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Psychological Diagnosis, the 'Package Deal' and Constructions of ASD

Niah Kim Wilson

**Portfolio submitted in fulfilment of the Professional Doctorate in Psychology
Department of Psychology, City University, London
June 2016**



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DECLARATION

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PREFACE

As a practitioner I have often encountered individuals for whom a psychological diagnosis has helped to make sense of their difficulties, providing them with a sense of security that their 'symptoms' will be understood and treated with the best knowledge currently available. It is also sometimes the case that I have found the opposite: individuals for whom a diagnosis has contributed to self-stigma, reduced self-worth and limited ideas about their future. Sometimes this negative view of themselves has been of greater difficulty than any symptoms the diagnosis describes. Via these differing clinical experiences, I have come to see that holding a psychological diagnosis is essentially a 'package deal', containing benefits, such as support or treatment, as well as risks for stigma and self-esteem (Link & Phelan, 2013). The effects of this deal appear to vary widely between individuals.

This body of work may be useful for practitioners who work therapeutically with people who hold diagnostic labels. Increasing numbers of people are diagnosed with psychological disorders now than at any other time (Collishaw, Maughan, Goodman, & Pickles, 2004; Nuffield Foundation, 2013, Young Minds, 2011). When we understand that holding a diagnosis is a 'package deal', it enables practitioners to facilitate the integration of the most useful and least limiting societal discourses that surround a diagnosis. Ultimately there are many ways to be human, yet concepts of 'normality' have become increasingly narrow (Rosenberg, 2013). This work seeks to remind us to respect and accept all forms of difference, and in the words of Levinas (1969; 2003), to 'welcome the other'; to ensure that *different* does not mean *less*. Therefore this portfolio is not only a reflection of my research and clinical experience, it is also an opportunity to contribute and to affect change.

The portfolio comprises of three distinct sections: A) a research article B) an empirical research study, and C) an extended case study. Each is based on my research interests and clinical experiences while undertaking my Professional Doctorate in Counselling Psychology at City University London. It attempts to demonstrate doctoral level skills in both research and practice: providing evidence of the depth of my philosophical thought, ethical consideration, critical

awareness of current literature, as well as my engagement with research design, analysis and the potential applications of this to clinical practice.

The portfolio begins with section A, a research article, which considers the use of psychological diagnoses and the medical model within counselling psychology practice. This article was stimulated by my own experiences during my training. On several occasions I encountered clients who did not have a diagnosis, yet I recognised certain characteristics related to a particular diagnosis. When considering the potential benefits and difficulties of a medical model perspective for these clients, I found that there was little literature addressing this in a balanced fashion. Some authors spoke of diagnosis as unquestionably beneficial in terms of accessing services and others spoke in purely critical terms about the risks for stigma and self-esteem. Balanced accounts were lacking, and little was written on how the benefits and risks inevitably vary for each individual. Therefore this article seeks to consider both the benefits and risks of psychological diagnoses, and in terms of the client, how and why 'one size does not fit all'. The article illustrates why diagnoses should be used with caution, asking whether they may be useful for an individual client, and discussing how to negotiate this within our clinical practice.

Section B, the empirical research study explores the concept of 'the package deal' of diagnosis via one label in particular: Autistic Spectrum Disorder (ASD). As diagnoses of ASD are increasingly commonplace (Taylor, Hershel, MacLaughlin, 2013), it was considered important to understand the constructions surrounding this label. A diagnosis of ASD is generally given in childhood and is therefore likely to affect what children with this label may come to learn about themselves (Mead, 1934, Scheff, 2005). This study explores how people, at a societal and community level, perceive or 'construct' someone with high-functioning ASD. It considers the implications these constructions might have in terms of their well-being; how they may limit or empower someone with ASD. Such awareness may assist practitioners to incorporate the most helpful discourses, and depower those that may be potentially limiting. There is currently a lack of literature specifically considering the 'package deal' of ASD and so this study offers an explicit exploration of this. I hope this may encourage the 'package deals' of other diagnoses, and the implications of these, to be similarly explored.

Section C) the extended case study, provides a detailed account of my clinical work with one client within an NHS psychosis service. This client presented with concerns related to his psychological diagnosis, appearing to experience this as a 'package deal'. His access to medication had been helpful, but his label of 'paranoid schizophrenia' had contributed to a pathologised view of himself, which frequently led to feelings of hopelessness and shame. My work with this client has been presented here to demonstrate how this 'package deal' can present in practice, and how I worked to improve this. Via careful attention to my client's discourses, I shifted away from a medical model perspective of schizophrenia to the ACT model, which offered this client a beneficial re-interpretation of his experience as a natural part of 'human diversity'. Through incorporating multiple helpful discourses about his experience, this client expressed a reduction in self-stigma, and a rebuilding of a sense of hope and empowerment.

Together, the components of this portfolio provide a detailed consideration of the benefits and difficulties related to psychological diagnoses, along with illustrations of how this can present within society, the community and also within clinical practice. I have also attempted to offer recommendations for clinical practice and societal work that could assist to address the difficulties individuals may currently experience. I hope this body of work successfully demonstrates both competence and consideration within my research and my clinical practice. Above all, it has helped me to synthesise my training experiences – reflecting that I now finish my training with a non-pathologising, humanistic and pluralistic approach to both knowledge and practice.

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A) RESEARCH ARTICLE

Psychological Diagnosis and 'the Package Deal'

Niah Wilson

Abstract

Context and focus: *This paper considers the use of psychological diagnoses within counselling psychology practice. It begins by discussing counselling psychology's relationship to the medical model. It then discusses the importance of considering diagnosis from an individual's perspective; illustrating how this is often experienced as a 'package deal'. The benefits of diagnosis, such as access to services and its sense-making function are discussed, along with the difficulties some individuals experience, such as risks for stigma and effects on self-esteem. This is followed by exploration of how a label may become negatively internalised.*

Conclusions: *Given the benefits of diagnosis experienced by some individuals, the inclusion of the medical model within counselling psychology's professional identity, and our increasing presence in the NHS, the necessity to engage with diagnoses is likely to continue. Therefore the most useful question that remains is 'how' counselling psychologists should engage with this. One particular therapeutic model may assist practitioners to negotiate this issue within practice: pluralism, Via a pluralistic approach to practice the medical model may be one of many perspectives that would be available but would be utilised purely in service of the client. Finally, the benefits of prioritising a formulation-led approach are also discussed.*

Keywords: *psychological diagnosis, stigma, medical model, pluralism, formulation*

Introduction

Counselling psychology incorporates many schools of thought, but is traditionally described as having humanistic roots (Cooper, 2009; Strawbridge & Woolfe, 2010). In the current era of counselling psychology, practitioners are increasingly working within the National Health Service (NHS) in which the objective medical model of psychological disorders is dominant. Counselling psychology journal articles often explore how counselling psychology can advocate the use of diagnostic categories, while also holding a non-pathologising viewpoint (Larsson, Brooks & Loewenthal, 2012; Williams & Irving, 1996). In essence, the field of counselling psychology appears to be constantly engaged in a debate about how to best work with the medical model. For trainee counselling psychologists engaged in NHS training placements, working with diagnoses often presents a conflict, with each trainee attempting to find their own balance between a humanistic and medical perspective. This paper explores this negotiation.

The paper considers the use of psychological diagnoses from two perspectives. Firstly, it explores where this sits within the traditions and formation of this division. Secondly it explores the use of diagnosis in terms of a client's perspective. Evidence suggests that, for many people, holding a diagnosis is a 'package deal' (Link & Phelan, 2013) and therefore the usefulness of a formal diagnosis will differ for each client. Via consideration of these two perspectives on diagnosis counselling psychologists may be better aided in determining how to work with the medical model within certain clinical and NHS settings: a way that is congruent with our own epistemological position, and guided by our clients.

Counselling psychology and the medical model

From its conception as a division, counselling psychology has been caught between two very different epistemological positions. The first is an empirical objectivist and positivist epistemology, which considers psychological difficulties to be definable diagnostic entities. In contrast, phenomenological, humanistic and constructivist stances are also adopted. These perspectives assume there is no 'one way of knowing' (Larsson et al., 2012; Ponterotto, 2005) and subjective and individual interpretations of experience are of strongest focus. This is a conflicted

position (Brown, 2002). Counselling psychologists desire to respect our clients' individuality, via a humanistic approach, but we also want to know 'what works' in terms of psychological theory and research (Frost, 2012).

Reviews of this debate indicate that citing one perspective over the other is ultimately fruitless. If counselling psychology can truly maintain its stance against any 'one way of knowing', then rejection of any one approach, including that of the empirical medical model may not be the answer – essentially that is not what counselling psychology is. However, becoming strongly rooted to any one epistemology also has its risks. Thus counselling psychology is particularly well placed to demonstrate multiple and non-rigid perspectives within our work. Therefore, although important to question our use of objective diagnoses, perhaps the most useful question is *how* counselling psychologists should engage with this (Larsson et al., 2012).

Diagnosis, the individual and 'the package deal'

Counselling psychology has a strong ethos that directs practitioners to work from the client's perspective. A diagnosis may, on first sight, appear simply to serve an individual, but critiques have pointed out the many others who have vested interests in this practice. Such authors illustrate how psychological diagnoses are intertwined with social practices and institutional interests (Boyle, 2007; Harper, 2013; Pilgrim 2007). Harper (2013) states that diagnosis 'has become institutionally embedded – the planning, funding and organisation of services is predicated on the diagnostic system' (p. 79), in which case a diagnosis may come to serve the system rather than the individual. In addition, Moncrieff (2010) illustrates how psychiatric diagnoses have close 'links with the pharmaceutical industry' (p. 372) and that the practice of diagnosis also assists policy makers to reattribute responsibility for wider social problems to medical 'technical experts' (p. 381). Such views bring in to question *who* it is that the diagnosis ultimately serves. Therefore, as psychologists working within the current diagnostic system, it is important to ensure that a diagnosis serves the client rather than a societal requirement to categorise, monetise and maintain current institutional practices. Our humanistic/person-centred underpinnings remind us that we must be guided by the client. From a client's point of view the value of psychological diagnosis

appears to vary greatly. For some it may provide great relief, and for others it can increase the risk of stigma and negative effects on self-esteem. Holding a psychological diagnosis appears to be a 'package deal' and the effects of this deal appear to vary widely between individuals.

The concept of diagnosis as a 'package deal' was first put forward by Link and colleagues (Link, 1987; Link & Phelan, 2013). A user-led qualitative study by Pitt et al. (2009) also supports this concept. Pitt et al. found that diagnosis can involve both positive and negative aspects, and stated that it 'can be a "means of access" as well as a "cause of disempowerment". It can help by "naming the problem" and hinder by "labelling the person"' (p.419). Similarly, Rosenfield (1997) investigated both the positive and negative effects of holding a label, reporting that services had positive effects on quality of life; finances, safety and health, but that stigma had equivalent effects on each of these factors. In addition, Portway and Johnson (2005) state that a clinician cannot predict the short or long term consequences of diagnosing or not diagnosing. A diagnosis therefore becomes 'a source of risk, in itself in that it may influence or alter the child's life course to his or her advantage or disadvantage' (p. 81). These studies illustrate why the use of psychological diagnosis should be considered very carefully; in terms of each individual's needs, goals and personal beliefs about their experience. In order to better understand how a diagnosis *could* be experienced by a client we must first make ourselves aware of the multiple ways in which each client could both derive benefit and experience difficulty.

Potential benefits of a diagnosis for the individual

Discussion of 'the package deal' begins with a consideration of the benefits of diagnosis. For individuals, several benefits of obtaining a psychological diagnosis are well recognised and will be discussed below.

1.1. Access to services and financial support

A diagnosis can assist with access to particular services, such, assertive outreach and early intervention teams (Kings College London, 2015; The National Autistic Society, 2015; Rethink, 2015a). The NICE guidelines offer clear treatment paths for each diagnosis, where all support it based on evidence-based

treatment (NICE, 2011). A diagnosis also allows access to medications without which people could not obtain, such as anti-depressants, anxiolytics for anxiety, and antipsychotics. In addition, people with a mental health diagnosis can receive financial assistance. Under the Equality Act, if a diagnosed mental health condition such as depression, bipolar and schizophrenia impedes daily activity long-term, the person is considered to have a 'disability' and is entitled to financial benefits (UK Government Equalities office, 2010; GOV.uk, 2015).

1.2. Sense-making and externalising difficulties

For many people a diagnosis acts as a form of 'sense-making'. It can offer a unifying explanation, which can result in a sense of relief that difficulties may now be better managed. It helps to explain 'why' someone may have found certain things consistently difficult, perhaps for many years, and across many situations; it may legitimise their distress (Pitt et al., 2009). Individuals may also feel aided by referring to a psychological diagnosis when communicating difficulties to others. It may help to confirm the impact that the disorder has on their daily life; ensuring others do not under-estimate the seriousness of their difficulties. For example, in education environments, sharing an ASD diagnosis with teachers may ensure the individual is not blamed for their difficulties or challenging behaviour (Whitaker, 2006).

In addition, via a diagnosis, symptoms can be reattributed to the label, relieving the individual from a sense of responsibility for behaviours in line with their symptoms (Pitt et al., 2009). Although this may not be the case for all individuals, for some this may have a buffering effect on self-esteem. For example, a person may wish to say "it is not me, it's my ADHD". This externalisation of symptoms from the 'self' may protect an individual from self-blame, both in their own eyes and others (Cheng, 2014).

1.3. Collective identities and collective action

Holding a diagnosis long term may also benefit the individual by way of 'joining a community'. A diagnosis can become a form of 'shared identity' by which individuals may resolve any sense of isolation created by their difficulties or differences. Support groups are accessible via several main mental health organisations such as Rethink and Mind. These groups focus on self-help,

information and peer support. In addition, a collective identity also offers benefits on a wider societal level. A person may feel empowered by engaging in forms of social action and campaigning (Rethink, 2015b). Groups can lobby, or seek to educate others, in order to effect positive change. It is via such collective movements that the civil rights of individuals become protected and assured. Extensive efforts of collective voices representing people with disabilities have created many positive changes at a societal level such as addressing discrimination, ensuring legal protection and improving the accessibility of public spaces (Bagenstos, 2009; Fleischer, 2001; Shapiro, 1993; Szele, 2015).

Potential difficulties of a diagnosis for the individual

Access to services and professional treatment, assistance in securing benefits and community support are among the main benefits a diagnosis can bring. There is however, a proportion of people for whom their diagnosis may result in more difficulty than benefit. Literature on stigma will be considered here before further exploration of the negative internalisation of labels.

2.1. Stigma research and labelling theory

Diagnoses can alter the way people see each other, increasing experiences of social stigma. A diagnostic label can affect a person's reputation and the way that they are treated by others (Cheng, 2014; Heitler, 2012). Countless studies have demonstrated how labels can create a narrowing and restricted view of the whole person (Heitler, 2012). This increases stigma and compromises their mental health (Westbrook, Bauman, & Shinnar, 1992; Jahoda & Markova, 2004). Such research indicates that when someone deviates from the dominant social norm, it is the particular domain in which they differ that can come to define their entire social identity. They may become dehumanised by this restricted and limiting view (Jahoda & Markova, 2004). A diagnostic label can serve to highlight the exact domain of a person's deviation, and therefore it is likely that it plays an active role in creating this restricted view. When a label, such as a diagnosis, is attached to an individual, people have a tendency to see the diagnosis, and not the person (Heitler, 2012).

In the 1980s labelling theory (Link, 1987; Link, Cullen, Struening, Shrout & Dohrenwend, 1989) suggested that a label puts a person at increased risk of further psychological difficulties. Link and colleagues (1997) found that the negative effects of stigma are often greater than the negative effects of a disorder itself. Further studies have also found that being labelled with a psychological disorder negatively affects employer's perceptions, directly narrows employment options, and creates difficulties renting accommodation (Ozawa & Yaeda, 2007; Page, 1977). A later study concluded that treatment can lead to symptom reduction but that the negative effects of stigma are enduring (Link, 2008).

It has also been found that stigma is shaped by the perceiver's attribution of the underlying cause of the disorder. In the 1950s, with the introduction of medication, it was assumed that a medical explanation of psychological disorders would decrease stigma. As such, it was considered that the premise, 'mental illness is a disease like any other', would reduce personal responsibility and thus reduce stigma. Time has demonstrated that this assumption may not necessarily be correct. In fact it appears that when the behaviour of an individual is perceived as being not consciously under their control it creates a fear of unpredictability and dangerousness, thus reinforcing the stigma (Canadian Health Services Research Foundation, 2013).

Evidence of the increased risk of stigma with an 'illness' model has now steadily come forward. Mehta and Farina (1997) found that when someone's disorder is attributed to biological causes, rather than psychosocial (traumatic past experiences), perceivers will respond more punitively, regardless of their explicit statements otherwise. Read (1997) suggested that because all psychiatric labels are now equated with biological and genetic influences, perceivers may feel justified in viewing those with labels as 'categorically different' from themselves, thus appearing to justify the associated stigma.

Finally, Martinez and colleagues (2011) also demonstrated how the 'illness' label itself directly affects the perceptions of others. They found that the 'mere label of chronic mental illness triggers dehumanising responses' in the perceiver, with a series of negative social consequences for the bearer of the label (p. 10). Similarly, Harris and Fiske (2006) found that when someone perceives a person to have a mental disorder that they subsequently ascribe a lesser degree of 'humanness' to the person. This essentially separates those with mental

disorders from others, creates a sense of 'otherness', and propagates social rejection.

2.2. Internalisation of the label

Stigmatising opinions can also become internalised (Martz, 2004). Therefore a diagnosis can not only have detrimental effects on an individual's social identity, but also their self-concept (Macionis & Gerber; 2010). Labels are likely to become woven into a person's identity shaping how others see them and how they see themselves (Mead, 1934; Sheff, 2005). Therefore there is potential that a diagnosis can contribute to limited views of one's own potential or increase the risk of other psychological difficulties, otherwise known as an iatrogenic effect.

For example, there is extensive research demonstrating a high level of depression in people with an ASD diagnosis. Authors suggest this may be due to a higher vulnerability to lower self-worth (Ghaziuddin, Ghaziuddin, & Greden, 2002; Shtayermman, 2009). Capps and colleagues (1995) reported that high-functioning individuals with ASD believe themselves to be less competent than other people, and as a result have reduced self-worth. Similarly, the more socially competent the person with ASD is, the more negatively they view themselves (Sigman, Dissanayake, Arbelle & Ruskin 1997). Is this lowered self-esteem due to the difficulties of living in contrast to a mostly neuro-typical environment, or could it also be related to an autistic person's perception of themselves as disordered and inherently faulty compared to others? In other words, do such studies indicate that the label of 'disorder' has become internalised?

There is some evidence, from qualitative studies that this may occur. Humphrey & Lewis (2008) indicated that people with AS may sometimes construct their AS in negative terms, stating that others believe them to be a 'retard', 'not normal', 'a freak' and 'odd', further expressing a desire to be made 'normal'. Some people also stated that sharing their diagnosis had meant they had been treated as less competent, which had further contributed to their negative self-concept. The authors therefore suggested that for some people the 'disordered' view of a person may lead to a 'loss of individuality and the limiting of people's expectations' (p. 31).

Several psychological theories can be utilised to demonstrate how the internalisation of diagnostic labels may take place at a psychological level. Cognitive Behavioural Theory, which originally derived from the work of Beck (1967), considers depression to be based on a cognitive attributional triad (Ultrasix Interactive Healthcare, 2006-2013) where a person believes negative events to be:

- 1) permanent in nature,
- 2) due to internal rather than external reasons,
- 3) and generalised across their skills and abilities.

Some psychological diagnoses, such as developmental disorders (ASD, ADHD), are considered to be lifelong disabilities. This equates to an assumption of:

- 1) permanent dysfunction across the lifespan,
- 2) internal reasons for dysfunction (owned by the individual alone),
- 3) and general dysfunction across many domains of life.

Therefore, like the attributional triad of depression, if these disorders are considered to be permanent, internally owned and general, is it unreasonable to consider that this life-long label of dysfunction may in itself predispose a person to depression? (See Figure 1 below).

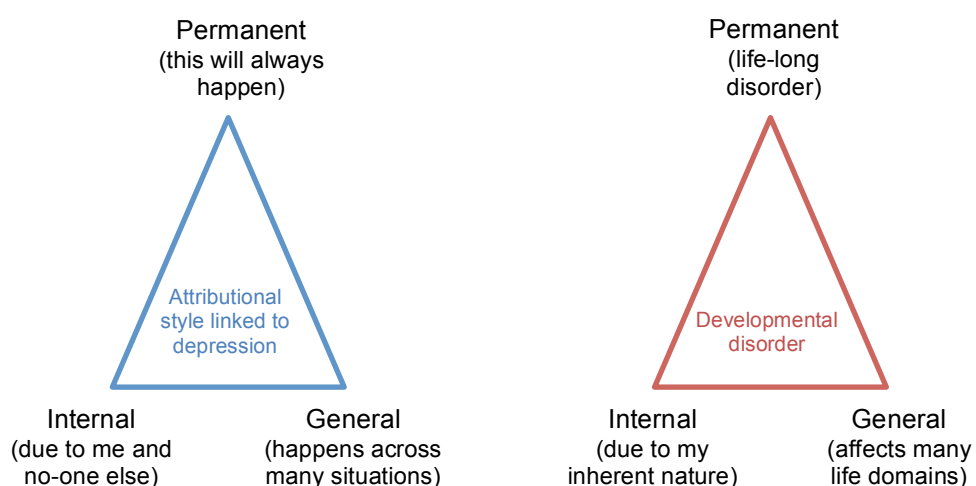


Figure 1: Cognitive triad comparisons - the attributional style linked to depression and the potential psychological experience of a developmental disorder diagnosis.

In Cognitive Behavioural Theory it follows that the consistent lived experience of this attributional triad is likely to become a 'core belief'. Such strongly negative core beliefs are at the heart of depression (Beck, 1996; Greenberger & Padesky, 1995) and despite consistent therapeutic efforts at a cognitive level, these can be very difficult to affect or to alter.

Similarly, Relational Frame theory (RFT) may also be utilised to explain the process of internalisation. RFT (Hayes, Barnes-Holmes & Roche, 2001) considers the learning of associations between things as the building blocks of all cognition and human language. According to RFT it is the ability to learn and apply 'relational frames' that is at the core of all human language, cognition and therefore psychological experience (Hayes, Strosahl & Wilson, 2012, p. 44). A relational frame can be demonstrated as follows: when someone has learnt that '*I* = *Asperger's*' and also that '*Asperger's* = *disordered*', a process of 'combinatorial entailment' would associate '*I*' with '*disorder*' (see Figure 2 below). This indirectly learnt association is known as a 'derived stimulus relationship'. The development of negative 'relational frames', such as this, would predispose someone to psychological distress and have further negative consequences for future behaviour.

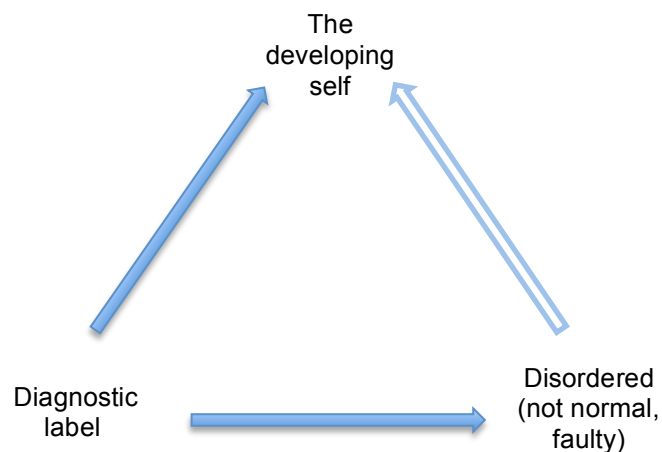


Figure 2: A relational frame of disorder. 'Combinatorial entailment' directly relates two stimuli, so that a third relationship can form. Here we see a direct relationship between 'the self' and a 'diagnostic label' and similarly, a direct relationship between a 'diagnostic label' and learning that this is a 'disorder'. Once these 2 stimuli relationships are achieved, a 'derived' relationship between 'disorder' and 'the self' will emerge, and hence an association of oneself as 'disordered' is permanently established. Behavioural theory states that such relationships cannot be unlearned.

Relational frames can produce self-perpetuating behavioural loops. Although adaptive for survival in many cases, this form of behaviour is insensitive to change, creating behavioural persistence despite negative consequences. This insensitivity to change also correlates highly with psychological rigidity (Wulfert, Greenway, Farkas, Hayes, & Dougher 1994). Therefore rigid adherence to behaviours based on unhelpful relational frames serves to narrow behaviour, ensuring the relational frame is unlikely to be augmented with newer, more helpful, relationships (Hayes et. al., 2012, p. 55). Therefore, for someone who has come to learn that they are 'disordered', this may create a self-fulfilling loop, which acts to limit both their behaviour and their view of their own potential.

Another point regarding relational networks is that these work by addition and not subtraction. That is, once we learn to think about something in a certain way, it remains permanently in our relational repertoire. In other words, once learnt, a relational frame cannot be unlearned, leaving only new learning or response inhibition as the only options available to mediate the effects of this (Hayes et al., 2012). Therefore, in the case of a psychological disorder diagnosis, once someone learns they are 'disordered', this cannot be unlearned.

Where do we go from here?

Considerable discussion has illustrated that psychological diagnosis, from a client's perspective, can be a 'package deal'. This is a practical reality that is consistently under-addressed. Certain evidence suggests that some people derive benefit from their diagnosis. However, given the considerable evidence concerning stigma and negative effects on self-esteem, it appears that psychological diagnoses should be used with great caution. This may not be occurring currently where psychological services are based within a 'health system' where a medical model of psychology is currently dominant. Golsworthy (2004) suggested that, although contentious, it is the societal duty of counselling psychologists to question the supremacy of any dominant form of knowledge. Therefore the most useful question to ask may be *how* or *when* it may be appropriate to engage with this. Consideration of ways to approach this within clinical practice will now be presented.

A pluralistic approach to practice

One possibility that may assist in negotiating use of a medical model perspective within counselling psychology practice is pluralism. Pluralism, developed by Cooper and McLeod (2011) supports multiple therapeutic models with differing epistemological stances. For example, a practitioner may work with a CBT approach, predicated on the basis of a diagnosis and support the use of medication, while also working in a person-centred manner. They may employ therapeutic techniques from either, but these are chosen purely in service of the client, rather than their own preference; 'the client is central, not the therapeutic perspective' (Frost, 2012, p. 60). Via a pluralistic approach the medical model is not held as dominant, but becomes one of many possible perspectives a practitioner may consider.

Cooper & McLeod (2011) discuss two underlying principles required to apply a pluralistic philosophy to practice: 1) Lots of different things can be helpful to different clients, 2) If we want to know what is most likely to help clients, we should talk to them about it (p. 6). This encourages practitioners to remain open to multiple perspectives and base their therapeutic decisions on 'what works'. In addition, a strong focus on being 'guided by the client' ensures the use of any modality, including a medical model perspective, would be employed only on the premise that it is done so in consultation with, and in service of, the client. Hence, a medical model perspective can be provided for those who find it useful, and avoided for those who may not.

Therefore, via the use of pluralism, counselling psychologists and their clients can benefit from the strengths of a medical model approach, if found useful, or they can choose an alternative perspective if not. This gives counselling psychology a clearly beneficial selling point (Frost, 2012). Cooper (2009) suggests that pluralism may ultimately assist counselling psychologists to carve out a unique professional identity as 'practitioners with an expertise in responsiveness and the development of individually tailored therapies' (p. 124).

Prioritising a formulation-led approach

It must be noted here however that some counselling psychologists (along with some clinical psychology colleagues) take a stronger position on diagnosis and use of a medical model. They may prefer to avoid its use entirely and favour a formulation-led approach alone. For all counselling psychologists, rather than adhering strongly to any form of diagnostic conception of a client's difficulties, prioritising a formulation-led approach is generally encouraged across the division (BPS, 2007; HCPC, 2012).

