially its tendency towards loneliness. Many families suffered further, as psychologist Bruno Bettelheim offered autism's first purported cure, breaking up families by institutionalising children (Offit, 2008).

Since then, the refrigerator mother theory has become discredited. Aside from the fraudulence of Bettelheim's work on treating autism (Offit, 2008), the premises on autism itself were untrue. Regarding causation, a neurological revolution demonstrated the biological basis of autism (Silverman & Brosco, 2007). Regarding autism's features, parents and their autistic children tend to form secure attachments (Gernsbacher et al., 2005). Indeed, the depth of the child's autism appears unrelated to the quality of the parent-child relationship (Beurkens et al., 2013).

Public, professional, and self-blaming of parents abound. Given autistic children's generally typical physical appearance and behaviours that others often experience as disruptive, onlookers may regard them as spoiled, rude brats, reacting angrily and insensitively (Gray, 1993b). Similarly, moral judgements and rejection happen more frequently to autistic people with subtler manifestations of autism and who make more active social attempts (Shtayermann, 2007), probably because they are more likely to be perceived as odd rather than disabled (Weiner, 1993). Many professionals, especially (and unfortunately) some of those who clinically work with families, still hold parents as at least partially responsible for "invisible" neuropsychiatric disabilities, although understandably familiarity with the parent disability community (such as support groups) tends to reduce blaming (Johnson et al., 2000). Even parents often blame themselves, regardless of the perceived cause, such as feeling guilty for passing on their genes if they make a biological attribution (Mercer et al., 2006),

or for environmental exposures if they believe toxins (for example, in vaccines) trigger autism (Fitzpatrick, 2008). This may produce insecurities that detract from the child's needs.

A variety of cultures have blamed parents for causing autism, and while often harmful, these beliefs do not always interfere with helpful parenting. Few psychoanalysts practice with autistic people anymore in the West, except in France, where the misguided approach has caused increasing controversy (Chamak, 2008; Houzel, 2018). South Koreans (among other cultures) sometimes blame mothers for causing autism, associating it with reactive attachment disorder; the stigma isolates families and poses obstacles to obtaining needed services (Kim, 2012). Yet the Navajo, while traditionally regarding autism as the result of witchcraft for punishment of past wrongdoing by the family, immediately come to accept autism after a healing ceremony and proactively include autistic people in society (Kapp, 2011).

Meanwhile, Western society at times continues to insinuate that parental influence such as parent-child interaction and the screen time their baby receives may contribute to the development of autism (e.g. Gordon, 2020). For example, the media pounced during the height of the COVID-19 pandemic on a poorly designed recent study (Heffler, Sienko, Subedi, McCann, & Bennett, 2020) that failed to show this using a weak screening instrument (Guthrie et al., 2019). Reflecting not only the flaws of the study but also the backlash against the legacy of the refrigerator mother model, scientists leapt to critique the study (Science Media Centre, 2020), which also received publicity (e.g. Haridy, 2020).

Medical model: pro-cure movement

According to the medical model, the sick or diseased person is neither responsible for the origin nor the solution to his or her problems; instead, the professional knows best. This combination stands opposite the moral model; the medical model seeks to absolve people of blame and encourages the use of help (Brickman et al., 1982; Weiner, 1995). Nevertheless, it fosters dehumanisation and dependency (Brickman et al., 1982; Kapp, 2019), of major concern given the model's dominance in autism. Its aggressive interest in a cure also hinders more helpful coping.