Formulations have benefits, for both individuals and clinicians. They can draw on psychological theory to make sense of a client's problems, and give rise to a treatment plan, created collaboratively with the client. Most importantly, the success of a formulation is determined by its 'usefulness' or 'fit' to the problem, rather than an objectively determined 'truth'. A formulation-led approach could be used to form a more integrative model, where psychosocial causal factors are prioritised when seeking to understand the problem (Johnstone & Dallos, 2006; Vanheule, 2012). Prioritising this approach ensures we primarily recognise the person's difficulties within a wider context, as someone who may have been affected by certain limiting, damaging or disempowering discourses, rather than as the personal holder of pathology. This makes a formulation-led approach useful in defusing an individual's concerns regarding the potential stigma that a formal diagnosis could bring: providing a less limiting or deterministic conception of their difficulties. Therefore, wherever possible, a formulation rather than diagnostic approach is encouraged.

Conclusions

This paper aimed to illustrate that the practice of psychological diagnosis must be considered carefully, as clients may experience a diagnosis as a 'package deal'. For some individuals, a medical model conception of their experience may be beneficial, due to its sense-making function and assistance in accessing services. For others a diagnosis may exacerbate their difficulties, with evidence that individuals may experience stigma and damage to self-esteem. Therefore, as practitioners, conceiving of clients primarily in terms of diagnostic categories must be cautioned and its use considered solely in terms of the needs of each

individual client. One possible suggestion for negotiating this within practice has been suggested: pluralism. Via a pluralistic approach to practice a medical model perspective becomes one of many perspectives we may hold, and one that would be employed purely in the service of the client. Wherever possible, a formulation-led, rather than diagnostic approach, could avoid many of the complications a diagnosis may bring, and should therefore be prioritised and further encouraged.

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Appendix 1

Counselling Psychology Review - Notes for Contributors

1. Length:

Papers should normally be no more than 5000 words (including abstract, reference list, tables and figures), although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.

2. Manuscript requirements:

The front page (which will be removed prior to anonymous review) should give the author(s)'s name, current professional/training affiliation and contact details. One author should be identified as the author responsible for correspondence. A statement should be included to state that the paper has not been published elsewhere and is not under consideration elsewhere. Contact details will be published if the paper is accepted.

Apart from the front page, the document should be free of information identifying the author(s). Authors should follow the Society's guidelines for the use of non-sexist language and all references must be presented in the Society's style, which is similar to APA style. For an electronic copy of the Society's *Style Guide*, go to the Publications page of www.bps.org.uk and then click on Policy and guidelines/General guidelines and policy documents and choose Society Editorial Style Guide from the list of documents).

For articles containing original research, a structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.

Approximately five keywords should be provided for each paper. Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc., for which they do not own copyright. Graphs, diagrams, etc., must have titles.

Submissions should be sent as email attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add 'CPR Submission' in the email subject bar. Please expect an email acknowledgment of your submission. Proofs of accepted papers will be sent to authors as email attachments for minor corrections only. These will need to be returned promptly.

3. Submissions and enquiries should be e-mailed to: Dr Terry Hanley. Email:

B) EMPIRICAL RESEARCH

The Social Constructions of ASD

Abstract

Background: A psychological diagnosis presents an individual with a ‘package deal’ in which treatment and support comes hand-in-hand with stigma and effects on self-esteem (Link & Phelan, 2013; Pitt et al., 2009). This study explores the ‘package deal’ of one label in particular: Autistic Spectrum Disorder (ASD). Societal perspectives that shape this diagnosis are considered, beginning with professional views and common stereotypes, before critiques of autistic writers and social constructionists. A focus on high-functioning ASD (HFA) and Asperger’s syndrome (AS) leads to the research question: How is AS/HFA constructed currently, within society and at a community level? By considering how these constructions shape the ‘package deal’ we are better placed to make recommendations for improvement.

Method: 30 societal texts (professional articles, newspapers, TV/film/fiction) discussing AS/HFA and 8 community interviews with people who ‘know someone with a diagnosis of HFA/AS’ were conducted. These were analysed using Foucauldian Discourse Analysis, via Willig’s six steps (Willig, 2008).

Analysis: Analysis highlighted four dominant constructions shared between societal texts and community interviews: ‘a disorder’, ‘a difference’, ‘a predisposition for high intelligence’ and ‘a problem’. Within newspapers, limiting and potentially harmful constructions of AS as ‘an observable weirdness’ or ‘a trait of criminality’ were commonplace. In contrast, constructions unique to community interviews, of AS as ‘an acceptable difference’ and an ‘individual experience’, had the potential to serve in an empowering and protective manner for the AS person.

Discussion: Findings suggest the ‘package deal’ of AS includes both limiting and empowering discourses. Pluralistic discourses in the community offered the AS person multiple subject positions, providing the best potential for support, empowerment and individuality. For clinicians, a pluralistic approach such as this could provide clients with access to multiple discourses while also supporting and respecting individuality and acceptance of difference: a better ‘package deal’.

1. INTRODUCTION

Rationale for the research

In the current era of counselling psychology, practitioners are increasingly working within the National Health Service (NHS) in which the objective medical model of psychological disorders is dominant. Although counselling psychology incorporates many schools of thought, it is described as traditionally having humanistic roots (Cooper, 2009; Strawbridge & Woolfe, 2010). Many authors explore how counselling psychology can advocate the use of diagnostic categories, while also holding a non-pathologising viewpoint (Larsson, Brooks & Loewenthal, 2012; Williams & Irving, 1996). In essence, the field of counselling psychology appears to be constantly engaged in a debate about how best to work with the current diagnostic system. This thesis has developed from this questioning stance but considers the use of diagnosis, not in terms of the above debate regarding the epistemological stance of counselling psychology, but in terms of the needs of our clients.

For clients, the benefits of receiving a diagnosis are well recognised. Diagnoses can assist with access to services, such as talking therapies, assertive outreach and early intervention teams (Rethink, 2015; Kings College London, 2015). The NICE guidelines offer clear treatment paths for each diagnosis, where all support it based on evidence-based treatment (NICE, 2011). A diagnosis also allows access to medications without which people could not obtain. Many individuals have reported such medications to be effective, as the following statement illustrates:

'I was assessed and prescribed a variety of drugs, including olanzapine and various benzodiazepines... Over a few days, the medication took effect, and that coupled with the kind behaviour of the staff began to calm me.' - anonymous (Mind, 2015)

In fact, for some people, not having an explanation for their difficulties or differences can be a highly distressing emotional experience as they may face many practical difficulties both a work and at home. For example, Bipolar UK (2015) suggest that:

'the key to coping with bipolar is early diagnosis....Bipolar, if you don't treat it, can harm relationships, damage careers and destroy lives'.

Therefore, for many people a diagnosis acts as a form of 'sense-making'. It can offer a unifying explanation, which can result in a sense of relief that difficulties may now be better managed. It may help to explain 'why' someone may have found certain things consistently difficult, perhaps for many years, and across many situations, hence legitimising their distress (Pitt et al., 2009). Some individuals explain that a diagnosis has offered them a framework in which they, and their difficulties, finally 'make sense' (NHS choices, 2015a) as the following statement illustrates:

'For a long time describing my life as a train wreck would not have been far from the truth. [But] this was all before I was diagnosed with Asperger syndrome.' - anonymous (The National Autistic Society, 2015a)

A diagnosis also provides a way for symptoms to be reattributed to the label, relieving the individual from a sense of responsibility for these (Pitt et al., 2009). This may have a buffering effect on self-esteem. In education, a diagnosis may also 'help defuse charges of laziness or stupidity levelled by teachers, parents, or peers' (Cheng, 2014, p. 1). Individuals may also benefit from 'joining a community'; feeling supported by others who have similar difficulties. Support groups are accessible via several main mental health organisations such as Rethink and Mind. These groups can focus on self-help, information and peer support. For some people, groups can be hugely powerful and transformative as the following Rethink group member states:

'The group is a sympathetic and a non-judgmental listening space. I feel I am among people who care about me and really understand. I get help with information and we share ideas on how to cope.' (Rethink, 2015c)

Despite the benefits many people may experience, for some people being labelled with a psychological disorder can have negative effects on their well-being. There has been a great deal of research suggesting a diagnosis can result in significant social stigma. (Jahoda & Markova, 2004; Link, 1987; Westbrook, Bauman, & Shinnar, 1992). Awareness of an individual's diagnosis may negatively affect employer's perceptions, directly narrowing employment options,

as well as creating difficulties renting accommodation (Ozawa & Yaeda, 2007; Page; 1977). A further study concluded that treatment can lead to symptom reduction but that the negative effects of stigma are enduring (Link, Castille & Stuber, 2008).

Social stigma has also been found to contribute to internalised self-stigma and negative self-concept (Macionis & Gerber; 2010; Martz, 2004). Rather than providing a way of externalising difficulties, separate from self-worth and identity, for some a label may become deeply internalised evidence of an inherent 'fault'. It can turn 'problems' into 'symptoms'. We can see how it may be experienced negatively in the following quote:

'I got a diagnosis of schizophrenia. With this I got the message that I was a passive victim of pathology. I wasn't encouraged to do anything to actively help myself. Therapy meant drug therapy. It was hugely disempowering and undermining, exacerbating all my doubts about myself. And the impact was devastating because it just served to make the voices stronger and more aggressive because I became so frightened of them. What started off as experience became a symptom... This all happened in a shockingly short space of time. I went into that hospital a troubled, confused, unhappy 18-year-old and I came out a schizophrenic. And I was a good one. I came to embody how psychosis should look and feel.' - Eleanor Longden (2010)

A review of these benefits and difficulties indicates that the experience of living with a psychological diagnosis can vary greatly for each individual. For some it may provide considerable relief, and for others it can increase the risk of stigma and negative effects on self-esteem. Holding a psychological diagnosis therefore appears to be a 'package deal' and the effects of this deal appear to vary widely between individuals. This concept was first put forward by Link and colleagues (Link, 1987; Link & Phelan, 2013) and several studies support this conclusion. A user-led qualitative study by Pitt et al. (2009) found that diagnosis can involve both positive and negative aspects, and stated that it 'can be a "means of access" as well as a "cause of disempowerment". It can help by "naming the problem" and hinder by "labelling the person"' (p.419). Similarly, Rosenfield (1997) investigated both the positive and negative effects of holding a label, reporting that services have positive effects on quality of life; finances, safety and

health, but that stigma had equivalent effects on each of these factors. Review of such studies indicates that the largest factor involved in negative experiences of diagnosis stem from social stigma. Therefore it is the perceptions of others, within wider society and within communities, which plays a pivotal role in shaping the 'package deal'.

This study explores the concept of 'the package deal' of diagnosis via one label in particular: Autistic Spectrum Disorder (ASD). As diagnoses of ASD are increasingly commonplace (Taylor, Hershel, MacLaughlin, 2013), it was considered important to understand the associations surrounding this label. A diagnosis of ASD is generally given in childhood and is therefore likely to affect what children with this label may come to learn about themselves (Mead, 1934, Scheff, 2005). This study explores how people at a societal and community level perceive or 'construct' high-functioning ASD. It considers the implications that these constructions might have in terms of the well-being of someone holding this label, exploring how these may limit or empower someone with ASD. Awareness of these constructions may assist practitioners to incorporate those that are most helpful, and depower those that are not. It is hoped that this exploration of 'the package deal' of ASD will encourage the same for other diagnoses, and the implications of these for the individual, to be similarly explored.

There is currently a lack of literature explicitly considering the 'package deal' of ASD. There is however some evidence that there may be difficulties associated with this diagnosis. Several quantitative studies have reported high levels of depression in people with ASD. Authors suggest this may be due to a higher vulnerability to lower self-worth (Ghaziuddin, Ghaziuddin, & Greden, 2002; Shtayermman, 2009). Capps and colleagues (1995) reported that high-functioning individuals with ASD believe themselves to be less competent than other people, and as a result can have reduced self-worth. Similarly, the more socially competent the person with ASD is, the more negatively they view themselves (Sigman, Dissanayake, Arbelle & Ruskin 1997). Similarly, qualitative studies reported that, for some people with ASD, sharing their diagnosis has meant they had been treated as 'less competent'. This indicates that there may be a 'loss of individuality and the limiting of people's expectations', which may contribute to a negative self-concept (Humphrey & Lewis, 2008, p. 31).

To begin this exploration of the 'package deal' of ASD I¹ will discuss the historical development of the diagnosis, before considering two current societal perspectives: professional views and common stereotypes. As the above discussion illustrates, it is these constructions that are likely to shape the 'package deal' for those hold this diagnosis. I will then discuss the views of some autistic writers and advocates before turning to a focus on high-functioning ASD (HFA) and Asperger's Syndrome (AS). There is a current debate as to whether AS is best conceived of as a 'difference' or a 'disorder'. This debate will be explored before I then consider qualitative studies and social constructionist views on AS. The chapter will end with a focus on the research question: How is AS/HFA constructed currently, within society and at a community level? The study seeks to explore what people with AS/HFA may come to learn about themselves from those around them. How does this shape their experience of the diagnosis? Awareness of such constructions ensures that we are better placed to make recommendations for improving the 'package deal'.

The emergence of ASD

One hundred years ago, all children who would today receive an ASD diagnosis would have instead been diagnosed with a form of 'idiocy' or dementia, and before that many were ignored or even abandoned. Autism emerged as a diagnostic category in the 1940s and is intimately related with the emergence of other 20th century professional, governmental and parental practices and attitudes. What makes a diagnosis of autism possible today for any person perhaps has less to do with their biology, and more to do with the cultural practices rooted in 20th and 21st century life (Nadesan, 2005).

Pre-19th century, the standards of normality that define many of our current disorders did not exist, and the concept of 'child development' had not yet emerged. Psychiatric and psychological diagnoses focused on severe adult mental illness, with diagnostic divisions focussing on the presence or non-presence of hallucinatory symptoms, creating basic distinctions between

¹ This thesis is written in first person, rather than 3rd. This is intentional. As this thesis later explains, this is a qualitative study where my own perspective is acknowledged to effect my perceptions. Using 'I', rather than 'the researcher' is designed to openly reflect this stance.

psychosis and neurosis. Diagnostic classifications shifted and changed throughout the 19th century, intimately interwoven with the arrival of a matrix of societal institutions, practices and attitudes. These were ultimately led by the shift from 'sovereignty' over territories, to 'government', which focused on the administration of populations (Foucault, 1991).

Diagnostically speaking, these were changing times. 'Governmental power' brought with it the introduction of systematic and institutional practices aimed at securing social stability. The reinforcing of both moral and class distinctions led to increasing awareness of 'deviant' populations. The creation of 'mad-houses' and formalised childhood education reflected new practices of dividing populations (Nadesan, 2005). From this point onwards, private life became subject to increasing government interest and policy.

With the monitoring of populations came the standards of 'normality'. Deviant persons therefore became the target of treatment seeking to resolve or manage such deviance. Foucault (1965, 1979, 1991) suggested that the arrival of these governmental institutions and surveillance practices began to create distinct forms of social control, in which education became less about liberating young minds and more about formalised discipline and moral security.

Childhood increasingly became viewed as the optimum time to ensure future adult health and wider spread social stability. In order to ensure these aims, the professions of 'child psychiatry' and 'educational psychology' arose. Via these two professions, the foundations were laid for the current concept of 'child development'. Formalised education paved the way for both observations and measures of 'normal' childhood behaviour, enabling those who were 'abnormal' to be more easily recognised.

With the 'childhood development' scene set, and certain societal institutions and practices present, the diagnostic concept of 'autism' now became possible. Leo Kanner, an Austrian American in the US, was the first self-identified 'child psychiatrist'. His 1943 paper about his clinical observations of 11 children, entitled 'Autistic Disturbances of Affective Contact' was his first attempt to delineate 'autism' as a distinct psychiatric disorder. He originally drew on Bleuler's description of dementia praecox, adapting the term 'autistic' to describe

a tendency to withdraw from the external world. 'Autism' became the term with which he described the existence of a certain pattern of communication delays, behavioural repertoires and social-interaction nuances. At this time, autism was classed as a form of childhood schizophrenia.

Societal Perspectives on ASD

I shall now explore autism as it is more commonly perceived of currently. How people perceive and describe autism inevitably shapes the experience of those who hold this label. It is these conceptions that may contribute to 'the package deal'. Here I shall consider two current societal perspectives: professional views on ASD, followed by several common societal stereotypes.

1) Professional perspectives

1.1. Diagnosis and the autistic spectrum

Health care professionals conceive of ASD as a disorder and a disability. This is a very dominant societal conception which shapes the lives of people with 'ASD' currently. Autism first became recognised as a distinct disorder in 1980 when the DSM-III was published, formally distinguishing it from Schizophrenia. It appeared under a new category entitled 'Pervasive Developmental Disorders'. In the DSM-IV (1994) the diagnosis of Autistic Disorder/Infantile Autism (299.00) was defined as:

1. Qualitative impairment in social interaction
2. Impaired communication
3. Restricted, repetitive and stereotyped patterns of behaviour, interests, and activities.

This has been further expressed as the 'triad of impairments', where social interaction, social communication and imagination difficulties are considered to be the three main deficits (NHS Choices, 2015b). Diagnosis required onset before three years of age.

Recently the diagnoses of autism, along with Asperger's Syndrome, PDD-NOS, and Childhood Disintegrative Disorder, have been collapsed into a wider

diagnosis of ASD (within the DSM-V). The DSM-V (299.00) considers a diagnosis of ASD to constitute the following characteristics, presented here in condensed form:

1. Persistent deficits in social communication and social interaction across multiple contexts
2. Restricted, repetitive patterns of behaviour, interests or activities.

Symptoms must be present in the early developmental period and cause clinically significant impairment in social, occupational, or other important areas of functioning.

The collapsing of these diagnoses into the one label of ASD has occurred due to increasing research evidence that the previous categories (namely AS, PDD-NOS and HFA) did not accurately represent discrete subtypes of autism (Happé, Ronald, Plomin, 2006; Skuse, 2009; Sanders, 2009). There was an increasing lack of consensus among clinicians as to where the boundaries of one subtype ended and another began, with diagnosis of these subtypes having taken place 'idiosyncratically and unreliably across different clinicians' (Happé, 2011).

The idea that these subtypes of autism were not discrete entities began with Judith Gould and Lorna Wing's work nearly four decades ago. In 1979, they conducted a study with children in Camberwell in which they found there were no clear-cut distinctions between different subtypes of autism (AS, HFA and classic autism). Wing and Gould concluded that 'the distribution of the variables among the subgroups suggested that they formed a continuum of severity rather than discrete entities' (p. 26). This continuum has now widely become known as 'the autistic spectrum'. Increasing evidence citing the lack of validity and distinctiveness between the subtypes of autism means these have now been abandoned. In addition, research has increasingly shown that there is little difference in outcome for people with HFA compared to people with AS. Although people with HFA exhibit delays in language acquisition, compared to those with AS, by adolescence and adulthood there appears to be no difference in IQ or developmental level (Happé, 2011).

Some have criticised this move, citing concerns that this move will risk missing many who should receive support via a diagnosis. A study by Huerta and colleagues (2012) indicated that most children with DSM-IV diagnoses of AS

'would remain eligible for an ASD diagnosis under the proposed DSM-V criteria. Compared with the DSM-IV criteria for Asperger's disorder and PDD-NOS, the DSM-V ASD criteria have greater specificity...'.

Several studies indicate that the diagnostic process in the UK currently involves mixed experiences for both ASD individuals and professionals involved in the diagnostic process. In a survey by Jones, Goddard, Hill, Henry and Crane (2014) 128 ASD adults reported mixed levels of satisfaction with the diagnostic process, with 40% 'very/quite' dissatisfied and 47% 'very/quite' satisfied. The factors predicting satisfaction included the extent of delays in the diagnostic process, the number of professionals that were seen, the quality of the information provided by professionals and the level of support provided post-diagnosis.

A further survey by Rogers, Goddard, Hill, Henry and Crane (2015) considered the views of professionals in relation to the diagnostic process, with data indicating that 'around 40% of services were failing to provide timely assessments' and professionals further expressed dissatisfaction with post-diagnostic provision. There were also some concerns about the validity of diagnostic tools in terms of detecting atypical autism, such as in females. In this survey professionals also described their challenges in ensuring caregivers were able to understand the diagnosis, pitching information at the right level to aid this and further managing distress surrounding around receiving a diagnosis (pg.1).

1.2. Genetic and neurological research

Evidence now supports the view that autism is highly heritable (Abrahams & Geschwind, 2008; The National Autistic Society, 2009). Research suggests there are at least two distinct genetic aetiologies of autism. An estimated 10% of autism cases may be due to a single gene mutation of large effect, creating ASD symptoms. This is known as the de novo type.

Findings have also demonstrated that in a large number of cases, ASD runs in families. This has become known as the multiplex type (Levitt & Campbell, 2009; Silverman et al., 2002). These 'multiplex' families carry a combination of certain genetic variations, each increasing the risk of ASD, which are passed down the generations. Autistic traits among family members eventually surpass a certain

threshold producing a more recognisable form of autism. Further research also shows that autistic traits are normally distributed across the population (Ronald, Happé & Plomin, 2005), providing further support that multiplex families represent a particularly strong collection of normally distributed autistic traits.

On a neurological level, differences in the autistic brain have also been documented. Autistic children often have a larger than normal head size which has been found to be related to increased amounts of white matter (Courchesne, Redcay & Kennedy, 2004). Similarly, the amygdala and cerebral cortex has been found to be abnormally large in autistic children between two and four years of age (Mosconi et al., 2009). Similarly, genetic linkage studies have indicated a reduction in reelin glycoprotein in the cerebellum may play a causal role in autism (Fatemi, Snow, Sary, Araghi-Niknam, Reutiman, Lee, et al. 2005). The above research therefore supports the concept of ASD as a biological entity, which can be defined through observation of particular deviations in the genetic and neurological systems of particular 'affected' individuals.

1.3. Psychological Theories of ASD

Psychological research on autism is vast. Here I will present three theories that attempt to account for the main deficits in autism. These theories, frequently referred to in both research and societal literature, are:

- The weak central coherence theory
- A Theory of Mind deficit (ToM)
- Empathising/systemising (E-S) and Extreme Male Brain (EMB) theories

1.31. The weak central coherence theory

Advanced by Frith in the late 1980s, the 'weak central coherence' theory proposes that the key underlying deficit in autism is an inability to 'see the bigger picture', with autistic individuals having a natural tendency to attend to the 'smaller parts' at the cost of the whole. Several studies supported this assertion, finding that autistic individuals had superior performance compared to controls in an 'embedded figures task' in which hidden shapes had to be found as quickly as possible (Happé, 1994; Jolliffe & Baron-Cohen, 1997; Shah & Frith, 1993).

Findings in verbal-semantic tasks suggested autistic people had 'fragmented perception' of the 'bigger picture' and were therefore less able to derive context of meaning from sentences. For example when presented with the sentence 'she had a tear in her eye' or 'she had a tear in her dress', autistic people are more likely to mispronounce 'tear' due to an over-focus on the individual words in the sentence, at the expense of the context of the sentence overall (Baron-Cohen, 2009a).

Some researchers have not been supportive of the weak central coherence theory (Mottron, Burack, Stauder & Robaey, 1999; Ozonoff & McEvoy, 1994). Natasja van Lang (2003) noted that processing the global 'bigger picture' information can be achieved when particular focus on this is requested, suggesting that it is a preference for localised, rather than global processing, that underlies the autistic difference (Happe & Frith, 2006). Mottron and colleagues (2006) instead propose that it is an 'over-functioning of brain regions typically involved in primary perceptual functions may explain the autistic perceptual endophenotype.'

1.32. A Theory of Mind deficit

The second theory proposes that 'theory of mind' deficits may play an integral role in autism (Baron-Cohen, 1995). Having a 'theory of mind' is assumed to enable people to 'put themselves in someone else's shoes' and to consider their thoughts and feelings, as well as understanding and predicting their behaviour. Evidence that autistic children have impaired 'theory of mind' is indicated by an absence of pointing (joint attention), a lack of ability or interest in following another person's gaze (being interested in what they are thinking or seeing), a reduced interest in pretend play, and delays in being deceptive.

People who have an impaired theory of mind may feel anxious around others due to confusion about people's actions or intentions. They may not be able to read someone else's body language accurately and may take certain phrases literally, rather than making sense of the phrase in the context of the person's intentions (Baron-Cohen, 2009a). For example, 'pull your socks up' is often used to imply that someone needs to work harder. Some autistic people may see this as a

visual image and an instruction, rather than focussing on the wider context of the speaker's intention.

This theory does well to explain what appears to be a core deficit in autism, although critics state that it still doesn't address the patterns of intellectual strengths found in some autistic people (Baron-Cohen, 2009a; Klin, Volkmar & Sparrow, 1992).

1.33. Empathising/systemising (E-S) and EMB theories

The E-S theory considers the differences in the sexes to be defined along dimensions of empathising and systemising. The theory proposes that individuals with autism are impaired in empathising, alongside intact or superior systemising (Cohen, Knickmeyer, & Belmonte, 2005). The originator of this theory, Baron-Cohen, has now developed this further to become known as the 'extreme male brain' (EMB) theory (Baron-Cohen, 2003), in which autism is presumed to be at the extreme end of the typical male profile. Baron-Cohen states that 'the male brain is programmed to systemise and the female brain to empathise and that Asperger's syndrome represents the extreme male brain' (cited in Benenson, 2003, p. 132).

Baron-Cohen has presented much research in support of the EMB theory of autism, using the 'Empathy Quotient' (EQ) and 'Systemising Quotient (SQ)' developed by himself and colleagues. Several main criticisms state that much of this research has not been adequately replicated (Buchen, 2011; Carter et al., 2007; Spelke, 2005). Other criticisms include that the EMB theory does not adequately account for many neurological features such as repetitive movements, clumsiness and sleep problems (McGough, 2003).

1.4. Is ASD a unitary concept?

Each of the above theories has its strengths and weaknesses. Happé and colleagues (2006) point out that, at present, there is no one cognitive theory that appears to account for all the key features of autism. There has been no 'one' deficit found to explain all three of the impairments in the diagnostic triad, with

most psychological theories addressing only one area of the triad strongly. Given these findings, several researchers are now questioning whether ASD is a coherent syndrome (Skuse, 2009; Happé, Ronald, & Plomin, 2006; Skuse, 2009).

Varying evidence at behavioural, cognitive and genetic levels suggest that each impairment of the triad would be best studied independently. Happé and colleagues (2006) analysed data from over 3000 twin pairs and found modest to low correlations between the three impairments of the triad. They concluded that 'the degrees of social difficulty, communicative impairment and rigid/repetitive behaviour are only modestly related', providing strong evidence that the current diagnosis may actually consist of three separate impairments (Happé et al., 2006, p. 1218).

The research of Happé and colleagues also suggested that there may be separate genes that contribute to each of the three impairments and that each part of the triad is highly heritable. Often one family member shows only one of the impairments in isolation, and so inheriting more than one of the impairments is likely to come from multiple relatives – multiplex families, as noted above in our discussion of genetic research. Happé and colleagues (2006) suggested that there may be some evidence of a small degree of genetic overlap between the three impairments, as they do co-occur slightly above chance level, but suggested that searching for causal genes for autism, as a 'whole', seems pointless. Understanding the genes that contribute to each impairment might ultimately lead to more effective treatments. Therefore, it appears that it would be most useful for clinicians to measure each impairment of the triad independently, rather than giving an overall rating of severity. If each impairment is largely independent, then rather than looking for a single cure or intervention, symptom-specific treatments may be more effective.

In summary, the above review of the professional perspectives of ASD are important to consider as these are currently the dominant views influencing many who work with people with ASD, and their families. For such professionals ASD is considered to be a genetic and lifelong 'psychological disorder', which directs action for 'treatment' and 'interventions': shaping the daily experience of people with ASD.

2) Societal stereotypes and misconceptions

The discussion of societal perspectives will now continue with a consideration of several of the current societal stereotypes of ASD that are also likely to shape the experience of people holding this label. The diagnosis of autism, like many psychological diagnoses, has become associated with various societal stereotypes and misconceptions. These stereotypes are likely to effect how someone with ASD is treated by others, and may shape how they come to view themselves. Mental images of a child rocking in the corner, of being aloof and socially detached are common societal constructions of autistic children. Further misconceptions, that currently shape the perception of autism, are highlighted below.

2.1. *Savant and genius abilities*

The stereotype of a person with autism as a ‘savant’ appears to be a constant source of societal fascination where the person with autism is seen to possess ‘Rainman-like’ magical powers of intelligence (Murray, 2006, p. 63; Stevens, 2011). Depictions of high-functioning people with autism as professors and savant-like computer geniuses are common in film, TV and fiction. Several authors have documented the great capabilities of autistic individuals who consider themselves to be successful not *despite* their autism but *because* of it (Baron-Cohen, 2002; Grandin; 1996). This focus on positive strengths is an important counter-balance to previous conceptions that people with autism are usually ‘low-functioning’. However, the outstanding abilities of certain individuals have come to represent the whole, and a diagnoses of HFA or AS is now commonly associated with computer or academic genius (Lane, 2004; Szalavitz, 2012).