While the transition from the moral to the medical model reduces judgement and empowers parents (Farrugia, 2009), it lowers expectations for autistic people (Chambres et al., 2008), with destructive effects at times. After Bernard Rimland, through his credibility as both a psychologist and father of an autistic son, organised parents into a medical movement, the field began to adopt Rimland's view at the time of autism as an organic disorder (Silverman & Brosco, 2007). Yet with professionals' emerging position on autism as a developmental disability rather than parent-induced psychosis came expectations of little learning or remediation and instead institutionalisation, devastating prospects that parents defied with belief in a cure (Gray, 1993a; Stone & Rosenbaum, 1988). Psychologist Ivar Lovaas claimed to offer recovery through intensive behavioural intervention (Ne'eman, 2010), but thought that autistic children were so deficient in social motivation that he needed to abuse (e.g. electric shock, slap, scream) them so they would learn (Koegel, 2011; Larsson & Wright, 2011). While those aversive practices have mostly ended, behaviourists continue to defend Lovaas (Koegel, 2011; Larsson & Wright, 2011) and questionable treatment continues as

desperate parents experiment with unproven and sometimes dangerous types of alternative medicine (Fitzpatrick, 2008).

Damage from such low expectations often extends into interfering with family and community life, as seen from the example of bilingualism. Learning two languages does not harm, and may even help, autistic children's development of language and communication (Hambly & Fombonne, 2012; Ohashi et al., 2012; Peterson et al., 2012; Valicenti-McDermott et al., 2013). For young children generally it helps to promote theory of mind, executive functioning, and pragmatics (Akhtar & Menjivar, 2012). Yet many professionals and some parents think learning multiple languages will stunt the child's growth (Yu, 2013), even though the family may speak and value the native language (Jegatheesan, 2011).

Similarly, the medical model operates from a deficit basis that pathologises neutral differences and even strengths, illustrated through oxytocin as a treatment for autism. Oxytocin, while famous for helping people trust and bond with in-group members, also raises conformity with the in-group, and promotes envy, gloating, conflict, and ethnocentrism towards out-group members (see Stallen et al., 2012, for a review). It is not necessarily different in autistic children (Miller et al., 2013), as acknowledged by a group of researchers (Dadds et al., 2014). Yet they studied it as a treatment for autistic children anyway, and found it did not help, recommending caution against it (Dadds et al., 2014). One might question the ethics of trying to increase oxytocin and whether it might remove autistic people's possible tendency towards reduced prejudice against out-groups (Kirchner et al., 2012), yet the medical model encourages compliance with even coercive treatments so long as they are provided by experts (Brickman et al., 1982).

Among further evidence against the medical model, parents and their child cope better when parents take a more positive approach. In cultures such as where religious or spiritual beliefs hold that a child with a disability is a blessing (Blacher et al., 2013; Carr & Lord, 2013; Dychess et al., 2004), or interdependent social structure means that parents expect to have closer, more personal social networks and more time caregiving as a normal fact of life, as in Cuba (Sotgiu et al., 2011), parents perceive more positive impact from having an autistic or otherwise disabled child. Parents who begin with a medical orientation also tend to cope better over time by moving towards a positive perspective, reframing their attitude towards their child (such as an exciting challenge rather than a threat: Cappe et al., 2011; Roesch & Weiner, 2001) and making appropriate lifestyle adaptations. For example, religiosity and spirituality themselves tend to help, while participation in religious activities (which may be overwhelming for the child) may hinder, parents' well-being (Ekas et al., 2009). Seeing the child's autistic traits as positive characteristics rather than as symptoms not only reduces parents' stress but also instils more confidence in the child's ability to do things for him- or herself and in the child's future (as with ADHD: Lench et al., 2013). This encourages the young person to take risks and make personal discoveries through experience, reducing parents' tendency towards overprotectiveness (for example, discouraging their teenager's interest in dating: Nichols & Blakeley-Smith, 2009).

Unfortunately, while this model of autism has adapted and encountered resistance, the medical model remains the dominant lens through which society views autism. Despite heavy personal and financial investment in early intensive behavioural interventions, no autism therapies for young children show strong evidence, due to weak study designs or risk of bias (Sandbank et al., 2020). Applied behavioural analysis-based studies especially suffer from conflicts of interest for which they rarely account (Bottema-Beutel, Crowley, Sandbank, & Woynaroski, 2020). The approaches with the most evidence have responsive, naturalistic, developmental principles, such as following the child's lead (Kapp, 2018; Sandbank et al., 2020). Nevertheless, autistic people continue to be dehumanised, pathologised, and essentialised because of the pervasiveness of the medical model, not least approaches that reduce autism to a social disorder (Kapp, 2019).