2.2. *People with autism ‘lack empathy’*

The misconception that people with autism lack empathy may have developed due to observations that they may sometimes relate to non-autistic people in non-typical ways. Bogdashina (2006) states that empathising is most natural when individuals share the same way of experiencing the world (p. 86). A person with autism’s perception of the world can be quite different to that of someone without

autism (as can two people without autism). This may lead to a belief that people with autism do not empathise. Therefore, this is a misconception formed from a non-autistic assumption that there is only one way of experiencing the world (Bogdashina, 2006). The E-S theory discussed above, may also have added to this simplistic idea that people with autism are low in empathy. Taken to an extreme, the idea that a person with autism is lacking in empathy can lead to a dangerous situation in which they are placed outside of the moral community and considered a risk to others; suggesting that they would be more likely to engage in criminal or violent activity.

Recent research can now assist to defuse this concern, indicating that this assumption is too simplistic, as empathy is now known to involve both cognitive perspective-taking and emotional elements. One particular study indicates that people with autism may show differences to non-autistic people on 'cognitive empathy' but not 'emotional empathy' (Dziobek et al., 2008). Due to having a different theory of mind, taking a non-autistic person's perspective can be difficult for someone with autism. This research showed that, when another's perspective is understood, a person with autism generally has the same level of empathy as someone without autism. Other authors now, including Baron-Cohen (2009b, p. 1595), have stated that people with autism can also be highly moral and that many are recognised as having a keen sense of social justice (Bogdashina, 2006, p. 87). An explicit acknowledgement of these factors may assist in easing the public concern that people with autism may be a risk to others.

2.3. People with autism are 'unusual/odd'

Due to different perceptual and sensory experiences, the behaviours and interests of people with autism are often misunderstood, and can appear confusing and hence socially 'odd' to non-autistic people. Some people with autism may show repetitive behaviours, such as flapping their hands and spinning around. Others may have unusual patterns of speech, such as particular fluctuations in pitch, loudness and tone. Some people with autism may appear to be pedantic, or overly formal in their manner (Bogdashina, 2006). Dramatised film portrayals of the social and communication difficulties of autistic people have contributed to a societal perception of the autistic person as 'weird' and 'strangely behaved'. Therefore the concept of social 'oddness' has become synonymous

with ASD. This may lead to over-focus on these aspects of a person, creating a narrow and restricted view of them. People with autism have also reported concern that other people may perceive them as 'unusual' or 'odd' (Humphrey & Lewis, 2008; Portway and Johnson, 2010), which can lead to a fear of judgement, avoidance of social situations and a sense of isolation.

Internal views on ASD: the autistic voice

A great deal of research and writing on autism has come from the perspectives of professionals, such as psychiatrists and psychologists, each describing how autism looks from the outside. More recently views on autism, written by people with autism and their family members, have provided great insight into the inner-realities of living with autism. These views are becoming more accessible via published autobiographies and the work of autistic advocates and therefore may increasingly contribute to shaping the constructions of this diagnosis. Accounts of autism in this form are not only illuminating but also hugely important: who else knows autism as well as those who live it themselves? Autistic authors tell us how autism feels for them in terms of their perceptual and sensory experiences, sharing how different the world can seem, and hence assisting others to make sense of why autistic individuals, on the outside, may seem different to others. Such writers point out the 'one-sidedness' (Bogdashina, 2006) of mainstream professional perspectives and seek to share their own understandings of what autism is, via first hand experience (p. 13). Here I shall consider the perspectives of autistic writers and advocates who have re-interpreted the traditional professional perspectives of ASD from an autistic perspective. Such writers have re-conceptualised the 'triad of impairments' and also revisited the concept of 'Theory of Mind', providing an important subjective balance to professional perspectives above.

Redefining autism: sensory and perceptual differences

Williams (1996) points out that traditional professional perspectives on autism attempted to 'treat' 'symptoms', and were usually aimed at lessening these so that the person appeared to be more 'normal' (p. 19). But for some people with autism, these 'behaviours' are a core part of themselves, and their personality.

Williams has re-interpreted the diagnostic triad of impairments into specific problems that individuals may recognise from an autistic perspective:

- 1) Problems of control (such as compulsion, obsession and acute anxiety)
- 2) Problems of tolerance (sensory and emotional hypersensitivity)
- 3) Problems with connection (attentional, perceptual, system-integration, and right-left hemisphere-integration problems) (p. 25).

Via this triad, the stereotyped behaviours noted in the DSM definition of autism is reconceptualised as an autistic person's 'compensatory strategies' for sensory difficulties they may be experiencing. This view provides insight into the individual's perspective, inviting understanding of their sensory and perceptual experience, rather than seeking to objectify and control stereotyped behaviours themselves.

Many autistic authors have discussed the difficulties they may have with social communication, along with different sensory-perceptual experiences (Grandin; 1996; Higashida, 2013). They provide accounts of sensory overload (auditory, visual, touch) experienced in common daily environments, where non-autistic people are generally unaware of such sensory elements. Difficulty in managing these high-intensity sensory experiences can lead to anxiety, confusion and stress. This may also help to illuminate why some people with autism may exhibit 'challenging behaviours', desiring to avoid certain environments, or maintain a predictable routine. Such perspectives are hugely important as they add the necessary subjective balance to the long held objective views on autism.

ToAM (Theory of Autistic Mind)

One of the leading theories of autism (as discussed above) is that of 'Theory of Mind' (Baron-Cohen, 1995), which proposes that people with autism have a deficit in understanding the minds of others. Bogdashina (2006) points out that these individuals do in fact develop a theory of mind, but that it is simply different from non-autistic individuals (p. 12). As people with autism have a different perceptual and sensory experience of the world, this is likely to affect how they interpret interactions with others during their early development. This would lead

to the development of a different 'theory of mind': a Theory of Autistic Mind (ToAM).

Bogdashina (2006) similarly points out that such a 'one-sided' interpretation of autistic individuals cognition demonstrates how limited professionals can be in their own abilities to 'mind-read' (p. 13). In other words, many non-autistic people find it hard to understand the autistic mind, and could therefore be considered as having a deficient ToAM. Many autistic authors and advocates (Temple Grandin, Ari Ne'eman, John Elder Robison) are now helping the neurotypical world to understand the world from an autistic perspective. Such views have the potential to increase understanding and acceptance of the different experiences of people with ASD.

HFA/AS: Difference or disorder?

In recent years the conception of ASD as a 'disorder' has also been questioned. Some individuals and professionals now consider that high-functioning forms of autism, such as HFA and AS, can for some, be merely a different cognitive style, rather than a disordered one (Baron-Cohen, 2002; Elliman, 2011). Some consider AS to be a neurological difference that has been socially constructed as a disorder (Malloy & Vasil, 2002).

Baron-Cohen (2002) has written extensively on this debate and points out that people with AS often show particular areas of strengths, not despite their AS, but because of it. Studies in support of this suggest that people with AS possess superior attention to detail (Happé, 1994b; Jolliffe & Baron-Cohen, 1997, Shah & Frith, 1993) and also perform better on some subscales of intelligence tests (Mayes & Calhoun, 2008; Shah & Frith, 1993). In addition, it is often suggested that many successful historical figures (Einstein, Darwin, Newton, Mozart) and more modern entrepreneurs and creatives (Bill Gates, Warhol, Isaac Asimov) may have had traits associated with AS, which have contributed to their success. The suggestion that such figures were autistic offers a very different view of the ASD person: a view based mainly on personal strengths rather than deficits, suggesting that autism is not 'all bad' and perhaps may not be something we must unquestionably seek to 'cure'.

During initial literature searches I also came across many AS websites containing personal debates about whether AS is best conceived of as a 'disorder' or as a 'natural human difference'. Some autistic individuals saw themselves as disabled, and others appeared strongly opposed to this; angered by disablist views. There seemed to be split views within the autism community. Most registered organisations that work to support people with autism referred to AS in terms of 'deficits' whereas individual bloggers and people in AS chat rooms expressed happiness with themselves and did not share the 'disordered' view. This was also the finding of study by Clarke and van Amerom (2007) who described the effect of the disordered view on autistic individuals as a 'problematic impact of medicalization or pathologisation' which they state causes additional or 'surplus suffering' for AS individuals (p. 772).

The frustration someone with AS experiences due to mainstream 'disordered' assumptions can also be seen on a spoof website entitled 'Institute for the Study of the Neurologically Typical', which provides a glimpse of how the 'disordered' view may be experienced. To do so it creates 'Neurotypical syndrome' (NS) as seen from an autistic perspective, describing people with this disorder to be preoccupied with social concerns and conformity, along with having delusions of superiority. It describes NS as being genetic in origin and tragically affecting a huge proportion of the population (Muskie, 2002). The author also describes his anger about the emotions of people with autism being described as flat; along with suggestions they may lack empathy. Such accounts indicate that for some people with AS it can be difficult to escape constructions they themselves do not agree with. Such individuals express frustration that their identity has been 'limited' by these societal stereotypes surrounding the diagnosis, indicating that they had been positioned as societal 'others' whose label had been used to certify them as defective and less valued.

Baron-Cohen (2002) offers some support for the 'difference' view of AS, stating that although some neurological differences in the brains of people with AS have been reported, this does not mean that their brain is necessarily 'disordered'. The particular differences found in people with AS may only be seen as a disability when the person is placed in a context that is in clear contrast to their own patterns of strengths. When people with AS work to their strengths it can be a clear advantage in certain career areas. Baron-Cohen does suggest however,

that despite the rising view of AS as a 'difference', there may be reason to retain the status of AS as a legal disability in order to ensure that those who do experience AS as a disability can receive the support they need (2002). Therefore an assumption that AS is *not* a disorder may not necessarily be beneficial either. It seems that it is most useful to consider this debate between 'difference' and 'disorder' on an individual basis, as determined by the individual and family.

Neurodiversity and the social model of disability

The debate regarding 'difference' versus 'disorder' is popular among many people diagnosed with AS. Since Internet usage has increased, some people with AS have found a collective voice (Singer, 1999) through which they can seek wider recognition and support for their difficulties. For others this has provided a way to campaign to change the 'disordered' view of AS, via autism rights and neurodiversity movements. These civil rights movements seek to establish 'neurological difference' as an acceptably acknowledged social category, as is the case with differences in gender, sexuality and ethnicity. Neurological differences are considered to be authentic aspects of natural human variation, which are not pathological and should not, and cannot, be 'cured'.

The neurodiversity view does not, however, deny the difficulties people with ASD may face due to their differences, but rather seeks to ensure respect for such differences. It seeks to make society more accepting by establishing support systems to enable people with neurological differences to live as they are, rather than being forced to conform to concepts of societal normality. There is some support that this view can be beneficial. Griffin and Pollak (2009) looked at the self-identities of 27 students in the UK with various learning disabilities (dyslexia, ASD, ADHD). Via thematic analysis of semi-structured interviews they found that those who considered themselves to be 'different' (neurodiversity view) expressed greater career ambition and higher self-esteem. Students who viewed themselves as 'disordered' expressed views of being disadvantaged and believed they were 'suffering' from their 'symptoms'. Their discourses indicated low self-esteem, high negativity and minimal optimism regarding their future.

Many who accept the 'difference' view of AS have come to use the term 'Aspie' to assert that AS is a core part of their identity and should be seen as an acceptable personality variant: *different* not *less*. This autism rights movement campaigns for autism to be accepted as a 'natural genetic variation', and does not support the medicalised view of autism as a genetic defect, or something caused by environmental pollutants or vaccines. Misguided attempts to 'cure' autism are considered to be as unethical as the historical efforts to 'cure' left-handedness.

In addition to the neurodiveristy view which has arisen in contrast to the medical view of AS, a related political movement exists within the field of disability research: 'the social model of disability'. In this model, the disability is not located in the person as the medical model denotes; the disability is located between the person and the society. The social model of disability asks us to consider whether AS has become a disability due to unfair societal expectations and barriers (Oliver, 1983). It attempts to address discrimination and concepts of disability by proposing that disability is created by the society, not the person, and therefore the responsibility to address this lies with all members of a society. For example, for people with AS, certain types of communication may be difficult, and therefore this model would suggest that wider use of computer technology should be encouraged and supported.

The social model of disability has potential benefits for the psychological well-being of someone with AS. It places responsibility on wider society to remove barriers and discrimination, and proposes that the person with AS does not need to conform to societal norms that may otherwise cause them continual distress and frustration. Rather than changing the person, we change the environment. When applying this model, AS becomes an 'acceptable difference', not just in theory, but also in practice. Shakespeare (2013) states that application of this model has been found to be 'effective *psychologically* in improving the self-esteem of disabled people and building a positive sense of collective identity' (p.217). He states that it has been an invaluable tool to remove barriers but suggests that further sophistication is now required in terms of the interplay between individual and environmental factors, which could provide a more complex and personalised understanding of disability.

The social model of disability has contributed considerably to societal improvements for autistic individuals. Rather than considering ASD as individually owned, being considered to be a disability caused by social barriers leads to very different forms of action. For example, in special education, rather than advocating Applied Behavioural Analysis (ABA) the social model would instead support the TEACCH model (Treatment and Education of Autistic and related Communication Handicapped Children). ABA is 'a systematic way of observing someone's behaviour, identifying desirable changes in that behaviour and then using the most appropriate methods to make those changes' (The National Autistic Society, 2015b). Based on a theory of learning known as operant conditioning, 'challenging' behaviour is modified via rewards for desirable behaviour, in essence aiming to shape the learning of autistic children to better-fit concepts of socially desirable behaviour. In contrast the TEACCH model actively respects an autistic person's difference, and seeks to adjust the learning environment to accommodate their needs. TEACCH aims to respect the 'culture' of autism: teachers work more as interpreters than as modifiers (Mesibov, Shea, & Schopler, 2004). Both interventions use visual aids to accommodate an autistic child's preferred visual way of learning, but learning targets are based on different assumptions regarding the overall desired educational outcome.

This research: Asperger's and the 'package deal'

We have explored the current societal stereotypes related to the ASD diagnosis, as it may be these constructions that contribute to shaping the experience of people who hold this label. This study will now further focus on research relating to high-functioning forms of ASD: AS and HFA, which have recently been collapsed together under the ASD diagnosis.

A focus on AS/HFA has been chosen for several reasons. In light of the current 'difference' versus 'disorder' debate, it seems that for some individuals with high functioning ASD, the societal messages surrounding the label are of bigger concern than the autistic difficulties they experience. Also, due to an increasing awareness of autism, there has been a much-publicised increase in the numbers of children now diagnosed. As the definition of ASD is now broader than originally described by Kanner, it is estimated that nearly 50% of these diagnoses are now people with high-functioning ASD (Lasser & Corley, 2008). Therefore it appears

increasingly important to consider the societal constructions surrounding this label, so as to ensure individual's experience more benefit than difficulty.

This study explores AS from a social constructionist perspective, asking what society currently perceives AS to be, and further asks how these constructions may shape the experience of someone who holds this label. I shall now consider a collection of qualitative research on AS before focussing on social constructionist writings. After a review of such research, I shall further explore the current societal and community constructions of AS via my own research design.

Qualitative research on AS

Societal stereotypes of autism are prevalent within the media and several studies have considered these and their potential effect on the person with autism. Draaisma (2009) studied depictions of autism (including AS) in TV, movies, novels and autobiographies and found that media representations of autistic special abilities appeared to contribute to a 'harmful divergence between the general image of autism and the clinical reality of the autistic condition' (pg. 1475). Draaisma observes that within such representations there appears to be only 'two options for an autistic person: either he is mentally handicapped...or he is a savant with mental powers exceeding those of two Cray supercomputers....It is either diminished capacity of superhuman capacity, but nothing in between' (pg. 1477). If a person with autism feels misrepresented by such extremes then it may create unrealistic expectations for them, self-disappointment, frustration and a feeling that they are constantly misunderstood.

Jones and Harwood (2009) also considered representations of autism/AS in Australian print media between 1996-2005. Their findings suggested that autistic people were subject to two main stereotypes: that they were 'dangerous and uncontrollable' and also 'unloved and poorly treated' (Pg. 5). In a further study, Huws and Jones (2011) found that within British newspapers autistic people were also represented as 'victims' as well as being vulnerable and easily led. Their findings also indicated that articles tended to infantilise autism via a focus on children rather than adults. Their most striking finding was that a large proportion of stories were not based on interviews with autistic people: the autistic voice was largely absent and instead the focus was on third-person accounts. Similarly, Bie

and Tang (2015) studied representations of autism in newspapers in China between 2003 and 2012 and they also noted that the voices of autistic people are often absent within the media 'unless they are autistic savants with special talents' (pg. 884) indicating that the autistic voice and experience appears to be undervalued unless presented alongside an extreme trait of interest to the wider public. Findings from such studies suggest that the risks of misrepresenting autism are high, with homogenised ways of representing autism making any forms of autistic diversity or individuality unlikely to be recognised.

Apart from such studies on media representations, further qualitative studies have provided some insight into the lived experience of people with AS, exploring how people with AS perceive themselves in relation to others, and how they make sense of their AS. Accounts of social and communication difficulties are common themes within qualitative studies (Carrington & Graham, 2001; Carrington, Templeton & Papinczak, 2003; Jones & Meldal, 2001, Muller, Schuler & Yates, 2008). People with AS describe difficulties with certain aspects of language as well as relational concepts, such as friendship. These experiences appear to correlate well with the difficulties described by autistic authors, as discussed above. Several of these studies also discussed things that people with AS found were useful, including a supportive community of other people with AS and the benefits of the internet in terms of managing social relationships and easing communication difficulties (Jones & Meldal, 2001; Muller, Schuler & Yates, 2008).

Some studies presented findings indicating that people with AS may have concerns about 'fitting in' and that they may feel they are 'masquerading' in social environments in order to avoid be identified as different. Carrington & Graham (2001) conducted inductive analysis of semi-structured interviews with two 13-year-old boys who have a diagnosis of AS, and their mothers, in Australia. One mother described how considerable stress was associated with her son's masquerading, as he attempted to mask his deficits at school. She stated that '...he hides it. They don't know that he's stressed at school.' She then explains that he would 'explode' as soon as he would 'reach the safety net at home' (p. 42). The authors further state that this masquerading may lead to depressive symptomatology. This was a small descriptive study, not generalisable to all children with a diagnosis of AS, but the authors suggest however, that these

views are likely be shared by other families and people with an AS diagnosis.

A further study by Jones & Meldal (2001) similarly described how people with an AS diagnosis may attempt to 'fit in' and 'role play at being non-autistic' (p. 35). Via a grounded theory approach, they analysed five first-hand accounts of people diagnosed with AS who spoke about social relationships on Internet 'home pages'. One participant stated 'eventually, and albeit very painfully I even learned to pass as one of you, but it hurt me, and any time I tried to believe in it I felt like I was being destroyed.' The authors state that the accounts of people with an AS diagnosis indicated a high 'degree of insight and awareness into being "different"' (p. 40) and that it may be an inaccurate general assumption that people with AS have little or no interest in social relationships. Again, however this was a small collection of accounts which claimed to have been written online by people with an AS diagnosis. Further in-depth personal interviewing techniques may provide a more detailed picture of the social concerns experienced by people with an AS diagnosis.

Further studies suggest that people with an AS diagnosis may hold concerns that others hold perceptions of them as being 'unusual' or 'odd'. Portway and Johnson (2010) have suggested that people with AS may be concerned about potential punitive judgements of others, and may therefore avoid social situations which then creates a sense of isolation and greater risk for depression. Twenty-five young adults with a diagnosis of AS (four females and 21 males), and 18 sets of parents were asked to tell their life stories in their own words. These unstructured interviews were analysed using constant comparative analysis where the core theme of 'not fitting in' was identified. One participant stated: 'At school I was always teased by the other children. They would call me names, throw stones, and pull my hair...' (p. 78). Isolation and loneliness were identified as common themes, with participants reporting a desire for social relationships, but being rejected, bullied and misunderstood by others. The concerns of people with AS regarding the judgement of others appears to make sense in light of the common social stereotypes surrounding AS, which may serve to increase negative focus on particular differences in behaviour.

The above studies indicate that people with AS may sometimes experience social difficulties due to their perceived differences. For some people negative

constructions of AS may become internalised, negatively effecting their view of themselves. One study by Humphrey & Lewis (2008) supported this conclusion. It involved semi-structured interviews with 20 pupils in north-west England, with a diagnosis of AS using interpretive phenomenological analysis to explore how pupils constructed their understanding of what AS means to them. Findings indicated that pupils sometimes constructed their AS in negative terms. Some expressed concern that others at school believed them to be a 'retard', 'not normal', 'a freak' and 'odd', and further expressed a desire to be made 'normal'. Some pupils also expressed that sharing their diagnosis has meant that they had been treated as 'less competent', which had further contributed to their negative self-concept. The authors therefore suggest that for some people the societal wide 'disordered' view of AS may lead to a 'loss of individuality and the limiting of people's expectations' (p. 31). In contrast, the same study also found that some people had successfully 'grown to accept and even celebrate their differences' (p. 32) and that this appeared to be facilitated by positive relationships with peers. Therefore this study provides some evidence that the experience of living with an AS diagnosis is intimately related to how others perceive and hence treat the person. It has provided a useful small-scale 'insider' account, which could increase the understanding of the experiences of AS pupils in schools, however considering the views of teachers and other children surrounding these pupils may have provided a further enriched picture of the attitudes and judgements AS pupils may experience.

Social constructionist perspectives on AS

Some social constructionist writings have demonstrated how the diagnosis of AS can be seen to serve the interests of current social and institutional practices. These writings strongly question the assumptions that lie behind the medical model of AS. Traditionally social constructionists have widely criticised the concept of 'disorders'; stating these to be socially constructed and based on current concepts of 'normality' (Canguilhem, 1966; Foucault, 1991). Writers have attempted to illuminate how we construct others with diagnostic labels, demonstrating how we do so in order to justify certain forms of social action. Such work has provided an understanding of how constructions create specified 'subject positions' which govern an individual's possibilities for action, and shape their subjectivity.

Waltz (2005) analysed a number of influential case studies that have come to form a core narrative of autism. Using a cultural studies approach such texts were examined in terms of ideology, voice and power, with Waltz illustrating how the 'othering' of autistic people 'shores up the ultimately hollow construction of normalcy, a category that can be defined only by what it excludes' and creating a 'marginalisation of lived experiences of autism by the dominant medical discourse' (pg.434). Further writings suggest that the medical construction of AS is a social construct that has particularly been adopted for its value in special education where professionals help to rehabilitate and 'normalise the child' (Molloy & Vasil, 2002). The education system was pivotal in the creation and dissemination of the diagnosis of AS, and the majority of diagnoses of AS occur shortly after a child enters the school system. Therefore the category of AS appears to be used to facilitate communication between special educational professionals (speech therapists, educational psychologists and occupational therapists) regarding the child's perceived 'needs' for which 'intervention' will be targeted.

When looking at parents' constructions of the 'problem' we also gain insight into how families construct AS. Avdi, Griffen and Brough (2000) carried out 11 semi-structured interviews with parents of children who were undergoing an assessment for their child with social communication difficulties at a child development centre in the West Midlands of England. Via a discourse analysis approach their findings indicated that parents used three main discourses to construct 'the problem' when seeking an assessment for their child: the discourse of normal development (and the parents role in promoting this), medical discourse (which assumes there to be a knowable cause, treatment and prognosis), and the discourse of disability (a state of permanent 'otherness' and developmental deficiency). This indicated that parents might consider their child's deviation from normal development as a 'problem' requiring medical intervention, while also holding particular concerns around permanent 'differentness' and potential stigma. Via the medical construction of AS, parents were therefore justified in seeking 'treatment' which essentially aims to 'normalise' their child.

A following discourse analysis study by Farrugia (2009) gives us a clue as to how, post-assessment, parents may subsequently come to use the diagnosis. His findings revealed that parents of autistic children can experience a 'spoiled'

social identity due to their child's behavioural and social differences. He analysed 12 interviews investigating Australian parents' personal experience of stigma due to having an AS child. He found that parents believed the diagnosis to be critical for them to personally avoid experiencing stigma. Employing a medical explanation for their child's difference enabled them to separate their child from their own social identity, relieving their own fears of stigma and isolation.

Therefore, the above social constructionist research indicates that there appears to be a blurry distinction between the 'needs' of the child, their parents and the school, whose aim is to have the child reach government-set educational targets. The discourses surrounding someone with a diagnosis of AS appear intimately intertwined with the interpersonal needs of people other than the child. Hence the child's subjectivity would become dependent on the way in which AS is constructed, and thus how they come to be positioned by others. Such research invites us to question *who* the diagnosis ultimately serves. Further research on the way professionals, family and wider society construct AS could further illuminate the various vested interests in use of AS as a diagnosis.

In addition, several authors have considered how, once diagnosed with AS, a child may be at risk of being defined by their label; unable to exist beyond this construction imposed upon them by others (Malloy and Vasil, 2002). This may contribute to a loss in their individuality, as well as limiting other people's expectations of them. Any behaviour may potentially become filtered through the label and interpreted as 'symptoms' that can be rationalised to fit the diagnosis. Similarly, Portway and Johnson (2005) state that a clinician cannot predict the short or long term consequences of diagnosing or not diagnosing a child. A diagnosis therefore becomes 'a source of risk in itself, in that it may influence or alter the child's life course to his or her advantage or disadvantage' (p. 81). Therefore, social constructionist perspectives ask us to be aware of our own intentions when considering a diagnosis of AS: in particular, who the diagnosis serves, and the long-term implications for the individual.

Stevens (2011) further illuminates this restricted view of people diagnosed with AS. Her findings indicate that once diagnosed, people with AS can be perceived in narrow terms, such as having extraordinary talent or at the other extreme, as a disability. She analysed texts from the UK that comprised of newspaper articles,

two autobiographical accounts and two novels involving AS characters. These were chosen as likely sources by which people may come to learn about AS. She conducted several focus groups with childcare practitioners working with AS children in out-of-home care, potential staff and students. Using a discourse analysis approach her findings suggested that AS is commonly associated with high intelligence, special skills and genius, as well as disability. She discussed these polarising conceptions of AS and concluded that many children are likely to exist in between, and hence become 'completely invisible within the discourse' (p. 490). Stevens considers the implications of such narrow conceptions of AS and concludes that 'we must write about and represent these children as real people living ordinary lives and not simply accept the extraordinary representations that exist.' (p. 491).

The above study is useful as it considers a range of constructions of AS within society as well as people involved with the support and education of people with AS. Further studies could extend this further by considering how AS is portrayed in the UK via additional forms of media, such as TV and film, as well as expanding the range of texts to include articles aimed at professionals. In addition, interviews aimed at considering constructions of AS among a wider collection of professionals and community members who work and live with AS people could also provide a more detailed picture of the current available discourses that may shape the experience of AS people currently.

The research question

As this Introduction chapter has shown, research on AS originally began with traditional quantitative research methods. These attempted to look at AS as an 'objective' and measurable entity, utilising a purely medical model perspective. More recently, some qualitative studies have provided insight into the lived experience of AS. Social constructionist writings have considered the constructions some parents have of AS, and the way in which the diagnosis serves certain social and institutional practices.

There were few studies located however that looked at the wider societal constructions of AS. This was surprising given the qualitative studies that suggested people with AS may hold considerable concern about the perceptions of others. People with AS expressed the need to 'masquerade' and described a

fear of being judged as 'odd' and less 'competent' than others (Carrington, Templeton & Papinczak, 2003; Humphrey & Lewis, 2008; Portway & Johnson, 2010). Such studies indicate that the constructions used by others are likely to contribute to how a person experiences this diagnosis. These may shape a person's view of themselves. Studies that looked directly at society-wide constructions of AS could be an important first step in understanding and addressing any unhelpful assumptions. From a counselling psychology perspective, the subjectivity of a person is of primary concern in our work. As the subjectivity of people with AS is shaped by the constructions and actions of those around them, awareness of these would provide useful insight into the potential subjectivities of clients who may hold this diagnosis.

This study will therefore take a broader approach to data collection than Stevens (2011) discussed above. It will firstly consider a wider spread of societal texts, in an attempt to identify a broader range of societal discourses in common usage in the UK currently. However, people with AS are not only affected by the constructions of AS disseminated in societal texts; it is also the views of people within their own community that shape their experience. Consideration of the constructions present within a wider spread of people across a community of people who 'know someone with AS' could also provide valuable insight. The research question of this study therefore asks: how is AS constructed currently in the UK, at both a societal and community level? A broad range of data sources will attempt to provide a detailed view at both levels. The implications of these constructions for the practical and subjective realities of AS people will then be considered. This will better enable recommendations as to where both clinical and societal-level work could focus. As practitioners, and as members of wider society, it is an ethical priority that we bring to attention and actively resist discourses that may be potentially limiting. This study is an attempt to identify any harmful discourses, providing a basis upon which we can direct our action to prioritise those that are helpful and empowering for a particular individual's psychological development and well-being.

What's in a name? A word about terminology

The terminology used to describe autistic individuals in this thesis will now be considered carefully. A common approach has been to use 'people-first

language' in which the person is named first and separated from the 'disability' i.e. 'person with autism' (as I have utilised so far). This approach arose in the 1980's and was proposed by disability advocacy groups. These advocates wished to emphasise that someone is a 'person first' and that the 'disability' is a secondary aspect: not a characteristic of the person's identity. This terminology, like many aspects of language, appears to have derived from a particular time and place when disability was widely perceived to be a negative aspect of a person. Therefore this terminology arose in an attempt to protect individuals from such prejudice.

Currently a different view has gained support (and one I have become aware of while writing this thesis). Many advocates of autism now prefer 'autistic person' or 'autistic individual' as they wish others to understand that autism is a core part of their identity, much as many other societal groups wish this to be recognised; for example as gay, bisexual and jewish communities. Many state that autism is not something that can be separated from who they are and does not necessarily have to be perceived negatively. For example, we do not currently say someone 'has gayness' or 'has jewishness'. Autism advocates strongly state that autism is not something to be ashamed of: that it is not an 'illness' to be cured. This does not mean to say that someone does not experience significant difficulties, but rather that it should be accepted as a natural and valid part of human diversity.

As such, I have chosen to use 'autistic person' from here onwards: for someone with a diagnosis of AS I will use the term 'AS person'. This is due to recognition of the power inherent in language, and awareness of the implications of the discourses we each choose to participate in. Despite the significant difficulties autistic people may face, I wish to support the view that autism is nothing to be ashamed of. However, I am aware that the terminology of autism is a contentious issue and that some autistic people and their families may prefer the earlier convention. If such terminology causes offence I deeply apologise. Ultimately it is for each individual and family to choose what feels right for them. At the very least, I hope that this decision reflects the way that autism could be – something that no longer needs to be separated from the person due to concerns regarding stigma. Via affirming this within our language it may help to bring understanding that autism can be considered to be a natural part of human diversity, and that by doing so individuals can feel both accepted and supported.

2. METHODOLOGY

During the initial stages of this research, literature searches indicated that there was a lack of qualitative studies looking at the societal constructions of AS. However, rich qualitative data was viewable in news articles, professional organisations and in artistic/cultural sources. The importance of studying the social constructions surrounding AS also become more apparent through exploration of online AS communities. Individuals were noted as varying in their conception of AS as a 'disorder' or as a 'difference'. Some frustration at the limitations of the 'disordered' conception of AS have also been noted (Clarke & van Amerom, 2007). Viewing such accounts indicated the importance of identifying certain social constructions of AS that, for some people, may mean that the diagnosis creates more difficulty than benefit.

Research Aims and Design

This study utilised Foucauldian Discourse Analysis (FDA: Parker, 1992, Willig, 2008) to explore some of the social constructions and discourses surrounding the label of AS and HFA. It attempted to consider the implications of these constructions in relation to subjectivity, positions and practice in order to better understand what *can* be felt and experienced by individuals with an AS diagnosis.

The study began with the analysis of societal texts considered most likely to capture the current dominant societal discourses in the UK currently. These included newspapers, professional articles and artistic/cultural sources. Data collection was limited to samples published within the last 5 years. This ensured sufficient data was collected and analysed, while still remaining recent enough to be considered 'current'.

After texts were analysed, individual interviews were conducted within a community of people who each knew 'someone with a diagnosis of AS or HFA'. Rather than interviewing people with an AS diagnosis themselves, it was the constructions that were held by those surrounding AS people, such as parents, friends, teachers and health professionals that was of interest. These constructions create the world around someone with an AS diagnosis, helping to

shape their identity and their own understanding of who they can and cannot be. Therefore, to be clear, the choice not to interview people with a diagnosis was purposeful. It did not suit the design of the study well. As a result of choosing this design, I am aware that I cannot bear witness to any collective voices shared by the people who share this label. Instead, it is the collective that surrounds them, who are my 'research group' or 'collective' of interest here.

A process of master analysis aimed to bring together the two master domains: societal texts and community interviews to provide an overview of the current dominant discourses of AS in the UK currently. This design also enabled observation of any differences and similarities between each master domain, as well as smaller subdomains. Therefore the design attempted to provide a coherent overview of the dominant constructions of AS across UK society currently, as well as a more detailed understanding of how AS is constructed within particular societal and community sources.

Epistemological Development of the Research

The epistemological position of this research could best be described as a social constructionist, critical realist, and pragmatic perspective. The research question was formed from a social constructionist perspective. In addition, the study takes a critical realist approach towards AS, and does not debate the actual existence of AS as an experienced phenomenon. Finally, discussion of the analytic findings and the resulting recommendations for practice are made from a strongly pragmatic perspective – considering what is most useful for the individual, rather than recommendations based on any form of ultimate truth.

Social Constructionism

In its essence, social constructionism takes a critical stance towards any one way of seeing the world, making it a relativist ontology and hence in direct opposition with positivist empirical science. This perspective considers there to be no such thing as an 'objective fact'; denying that any knowledge derives from our direct perception of reality. It 'cautions us to be ever suspicious of our assumptions about how the world appears to be' (Burr, 2003) stating that the ways in which we

order the world, and the categories with which we choose to do so, are in fact constructed (p. 3).

With its origins in 20th century philosophy and sociology, social constructionism soon moved into psychology with Gergen (1973). Many notable figures have emerged since (Billig, 1991; Burr, 2003; Harré, 1984; Potter and Wetherell, 1987), each of whom proposed several key concepts:

1. A critical stance towards positivist approaches
2. That knowledge is historically and culturally specific
3. That knowledge is linked to social action.

Social constructionists have pointed out that what constitutes a 'mental health condition' or 'disorder' in one culture, time or place, may not do so in another (Walker, 2006; Horwitz, 2011). Psychosis may be considered a mental illness in a Western culture, where labels are based on deviation from the norm, whereas in other cultures a person may be revered as having access to spiritual voices. Such cultures may provide more hopeful scripts in which the person who hears voices is 'celebrated' rather than 'treated' (Jablensky et al., 1992). Similarly, homosexuality was once considered a disorder and listed in early DSM additions in decades past, but is no longer considered so (Pilgrim, 2007).

Social constructionism also illustrates how constructions of knowledge have a direct relationship with action. When homosexuality was considered an 'illness' people were forced into humiliating and harmful 'treatments'. When constructed as a 'crime' many were incarcerated. Constructions form our basis for action, and have direct effects on our experiences in society. Constructions directly inform power relations – dictating what certain people *can* and *cannot* do, and how we treat others (Billig, 1991; Burr, 2003; Potter & Wetherell, 1987).

Critical Realism

While attempting to illuminate the socially constructed aspects of a particular diagnostic category, I do not completely deny an essence of 'realness' to the phenomena in question. I do not debate that there may be a 'difference' captured by certain psychological labels, but I do consider that the way in which they are

socially constructed plays a large part in how a label is defined and hence experienced. This appears to fit with a critical realist perspective.

As the limitations of positivist empirical research have shown, there is little about the world we cannot know without this being determined from a 'human perspective'; the world is interpreted in ways that matter to us. Critical realism 'combines the realist ambition to gain a better understanding of what is 'really' going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to this reality' (Willig, 2008, p. 13). A critical realist approach assists to adopt a perspective that enables both freedom of choice, and action, to improve well-being and quality of life.

Pragmatism

Ultimately, within a universal frame, it may be the case that there are multiple truths, but the reality apparent to us from a human perspective cannot be discounted. We live a human life, and from a human perspective, and therefore there may be certain things that may be adaptive to consider 'truths'; things that guide us to action to improve our own survival and well-being. Marks & Yardley (2004) argue that 'from the pragmatist perspective *all* human inquiry involves the interpretation, intentions and values which constructivists regard as paramount – but must also necessarily be grounded in the empirical, embodied experience which realists regard as fundamental' (p. 5).

The application of social constructionist critique can be difficult due to a relativist ontology which provides no basis upon which to support one 'truth' over another (Potter as cited in Parker, 1998). A pragmatic perspective, when applied to social constructionism, can be very effective in creating necessary change. Social constructionism may assist to breakdown dominant societal assumptions of 'knowledge' but the additional application of pragmatism allows us to then direct our action based on what 'works' in the service of health and well-being. After viewing the dominant social constructions of AS, this research also seeks to consider ways in which to improve 'the package deal' of AS. Therefore adopting a pragmatic approach better enables recommendations for improvement to be made.

Closing thoughts on epistemology

As with any piece of research, the rationale for this research stems from a particular epistemological position, a certain viewpoint from which to explore this research question. It is likely that a different position may provide equally interesting insights. As a final year doctoral trainee who will likely utilise different epistemological positions in the future, I hope that counselling psychology, as a division, maintains its uniquely critical stance to any one way of being – to never become too rigid or unquestioning. Counselling Psychology is particularly well placed to demonstrate these multiple and non-rigid perspectives within both our research and practice. And so, as would be consistent with the division, the position employed here is acknowledged as one of many that are possible.

Discourse analysis: An epistemological fit for our design

‘When people talk to each other, the world gets constructed’ (Burr, 2003, p. 8). Language is therefore a form of action. It is not simply reflective of our internal states or a way to passively describe the world. It is considered to be a way in which we actively construct knowledge, and our world. Therefore language becomes our form of data here when we wish to study the ways in which our knowledge of particular things are created.

In the early stages of formulating my research question, several methodologies were considered, including mixed methods, IPA (Smith & Osborn, 2003), discursive and FDA (Edwards & Potter, 1992; Harré & Stearns, 1995). A mixed methods approach was initially explored, where some quantitative data would be collected via questionnaires alongside a qualitative element, but it was decided that a strong qualitative approach would better address the gaps in the literature on AS. As my interest lay in the ‘societal discourses’ surrounding this diagnosis, IPA was not suitable: phenomenology did not align well with the epistemological background of this research.

Discourse analysis was then explored. This analytical method arose as part of a ‘paradigm revolution’, where critique of the old positivist paradigm created a shift towards recognition of the ‘personal, institutional, and political stakes’ inherent in such approaches (Parker, 2012, p. 472). Until this time psychology had rarely questioned its own assumptions, studying those on the outside and ‘rarely

including itself in the phenomena it described' (Parker, 2012, p. 472). Discourse analysis now assisted researchers to critique and 'problematize the categories' and concepts inherent in mainstream research (Willig, 1999, p. 2). This revolution became known as the 'turn to language' (Harré & Secord, 1972). Beginning with the work of Foucault, Gilbert and Mulkay (1984), and Potter and Wetherell (1987), discourse analysis soon split into two branches: discursive and FDA. Discursive analysis looks at the strategies people use within language to achieve their personal and interpersonal goals (Potter & Wetherell, 1987; Edwards & Potter, 1992). Alternatively, FDA considers power and the ways in which discourses dictate what is available to be said and by whom within societies (Parker, 1992; Willig, 2008).

FDA lends itself well to a social constructionist epistemology, as utilised here to explore our research question, by looking at the power inherent in societal discourses. It allows for a critique of traditional empiricist and positivist epistemologies and offers a suitable platform from which we can consider the human contribution to our world and our constructions of it. This thesis aims to consider the available subject positions, implications for action and subjective possibilities existing within certain discourses. FDA was therefore the natural method of choice here. In the words of Parker (1992), 'it is better to start with a wish to deconstruct power and ideology and then look at how a study of discourse dynamics could help' (p. 11).

Michael Foucault (1926-1984) was a French philosopher, social theorist and critic. He considered power to underpin every level of our social interactions and demonstrated how knowledge and power is often used in the form of social control. Foucault noted how people are prey to subtle forms of power by accepting certain social practices as normal (Gergen, 1999). He considered language to contain 'patterns of meaning' and that these play an important role in power relations (Parker, 1999, p. 3).

FDA has been applied to many aspects of society, illuminating practices and knowledge previously accepted as truths. Medical discourse, for example, exists in many forms: journals, texts, reports, lectures, medical TV programmes, and the everyday speech of health professionals. Foucault (1972) suggested that even the physical interactions a patient experiences with a doctor (discursive practices) should also be treated as discourse as these practices are also invested with meaning and can reproduce institutions. What is of interest in FDA

is how a particular discourse can reinforce certain institutions or subvert others when it is used. Medical discourse contains certain rights, and hence power, when some use this discourse (doctors), and naturally excludes others (patients) who may feel in a position of powerlessness when it is deployed. It is important that when considering these discourses, we ask who gains and who loses from their use, and who would want to promote it and who would not (Parker, 1992).

In its essence FDA enables us to show how things could be different. We can consider how current constructions facilitate or limit someone and also consider alternative constructions. This sounds very useful in theory. Willig (cited in Parker 1998) argues that discourse analysts have been powerful in deconstructing many aspects of societal life, but that they often remain as 'observers and commentators', leaving the action and change-making for others to make (p. 15). Therefore this research seeks to illuminate the current 'package deal' of AS and then propose recommendations for improvement. Willig reminds us that 'inaction is a form of action' and that if we don't bring our recommendations into action then by default we 'end up legitimating the status quo' (Willig as cited in Parker, 1998, p. 15). Ultimately, what is the point of discourse analysis if nothing is achieved?

3. METHOD

The following section provides a description of how the study was conducted. Firstly I will outline the study's design, which involved the creation of two master domains (societal texts and community interviews) in order to adequately address the research question. These two master domains were then subdivided into four smaller subdomains to enable a sufficiently wide spread of data to adequately address the research question.

I will then describe how data was collected and coded, before outlining how all forms of data were analysed. A process of master analysis then combined each analysed article into a type, and then into four subdomains. All data was then collapsed into the two master domains that were designed to address the research question at hand. I will end the chapter with a discussion of methodological reflexivity as well as aspects of the design and research process that required particular ethical consideration.

The Two Master Domains

This study consisted of data from two 'master' domains: Societal Texts and Community Interviews in order to address the question: how is AS is constructed in wider society, and how is it constructed in the community? The study also considered whether there are any constructions that were shared between the two master domains, and whether there were any that were unique to each. Figure 1 represents the research question diagrammatically.

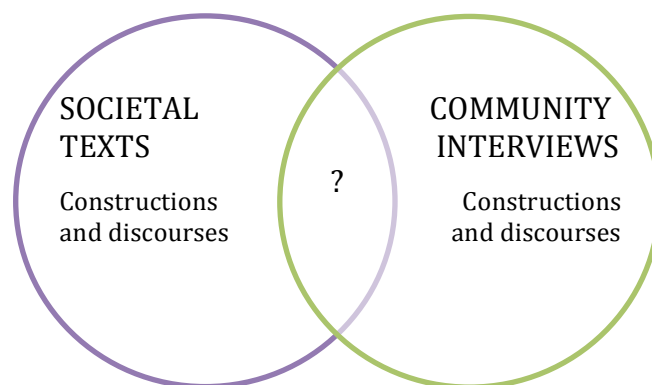


Figure 1: The two master domains.

Willig (2000) discussed each of these levels as the two major ways in which discourse analyses have traditionally been conducted: deconstructing expert and societal texts (focus 1) and the analysis of lay people's talk (focus 2). Both are considered to generate valuable insights. Although the majority of discourse analyses have involved one or the other, the research methodology employed here has attempted to combine both focus 1 and 2 in order to consider discourses at both societal and community levels.

The Four Subdomains

The two master domains were divided into 4 subdomains. The Societal Text master domain consisted of three subdomains: Newspapers, Professional Articles and TV/Film/Fiction. The Community Interviews 'master' domain contained only one subdomain (existing at both master and subdomain levels) and hence retained its title of Community Interviews as a master domain. This collection of subdomains was chosen as it was considered most likely to provide access to the widest and most dominant collection of discourses on AS in the UK currently. Figure 2 represents the complete set of four subdomains in the study.

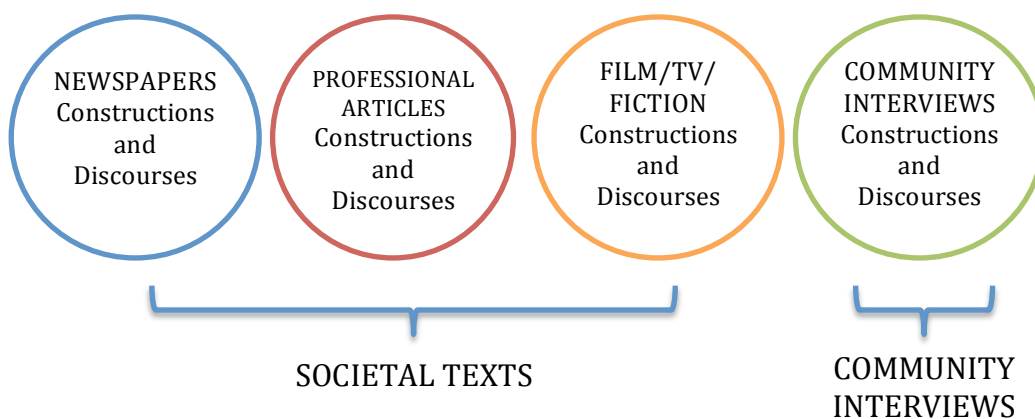


Figure 2: The four subdomains in the study. Newspapers, Professional Articles and TV/Film/Fiction belong to the 'master' domain of Societal Texts. Community Interviews exist at both subdomain and 'master' domain levels.

Each of these four subdomains also contained sub-categorical ‘types’:

Subdomain 1: Newspapers - consisted of three different types: Broadsheets, Tabloids and Online News.

Subdomain 2: Professional Articles - consisted of five types: Medicine, Education, Speech and Language, Occupational Therapy and Psychology.

Subdomain 3: Film/TV/Fiction - consisted of three ‘types’: TV, Film and Fiction.

Subdomain 4: Community Interviews - participants could be divided into five types: Teaching, Speech Therapy, Parents, General Practice, and a community ASD Charity.

Figure 3 represents the relationship between the four subdomains and their individual data types:

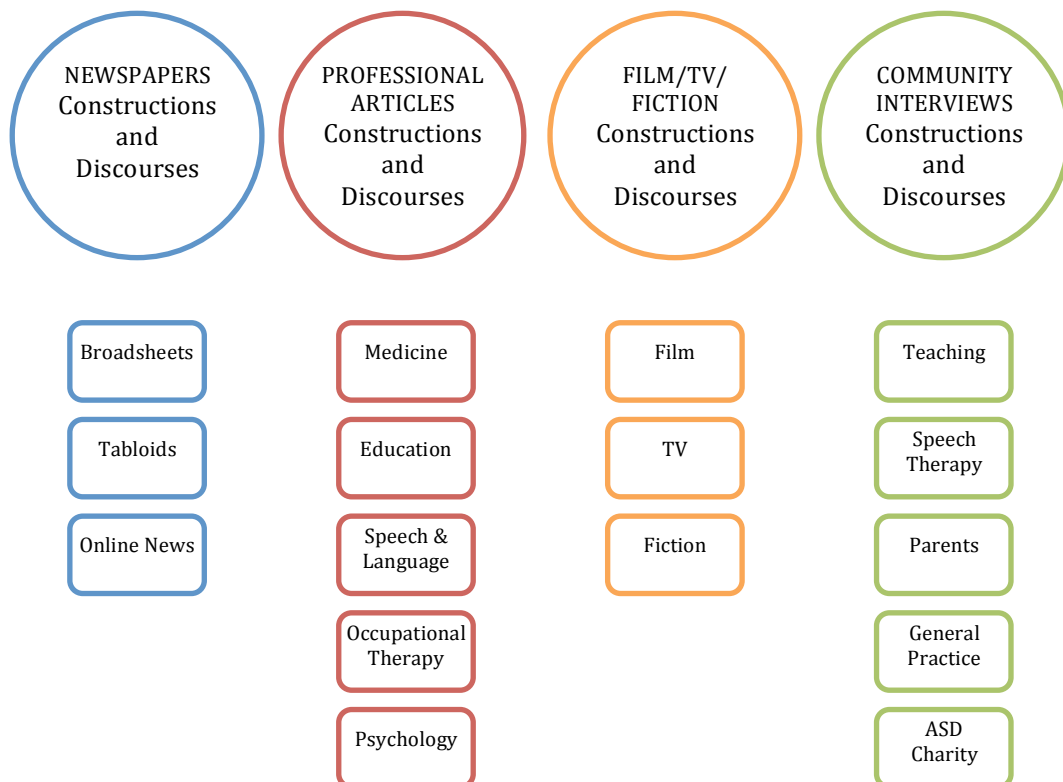


Figure 3: The four subdomains and their types.

Analysis Part 1: Societal Texts (subdomains 1-3)

Locating Suitable Texts

To ensure data collection that was as sufficiently rich as possible, three subdomains of Societal Text data were chosen: (a) Newspapers, (b) Professional Articles and (c) TV/Film/Fiction. Editorials, rather than research papers, were chosen where possible, as they were more likely to discuss any controversies in the field. It was hoped that this selection would provide sufficient access to the main societal discourses present at professional (Professional Articles) and general societal levels (Newspapers, TV/Film/Fiction).

When sourcing data for the subdomain of Newspapers, online websites for UK newspapers were searched using the term 'asperger' and 'high-functioning autism' in order to locate appropriate articles written within the last five years. Very little was found when searching 'high-functioning autism' possibly as this is a reasonably recent term. Editorials were easily locatable within newspapers when searching for 'Asperger' as AS has been regularly discussed in the media over the last five years.

When sourcing data for the subdomain of Professional Articles, a variety of different searches were conducted. Firstly an Internet wide search, to discover the main journals within each field, was conducted. Journals that were searchable directly online were searched using the term 'asperger' and 'high-functioning autism' in order to find appropriate articles written within the last five years. If there was no direct online access via a journal, or an organisation's website, then academic search engines via City University library were used to access particular academic subscriptions. Google Scholar also provided access to some articles. Within Professional Articles, editorials on AS or HFA were, on occasion, more difficult to locate. It was sometimes the case that an 'editorial' article particularly focusing on AS or HFA had not been written within the last five years. When this was the case, the closest match article was used. Sometimes this may be a story regarding a particular professional's work with someone with an AS/HFA diagnosis and the article may be seeking to share the experience with other professionals. Once 30 articles were located they were saved in preparation for coding, and searching ceased. None were excluded: being a professional UK article that discussed AS was the only criteria.

When sourcing data for the subdomain of TV/Film/Fiction, the methods varied depending on the type. Online searches were the initial starting place for each type. When sourcing TV programmes for the TV type, Wikipedia was a useful source as it provided an article discussing AS in popular culture, providing a list of cultural sources. TV on demand' websites (4OD, ITV, 5 on Demand) were then searched using the term 'asperger' in order to locate programs associated with Asperger's that have aired in the UK within the last five years.

When sourcing for the Films type, IMDB provided a list of films containing characters who are associated with AS. Finally, when sourcing for the Fiction type, Amazon.co.uk provided a useful search engine for finding the most widely available fiction in the UK relating to ASD.

UK publications, TV programmes and films were considered the most appropriate for the study, but where a UK example could not be found to exist within the last five years, the most popular and most generally available equivalent was chosen. This occurred with Films, where UK made films containing characters recognised as AS/HFA were not locatable, so two US films currently considered the most popular and most widely available in the UK were chosen.

File coding for type

The total number of texts collected for the master domain of Societal Texts consisted of 30 individual sources. Once selected, the texts were divided, by type, and a file coding system was devised.

In the Newspaper subdomain, Broadsheets were considered a type and would begin with the prefix 'BS'. As there were three different broadsheets, a further 1, 2 or 3 was added to the 'BS', and then articles from each broadsheet were given an 'a' or 'b' accordingly. For example an article from the Guardian entitled 'Asperger's syndrome dropped from psychiatrists' handbook the DSM' was coded 'BS1-a'. Tabloids, as a type were coded to begin with 'TB' and followed the same process above as with Broadsheet coding, for example TB1-a. Online news articles were coded with the prefix 'ON', such as ON1-a.

In the Professional Articles subdomain each text was also subdivided by its type. Education was coded as ED, Medicine as MD, Occupational therapy as OCC,

Psychology as PSY and Speech and Language therapy was coded as SLT. For example, an professional educational article would be coded as 'ED-a', or 'ED-b'.

Texts from the TV/Film/Fiction subdomain were coded with the following prefixes: 'TV' for TV programmes, 'FIC' for fiction, and 'FLM' for film.

A complete list of Societal Text data and coded file names are as follows:

Subdomain 1 = 14 x Newspaper Articles:

Six articles from three different broadsheet newspapers:

2 x guardian (BS1-a, BS1-b)

2 x Independent (BS2-a, BS2-b)

2 x Telegraph (BS3-a, BS3-b)

Four articles from three different non-print online news sources:

2 x BBC news online (ON1-a, ON1-b)

1 x Sky News online (ON2-a)

1 x channel 4 News Online (ON3-a)

Four articles from three different tabloid newspapers:

1 x Daily Mail (TB1-a)

2 x The Mirror (TB2a, TB2b)

1 x Daily Star (TB3a)

Subdomain 2 = 10 x Professional Articles from varying sources:

2 x education (ED-a, ED-b)

2 x medical (MED-a, MED-b)

2 x occupational therapy (OCC-a, OCC-b)

2 x psychology (PSY-a, PSY-b)

2 x speech and language (SLT-a, SLT-b)

Subdomain 3 = 6 x Film, TV and Fiction from varying sources

2 x TV (TV-a, TV-b)

2 x fiction (FIC-a, FIC-b)

2 x film (FLM-a, FLM-b)

A full list of Societal Text data references can be viewed in Appendix 1.

Analysis

Willig's (2008) six steps were chosen as the most appropriate guide for analysis. Compared to Parker's (1994) 20 steps and those proposed by Potter and Wetherell (1987), it was felt that Willig's steps provided the best match to the research question at hand. Rather than looking at ideology, institutions and power as Parker does in his later stages, the remit of this study wished to focus on factors that affect the psychological well-being of an individual. Willig's six steps helped to focus analysis within this appropriate remit. In particular, as 'subjectivity' is included as its own step it allows detailed focus on what 'can' potentially be felt by certain people within these discourses, assisting to illuminate what potentially 'can' be felt within the 'package deal' of AS.

In short, Willig's steps provided a clear process through which the transition of discourses at a societal level can be tracked right down to their implications for an individual's psychological experience. This tracks an aspect of my own research question in considering how discourses at the societal level may filter down to have implications for an individual's psychological experience and well-being.

Analytic Procedure for Individual Articles

An analytic procedure was designed in order to produce the most engagement possible within each text, with the aim to extract constructions and discourses in the fullest and most multi-perspective manner possible.

1. Individual article 'holistic view'

Initial readings aimed to gain a 'holistic view' of the text, and how it affected the reader as an integrated whole. Notes were taken each time it was read, and each article was read in full at least three times. This step was considered best to employ before further detailed engagement with each text occurred, which may make this holistic view less accessible.

2. Individual article coding

Each article was then coded line by line, with the article title being coded as number '1' and continuing onwards sequentially until the end.

3. Individual article notes

Each line of text was read and re-read at least three times. A document for each article was created to capture notes written about the manner in which the article was composed. Reflection on the word choice and any potential underlying latent meaning was noted. This process took place over several sittings, and on different days, in order to provide the opportunity to notice and take in different perspectives.

4. Individual article analysis

Each article was then analysed using Willig's six steps. A document (Analysis Template: see Appendix 2) was created for each article that worked systematically through each of the six steps. This began by looking for constructions of AS used within the article (step 1), followed by locating these within wider discourses (step 2). The function of each construction in terms of possible action was considered (step 3) and how individuals could be positioned within such discourses (step 4). The 5th step explored how certain constructions and positionings restricted or enabled an individual's opportunities. Finally, in the 6th step, constructions were considered in terms of subjectivity such as what *can* be felt, thought or experienced (Willig, 2008). The six steps were each revisited and repeated for each article over several sittings, so as to again, provide enough opportunity to engage with the text from different perspectives that different sittings sometimes generates. See Figure 4 below for a diagrammatic representation of Individual Article Analysis.