Enlightenment model: learned helplessness

Like the moral model, the enlightenment model holds people responsible for creating their problems, but instead of people solving the problems themselves (which they are seen as unwilling or unable to do), the model has authorities help people work through problems. Under both models, people may have caused their problems through low motivation. The closest match in autism is social motivation theory, according to which reduced interest in people from infancy on causes young children to withdraw from or less actively engage in social interaction, -reducing social learning and leading to the cascading impairments of autism in need of treatment (Chevallier et al., 2012). A comprehensive challenge to this theory is beyond the scope of this chapter, but evidence shows that autistic people often show strong social drives (strong emotional empathy, reduced prejudice, and diverse relationships) but often struggle to interact with at least non-autistic people (Kapp, Goldknopf, Brooks, Kofner, & Hossain, 2019a). Before becoming aware of their autism, many autistic people do blame themselves for their differences, until diagnosis (e.g. in adulthood) offers a sense of explanation and relief (Leedham, Thompson, Smith, & Freeth, 2020; Punshon, Skirrow, & Murphy, 2009). Yet the tenets of social motivation theory appear incorrect, and ironically the negative self-image required by the enlightenment model (Brickman et al., 1982) perpetuates learned helplessness rather than motivation to comply with interventions.

Consistent with the enlightenment model's requirement that people must accept a starkly negative self-concept (in order to submit to others' control, a point addressed later in this section), as autistic people become more "enlightened" about their differences, they tend to view themselves as more incompetent, which increases distress. Children and adults with subtler autism (Mazurek & Kanne, 2010; Sterling et al., 2008), more emotional awareness (Capps et al., 1995), closer friendships (Mazurek & Kanne, 2010), and higher cognitive abilities (Mazurek & Kanne, 2010; Sterling et al., 2008; Vickerstaff et al., 2007) tend to regard their autism as more severe and endorse more anxiety and depression, likely reflecting increased internalisation of stigma of difference. Similarly, during adolescence, a time when identity and fitting in become most salient, social anxiety tends to increase for autistic youth even as it decreases for typically developing peers (Kuusikko et al., 2008). Autistic youth with higher cognitive abilities and anxiety – and, thus, probably, self-awareness – are more likely to take risks, motivated by fear of failure, even as that increased anxiety tends to inhibit typically developing peers (South et al., 2011).

Despite growing self-awareness and willingness to take risks, many autistic youth make attempts to fit in that prove unsuccessful. Many make regular initiations towards peers but suffer high rates of loneliness-inducing rejection (Bauminger et al., 2003). Many students face alarming rates of peer victimisation, with heightened sensitivity to ridicule and memory of past mocking experiences; some sadly come to expect it (Sreckovic, Brunsting, & Able, 2014). Loneliness; low support from classmates, friends, and parents; anxiety; and withdrawal all contribute to depression among autistic youth (Kapp et al., 2011).

Autistic youth have options that could improve their relationships or coping but require some acceptance of their differences in contrast with the enlightenment model. They might have better relationships if they pursued them with other social “misfits”. Rejected children report the most interest in interacting with autistic peers once aware of their disability (Campbell et al., 2005). In turn, autistic children, adolescents, and adults often prefer the atypical communication style of one another (Granieri, McNair, Gerber, Reiffler, & Lerner, 2020; Morrison et al., 2020), because of their similarities in communication behaviours (Granieri et al., 2020) and assumptions or demands (Heasman & Gillespie, 2019). Many autistic people experience a sense of belonging together or find they relate to one another exceptionally well (Crompton, Hallett, Ropar, Flynn, & Fletcher-Watson, 2020; Schilbach et al., 2013), with autistic people matching non-autistic people in the effectiveness of their communication among their own group (Crompton, Ropar, Evans-Williams, Flynn, & Fletcher-Watson, 2020). Furthermore, some support services may help, but autistic youth may dislike them for fear of stigma and harm to their reputation (Camarena & Sarigiani, 2009; Humphrey & Lewis, 2008) – and supports become less available after secondary school (Gerhardt & Lainer, 2011; Shattuck et al., 2011).

Self-perceptions aligned with the enlightenment model lead autistic and other people to become fixated on their problems and redesign their lives around ultimately gaining the self-control to deal with them, even when the real problem lies in external factors. Most autistic youth perceive themselves as different, which many blame for social failures (Barnhill, 2001) and negative events (Barnhill & Myles, 2001), all of which tends to depress them (Hedley & Young, 2006; Meyer et al., 2006). Many such self-conscious youth and adults exert effort to inhibit unusual behaviours or “pass” for neurotypical. Such attempts to mask autism or camouflage tend to worsen mental health, but many autistic people feel obligated to engage in it (e.g. to reduce bullying: Mandy, 2019). While they may receive more acceptance from typically developing peers with more passive interaction styles given the stigma of atypical social approaches (Jones and Frederickson, 2010), that phenomenon reflects unfair norms. Instead of attributing social rejection to individual differences such as in personality, it may be more accurate to attribute them to attempts of the in-group to maintain status over out-group members, requiring social change (Killen et al., 2013). Indeed, despite the listing of social-emotional reciprocity as a deficit of autism, reciprocity must work both ways, and frequently non-autistic people fail to demonstrate it (Milton, 2012).

A growing body of evidence supports the double empathy problem model that the social challenges autistic people experience lie in the mismatch between autistic and non-autistic people’s communication styles (Milton, 2012). While autistic people and non-autistic people share information well among their own group, communication breakdowns happen between autistic and non-autistic people (Crompton et al., 2020b). Non-autistic people often fail to read autistic people’s behaviour (Sheppard, Illai, Wong, Ropar, & Mitchell, 2016), such as facial expressions (Brewer et al.,

2016), and this misunderstanding appears to contribute to unfavourable impressions both via experimental performance (Alkhalidi, Sheppard, & Mitchell, 2019) and self-report (Gillespie-Lynch et al., 2021). Indeed, non-autistic children and adults tend to quickly make negative judgements against autistic peers (Stagg et al., 2014; Sasson et al., 2017) based on factors that have more to do with the non-autistic perceivers than the autistic people (Morrison, DeBrander, Faso, & Sasson, 2019). Autistic and non-autistic people implicitly acknowledge this mismatch by self-reporting more autistic traits when interacting with or perceived by their out-group than their in-group (fellow autistic or non-autistic people: Gernsbacher, Stevenson, & Dern, 2017). Despite these data demonstrating the empirical failures of the enlightenment model but providing support for Milton (2012), fellow autistic scholar Chapman (2021) offers a compelling social ecological model that society benefits from this neurodiversity, such as from a cognitive division of labour.

Compensatory model: neurodiversity movement

According to the compensatory model, people suffer not from internal deficiencies but the failure of the social environment to provide the resources they deserve, requiring people to take the lead in solving their problems or transforming the environment. Brickman and colleagues (1982) imply that the civil rights movement belongs under this model, offering the Reverend Jesse Jackson as an example. Similarly, the neurodiversity movement operates out of the civil rights tradition. As Brickman et al. (1982) note, this model may be superior because it encourages people to seek help (since they are not responsible for the problems), but they must exert control over their lives (since they must determine how to leverage help towards solutions).