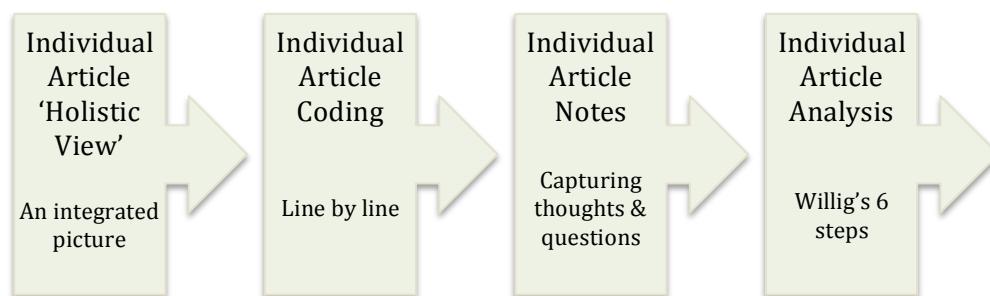


Figure 4: A representation of the stages of individual article analysis

Locating Constructions and Discourses

Constructions were identified within the texts by considering the ways in which the person with an AS diagnosis was 'created' by the speaker and how the language sought to describe AS to the reader. Through the particular word choice employed, I attempted to gauge how was the reader was told what Asperger's was, and what it wasn't. Often constructions were apparent through the use of explicit phrases, and other times they were implied via more implicit or subtle expressions of language. Specific examples of differing deployments of constructions will be discussed in the Analytic Findings chapter.

Individual constructions generally form part of collections of more widely available societal discourses. The use of a particular construction can indicate which wider societal discourse the speaker may be drawing upon. In other words, discourses can be considered to be 'recurrently used systems of terms used for characterising and evaluating actions, events and other phenomena' (Potter & Wetherell, 1987, p. 149). Parker (1992) suggested that we label sets of metaphors and statements we find as 'discourses', rather than Potter and Wetherell's 'interpretative repertoires' which may imply there is a limited range of terms within this repertoire. This 'feeds the positivist fantasy for an ultimate complete picture of a particular system, a totality of meanings...' (Parker, 1992, p. 11). In keeping with Parker's view, we shall refer to 'discourses' here.

Type analysis

After each individual article was analysed, and Willig's six steps had been used to complete the analysis template for the article, a combined list of 'frequent' constructions was created for each type of Newspaper (BS, TB, ON), each type of Professional Article (MED, ED, PSY, SLT, OCC) and each type of TV/Film/Fiction (TV, FLM, FIC). This was created via a simple count of how many times the construction was deployed within each article, which were combined to form a document of 'frequent constructions' across the type. See Figure 5 below for a representation of individual article analysis being combined by Broadsheet Newspaper type.

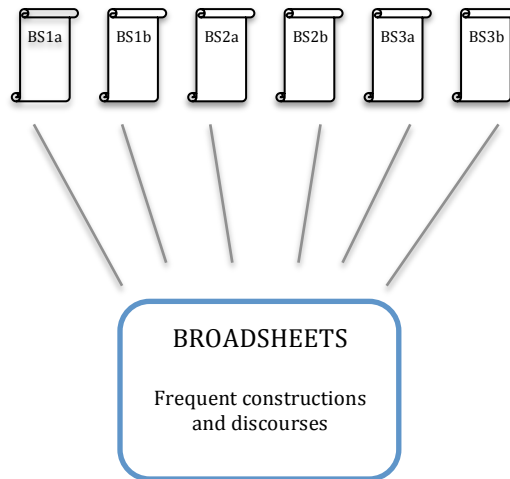


Figure 5: Individual broadsheet analysis being combined by type

‘Frequent constructions’ once combined by type contained a combination of those that were both prominent within articles, and common across articles. For example, the term ‘disorder’ was found to be present once or twice within each article, and so was ‘frequent’ across articles. In addition, there were also constructions that were highly prominent within articles such as ‘odd/weird’, and thus would be considered ‘frequent’ as it appeared four times in the article compared to ‘highly intelligent’ which only appeared once. Focusing on frequent constructions does not necessarily mean that those less frequent are not powerful, but a decision was taken here to not carry these forward as they did not appear to represent the type. Appendix 3 shows an example of this ‘combined analysis by type’, for the subdomain of Newspapers.

Subdomain Analysis: Societal Texts

By using the ‘frequent’ constructions from data types, a combined list of ‘major’ constructions and discourses was then created for each of the three subdomains of societal texts: Newspapers, Professional Articles and TV/Film/Fiction. A diagrammatic representation, showing how the analysis of all individual societal texts were collapsed into types, and then into subdomains, can be seen in Figure 6 below.

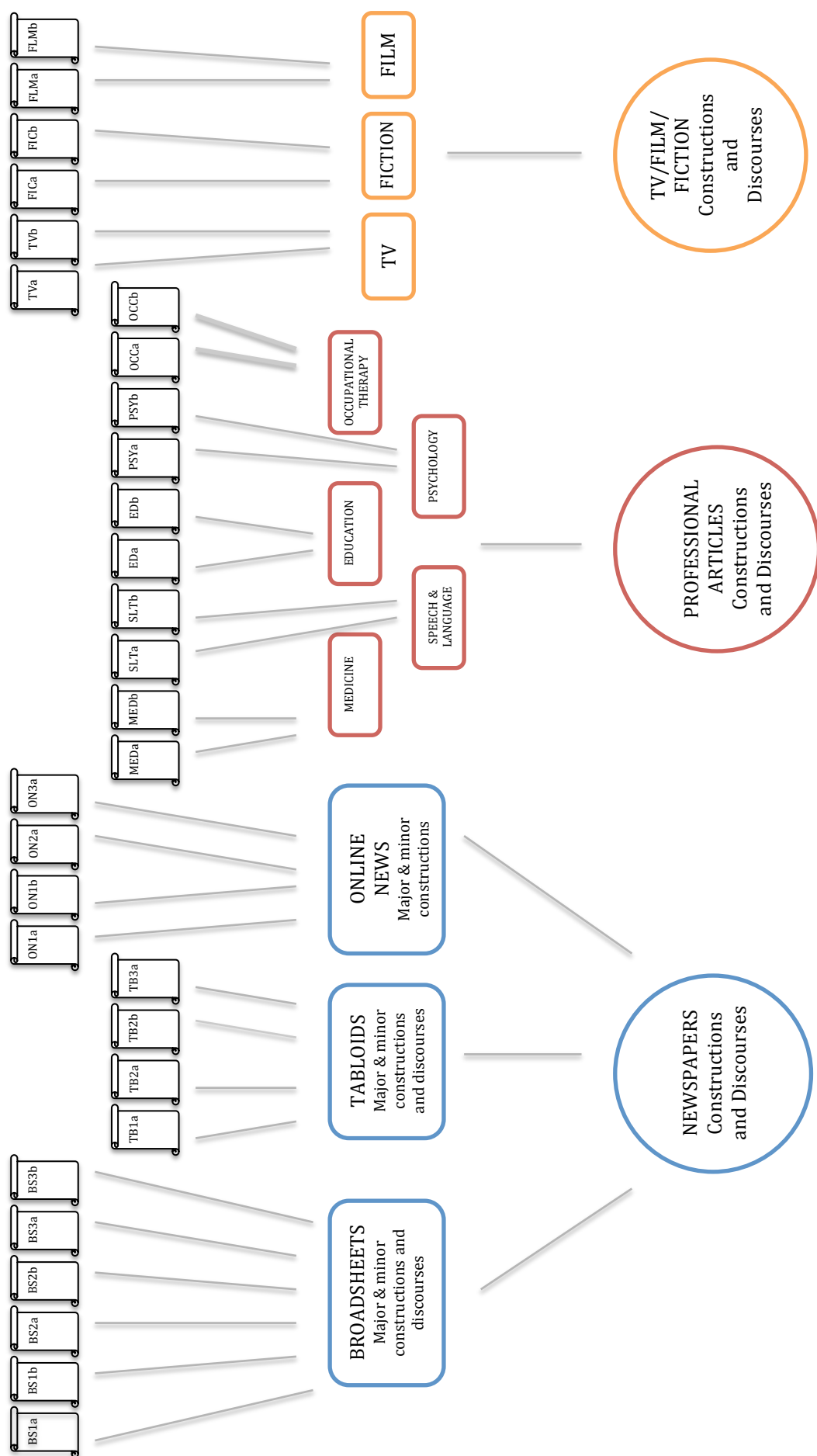


Figure 6: Individual article analysis combined by type, then into 3 subdomains.

Analysis Part 2: Community interviews (subdomain 4)

Why these participants?

I have chosen to focus on exploring the views of individuals surrounding someone with an AS diagnosis, as they are inevitably some of the people who shape the lives and psychological experience of someone holding this label. During the formation of the research question it was found that the lowered self-esteem of individuals with high-functioning ASD was related to their social experiences with others (Capps et al., 1995; Sigman et al., 1997). I wished to see what messages were available to someone with a diagnosis of Asperger's: about their perceived identity, and what they *can*, and *cannot* do, as someone holding this label.

Recruitment procedure

Participants were recruited via advertising/recruitment requests in community sites such as community centres, libraries, youth and adult education centres (See Appendix 4: Recruitment flyer). Recruitment advertising used the terms 'Asperger's' and 'high-functioning autism' to reflect the recent collapse of Aspergers' into the 'high-functioning' ASD bracket. It was felt that, despite the formal label of Asperger's being recently abandoned in favour of HFA, it was still the most widely used term within the community to describe individuals with milder autism, and so would still be used for recruiting purposes. Recruitment excluded non-UK residents, anyone under 18 years, and anyone experiencing any considerable personal stress at the time. English as a first language was not specified, but they did need to speak English well enough to speak on the topic effectively. Respondee were also excluded if the person they knew did not have an official diagnosis. Ten people responded to advertising, one person dropped out before interview, and another person was excluded as they did not meet the above criteria fully.

Via purposive, maximum variation sampling (Lund Research, 2012; Sage, 2013), a 'mix' of cultures, gender, age and occupation was sought. I also decided to limit the number of parents or other particular community members to a maximum of two to avoid narrowness of participants' perspectives. By setting this sampling

restriction I was not seeking to create a sample that would be representative of the general population, but rather I was aiming to capture a sufficiently wide range of perspectives on AS. However, as no more than two parents or teachers responded, in practice I did not need to exclude participants due to sampling concerns. Recruitment finished when eight suitable respondees were successfully recruited, so as to not collect more data than I could effectively analyse. Information on the study was given to each potential participant and possible dates for their participation were noted.

Participant Demographics and Context

The eight participants in this study have been chosen on one basis alone: that they 'know someone with a diagnosis of AS or HFA'. I sought to select people who had varying relationships to the person with an AS diagnosis. I advertised in a wide variety of community locations. Out of those who responded, the following took part: 3 x parents, 2 x teachers, 2 x speech therapists, 1 x GP. All participants were British females, with some variability on culture, age, religion and type of relationship with someone with an AS diagnosis'.

Interview Environment and Data collection

Interviews took place within the local community – participants were given a choice of location as to what would be convenient for them. It was important to ensure they felt comfortable and secure when taking part. This included their home or a room in a local community centre. Once informed consent was given, semi-structured interviews were recorded using an Olympus VN-6800PC digital voice recorder (see Appendix 5: Participant consent form; Appendix 6: Study information for participants). An Interview schedule was created containing a mix of questions designed to best elicit constructions of AS, including exploration of what they and others thought about AS, and participants engagement with this subjectively (see Appendix 7: Interview Schedule). During the interview I asked questions and offered responses in a facilitative manner and maintained an open and non-judgemental attitude that aimed to invite further elaboration within a comfortable atmosphere. All data was anonymised, digitally stored, locked by a password, and then encrypted to ensure maximal protection and security.

File coding for type

There were eight participant recordings in total. Each recording was coded for type as was done for all societal texts. Each type of interview was given a prefix ('TEA' for teaching, 'PAR' for parents, 'SPT' for speech therapy, 'GP' for general practice, 'CHA' for ASD charity) and then a letter ('a' or 'b') to indicate its position in the type.

A listing of interviews and their types can therefore be viewed as follows:

- 2 x Teachers (TEA-a, TEA-b)
- 2 x Parents (PAR-a, PAR-b)
- 2 x Speech Therapists (SPT-a, SPT-b)
- 1 x GP (GP-a)
- 1 x ASD charity (CHA-a)

Transcription

Transcription involved several stages, chosen for reasons relating to the analysis procedure to come. To begin, a specialist research transcriber assisted by transcribing speech in its basic form (contracted under a strict confidentiality agreement, with participants informed that no identifiable data would be shared). No pauses, inflections, stutters, or other indicators were noted. I wished to record this level of detail myself. The way in which things were said, any pauses, stutters or hesitations before certain constructions may contain meaning and may suggest some sort of relationship the interviewee may have with that construction. Therefore I wanted to pay careful attention to how this was transcribed myself.

Secondly, having the basic words of the interviews transcribed meant that I would be less likely to 'habituate' to the speech on a word level, and lose perspective on the meaning at a more integrated, higher level, which was important to the analysis itself. Habituation is something I had experienced as a problem when transcribing in the past. The way in which I went about composing the transcripts, was in order to allow personal attention to any nuances behind the words, while also avoiding the sense of habituation at a word level, which would make my engagement at a higher level more difficult at the analysis stage.

Transcription guidelines outlined by Jefferson (1985), and provided by Wetherell, Taylor and Yates (2013, p. 62; see Appendix 8), were adapted and used to guide my own transcription additions. Analysis began with a wide view of the interviews, which took place before the transcript coding. This was done intentionally to ensure that I could appreciate this wider view of the data before it became less accessible once immersing myself in a more detailed way. For consistency, a process of interview analysis was devised and can be described as follows.

Analytic Procedure for Individual Interviews

An analytic procedure for interviews was designed to produce the most engagement possible with each interview, with the aim to extract constructions and discourses in the fullest and most multi-perspective manner possible. This analytic procedure can be described as follows:

1. Individual interview 'holistic view'

Each recording was first listened to, without the transcript present. Notes were made on a new document, noting first thoughts on what was said and how. This was a holistic view of the interview, which was considered important to experience before further immersion in the detail contained in each paragraph and phrase. Here overall thoughts on the interviewee's descriptions and areas of focus were noted.

2. Individual interview word checking:

The interview was then played again, this time checking over the transcription to ensure it was accurate. This stage was straight forward – a careful checking of accuracy.

3. Individual interview transcription symbol additions

Transcription techniques and symbols suggested by Jefferson (1985) were applied to the text. The use of Jefferson's symbols was recommended by Potter (in Parker, 1998) and provided by Wetherell, Taylor and Yates (2013). The degree to which speech detail is recorded on a transcript is an important consideration because the transcription itself is a form of socially-constructed

text. What is decided to include or omit in essence ‘constructs’ the transcript of the recording (Wetherell et al., 2013). Therefore there was careful consideration about the degree of detail to include and omit. In order to decide on the appropriate level of detail for my analysis I examined the transcription symbols of Jefferson (1985) and also reflected on examples given by Wetherell et al. (2013). A selection of Jefferson’s symbols, described by Wetherell et al. (2013), were found to be most appropriate to capture pauses, emphasised words and unique segments of speech which may indicate a participants’ relationship towards particular constructions or discourses (see Appendix 8). However use of extensive transcription symbols can suggest that we are attempting to access ‘something that the participants do not themselves immediately know’ which would actually be more compatible with mainstream psychological research (Parker, 2012, p. 475;). Therefore a moderate number of Jefferson’s symbols were considered most appropriate here.

4. Individual interview coding

The transcript was then coded. Rather than line-by-line, as occurred with newspapers and academic articles, the coding took place in a phrase-by-phrase manner as this seemed the most natural ‘unit of meaning’ for this data.

5. Individual interview analysis

Each recording was listened to alongside its final transcription. A consistent set of analytic stages were followed in sequence, as had occurred with the societal text component of the study (see Figure 7). As with the text component of the study, the analysis template (Appendix 2) was used for each interview. This worked systematically through each of Willig’s six steps, looking at constructions, discourses, action orientation, subject positions, practice and subjectivity.

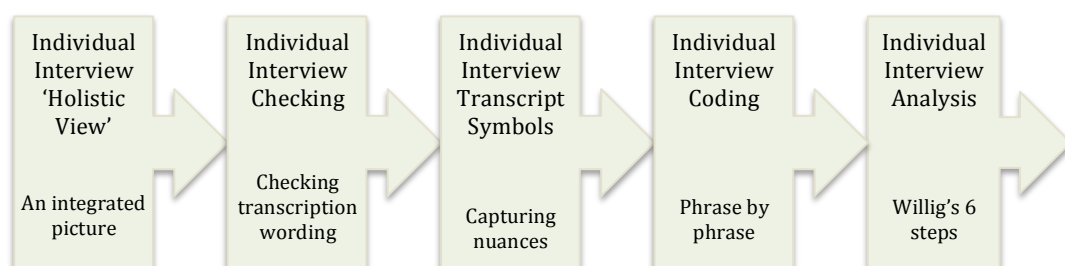


Figure 7: Stages of analysis for Community Interviews

Type Analysis

As with societal text analysis, a combined list of 'frequent' constructions and discourses was created for each type of interview (TEA, PAR, SPT, GP, CHA). Frequent constructions derived from a simple count within interviews, which when combined were considered to be the most frequently represented across that type (as was done with societal texts). 'Frequent constructions' once combined by type contained a combination of those that were both prominent within interviews, and common across interviews. Focusing on frequent constructions does not necessarily mean that those less frequent are not powerful, but a decision was taken here that they were not carried forward as they did not appear to represent the type.

Subdomain Analysis: Community Interviews

Using the list of 'frequent' constructions by type, a combined list of 'major' constructions and discourses was then created for all the interviews combined. Figure 8 shows the combined analysis process, first combining by interviewee type, and then into one subdomain.

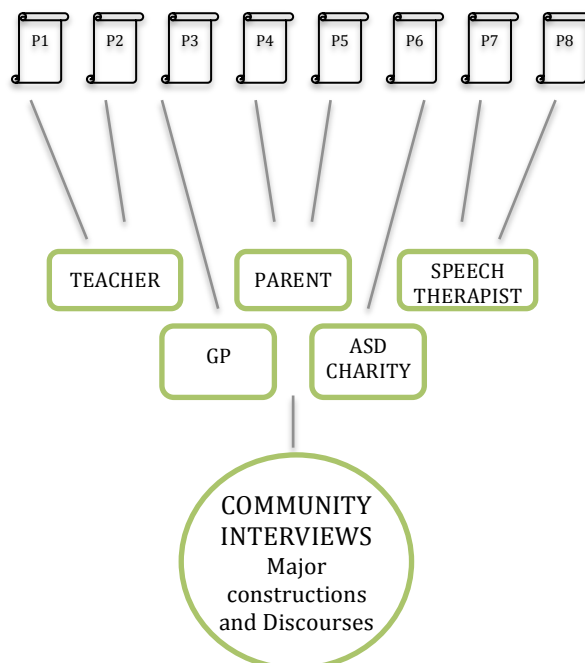


Figure 8: Combined analysis into type and then into one subdomain, for the master domain of Community Interviews.

Analysis Part 3: Bringing the four subdomains together

Part 1 (Societal Texts) and Part 2 (Community Interviews) of analysis completed the initial analysis of the study, across the four subdomains. Each of the 4 subdomains had provided a set of 'major' constructions and discourses. It was now possible to observe which constructions were unique to each subdomain, and whether there may be any that are shared between subdomains. This relationship is illustrated in Figure 9 below.

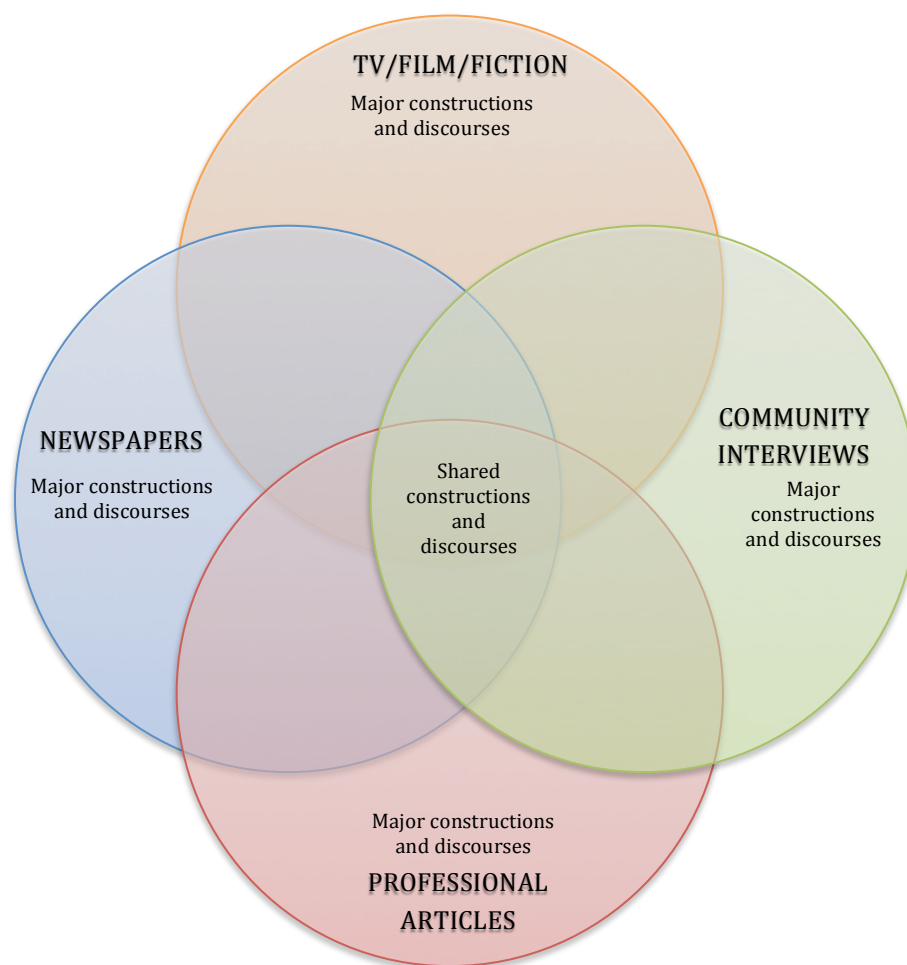


Figure 9: Analysis from Part 1 and Part 2 of the study. This provided major constructions for each of the four subdomains. It also provided an indication of what may be shared and unique to each.

Master Analysis

Part 1 (Societal Texts) provided three sets of 'major' constructions and discourses, one for each subdomain. These 'major' constructions and discourses were then combined into one 'master' domain (Societal Texts) where one set of 'dominant' constructions and discourses came to represent all societal texts in the study.

Part 2 also produced 'major' constructions and discourses for the subdomain of Community Interviews. As these 'major' constructions and discourses were already at the subdomain level, they were now considered to be the 'dominant' constructions and discourses for the 'master' domain of Community Interviews. Figure 10 shows a representation of the 'master analysis' where all 'major' discourses and constructions from the four subdomains were combined into two final 'master' domains.

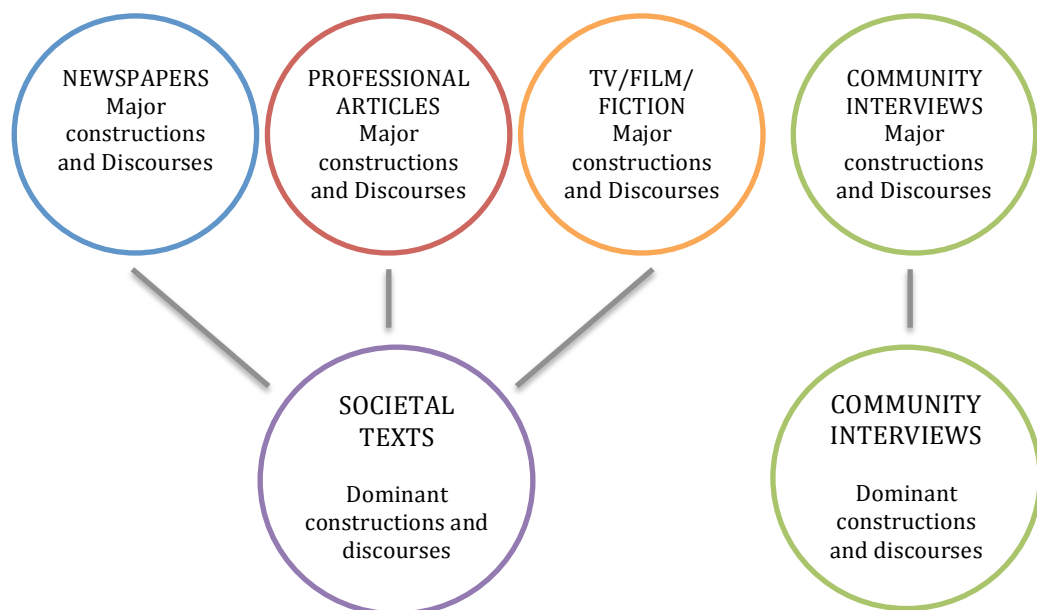


Figure 10: A representation of Master Analysis. Dominant discourses and constructions were combined from the four subdomains into two sets of dominant constructions and discourses.

As discussed at the start of the Method section, the research design sought to capture data at both a societal and a community level. This has resulted in a master analysis that has produced two sets of ‘dominant’ constructions and discourses. These can be shown to appropriately reflect the research question: ‘How is AS constructed at a societal and community level currently?’ A representation of how master analysis maps on to the research question is represented in Figure 11, below.

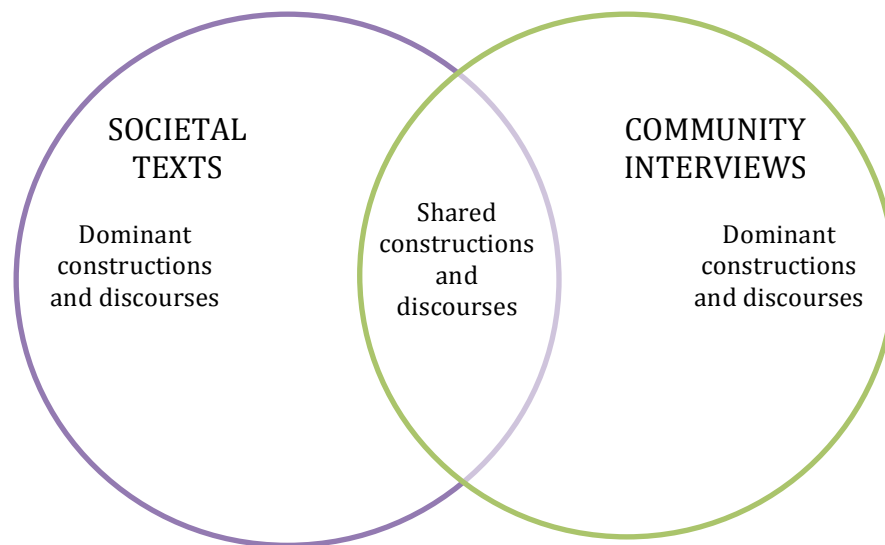


Figure 11: Dominant constructions for Societal Texts. These were located by collapsing the 3 text subdomains into one. The constructions found within Societal Texts can then be viewed in comparison to Community interviews. By doing so, it is also possible to see if there are any constructions shared between the two master domains, or any unique to each.

Methodological reflexivity

Gough (2003) suggests that practicing reflexivity ideally begins with an examination of one’s own theoretical epistemological position. Each researcher inevitably investigates their research question, and interprets their findings, by ‘weaving together quite particular social, political and theoretical ideas’ (King & Horrocks, 2010, p. 127). When considering how the research question developed I recognise that I was originally holding particular concerns regarding how the medical model of psychological experience was utilised within society. For

example, were others generally situating 'the problem' within an individual in order to suit their own goals or desires? This critical viewpoint was key to my decision in taking a social constructionist stance to the research question. My initial research proposal for this thesis was originally very critical of the medical model.