The neurodiversity movement believes that autistic people's disability lies mostly in an inaccessible, oppressive society designed for the privileges of the neurotypical majority, but that they must solve the problem through identifying as a community in solidarity with other minority groups (Baker, 2011). It began in response to self-advocates' perceived exclusion by parents' advocacy efforts and seeks the full participation of autistic people in society, especially in matters about them (Chamak, 2008; Sinclair, 2005). Family-led autism advocacy organisations continue to focus predominantly on causation and children, creating alarms about an autism "epidemic" and the urgent need for early intervention while neglecting the reality and needs of adults (Gerhardt & Lainer, 2011; Milner and Cho, 2014; Stevenson et al., 2011). Like other stigmatised groups (Frable et al., 1998; Salmon, 2013), self-advocates in the movement obtain social support from meeting with others with similar experiences, but they also encourage one another to take pride in autism as a natural, essential part of themselves (Chamak, 2008; Kapp, 2020). Although acceptance of autism both personally and from others (Cage, Di Monaco, & Newell, 2018), and outness as an autistic person and autistic community connectedness benefit autistic adults' mental health (Botha, 2020), the movement has attracted most controversy for its opposition to curing autism.

In particular, the chief claim against neurodiversity is that it does not apply to or serve the interests of "low-functioning" autistic people (see, for example, Jaarsma and Welin, 2012), which appears related to Brickman et al.'s (1982) main critique of the compensatory model – that it puts pressure on people (presumably especially the most vulnerable) to solve problems they did not create. Yet leaders of the neurodiversity movement prioritise ensuring that everyone has a reliable means of communication (Ne'eman, 2010; Robertson, 2010), such as through augmentative and alternative

communication methods, which work best when matched with the user's preference (Van der Meer et al., 2012). Similarly, parental following of their autistic child's lead tends to increase the child's language, especially for more language-impaired children (Kapp, 2018; Kapp, 2013). Autistic people with self-injurious, aggressive, or destructive behaviours (Ruef and Turnbull, 2002) and who struggle to communicate (Rossetti et al., 2008), likewise stress the need to exercise control over their lives. It is a matter of ethics and quality of life, as increasingly recognised by the developmental disabilities field, that all people should exert as much self-determination over their lives as possible, regardless of intellectual ability or support needs (Petry and Maes, 2009). Furthermore, much of the controversy seems intertwined with misunderstanding the overlap of the neurodiversity framework and the medical model in that advocates of both recognise that autism can inherently challenge quality of life and support (certain) means of ameliorating those aspects, as demonstrated empirically (Kapp et al., 2013; Gillespie-Lynch et al., 2017) and voiced by autistic scholars and activists (Bottema-Beutel, Kapp, Lester, Sasson, & Hand, 2020; Kapp, 2020).

The compensatory model seeks to build deprived people's power, and the critique of the neurodiversity movement often falls into a pattern of underestimating the "hidden" abilities of autistic people with higher support needs (Courchesne, Meilleur, Poulin-Lord, Dawson, & Soulières, 2015; McGonigle-Chalmers et al., 2013). Although excessive emphasis on autistic strengths might play into savant or "shiny aspie" tropes (Broderick & Ne'eman, 2008), even non-speaking autistic children deemed "untestable" often demonstrate visuospatial peaks of ability typical of autistic people (Courchesne et al., 2015), which are more common in individuals with lower verbal skills (Bölte, Dziokek, & Poustka, 2009). Most autistic adults have reported strengths they associate with autism when asked (Russell et al., 2019) and a social identity as autistic enhances the impact of these strengths on autistic people's self-esteem (Cooper, Cooper, Russell, & Smith, 2020; Cooper, Smith, & Russell, 2017) and quality of life (McDonald, 2020, 2017). Adopting an identity as an autistic person (for example, viewing autism as an equally valid way of being) similarly benefits the well-being and reduces stigma for both formally and self-diagnosed autistic people (McDonald, 2020; 2017), which suggests the benefits of the neurodiversity movement for self-diagnosed people's coping. While thinking of one's autistic traits as adaptable rather than static also benefits quality of life (McDonald, 2020, 2017), this again does not necessarily conflict with the neurodiversity movement, given the movement's support for mitigating challenges. Indeed, some autistic traits or diagnostic behaviours help to cope with others. For example, repetitive movements or vocalisations (which have been reclaimed by autistic advocates as stimming) help to soothe overwhelming sensations and emotions (Kapp et al., 2019b).