As stated above, this research derives from a social constructionist perspective. With this in mind, I sought to create interview questions that enabled interviewee's own constructions of AS to arise, rather than imposing my own. I felt conscious throughout the interviews to avoid any form of direction or imposition of my own conceptions of AS. After several interviews I felt increasingly comfortable with inviting fuller responses without concerns of directing interviewee responses.

In order to become further aware of my personal epistemological assumptions I subjected myself to a personal interview conducted by a fellow 3rd year Dpsych student, in which I was asked specific questions about my own relationship to the research. This was recorded and analysed as with all data in the study so far. I looked at the constructions and discourses I used. This assisted me to become aware of how these may be affecting my own approach to my analysis. At the start of analysis I could see that this critical stance towards the medical model was very much present and that I would most easily identify constructions related to the medical model.

During analysis, becoming aware of constructions that were outside of my own repertoire therefore took longer to identify, and some of these became more obvious to me as my analytic experience grew. I started to see certain constructions I had not noticed at the beginning stages of analysis. At the end of analysis I revisited all articles again, in order to provide an opportunity for the newly acquainted constructions to be identified, if they did exist within the earlier articles.

This development of my own analytic experience demonstrated that any person existing within a culture, such as myself, may be so inside certain discourses that it may inhibit my ability to see them clearly. This is a difficult issue to overcome and analysing my own epistemological stance was an attempt to address this to some degree. In addition, I clearly acknowledge that my own awareness of certain discourses in no way constitutes an account of all that may be present. As

Parker suggested (1992) 'reflexivity and discourse analysis are historically and culturally bound' (p. 21). The idea of reflexivity itself, although it may exist in other forms in other cultures, is particularly specific to this time in Western culture. The way in which I go about being reflexive in this thesis is therefore guided and constrained by my Western understanding of what is considered to be reflexive right now. What I, and others, may consider reflexivity to be in 10 years may differ still. I hope it will.

Finally, after completing my analysis I was able to observe how this process of reflexivity had affected my thesis overall. Via the reflexive process, after analysis I arrived at an unexpected change in the assumptions I held when the analysis first began. Initially I held particularly strong, and potentially simplistic, views about the use of the medical model. During analysis I found some things in keeping with this critical view, but surprisingly I found the medical model was also utilised in ways I had not expected. The data from the study did not appear to fully support the purely critical viewpoint I had previously held (this will be discussed further in the Discussion chapter). This recent adjustment to my own assumptions demonstrates how reflexivity constantly sat hand-in-hand with my analysis. As one expects when considering reflexivity, my views were likely to affect my interpretation of the data. But more unexpectedly, the data also appeared to have the potential to affect me: I could *affect* but also be *affected*.

Ethical considerations

Before recruitment, in order to ensure the welfare of potential participants, the study was granted ethical approval from City University's Psychology Department (see Appendix 9). Ethical considerations were of high importance during both the design and the execution of the study. I changed my mind several times during the conception of my design: fluctuating between individual semi-structured interviews and a focus group of four to six participants. Both have their benefits and difficulties, and each needed to be considered carefully to ensure I had access to the richest data possible, and that my choice was also mindful of my ethical responsibility towards each participant (King & Horrocks, 2010). A focus group is usually a good design option for discourse analysis studies as it can stimulate rich discussion between group members. However, it became clear that there were several reasons why individual interviews felt more appropriate here.

Firstly, I became aware of the sensitivity of this topic for the parents involved in my study. I wished to provide a sense of privacy for each participant, as this may be an emotional topic. Parents and other group members may have felt uncomfortable speaking about the 'person they know' within a group context. Even though all group members would sign an 'informed consent' form and would have been briefed on sensitivity towards each other, I felt some members might still feel inhibited or uncomfortable. Secondly, I also had concern that if there were particularly contrasting views of Asperger's within the group that this may cause friction or upset for some group members. Finally, as there was a potential that participants may also later encounter each other in the community I wished to avoid any adverse effects that such encounters could create. The identities of all participants have been kept completely confidential at all times.

By doing individual interviews rather than a focus group I felt it provided the most ethically considerate format to ensure the well-being of each participant. These issues were not considered lightly. Interviews rather than a single focus group has resulted in considerably more time and analysis for myself, but it appeared to be the most suitable way to avoid emotive group dynamics, to protect the privacy of each participant, and finally, to ensure their well-being both during and after taking part.

During the course of the study, I sought to engage in a thoughtful and ethical manner with all participants, considering recommendations for ethical practice in qualitative interviewing (British Psychological Society, 2014; King & Horrocks, 2010). Once recruited participants were informed of the aims of the study, the purpose of the interview, and what to expect when taking part. Each was assured that their privacy and identity would remain confidential during the research process and after. They were made aware that the study would be published as a thesis and that any further publication would adhere to the same obligation of ensuring their anonymity and confidentiality. Before the interview, they were made aware that they could stop the interview at any time, ask anyway questions along the way, and were assured they did not need to answer any questions they would prefer not to. They were also informed that they could withdraw from the study at any time without an explanation or penalty. Participants were debriefed after taking part, were given time to ask any further questions, and were offered further contacts for further information and support. No participant expressed concern, and all appeared pleased to have taken part. All participants were very

knowledgeable about AS. Some discussed an interest in particular aspects of AS and I offered appropriate references that I thought may be of further interest. They were again thanked for their participation, and were encouraged to make contact with myself, or my supervisor, if they had any concerns at any time.

Finally, to further ensure privacy protection and anonymity, no personally identifiable information was utilised at any point during my analysis or presentation. All data was anonymised, digitally stored, locked by a password, and then encrypted to ensure maximal protection and security.

4. ANALYTIC INTERPRETATIONS

Introduction to Findings

This chapter will discuss the main findings obtained from analysis. Individual articles and interviews were first analysed at an individual level using FDA discourse analysis, via the application of Willig's (2008) six steps. Major constructions were identified within each text. Individual analysis was then followed by a process of 'collapsing' individual texts into 'types' and then into four subdomains, and finally into two final master domains (Societal Texts and Community Interviews). This design was chosen to ensure a sufficient spread of data to adequately address the question: how is AS currently constructed, at both a societal and community level?

To begin, the analytic reading presented here is acknowledged to be one of many that may be possible. My epistemological and personal views are considered to affect my engagement with the data; with some aspects of the text inevitably drawing my focus over others. Therefore, reflexivity was in constant focus during my analysis. It reminded me to question my interpretations and to consider alternatives. In addition, it must be reminded here also that my analysis was conducted using a social constructionist framework. This means that I have not sought to 'uncover' any form of observable 'truth'. In order to recognise this I have provided as much direct access to the data as is practically possible. This enables readers to come to their own assumptions in regards to my interpretations of the data.

In addition, before presentation of text excerpts from the study, and my interpretations of these, it is also necessary to acknowledge that, although text from speakers is presented during a focus on a particular construction, these individual excerpts should not be seen as entirely independent statements of personal belief or intention. Some of the constructions speakers may deploy may represent individual viewpoints but these also inevitably represent wider social discursive practices. Speakers take up positions, but they are also positioned by powerful societal discourses, and so it is important to exercise care in regards to the intentions we attribute to others when we focus on such excerpts.

Finally, it should be noted that this analysis could have been presented in various other ways. I could have grouped my findings under common themes, or presented the text analysis before interviews. I have however chosen to present the data by considering each dominant construction across the study in turn. By doing so this does not mean to state that each construction, and its related discourses were entirely separate. Several of the dominant constructions had overlapping features; these will be described as they arise.

Analytic interpretations begin with the dominant constructions that were found to be shared across both master domains (society and community), before moving on to others that were unique to each domain. This method of presentation first enables a unified understanding of the data overall, before considering the differences between the societal and community data. By doing so it assists in making recommendations that are specific to each domain. These 10 dominant constructions will be presented in turn; with each discussed in terms of Willig's six steps. Therefore I will note what subject positions the construction makes available, and what can be said and done from within these positionings, between individuals, as well as the actions the construction may advocate at a societal level. The possible subjectivities of these positionings will also be explored i.e. what *can* be felt or experienced. The chapter will end with a unified summary of the main findings drawn from these 10 constructions.

Master Analysis

The final analysis of the two master domains is presented below in Figure 12. It highlights the constructions that were shared among Societal Texts and Community Interviews. It also indicates which constructions appeared to be unique to each master domain. The 10 dominant constructions identified were both prominent within the data, and widespread across the data types. However, these constructions were not utilised in isolation within each text or by individual speakers alone. The discursive processes found within both Societal Texts and Community Interviews were very complex. Multiple constructions were found to be present within each text and each interview. A process of 'negotiation' was observed, as speakers mobilised a collection of discourses, moving the AS

person throughout different subject positions in order to both makes sense of their differences, and to justify action towards them.

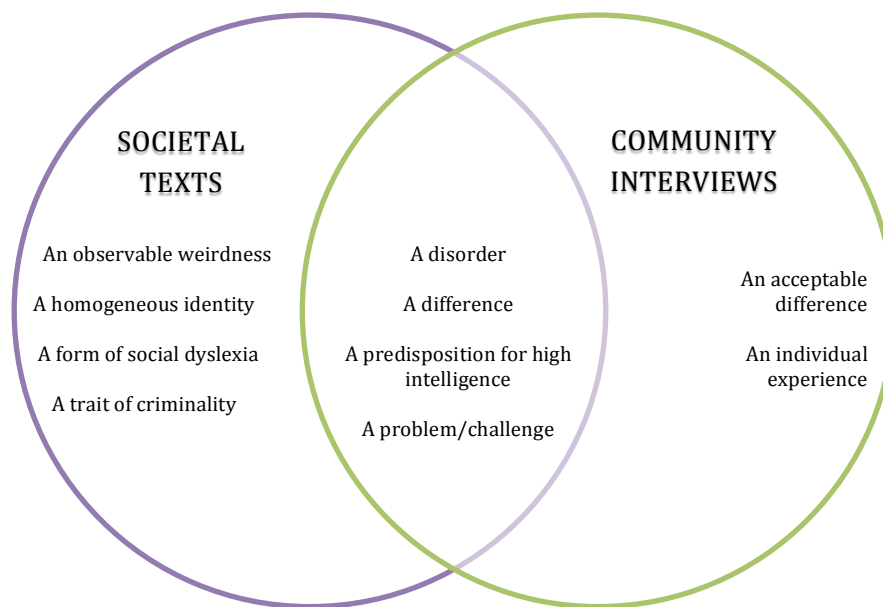


Figure 12: Master domain analysis. A diagram showing which constructions were shared with Societal Texts and Community Interviews, and which were unique to each master domain.

The following diagram (Figure 13) illustrates the origin of the each of the study's 10 dominant constructions. It provides a fuller picture of the four subdomains independently – indicating where certain constructions were more prevalent and how the subdomains differed from each other generally. Further information on how these constructions were situated within each type of the subdomain, as well as an illustration of additional constructions that were identified, can be seen in Appendix 11.

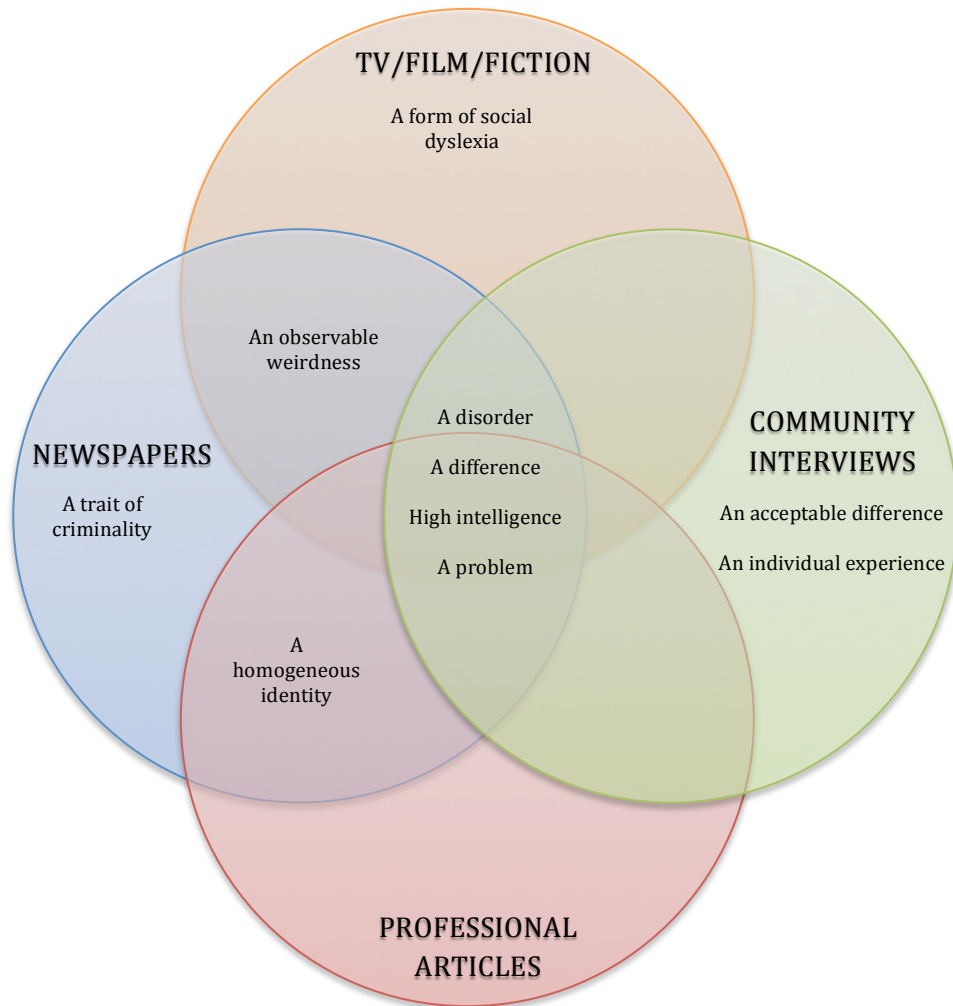


Figure 13: The 10 dominant constructions. The diagram illustrates which constructions were shared, and which were unique, to each subdomain.

1a) Constructions Shared by Master Domains

Four dominant constructions were shared by both Societal Texts and Community interviews. These constructions will now be discussed and are presented below in Figure 14. To ease readability, the abbreviation 'AS' will be used to represent both AS and HFA persons.

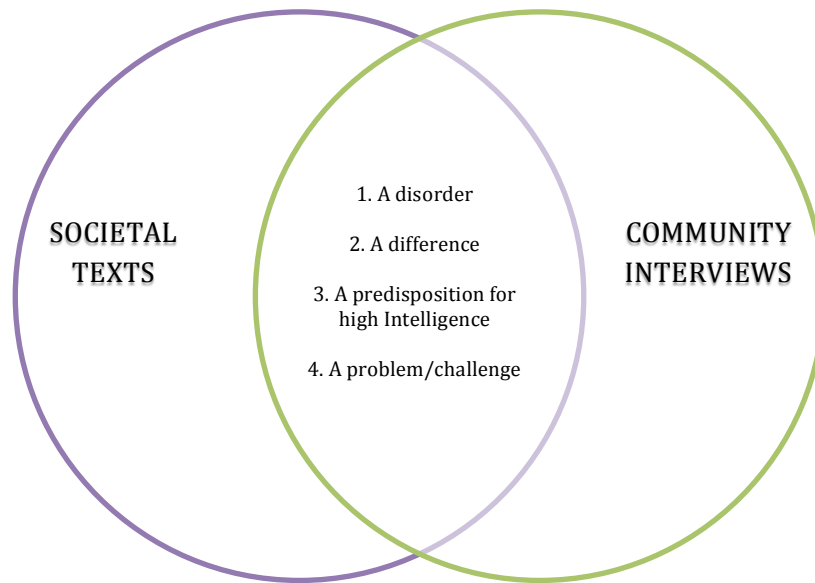


Figure 14: The four shared dominant constructions. These constructions were found to be common to both master domains.

The degree to which the constructions were shared is as follows:

1. A disorder: all four subdomains
2. A problem/challenge: for self, others and society: all four subdomains.
3. A difference: three domains: Newspapers, TV/Film/Fiction, Community
4. A predisposition for high Intelligence: three subdomains: Newspapers, TV/Film/Fiction, Community.

Dominant Construction 1: 'A disorder'

(ON1-b, Line 24) *'These disorders (which include Asperger's Syndrome) are characterized by difficulties in social interaction and communication and a restricted and repetitive repertoire of interests and activities.'*

NEWSPAPERS

PROFESSIONAL ARTICLES

(PA-Med-a, Line 14) *'Robustly diagnosed autism or Asperger's still requires the presence from early childhood of at least six specific symptoms across all three domains.'*

(TV-b, Line 8) *PROGRAMME NARRATOR: 'His condition makes it hard for him to deal with anything outside his normal routine.'*

TV/FILM/FICTION

COMMUNITY INTERVIEWS

(SPT-b, Line 14) *'Well in my experience they ah, follow the triad of impairment, however **my** experience is that they have a desire and a want to communicate, but don't know how to do it...'*

All Societal Texts and all Community Interviews shared this one major construction, which can be seen to derive from the professional perspectives on ASD that were outlined in the Introduction. Across the study, AS was constructed as a lifelong 'disorder' with individuals therefore in need of 'support' from health care professionals, family and society. It is the only singular construction that appears consistent across the entire study: it was found across all individual articles, all types and subdomains. Therefore this suggests it may be integral to both wider society and the community's understanding of what AS is at this current time in the UK.

This 'disordered' construction drew on a wider medical discourse, using terms common to the treatment of biological illness or disease. The use of such terms indicates that AS, when strongly conceptualised in a medical sense, assumes all different, unusual or atypical behaviour is due to a personally owned and underlying neurological impairment or disorder. The presence of this construction was usually signified by the speaker's deployment of diagnostic criteria, or explicit reference to AS as a 'lifelong' 'disorder' (BS3-b, PA-MED-a) or 'condition' (ON1-b, TV-b). The disordered construction also created AS as something real that can be 'found' (BS3-b) and observed via the recognition of certain 'symptoms' (BS3-b) and 'typical characteristics' (ON1-a).

Alongside explicit use of terms such as 'disorder' and 'condition', as presented in the highlighted examples above, the construction was often indirectly deployed by describing the AS person as experiencing 'difficulties', 'disabilities' or 'deficits' that they must 'deal with', therefore placing them as a passive 'sufferer' of their 'condition'. In some cases it was also represented as a kind of biological or genetic fault that the person may 'reveal'. This suggests that AS is a type of personal defect one may wish to hide from others; perhaps something to be ashamed of:

(BS2a, line 12) *'Boyle didn't need to reveal her Asperger's diagnosis to make people like her, but by doing so she is sharing with other sufferers the acceptance that celebrity has afforded her.'*

By 'revealing' her diagnosis, Boyle appears to have re-positioned herself from being the 'unliked other' to the deficient 'sufferer' of a 'condition'. By doing so the author may be suggesting that people will possibly admire her for revealing her perceived defect. This inadvertently reinforces the idea that AS is something that Boyle could have previously wished to hide.

The construction was also used by other people to position the AS person as disordered by placing them in opposition to others who 'deal with', 'handle', 'cope with' and 'support' them. The AS person becomes the sufferer of a medical disorder who requires intervention and support from others in various forms:

(TB2-a, Line 2) *'... wife of commons Speaker John – talks about his son's diagnosis and how she and her husband deal with his condition.'*

As the examples so far demonstrate, the 'disordered' construction creates several main subject positions. Firstly it positions the AS person as the lifelong 'disordered' one, who sits in contrast to those who are 'normal'. They are therefore in need of support and become positioned as a passive target of intervention. This construction also invites subject positions of 'the medical expert', who is tasked with addressing the 'deficits', and the family of the AS person who become long-term supporters and carers of the AS person. Finally, the general public, as a result, become cast as the majority group of 'normals' whose normality is reinforced by the identification and treatment of those who are 'not normal'.

Overall, examples of the disordered construction of AS were seen to operate as a type of 'sense-making model' in which unconceivable difference was reconceptualised as a medical 'disorder'. In other words, via this construction the speaker could 'make sense' of the person with AS, in an attempt to explain what previously unexplainable. The benefits of a diagnosis as having a 'sense-making' function were outlined in the rationale of the Introduction chapter. Speakers were observed to deploy this construction as a 'sense-making model' as can be seen in an article in the Daily Mirror in June 2012:

(TB2-a, Line 1) *"We thought Oliver was eccentric...until doctors said he had autism"... Here Sally, 43, talks about his diagnosis and how she and her MP husband deal with his condition. "I just thought Oliver was slightly eccentric, but again I had nothing to compare him to...So when he was three we took Oliver to a leading expert in autism. She did a series of tests and games to get him to communicate and diagnosed there and then that he had it."*

The extract shows how the 'disordered' construction has been adopted by the journalist, by using the words of Oliver's mother, as a superior explanation for Oliver's unusual behaviour. Oliver is moved from 'eccentricity' to 'disordered'. The professional medical opinion appears to illuminate Oliver's eccentric behaviour; via comparing it to the normal population it is found to be 'disordered'. Similarly, we can see how a difference in behaviour has become conceptualised as a 'disorder'. In the following example from an online news article the journalist deploys the mother's description to construct the son's behaviour as typical 'symptoms' of a 'syndrome':

(ON1-a, Line 13) *Amelie said: "George must have his toast cut up into 10 pieces with chocolate spread before he will eat it....He will give me a list of the things he wants and end his order with, 'please now, please now'." She added: "Sometimes, for one reason or another, I forget and give him jam but then he cries and runs off shouting that he is not my friend anymore." 'Amelie's description of her son's erratic behaviour at breakfast time is a typical characteristic of Asperger syndrome.'*

In a further extract we can see another example of how a medical construction of AS was deployed by the journalist to reconceptualise behaviour that may be difficult for the general public to make sense of:

(TB2-a, Line 38-39) *'....[Oliver would] have a major meltdown. John was quite embarrassed at first when this happened....and people in the store – his constituents – must have thought that I was a bad parent and unable to control my child properly. But I wanted to say to them, 'We're not bad parents and he's not being naughty, he's being autistic.'*

Here Oliver's mother appeared ready to deploy medical discourse in order to reframe Oliver's behaviour for others. She had implicitly positioned Oliver as naughty to the onlooker, and then repositions him using the 'disordered' construction. Interestingly, she uses the phrase 'being autistic' rather than 'he is autistic' as if it is a momentary way of behaving, such as being stubborn. Perhaps she prefers to resist the AS as a 'permanent' state of being, or possibly it indicates that his AS is only noticeable sometimes. Via this mobilisation she seeks to invite understanding from onlookers, rather than judgement, suggesting that the construction enables her to re-shape onlooker's impressions of Oliver's character. However, it also serves a secondary purpose, enabling her to deflect any criticism from onlookers regarding her parenting skills.

Overall, it appears that the medical discourse used to conceptualise AS becomes a framework with which to understand the person who's behaviour appears to be 'eccentric' (TB2-a) or 'erratic' (ON1-a). It is now conceived of in terms of 'deficits', 'symptoms', 'conditions' or 'disordered' behaviour. This appeared to provide a certain consensus on the nature of the difference, and an implied medical understanding that the cause of the difference has biological roots.

Not only was a medical diagnosis utilised by others to make sense of the AS, it was also observed to help some AS people 'make sense' of themselves, assisting to relieve them from a sense of personal responsibility for their difficulties. This externalising of difficulties was also discussed in the rationale of the Introduction chapter when the benefits of diagnoses were considered. An 'illness' model was seen to assist the person to conceive of AS as something that has *happened to them*, and not *caused by them*. By offering a medical explanation for their behaviour others may also be more accommodating. This self sense-making and removal of personal responsibility for the AS was deployed by journalists via deployment of quotes of AS-diagnosed individuals:

(BS2-b, Line 6) 'She was told she has Asperger's, and said it was "a relief" to finally receive a diagnosis "It's a condition that I have to live with and work through, but I feel more relaxed about myself. People will have a greater understanding of who I am and why I do the things I do."

(BS3-b, Line 1) '..."Knowing I have Asperger's is a relief"...Roughly a year ago, aged 36, Considine was finally diagnosed with Asperger syndrome, one of a spectrum of disorders relating to difficulties with communication and social skills that includes autism at its furthest extreme."For a few weeks after the diagnosis, I was wandering around thinking, 'Who the hell am I?' But naming my problem has helped me a lot. It's allowed me to make sense of so many things I didn't understand before – and is allowing me to move forward with my life.'

It may however, be that for some AS people, this societal 'sense-making' can be unhelpful or simply in contrast to their views about themselves, particularly if they feel their AS is not a disorder, but rather, a difference. The view of AS as a *difference* versus a *disorder* was discussed in the Introduction chapter. Accounts of AS individuals' online discussions indicated that some people were frustrated at the 'sense' other people made of them which, indicating that it may create limited experiences for them. Many expressed being treated as *deficient* and *impaired*, and therefore discounted from various societal opportunities.

Across the study the 'disordered' construction also appeared to not only be deployed at an interpersonal level; the medical model applied to AS also operated in practice at a societal level. In the following example, from The

Guardian in December 2012, the collapse of the diagnosis of AS into the broader category of ASD is discussed, along with the motivation for this decision:

(BS1-a, Line 19) *'The [DSM] changes will affect the diagnosis and treatment of millions of children and adults worldwide, as well as medical insurance and special education services. The aim was not to expand the number of people diagnosed with mental illness but to ensure those affected were more accurately diagnosed so they could get the most appropriate treatment, said [the] psychiatry professor who chaired the revision committee.'*

We can see that when a difference is described as a 'disorder' it is considered as something for which certain action *must* take place. We can see how this is played out when the health professional/professor, states that it is in each person's best interest to be 'accurately diagnosed' to ensure they get the 'most appropriate treatment'. We see a clear assumption that, under medical discourse, AS is considered a form of 'mental illness' and that a diagnosis *must* lead to 'appropriate' treatment: something *must* be *done*.

In addition, medical discourse was not limited to healthcare alone. It also appeared to be very effective in achieving desired goals for certain people across other aspects of society. For example, when medical discourse was deployed within education, extra support via an educational 'Statement of Special Needs' was seen to provide assistance for AS children during the school years. The following examples demonstrate how certain benefits, such as additional one-to-one support and an individualised program become justified, and hence more attainable, once the author positions the child in medical discourse:

(PA-Ed-b, Line 7) *'I was lucky to have one fantastic support teacher at secondary school as part of my statement of support. She went on courses and also worked with the other teachers supporting my learning in class. She even devised a staff handbook about the specific needs of people with Asperger's syndrome.'*

(PA-Ed-a, Line 3) *'The article discusses efforts of educational cooperation that were taken to help a middle school student with Asperger's syndrome become more socially accepted at school,'*

The above statements indicate the power inherent in medical discourse. For instance, there may be many children at school who may need extra support, and may also struggle, like the AS child above, to be 'socially accepted', but without a statement of special needs, which results from a medical diagnosis, additional support is less likely to result. Therefore medical discourse can be seen to justify deviations from normal practices in certain environments.

Similarly, in law, a medical diagnosis was observed to act as justification to deviate from expected practices. A diagnosis of AS was observed to be taken into account in a case involving criminal behaviour, demonstrating how particular legal allowances could be made for the AS person due to their diagnostic status. In The Guardian in December 2012 an article, entitled 'Asperger's syndrome dropped from psychiatrists' handbook the DSM' states:

(BS1-a. Line 8) *'The British hacker....is diagnosed with Asperger's and it contributed to a government decision not to extradite him from Britain to the US on cybercrime charges.'*

In this case, the author implies that the British hacker was able to avoid extradition due to his AS diagnosis. It appears that utilising a medical diagnosis of AS may have benefitted this individual in this context. However, such widely reported instances can have a negative effect on other people with AS; as all who hold this label can become associated with the criminal activities of the individual. Here, an already prevalent stereotype of AS people as computer geniuses gains a darker criminal edge. Several other articles have also made links between AS and cybercrime, inadvertently having the potential to suggest that AS people are more likely to engage in cybercrime. Hence, deploying the medical construction of AS within certain circumstances appears to be powerful, but with differential effects for an individual compared to the collective.

In fact, the power inherent in medical discourse has the potential to also deny individuals certain rights and opportunities that are generally enjoyed by others. A diagnosis of AS was seen to lead to certain societal limitations. One article, published by BBC News online in October 2012, reports the legal struggle of a man in Mexico who had been denied many of his basic societal rights due to his AS diagnosis. This denial of rights implies that the government views people with

disorders as deficient and incapable compared to other society members. The author of the BBC News article states:

(ON1-b, Line 6) *'It [governmental legislation] banned him from doing simple tasks by himself, such as applying for a passport, because of his condition....Mexican legislation makes straightforward tasks, such as buying a mobile phone, enrolling in university or applying for a driving licence, very difficult for people with Asperger's syndrome or other forms of autism.'*

After a lengthy court battle some rights were restored to the man, which was considered a victory, but the general entitlement of rights, that all other members of society enjoy, was still largely withheld and would still require a judge's approval on a case-by-case basis in the future. This idea of someone with a diagnosis of AS as being an incapable or deficient member of society is reflected in a further article in the Mirror Online in September 2014. Here the author deploys this construction by quoting an MP:

(TB2-b, Line 1) *'Tory MP tells autistic man: Keep quiet if you have mental issues. Insensitive [MP] said people with mental health issues should "possibly refrain from commenting in the public domain".'*

The idea that someone with AS is deficient appears to provide others with justification in discounting their views and even removing their right to speak. In a similar example, in the Telegraph in August 2011, an article entitled 'Woman's hour psychologist's autism evidence 'used as weapon' in divorce case', demonstrates how the diagnosis of AS can be considered as evidence of 'deficiency' which then provides justification to interfere with an individual's legal rights:

(BS3-a, Line 2) *'A child psychologist who has appeared on Radio 4's Woman's Hour tried to stop a father winning custody of his teenage daughter by claiming they both had a form of autism, a hearing was told.'*

These examples, in which the diagnosis had been used in an attempt to restrict societal rights, illustrate how the 'disordered' construction can, in certain circumstances, lead to real-world limitations on freedom and potential subjective

experiences of disempowerment and disrespect. A label designed to 'help' and 'support' can lead to a loss of autonomy and civil rights. The benefits and limitations may vary in different cultural contexts, but the limitations identified here could suggest that an AS person may perhaps wish to hide his or her diagnosis in certain circumstances, fearing a loss of the rights to which all others are naturally entitled. It appears that the 'disordered' construction invites both 'care' and 'control', as two sides of one coin – one is rarely present without the other.

Given the power medical discourse has to shape action, the 'disordered' construction is therefore likely to contribute to certain subjective experiences for all involved. For the AS person as 'disordered', medical discourse was observed to justify entitlement to 'support' or 'treatment'. This support may be useful if the person feels they require this. It may therefore offer them a feeling of positivity and hope. To be provided with a word for their difficulties can aid a separation of the difficulties from the self, resulting in a sense of relief from feelings of continual self-frustration. A diagnosis may also offer an end to their confusion about their differences and difficulties and suggest that these may have an underlying and understandable cause. In the below examples journalists have used the words of AS speakers to indicate some of an AS person's subjective experiences:

(BS2-b, Line 6) *'She was told she has Asperger's, and said it was "a relief" to finally receive a diagnosis..."It's a condition that I have to live with and work through, but I feel more relaxed about myself. People will have a greater understanding of who I am and why I do the things I do.'*

(BS3-b, Line 16) *"I swaggered through life but, in reality, I lived in fear pretty much every day. I acted like a completely normal person, and I suppose I was good at it. But, inside, it was a very different story... For a few weeks after the diagnosis, I was wandering around thinking, 'Who the hell am I?' But naming my problem has helped a lot. It's allowed me to make sense of so many things I didn't understand before – and is allowing me to move forward with my life."*

(BS3-b, Line 50) *'Since being diagnosed with Asperger's, I'd been working with an acting coach who has now become a good friend. We'd been trying lots of improvisational techniques to help me with some of the problems I experience.'*

For some people however, the AS diagnosis may position them as a passive recipient of services. For those who do not wish to have any intervention, this medicalised view may feel unnecessary and possibly unwelcome (Clarke & van Amerom, 2007). Therefore a major limitation of the 'disordered' construction for an AS person is that, subjectively speaking, it can create a subject position of 'dependent', 'disempowered' and 'deficient other'. It creates a restricted and limiting view that someone's particular way of being is essentially faulty. Any difference in functioning is described in terms of pathology and labelled as a 'deficiency' and as being generally 'disordered'. These views of the self may not only effect an individual's self-esteem, but also may contribute to negative evaluations from others.

In fact, as noted in certain qualitative studies discussed in the Introduction chapter, some AS individuals have expressed concerns regarding the punitive judgements of others. There is also a wealth of research on the negative effects of stigma related to holding a label of 'disorder' (Humphrey & Lewis, 2008; Mehta & Farina, 1997). The issue of stigma was found to be directly addressed in an article in the study (BS1-a). This article discussed the justification for recent changes in the DSM-V. It discussed Asperger's as being relabelled ASD, before discussing changes that were made to another label due to concerns the label induced stigma:

(BS1-a, Line 13) *'The term "gender identity disorder", for children and adults who strongly believe they were born the wrong gender, is being replaced with "gender dysphoria" to remove the stigma attached to the word "disorder".'*

In this article there is a clear acknowledgement that the word 'disorder' has serious implications for inducing stigma, yet AS has been stated in the same article, as now being renamed as 'Autistic Spectrum Disorder'. By describing this decision and not questioning the use of the term 'disorder' for AS, the article indirectly legitimises a strongly 'disordered' construction of AS. It presents an illogical situation where 'disorder' is not appropriate for those with gender dysphoria, yet there appears to be no problem in explicitly labelling an autistic person as disordered. Is stigma assumed, by the author, as acceptable in the case of people on the autistic spectrum? This surely has more to do with political activism, than what 'is' or 'is not' 'disordered' but it is also a clear example of how

socially constructed labels change with societal attitudes. The article therefore provides some acknowledgement of the negative subjective experiences of individuals who are labelled as 'disordered'.

However, it is not just the AS person whose subjectivity is shaped by this discourse; there are subjective implications for all who take part. For professionals within the health service a medical discourse was seen to provide a clear guide to behaviour, to 'treat', and for some, to seek to 'cure'. This subject position was clearly observed in all professional articles. Non-action or passivity on the part of the expert was not seen to be a component of medical discourse; action aimed towards 'treatment' was the only way. Therefore, subjectively speaking, the deployment of medical discourse may provide a psychological separation of roles such as 'the expert' and 'the patient'. This can re-enforce a sense of 'normality' and 'expert-ness' for the health professional who is placed in contrast to the 'disordered', 'patient' other.

Family members may also benefit under this discourse as they can seek help and support for the difference apparent in the AS person. However, there may also be a secondary gain, psychologically speaking, for family members who may seek to resolve the difference due to their own distress regarding this. For family, as with health professionals, medical discourse provides a psychological separation of roles, for example, 'you are the disordered one (the other) and qualitatively different from me'. For parents this may provide the benefit of feeling that they did not *cause* the 'disorder' due to bad parenting. Here a BBC News Online journalist uses words expressed by the mother of an AS boy to suggest she has gained a sense of relief after her son's diagnosis:

(ON1-a, Line 17) *'When George was diagnosed as having Asperger's at the Royal Berkshire Hospital in April, his 43-year-old single mother felt a sense of relief. "I used to think it was my fault - that I had been doing something wrong," [she] said... When I heard the actual words I cried but then I felt relieved.'*

We can see here that the mother is quoted as being relieved that her son's difference and behavioural difficulties can now be considered due to *his disorder* and not *her parenting*. The 'problem' becomes securely located within the person

labelled as AS, enabling others to feel relieved from any sense that they may have played a role in creating the difficulties.

Within this discourse there is a potential to deny natural human differences. As AS is considered an incurable lifelong disorder, the AS person is therefore permanently 'faulty' and hence may be perceived as a continual source of difficulty by the family. Therefore, when overly dominant in the speak of families, this construction has the potential to deny them a narrative that could enable a sense of long-term well-being. Subjectively it may lead to feelings of powerless for family members, as well as sadness and disappointment in a future lost to a permanent and lifelong 'disorder'. Finally, on a wider societal scale, for members of the general public the 'disordered' construction could evoke fear or anxiety regarding the AS person who is certified as not being 'in order' (which will be explored further later in this chapter).

Dominant Construction 2: A difference

(BS2-a, Line 2) *'She's not, and never has been, an ordinary woman to whom we can all relate.'*

NEWSPAPERS

(FIC-a, Pg. 17, line 36) *'Her brother had always been different.'*

TV/FILM/FICTION

COMMUNITY INTERVIEWS

(GP-a, Line 18) *'... he probably does realise he's different, but I, I don't know if he would understand why (1) he's different.'*

The construction of AS as a 'difference' was present in three out of the four subdomains in the study (Newspapers, TV/Film/Fiction and Community Interviews). However, compared to the 'disordered' construction, it was less prevalent across the study and has hence provides less data. This construction was observed to create a form of polarisation in which the AS person was considered 'different' or an 'other' – separate from the general population due to an undefined 'difference'.

The 'difference' construction was often deployed via the use of explicit terms such as 'different' (BS1-b) or 'eccentric' (TB2-a). This was also achieved via indirect implication, using terms such as 'they' or 'them' or 'you' to assign an 'out-group' of AS people and 'we' to signify an in-group. Discursively, the 'difference' was often constructed in terms of observable behaviours or unusual social interactions, and was also seen to be a global trait or integral part of the individual: something that had always been and was expected to persist:

(BS1-b, Line 3) *'From early in your life we have known that you were different...A*

bright light shone on your "differentness" when your brother's two children were diagnosed with Asperger syndrome and we began to understand that we live in an "Aspie" family.'

(ON2-a, Line 14) *'He was always different – keeping to himself, fidgeting and very quiet.'*

Often this 'difference' was described by those around the AS person, but sometimes authors utilised the words of AS people themselves in order to deploy the difference construction:

(BS3-b, Line 24) *'Considine sums it up as "a debilitating sense of detachment" from both the people around him and his surroundings...when I was 18, I went to the doctor and tried to explain that I felt this sense of detachment between myself and the rest of the world.'*

(FLM-b, Line 1) *TEMPLE: My name is Temple Grandin. I'm not like other people. I think in pictures and I connect them. (Image of temple walking inside a room containing visual illusions, with diagrams superimposed on top)*

The 'difference' construction was therefore situated within a discourse of 'otherness' and, as illustrated above, created two distinct subject positions: the AS person as the inherently 'different' one or 'out-group member' who sits in contrast to the in-group or majority norm. Via this construction, the AS person becomes positioned as a societal 'other' who is considered to be non-typical or 'not like other people' (FLM-a). This positioning can invite certain forms of action which can have varying implications for the AS person. In the below example a teacher reports that a student's difference had been negatively evaluated by his peers. His unusual social behaviours were seen to 'disgust' and hence distance his peers. This negative evaluation by his peers had appeared to provide them with justification to reject, isolate and 'make fun' of him:

(ED-a, Line 8) *'They said that students were calling Mathew, the new 7th grader, "weird" and "obnoxious," even "disgusting".... Other kids had already begun to isolate this new student....due to their stage of development, middle schoolers can barely help themselves from making fun of anyone who is different.'*

A further example demonstrates how this 'difference' can be evaluated negatively, where an author describes the AS person's success 'despite' their difference. The use of the term 'speculation' also suggests the general public have been attempting to evaluate this 'difference' for some time:

(BS2-a, Line 2) *'She's not, and never has been, an ordinary woman to whom we can all relate...Susan Boyle is no ordinary pop star – but then you knew that already...By any definition Boyle has been very, very successful, despite the fact that she has always been "different", in some unspecified, but much speculated-upon way.'*

Across the data, it was also noted that the 'difference' construction was often accompanied by the use of a medical discourse. This appeared to enable the difference to be 'made sense of', for those around the AS person. This can be observed in the following examples:

(BS1-b, Line 7) *'A bright light shone on your 'differentness' when your brother's two children were diagnosed with Asperger syndrome and we began to understand we live in an 'Aspie' family.'*

(ED-a, Line 19) *'Mathew's classmates would be informed that he was coping with Asperger's syndrome... The meeting helped Mathew's class mates recognise how lost he was in social situations...now the students' intention was to help rather than harass him.'*

By situating the 'difference' within a medical discourse, it enables others to 'make sense of' and to name the difference, shifting the AS person from 'unconceivable difference' to 'medically constructed difference'. Here the AS student is essentially moved from the 'different' to 'disordered' construction. By doing so it guides the behaviour of all involved. By reframing the student's past unusual or unsocial behaviour as a medical condition, the teacher was seen to invite support from the other students, rather than ridicule or harassment.

The construction of AS as 'a difference' also has implications when utilised at a societal level. In popular media, AS people were portrayed as an 'other' in a variety of societal contexts. Here we see how a newspaper article places AS people, as 'others', in opposition with a societal in-group of religious people. The article frames autistic people as 'non-believers' and the speaker then associates non-

believers with disorder. By doing so, the speaker seeks to discredit atheist beliefs as a symptom of disorder. The speaker effectively states that if an AS person does not happen to believe in god, it may not be due to free choice, or an informed and conscious decision, but rather a side effect of a deficiency in mentalising:

(TB1-a, Line 1) *'Are autistic people unable to believe in God? Ability to think "inside" other heads is key to religious feelings. Most believers think of deity as being who 'thinks. Autistic adolescents less likely to believe in God. Ability to "mentalise" - think inside other people's heads is key to belief. Men less able to mentalise than women. Belief in God - or other higher powers - might be linked to a person's ability to imagine what others think and feel. The discovery could mean that people who find it difficult to "mentalise" - think "inside" other people's heads, are unable to believe. "Mentalising" is the capacity to understand what another person is thinking - a crucial aspect in how people handle the social world. Religious believers usually think of their deities as beings who "think" in a way similar to human beings. People with autistic spectrum disorders have difficulty mentalising. "Autistic adolescents expressed less belief in God," say the researchers. "Religious believers intuitively think of their deities as personified beings with mental states who anticipate and respond to human needs and actions. Therefore, mentalizing deficits would be expected to make religious belief less intuitive," say the researchers, from the University of British Columbia.'*

Is religious belief an 'ability'? The speaker implies that an autistic person's decision to be non-religious could be invalidated and 'written off' as a symptom of disability and faulty neurological processing. The author draws on a psychological discourse to associate the non-religious 'other' and the autistic 'other', and by doing so attempts to discredit them both. Such examples show how being created as an 'other' can alter the structure of power and respect for AS people. Within many societal texts, as demonstrated in the above quote, 'otherness' appears to often be rationalised in terms of 'deficiency'. This serves to justify the discrediting of the AS person, and the closing down of opportunities and even, in some cases, the potential removal of societal rights, as the history of many minority groups has demonstrated.

In comparison to societal texts, within interviews, the use of the 'difference' construction was not associated with any negative evaluations of the AS person's character, and so did not appear to justify any form of negative action towards the

AS person. Within the talk of the community members, the 'difference' construction was generally deployed when discussing aspects of support. In the following example, the parent of an AS child does not seek to remedy the 'difference', but simply to support the child to become comfortable with this, to ensure positive psychological development and well-being:

(PAR-b, Line 53) *'I think as he grows up and as that sense of difference from his peers becomes more acute, I think my role is really to try and, um (1) yeah help him to keep that sense of self intact, you know.'*

Overall, the construction of AS as a 'difference' was seen to justify and guide the actions of in-group members, towards the AS person. This had the potential to lead to certain subjective experiences for the AS person. In some societal texts, being positioned as the different 'other' situated the AS person as a passive recipient of support or intervention aimed at resolving the 'difference'. Subjectively speaking, this may be an isolating, dependent and disempowering position – with the actions of those around the AS person continually re-affirming their position as an out-group member. Many of the same subjective experiences as that of the 'disordered' construction apply here especially when the 'difference' is evaluated negatively. The potential internalisation of this 'otherness' may contribute to self-stigma, sadness and shame. In community interviews however, being positioned as 'different' was discussed in terms of supporting the 'difference', and therefore the AS person would not likely be at risk subjectively speaking. Within the community of people interviewed here an AS person may feel supported to be 'who they are', without expectation to conform to particular concepts of normality. However, it is also worth noting here that an AS person, regardless of the constructions deployed around them, may experience their own sense of difference, and this in itself may contribute to some discomfort subjectively speaking.

For the 'normal' in-group, the 'difference' construction, as utilised in societal texts, may serve to justify the separation and isolation of others, as occurred with school children noted above (EDa). Hence for those in the in-group, subjectively speaking, their sense of 'normality' may be maintained due to their contrast to the out-group member. However, others may experience discomfort on behalf of the segregated or rejected 'other'.

Dominant Construction 3: A predisposition for high Intelligence

(BS3-b, Line 22) *'Although the afflicted often have above-average intelligence (famous sufferers are thought to have included Albert Einstein, Vincent van Gogh and Leonardo da Vinci)...*

NEWSPAPERS

PROFESSIONAL ARTICLES

(PA-PSY-a, Line 12) *'On certain subscales of intelligence tests, those with AS have even been found to perform better than their typically developing peers...'*

(FIC-a, Pg 22, line 27) *Penny stepped up behind him as the quiz provided its result. 'Above average intelligence, just ten points shy of genius.'*

TV/FILM/ FICTION

COMMUNITY INTERVIEWS

(CHA-a, Line 47) *'He's aware that he's really clever in **some** ways but, but people tend to tell him he's clever all the time. He's constantly told by people that he's terribly, terribly clever.'*

Across the study, a construction of AS as a 'predisposition for high intelligence' was observed. It was present in all subdomains indicating that it is highly associated with AS at both societal and community levels. The AS person was constructed as having particular 'special' or 'prized' skills related to their intelligence and general abilities, suggesting that if someone has AS they may also be highly intelligent. This construction appears to be drawn from both a societal stereotype of AS as comprising of genius or savant abilities, as well as certain professional perspectives which focus on the strengths related to AS (each of which were discussed in the Introduction chapter).

The 'high intelligence' construction observed within the data, was signified by the use of terms such as: 'gifted' (TB3-a), 'very smart' (PA-ED-a), positive 'strengths' (SPT-b) and 'special interests/skills' (FIC-a). Associations were also made between AS and famous societal 'geniuses' (BS3-b) such as Einstein and da Vinci. This construction of AS appeared to be a form, or sub-type of 'difference' or 'otherness' – drawing a line between this person and the rest of the population based on a perceived difference in intellect: creating an in-group of the normally-intelligent, and an out-group of highly intelligent AS people. It was situated within a discourse of 'otherness', but unlike the 'difference' construction a *particular* difference was specified; with high intelligence presumed to be a positive characteristic of an AS person, as the following examples illustrate:

(BS1-b, Line 27) *'It often involves high intelligence, the ability to focus and creativity. Many famous and successful people have Asperger's.'*

(PA-ED-a, Line 64) *'You've probably noticed that Mathew, like lots of people with Asperger's, is very smart and has an amazing memory.'*

Therefore it was often used by speakers as 'a positive' in order to counteract the more negatively perceived differences that are associated with AS (such as social difficulties). In the following community interview the phrase 'give you that' indicates that this construction can be used explicitly by speakers to 'balance up' or counteract the perceived difficulties associated with AS:

(PAR-a, Line 168) *'I'm often told he's bright...Sometimes I feel like people give you that as an autism mum, or the high-functioning autism mum, that "oh your child's going to be a computer genius when he's older".'*

In the above example, the mother of an AS child expresses how her son is repeatedly positioned by others as a potential computer genius. She notes that this is also accompanied by 'when he's older', which may serve to offer a prediction of a brighter future for the child than the current daily difficulties that may be experienced. Therefore when deployed in this manner it appears to function as a re-assuring statement directed at the mother to suggest that at some point there will be a positive upside to AS.

Sometimes this construction was also used by a speaker directly before talking about an AS person's 'deficits', suggesting it can function as a disclaimer that assists to prevent the speaker's following discussion of the AS person's difficulties as being perceived in a purely critical light:

(BS1-b, Line 4) *'Sure, you have always been witty and intelligent with a keen sense of fun....But you struggle to make friends, didn't get on too well at school and after a few short-term jobs you have been unemployed for a long time.'*

(TB2-a, Line 32) *'Oliver has "high functioning" autism, which can be often compared to Asperger syndrome. It means he doesn't have learning difficulties and is a 'bright' child but does have difficulties communicating and empathising.'*

In both of the above examples, the conjunction 'but' is used to connect the concept of high intelligence to the difficulties. The positive aspect of the person is first outlined, but is then seen to be cancelled-out when followed by the stated difficulties. In fact, in the first example, the speaker uses the phrase 'sure' to begin the statement, which acts to purposefully downplay the 'wit and intelligence' of the AS person, which is not considered to be of sufficient benefit to counteract the other difficulties associated with AS. She attempts to soften her negative view of AS, but overall we can propose that she believes the difficulties far outweigh any positive characteristics.

However, some speakers did not use the construction as a disclaimer before sharing a mostly negative view. Some speakers appeared to value the perceived 'high intelligence' of the AS person, not discounting or devaluing this due to an over-focus on difficulties. In the following example a speech and language therapist uses the construction to share her valuing of this perceived aspect of AS people. In fact she sees these 'amazing strengths' as justification to resist interventions aimed at changing, normalising or 'taking away' this aspect of the AS child:

(SPT-b, Line 284) *'Yeah, and I think some, some of the children I've worked with have got amazing strengths, amazing strengths which we just can't match, and would you want to take that away? ...and actually **because** they see the world*

*differently isn't that an asset? Because otherwise we might, **we** might miss something.'*

In the above example the speech and language therapist, positioned as the normally intelligent person, expresses admiration and encouragement for the 'amazing strengths' of the AS child. She then further recognises that these strengths, and especially this unique ways of seeing the world, might actually be of benefit to us all, without which we 'might miss something'. Therefore, in this example the construction is placed within a discourse of societal progress with the AS person being positioned as a valued societal asset: one who can contribute to creating a richer view of the world.

At a societal level, texts indicated that the construction appeared to operate as a form of societal fascination, in which the social inadequacies and disabilities of the AS person made the idea of high intelligence seem especially intriguing. The special skills of the individual were often presented in contrast to their disabilities: traits that appeared to radically contradict each other, hence suggested an intriguing personality profile. In the following example, the use of the phrase 'the afflicted' dramatically constructs AS people as 'sufferers' who have fallen prey to a terrible disorder or disease, but that despite this AS people, against all odds, can become societal geniuses. In the below example we can see how an association with the high-valued trait of genius serves to bolster the value of 'the afflicted' who are now considered to be in good company:

(BS3-b, Line 22) *'Although the afflicted often have above-average intelligence (famous sufferers are thought to have included Albert Einstein, Vincent van Gogh and Leonardo da Vinci)...*

However, when speakers position high-functioning AS people as societal geniuses, it may inadvertently position other lower-functioning autistic people, who may not show genius-like traits, as less valued; solely becoming 'afflicted' 'sufferers' who are intellectually inferior.

In terms of the potential subjectivity of an AS person, this construction could be both positive and potentially limiting. For some people, subjectively, the association with high intelligence may boost their self-esteem, providing

investment in a strong positive characteristic clearly valued by others. The below example is taken from an article which discusses the achievements of an AS teenager, Isaac, who has, at 16 years, become a successful fashion designer. The extract illustrates how the author deploys Oliver's words to suggest that AS can be a superior advantage over others. The author deploys Oliver's words to suggest that he rejects being positioned as disabled and instead claims it as positive aspect of his identity, further stating that his AS is integral to his success:

(TB3-a, Line 9) 'The way I am means I am able to make these clothes and express myself – I can have more imagination. It's a way for me to be myself and excel at something, and if I didn't have Asperger's I wouldn't be the same way.'

By using the phrase 'I can have more imagination' the author suggests that Isaac positions himself as possessing superior imaginative potential compared to other people. This assertion of superiority may however have developed as a way to resist implications of inferiority or stupidity; earlier in the article the author reports that Isaac had previously been heavily bullied at school for his differences. Therefore Isaac may deploy the 'high intelligence' construction in order to maintain or bolster his self-esteem and to fend off any implications of inferiority contained within the assumptions of others; resisting being positioned as a victim of his AS. Therefore some AS people may find this to be a beneficial construction, which can be deployed to protect both their internal and external identities. In addition, via the use of these quotes, the author of the article appears to inadvertently position Isaac as an inspirational role model for other AS people.

However, the societal wide use of this construction may contribute to some AS people feeling that others hold a limited or restricted view of their character. Whether highly intelligent or not, they may not wish to be defined by this aspect alone, and in fact their intelligence may not actually be respected, but rather seen as a 'quirk' of personality. As we saw in the above interviewee quote from a mother in the community, this construction can often be given as a 'gift to give' an AS person, or their family. This may however be experienced as a limiting assumption of their character and may become a source frustration to the AS person or their family. This sense of frustration was also shared by the mother:

(Par-b, Line 166): *I'm often told he's bright and to be honest that ↑irritates me too.*

NW: *Does it? Why's that?*

Par-b: *Because I ↑feel ↑like, I find it a bit patronising. Sometimes I feel like people give you that as an autism mum or the high functioning autism mum that, oh, your child's going to be a computer genius when he's older*

NW: *OK, yeah.*

Par-b: *And to be honest I'd rather he had **friends** and, you know.*

NW: *Yeah.*

Par-b: *So I think people often say this to make you feel better, you know, he's obviously very bright.*

NW: *OK. So it's those stereotypes maybe is it? that are, that are the*

Par-b: *Yeah, that's a good point. I think it's, a) a stereotype and b) something positive that can be thrown your way.*

NW: *OK. Yeah.*

Par-b: *Yeah. When I don't really think it's, I mean I don't, I don't think he's not bright but I just, yeah.*

NW: *OK. So maybe people are assuming that you need to have a positive comment thrown at you?*

Par-b: *Yeah (1) Yeah, I think so and I think it's almost like in those conversations sometimes I feel that it's, and I can understand this, it's an awkwardness. So people just want to give you something positive so we can all move on.*

As the interview extract shows, members of the societal in-group, may deploy the 'high intelligence' construction due to an awareness of the stereotype. Subjectively, when a speaker from the societal in-group labels an AS person as 'genius' or 'gifted' we may speculate that this can be related to their desire to 'offer' something positive in light of the perceived disability. This suggests that in-group members may sometimes feel uncomfortable about the disabilities associated with others. For other in-group members we could speculate that

deployment of this construction may be related to feelings of excitement, fascination or respect in regards to the AS person, or sometimes simply curiosity. However, consistent deployment of this construction may risk the speaker having an over-focus on this trait, which could eclipse their view of the 'whole' person: a rather two-dimensional picture of a three-dimensional personality. For example, in the film Rain Man (generally associated with ASD), the ASD character played by Dustin Hoffman shows exceptional memory and mental calculation skills. Other characters' over-focus on his exceptional abilities appears to contribute to a restricted view of him, creating a lack of recognition of his overall 'humanness'. This results in exploitation of this aspect of his character for gambling purposes.

Dominant Construction 4: A problem/challenge

(TB2-a, Line 7) *'We first realised Oliver has a problem when he was about six months old.'*

NEWSPAPERS

PROFESSIONAL ARTICLES

(Occ-b, Line 16) *'Children and young people with Asperger's often present with motor coordination problems.'*

(TV-b, Line 68) *Richard's mother: He might do or say the wrong things, something silly and ruin it [the date], Oh god (worried look).*

**TV/FILM/
FICTION**

**COMMUNITY
INTERVIEWS**

(SPT-a, Line 10) *'...And because of the difficulties of interacting (2) and the lack of understanding of why they're having difficulties, it can, it **can** lead to a lot of emotional upset.'*

Within the data, a construction of AS as 'a problem' or 'challenge' for the AS person, for others and for wider society, was identified. It was present within all four subdomains. Speakers in texts explicitly described the experience of AS people as a 'struggle' and talked about the 'difficulties' they may face due to their AS. This construction was mobilised by AS people, family, professionals and speakers within wider society, each of which constructed 'the problem' from differing subject positions. Examples of this construction from these differing perspectives will be discussed in turn.