The neurodiversity movement offers a variety of possible solutions to problems. In addition to social solutions such as services, non-discrimination protections, and respectful attitudes (Baker, 2011), the movement appears compatible with some clinical solutions. Direct evidence suggests near-universal recognition of autism's challenges and support for some means of mitigating them, with the goal of adaptive skills to navigate society (Kapp et al., 2013) rather than normalisation for its own sake (Ne'eman, 2010).

Some problematic treatments may be modified in their goals and what they target, such as parents who consider themselves allies applying behavioural therapy in ways they consider compatible with

neurodiversity (Savarese, 2010). Intense and focused interests that typify autism provide intrinsic motivation for knowledge and a positive “flow state” of engagement when immersed in them (Grove, Roth, & Hoekstra, 2016; McDonnell & Milton, 2014), and incorporating interest-based activities into daily life often has the therapeutic effect of improving functioning (Dunst, Trivette, & Hamby, 2012; Gunn & Delafield-Butt, 2016; Winter-Messiers, 2007; see also Murray & Lawson, 2005). Self-advocates also benefit from collaborating with non-autistic allies (Schwartz, 2004), which also helps parents (Greenburg & Des Roches Rosa, 2020). Accepting their autistic child helps parents understand them, which in turn improves the parent–child relationship (Oppenheim et al, 2012). Critically, the quality of support, rather than disability characteristics, appear to promote quality of life from autistic people’s perspective (Renty & Roeyers, 2006).

As awareness of the neurodiversity movement has grown, so have attitudes aligned with it: viewing autism as a positive identity that needs acceptance rather than a cure, yet still supporting amelioration of challenges (Kapp et al., 2013; Kim, 2020). Similarly, the networks of autistic co-researchers who join participatory autism research teams (Willingham, 2020) and of professional autistic autism researchers (Nuwer, 2020), continue to grow and make an impact (Nuwer, 2020; Willingham, 2020). For example, co-authoring articles that demonstrate the stigmatising effect of autism’s puzzle piece symbol (Gernsbacher, Raimond, Stevenson, Boston, & Harp, 2018) and of ableist language practices (Bottema-Beutel et al., 2020). This has led respectively to the journal *Autism* abandoning that representation of autism (Pellicano et al., 2018) and *Autism in Adulthood* adopting the language guidelines. This chapter began in 2009 (as university coursework) and the empirical evidence that has since emerged in support of the mismatch of autistic and non-autistic people’s communication styles and the damage of camouflaging exhibit how the neurodiversity movement continues to change the autism research landscape and beyond. Change cannot come soon enough; poor coping for too many autistic people results in autistic burnout (chronic exhaustion, skills loss, and reduced tolerance of stimuli: Raymaker et al., 2020). Autistic people are more likely to experience trauma but the relationship with suicidality is weaker than for non-autistic people (Pelton et al., 2020), yet people’s resilience has a limit.

Conclusion

The neurodiversity movement has earned its match with Brickman et al.’s (1982) overall preference for attribution of responsibility for the offset but not onset of problems. Through its social rather than personal deficit orientation, the neurodiversity movement has encouraged autistic people to accept and seek help that they might otherwise find too stigmatising. As a rights-based movement, it empowers autistic people to get the help they need, which in turn helps them and their family cope.

As Brickman et al. (1982) note, models work best when the help-givers and help-recipients operate from the same model, suggesting the need for widespread acceptance of neurodiversity. This has already begun to happen as, for example, most countries have signalled their commitment to disability rights as a human right (Harpur, 2012). Societies respect these rights when they balance (inter)dependence with respect for individuality and diversity (Sarrett, 2012). Nevertheless, the examples are non-exhaustive, and everyday practices often fall within multiple models (Brickman et al., 1982), suggesting the need for further study into the nuances of what people believe helps and what actually helps.

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