The 'problem' as deployed by the AS person:

Across the texts, AS people explicitly described their AS as a 'problem' as well as a collection of 'difficulties' that often lead to considerable frustration and anxiety on a daily level. These descriptions resembled the way autistic authors have come to describe their AS (as noted in the Introduction):

(BS2-a, Line 18) *'An articulate Boyle described her own experience in the interview: "I would say I have relationship difficulties, communicative difficulties, which lead to a lot of frustration. If people were a bit more patient, that would help." Thanks to these words, she and others are much more likely to encounter such patience.*

This construction may also be used by the AS person to separate-out 'the problem of AS' from themselves. Here we see an author reproducing quotes from an AS person that may indicate this separation:

(BS3-b, Line 8) *"I swaggered through life but, in reality, I lived in fear pretty much every day. I acted like a completely normal person, and I suppose I was good at it. But, inside, it was a very different story." What starts as a discussion about the problems facing a Victorian detective, placed under enormous public pressure to solve the brutal murder of a little boy, has suddenly segued into a conversation about the difficulties the actor himself faces on a daily basis. Roughly a year ago, aged 36, Considine was finally diagnosed with Asperger syndrome, one of a spectrum of disorders relating to difficulties with communication and social skills that includes autism at its furthest extreme. "For a few weeks after the diagnosis, I was wandering around thinking, 'Who the hell am I?' But naming my problem has helped me a lot.*

For the AS person this construction of AS as a 'problem' appeared to exist within a 'personal narrative' discourse, most notably positioning the AS person as 'the victim' self. The 'problem' construction was observed to be deployed in order to tell a story of the subjective position of 'the self' in relation to 'the problem'. Most notably it was deployed by the AS person to illuminate the difficulties they have experienced due to their AS, so as to invite understanding. After sharing her diagnosis publicly, Susan Boyle, quoted by an author in The Independent in September 2014, discusses her reasoning for doing so:

(BS2-b, Line 14) *'People will have a greater understanding of who I am and why I do the things I do.'*

(BS2-a, Line 17) *'I suspect the NAS are equally excited about the way Boyle's personal account can help broach the empathy gap for people who have no idea what it might be like to live with Asperger's. An articulate Boyle described her own experience in the interview: "I would say I have relationship difficulties, communicative difficulties, which lead to a lot of frustration. If people were a bit more patient, that would help." Thanks to these words, she and others are much more likely to encounter such patience. In fact Susan Boyle has already done so much to make us all more kind, less superficial, more tolerant people.'*

Susan expresses an expectation that by speaking about her 'difficulties' that the general public may understand her better. Susan had been mocked repeatedly in the press for her unusual characteristics, when appearing as a contestant on the television programme 'Britain's Got Talent' in 2009. It may be that her statement hopes to reduce the ridicule she had experienced regarding certain past televised comments and behaviours. If an AS person, such as Susan, achieves support and understanding via sharing their 'problem' it is possible that a sense of relief may result and perhaps a feeling that they are finally able to cope with the 'problem'. This may aid recovery of their self-esteem and lessen anxiety or frustration, as the following quote from Susan Boyle in The Independent in September 2014 illustrates:

(BS-2-b, Line 13) *'It's a condition that I have to live with and work through, but I feel more relaxed about myself.'*

Therefore, when constructing AS as a 'problem' the AS person may not only become a victim, but also a survivor. If an AS person was to recognise themselves as a 'survivor' of AS this may relate to feelings of pride, self-acceptance and raised self-esteem. This positioning as the 'survivor' however has certain implications. It places the onus on other AS people to similarly overcome and triumph over their AS. It inadvertently implies that disability only persists if one is unsuccessful in battling the AS. Therefore for those who do not identify as a 'survivor', a sense of shame may arise, as well as a feeling that their inability to triumph over the AS makes them inferior and disappointing to others.

For AS people who solely construct themselves as a 'victim' of a personal 'struggle', we can postulate that there may be a sense of 'unfairness', injustice, shame, guilt, frustration and powerlessness. As AS is considered to be a lifelong disorder this implies that the 'struggle' will continue for life: a permanent 'problem'. It is also possible that, due to the impact of their difficulties on a daily level, they may also hold a concern that they are a burden to others. Therefore this positioning may increase the potential that they may become depressed. When faced with these concerns, a person may then also have an increased likelihood of using their diagnosis as a 'crutch': becoming something external to blame their difficulties on in order to protect their self-esteem and fend off criticism from others.

The 'problem' as deployed by parents:

Several articles demonstrated how the 'problem' construction could be used by authors to suggest how parents may describe their child's 'problem':

(TB2-a, Line 7) *'We first realised Oliver has a problem when he was about six months old. Little things alerted me – like the fact he wouldn't make eye contact with me and his eyes just kept drifting away. I thought this was a bit odd, but because he was my first born, I didn't know what to expect.'*

(BS1-b, Line 4) *'...you struggle to make friends, didn't get on too well at school and after a few short-term jobs you have been unemployed for a long time...We learned that there is a genetic element to Asperger's and that the condition has a range of characteristics that fall on a very wide spectrum, ranging from people who need massive amounts of support to those who can almost (like you) get by as "normal". You've struggled over the years, and with no girlfriend and living alone you unfortunately found comfort in alcohol.'*

The above examples illustrate how via phrases such as 'Oliver has a problem' and by presenting a list of many things 'you struggle' with, that the problem is clearly located within the AS child. Their problem appears to consist of a diversion from expected norms of development, social experience and educational progression, therefore further constructing the problem as being one with global effects over several life domains. Parents were seen to mobilise the 'problem' construction of AS in order to gain support and understanding for their child's problem and for AS people generally. In the below example, we see how 'the problem' involves a diversion from typical development. The mother seeks to construct AS as 'the problem' in order to educate others regarding the intensive support required by AS people:

(BS-1-b, Line 23) *'I believe that you find it impossible to undertake the everyday tasks of housekeeping that to most of us are routine. As we grow up we learn those skills without really noticing. For some people with Asperger's, those skills must be taught systematically and carefully under the supervision of someone giving loving support.'*

Again we see how she uses 'you' and 'we' to indicate that her child is different from others due to 'his problem', which makes him unable to undertake everyday tasks, hence justifying the imposed supervision and teaching of others.

In addition, AS was described as a problem for parents themselves; something they had to 'cope with'. Here the author deploys the construction via the parent's words, suggesting the 'problem' required them to stretch beyond the normal limits of parental patience and understanding in order to adequately parent the AS child:

(ON1-a, Line 1) *'Coping with a Child with Asperger's'*

(ON1-a, Line 2) *'There are days when I think I just cannot do it anymore. The honest admission by Amelie (not her real name) about trying to be a good parent to her son...'*

The discourse of parenthood is evoked above. From this discourse parents are expected to 'do' parenting: to actively support and guide their children on a continual daily level until adulthood. Speaking within this discourse, the parent above states she cannot 'do it anymore' indicating that AS appears to add considerable stress to her parenting role. AS is created as a 'problem' for them within this parenting discourse, preventing the mother from adequately fulfilling her parenting role. Hence parents may mobilise this construction of AS in order to invite understanding, support and empathy from others for their own constant daily struggle.

For the family of the AS person, data suggests that subjectively speaking they may, like the AS person, feel themselves to be a 'victim' of the AS. The mother in ON1-a (above) seeks understanding and compassion for the 'problem'. She creates a sense that her child's AS can be overwhelming for her, interfering with an expected normal path of mothering. The mother situates herself a victim of the AS, feeling powerless to affect it, and possibly tired from the struggle of continually trying to 'cope with' it. However, for the AS person, awareness of a parent's struggle with AS may lead to a sense of guilt and a concern that they may be a burden.

The 'problem' as deployed by professionals:

Within the Professional Article domain, the exact nature of 'the problem' varied by type, being related to the areas in which that profession had evolved to address.

For example, in psychology AS was constructed by authors deploying the words of professionals who appeared to describe AS as a problem due to being 'diagnostically blurry', as well as a cognitive problem with seeing the 'big picture', as proposed by the weak central coherence theory (discussed in the Introduction):

(PA-Psy-b, Line 27) *'People will still use Asperger's as a descriptive, but it doesn't work as a diagnostic category because it doesn't have any clear boundaries that qualitatively distinguishes it from autism....Because also, although I'm not a clinician, the experience I have in clinical settings is that people are saying 'well, he doesn't really fit Asperger's, but it's the nearest we can get', or 'it will get him the services that he needs'.*

(PA-PSY-b, Line 133) *'...we can improve the ability of people with autism to see the big picture when they need to, without taking away their eye for detail.'*

Within occupational therapy AS was constructed by authors, deploying words of professionals, as a problem of motor co-ordination or 'sensory integration':

(Occ-a, Line 3) *'People with Asperger syndrome can have difficulties processing sensory information.... deficits in sensory modulation, in particular tactile hyper-reactivity, proprioceptive hypo- reactivity and in terms of general reaction he was hypo-reactive.'*

Within a medical discourse this construction of the 'problem', in terms of sensory processing difficulties, was seen to lead to certain interventions or treatments becoming justified. In the below example the author presents a speaker's construction of AS as a 'sensory processing 'problem' which is hence prescribed 'sensory integration' with the aim of teaching the AS person to independently calm their overwhelming sensory reactions:

(PA-OCC-a, Line 11) *'The client had some difficulty understanding the purpose of sensory integration, however, once Jo explained that it was a method of calming himself down with minimal staff support, the approach appealed to him.'*

Similarly, within a psychological discourse, an author reproduces a psychologist's construction of AS as a problem in seeing the 'big picture', which is then suggested to lead to specific interventions – here zoom in and zoom out guidance to assist with wider context focus:

(PA-PSY-b, Line 133) *'...we can improve the ability of people with autism to see the big picture when they need to, without taking away their eye for detail. We want to develop interventions to help, for example, kids to learn that some problems are 'zoom out' problems and others are 'zoom in', if you take a video analogy.'*

Within a school environment, an educational discourse was drawn upon and AS was seen as a 'social problem' for the AS student which created difficulties in forming and sustaining relationships with others within an education environment:

(PA-Ed-b, Line 15) *'Due to their social and communication difficulties, young people with Asperger's syndrome may struggle to develop relationships with other children and teaching staff.'*

However, AS appeared to be a 'problem', not just for the AS person, but for educational professionals as well. Within an educational discourse, AS was seen to be a problem for a teacher's patience: something that may interfere with their professional duties and potentially blight their professional demeanour. The below example illustrates that AS is something that requires more than a 'normal' level of understanding, hence making it a problem for teachers:

(PA-ED-a, Line 15) *'Normally understanding teachers were losing their patience. Even if you've never had a student like Mathew, you probably know what it's like to have a pupil who tests your tolerance. And the student who evokes a strong negative reaction in you is likely stirring similar feelings in classmates. Mathew's situation demanded action.'*

We can see how, when constructed as a 'problem' for professionals, this demands action: something must be done. The professional is positioned as the 'expert' who is tasked with fixing or resolving the 'problem'. Therefore, for professionals, subjectively speaking, we could propose that they may feel a

sense of responsibility to apply 'expertise' to 'improve' or 'resolve' the problem. However, for the AS person such interventions situate them as a passive recipient of support, which may lead to subjective feelings of disempowerment. For other AS people it may provide a sense of support.

Interestingly, within the above article, despite being described as a 'problem' for Mathew's peers and his teachers, the word 'problem' was not explicitly used. This was also the case in other articles in the Professional Articles subdomain. It was often described as a benign thing, for example 'Matthew's situation'. Sometimes the problem was also expressed or 'repackaged' as a 'challenge':

(ON3-a, Line 16) *'Mr Novia also ran a technology club, of which Lanza was a member. 'He often had little episodes like that where he would just shut down and pull within himself. Getting him back out of that would be challenging', he added.'*

This may suggest that, despite describing AS in problem-related language, it is difficult to speak openly and directly about AS as a 'problem' for some professionals. Perhaps they may feel that the AS 'shouldn't' be a problem for them, and when rephrased as a 'challenge' it implies a more active management of the AS.

The 'problem' as deployed within wider society:

At a societal level, AS was also not explicitly spoken of as 'a problem' but there was an indirect implication of this. AS was seen to be something that is 'increasing' and of which more 'awareness' is needed. This was often achieved indirectly by articles presenting statistics on the increasing prevalence of ASD, and the responsibility of all society members to be 'aware' of ASD. Sometimes this 'awareness' was encouraged in order to support those with ASD, and sometimes 'awareness' was discussed in terms of concerns over increasing prevalence:

(ON1-a, Line 7) *'A recent Reading Borough Council report revealed the number of children diagnosed with ASD in the town rose from 68 to 186 between 2000 and 2008. That prompted the council to hold the town's first Autism Awareness Week earlier this month.'*

(ON1-a, Line 34) *'A spokeswoman said: "You would expect about 205 children to have an autism diagnosis in Reading - based on the national 1 in 100 estimate. This shows that whilst in itself the increase might look significant, it is an accurate reflection of the increasing awareness and recognition of autism amongst parents and professionals and in line with what we would expect to see." Tom Madders, head of the society's campaigns, added: "There is some evidence to suggest that autism prevalence may be increasing; however the reasons for this are unclear.*

In the above example, the term 'prevalence' is commonly used to imply the increase of a negative factor (often associated with disease), so although not explicitly stated, it creates the impression of concern regarding the increase in AS 'illness'. However, AS was not only implied to be a societal problem affecting an increasing *proportion* of society members; it was also constructed as a problem that could directly increase certain risks for *all* members of the public, as seen in the following extract from an online news article in which the author quotes a blog writer:

(ON3-a, Line 22) *'A blog post entitled "I am Adam Lanza's mother" - detailing the experiences of a mother trying to look after her gifted, but mentally unstable and violent, son - has gone viral. In it, the writer Liza Long calls for a national conversation about mental health. In the wake of another horrific national tragedy, it's easy to talk about guns. But it's time to talk about mental illness she writes.'*

In this article, an AS person has become associated with a US school shooting. The speaker further associates 'the problem' of AS with a wider societal problem of 'mental illness', redirecting responsibility for the shooting away from US gun laws to a focus on deviant individuals. This deployment suggests that it is *awareness* of the 'problem' of AS that is required for the protection of the general public. Subjectively speaking, for the general public, AS then becomes something to fear: an increased risk for all, which requires vigilance and further awareness in order to address. For the AS person, when AS is constructed in societal media as a 'problem for society', this may lead to feelings that others perceive them as a constant concern or even a physical risk to their safety.

1b) Constructions unique to Societal Texts

There were four constructions that were found to be unique to the Societal Text master domain in the study (see Figure 15). A list of these is presented below, along with an indication as to the subdomains in which they were located.

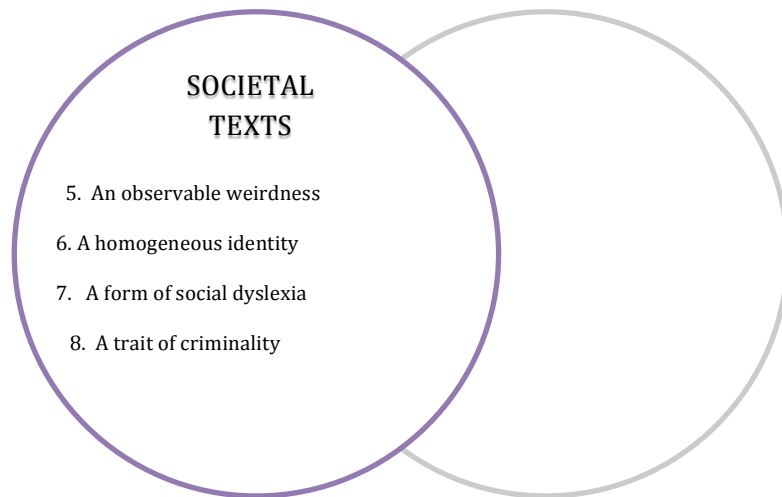


Figure 15: Constructions unique to societal texts

These unique societal text constructions were located in the following subdomains:

- 5. An observable weirdness: Newspapers, TV/Film/Fiction
- 6. A homogeneous identity: Newspapers and Professional Articles
- 7. A form of social dyslexia: TV/Film/Fiction
- 8. A trait of criminality: Newspapers.

Dominant Construction 5: An observable weirdness

(BS2-a, Line 9) *'...she has always been 'different', in some unspecified, but much speculated-upon way.'... She had already revealed in the VT that she was a 47-year-old, long-term unemployed woman who had never been kissed, and lived alone with a cat.*

NEWSPAPERS

(FIC-b Pg. 36, line 1) *'He's a freak. Even more of a freak than you with those red streaks in your hair! He walks weird. He just fell over on his own. I never touched him! Freak!'. ...that name Tom had called him. Freak. What if everyone started calling him a freak?'*

TV/FILM/ FICTION

The 'weirdness' construction was present in two out of the three societal subdomains: Newspapers and TV/Film/Fiction. It appeared to be related to a societal stereotype of AS people as 'odd' or 'unusual', as discussed in the Introduction chapter. It functioned as a form of the 'different' construction, in which the difference was explicitly seen to be perceived negatively and there was an active assertion that the AS person belonged to a non-valued out-group. The deployment of this construction perhaps said more about the speaker deploying it, than the AS person themselves. It indicated that the speaker was uncomfortable with the AS person, and suggested that they could be unaccepting of differences in others generally. Speakers deploying this construction were observed to desire conformity and would hence ridicule an AS person who did not meet the expected criteria of 'normality'.

Explicit terms such as 'odd' (ON2-a), 'eccentric' (TB2-a) and 'freak' (FIC-b) signified the presence of this construction, along with descriptions and on-screen

visuals of unusual behaviour implicitly designed to evoke a sense of 'weirdness' for the reader/viewer. Speakers were seen to use this construction to single-out and separate others into an out-group based on particular non-valued and ridiculed features of the person, such as differences in physical and social behaviour, or appearance. This is illustrated by newspaper journalists in the following examples:

(ON2-a, Line 4) *'As a teenager he would scuttle from class to class, pressing himself against walls and clutching a black briefcase "like an eight-year-old with a teddy bear". What has emerged in the aftermath of the Sandy Hook shooting is a picture of an odd, withdrawn and troubled boy.'*

(BS2-a, Line 22) *'When she first walked on stage to audition for Britain's Got Talent in 2009 with her grey hair and bizarre hip thrusts, Simon Cowell rolled his eyes and Piers Morgan scoffed and the audience laughed.'*

The examples above indicate that the construction of AS as 'weirdness' evokes a discourse of social etiquette. The construction is explicitly signalled by the author's use of the word 'bizarre' as well as setting this against the reactions of Simon Cowell and Piers Morgan, who 'scoffed' and 'laughed' in response. This indicates that when Boyle was constructed as 'weird' by these judges, it provided further justification for the audience to join in with this construction, as signalled by their laughing. Hence constructing Boyle as 'weird' served to utilise her as a source of comedy for viewers. In two further examples we can see how this construction has further implications for the AS person; leading to non-comedic forms of ridicule, rejection and avoidance:

(FIC-b Pg. 36, Line 1) *'He's a freak. Even more of a freak than you with those red streaks in your hair! He walks weird. He just fell over on his own. I never touched him! Freak!'*

(TB3-a, Line 19) *'I was bullied for being different but I didn't want to look the same as all the other kids...'*

The above examples show how unusual behaviour, or differences, in the AS person can confuse others, and may therefore lead to avoidance and rejection.

We can speculate that, when the AS person is considered to be *not* 'one of the pack', this may threaten the sense of physical or psychological security of some in-group individuals. In fact, some text examples could suggest that AS people warrant avoidance due to risk concerns. The following two examples demonstrate how authors can imply that the 'weird' AS person is unsafe:

(ON3-a, Line 2) *'Shy, awkward, lonely: the picture emerging of gunman Adam Lanza is all too familiar.'*

(ON2-a, Line 5) *'What has emerged in the aftermath of the Sandy Hook shooting is a picture of an odd, withdrawn and troubled boy. One law enforcement officer has said that 20-year-old Lanza had been diagnosed with Asperger's, a mild form of autism characterised by social awkwardness.'*

These articles again draw on a discourse of typical social behaviour or etiquette, where shyness, awkwardness and loneliness are seen as a deviation from expected social norms, hence constructing these behaviours as 'weird'. The articles indicate that, as Adam Lanza was well known to have AS and to be 'weird', it is therefore of no surprise that he went on to commit a violent act. Weirdness is implied as being an 'all too familiar' feature of a gunman. Therefore once constructed as 'weird' such attitudes would suggest that AS people are potential criminals and a general risk to the public.

Further data located in the study illustrates how the construction of 'weirdness' may have a relationship with professional views of autism, namely the E-S theory, which suggest AS people have an extremely low tendency towards empathy. The construction also appeared related to the societal stereotype of the AS person as 'lacking empathy'. Each of these perspectives were discussed in the Introduction. Several examples illustrate how certain behaviours might be interpreted as a 'lack of empathy', which as a result, can further become associated with both 'weirdness' and criminal acts:

(PA-MED-b, Line 16) *'Mental solipsism is much clearer in cases of severe autism, but Barnbaum points out the related difficulties with empathy even in adults with high-functioning autism or Asperger's syndrome. For example, she quotes Gunilla Gerland, who has autism and describes how she was unperturbed by the death of her father, comparing his loss to a bowl of fruit that was on the table one day and gone the next.'*

(PA-MED-b, Line 22) *'So Hume would have had to conclude that, if they do not spontaneously empathise, people with autism must lack a moral sense.'*

In the final example above (PA-MED-b) a discourse of morality is evoked. Assumed immorality of an AS person would imply an increased risk for criminality and harmful acts towards others. Such conclusions have the potential to lead to the alienation of AS people in many areas of social and professional life. Not only might opportunities become limited, this association may even lead to a segregation of AS people. As history has demonstrated, when people are considered to be degenerate, deficient and incapable of morality their very 'humanness' comes into question and at an extreme, may lead to policies in support of eugenics and mass sterilisation. Statements questioning the morality of AS people appear to be the first step on this path.

Subjectively speaking, being constructed in such dehumanising terms would be a strongly disempowering, rejecting and isolating position for the AS person. When constructed as 'weird' we can posit that an AS person may feel they are unvalued and 'less than' others and this may be accompanied by a sense of sadness, self-stigma and eventually long-term damage to their self-worth. They could eventually cease in seeking friendships due to an expectation that others will reject them, hence isolating them further. There may also be a feeling of frustration or concern that others may judge their unusual behaviour or appearance as a risk to their safety.

For those in the in-group, partaking in these constructions can be done so, either actively or passively. For an 'active ringleader' using these constructions may provide them with a sense of their own 'normality'. It may provide them with a sense of re-assurance regarding any differences they themselves may not wish to have revealed. Therefore they may choose to deliberately position themselves as the 'rejector' rather than the 'rejectee'.

For in-group members who are passive, allowing someone to be constructed as 'weird' or 'lacking empathy' appears equivalent to advocating these constructions. In other words, non-action is a form of action. We can suggest that those who stand by when these constructions are deployed, are likely to fear similar rejection themselves, and will therefore allow the focus of rejection to remain on the AS person. Such a vicious circle of rejection serves to ostracise the AS person further.

If such extensive rejection and ostracisation was to culminate in anti-social behaviour could the AS person legitimately argue that the public or the community are to blame for such actions?

Dominant Construction 6: A homogeneous identity

(ON1-a, Line 14) *'They also have problems with social interaction and have poor social skills.'*

NEWSPAPERS

PROFESSIONAL ARTICLES

(PA-ED-a, Line 23) *'Their cognitive intelligence is average or higher. Yet they have great difficulty interpreting everyday social cues such as facial expressions or body language. As a result, they often impinge on others. Typically, they stand too close, interrupt conversations, and continue to speak whether or not anyone is interested.'*

The construction of AS as a 'homogeneous identity' was present in two of the three societal domains: Professional Articles and Newspapers. It appears to have developed due to AS people being grouped as a single diagnostic category – therefore it comes hand-in-hand with the use of the diagnostic medical model of AS (as discussed in the Introduction chapter). The diagnostic label 'creates' AS people as a collective or group that share certain characteristics. It is the 'similarities' that are shared between them, which this construction aims to highlight. This construction is the 'other side of the coin' to acknowledging individuality and diversity.

The deployment of the construction involves explicit terms such as 'they' (ON1-a) and 'their' (PA-ED-a). It also uses indicators of frequency when referring to AS people, such as 'often' (BS1-a) to tell the reader that the characteristics described are common and frequent to the AS group. This construction evokes both an 'otherness' and a medical discourse which seeks to communicate how the 'collective out-group' of AS differs from the 'normal' population. This construction reveals that there is a direct relationship between some of the dominant constructions in this study. Here we see how when speaking of AS people in a 'homogeneous' sense, the 'disordered' construction is drawn upon, as well as 'a problem', alongside implied constructions of 'difference'. Therefore it demonstrates how speakers do not always deploy constructions independently of each other, but often in combination, with one construction serving to justify the mobilisation of others.

The use of this 'homogeneous identity' construction was deployed when speakers from Professional Articles or Newspaper articles sought to educate others regarding 'defining characteristics', difficulties or interventions currently associated with the AS diagnosis. In newspapers, speakers appeared to be engaged in 'awareness raising' by educating the general public about how AS makes people differ from 'the norm' in regards to general behaviour and daily life, as the following examples illustrate:

(BS1-a, Line 22) *'People with that disorder often have high intelligence and vast knowledge on narrow subjects but lack social skills.'*

(ON1-a, Line 14) *'They also have problems with social interaction and have poor social skills.'*

AS was not only talked about as a homogeneous identity in terms of the diagnosis, but also in terms of the struggles, challenges and differing abilities due to the AS, as evident in the following examples:

(BS3-b, Line 23) *'They are often unable to read signals that most of us take for granted...'*

(PA-PSY-a, Line 13) *'They also tend to have superior attention to detail and perform better at tests involving finding images embedded within other images...'*

Ironically, this construction, removes the idea of 'difference' at an individual level. AS instead becomes located within a collective 'differentness', no longer individually different, but typical to others in their own group. This collective construction of AS was observed to direct certain forms of action towards the AS collective. Within Professional Articles the use of the collective construction was usually aimed at disseminating suitable interventions designed to 'treat' or 'support' the 'defining characteristics' of the diagnosis that may be present amongst those who share this label. The following examples illustrate how authors represent AS people in a homogeneous sense. The construction appears to assist professionals to design and deliver interventions:

Occupational Therapy:

(PA-Occ-b, Line 22.) *'Cognitive approaches can help children and young people with Aspergers learn skills to manage the everyday activities that are important to them...'*

Psychology:

(PA-PSY-b, Line 133) *'I'd like to see if we can turn our ideas about detail focus into educational interventions. We think at the moment it's rather separable – how good you are at details, and how difficult you find it to put information together to get the big picture, are different dimensions. That encourages us to think that we can improve the ability of people with autism to see the big picture when they need to, without taking away their eye for detail. We want to develop interventions to help, for example, kids to learn that some problems are 'zoom out' problems and others are 'zoom in', if you take a video analogy.'*

The speaker in the above example, taken from a psychology article, refers to Frith's weak central coherence theory of ASD (as discussed in the Introduction), hence constructing AS as a difficulty in processing wider contexts. Such theories are generally based on an understanding that ASD is a definable entity shared amongst those with a diagnosis. This appears to enable the development of interventions for the collective, on a greater scale than could be achieved on an individual basis. However, it may be a general over-assumption that ASD is a 'unitary concept'; something that is experienced in a generally similar manner by each individual. This debate was also considered in the Introduction chapter. When ASD is considered to be a 'unitary concept' shared by all people with the

diagnosis, this may result in interventions that lack the individual tailoring that may be necessary to be sufficiently effective for each person.

A homogeneous identity was also observed to play an important role in other wider societal circumstances. In the following example, BBC news reports the story of a Mexican man who, due to his diagnosis of AS, was legally denied certain societal rights, such as applying for a passport, enrolling in university, or buying a mobile phone, without his parent's consent. The article shows how the homogeneous 'disordered' identity of AS can cause difficulties for AS people, but that by re-constructing the collective identity in a different form (as a legal disability) it was possible to demonstrate that Mexican legislation violated the United Nations Convention on the Rights of Persons with Disabilities. This enabled certain aspects of the law to be changed for the benefit of the man and the wider collection of AS people, with the journalist representing this via the man's quotes below:

(ON1-b, Line 8) *'The groundbreaking ruling is expected to have wider implications for the rights of people with autism in Latin America, says the BBC's Will Grant.'*

(ON1-b, Line 17) *'They [the lawyers] have asserted our rights and I believe this is a great step forward', he said.'*

As the above story first indicates a collective 'disordered' construction can sometimes be limiting for an individual. In fact, it can be particularly difficult for individuals when the collective becomes associated with explicitly negative events or individuals. This potential harm to all AS individuals was illustrated by the National Autistic Society (NAS), who released a statement after gunman Adam Lanza was found to have a diagnosis of AS. Articles making an association between his crime and his AS were wide spread. The journalist notes this connection by presenting a quote from a spokesperson from the NAS, indicating that they had become concerned that all AS people would be associated with the criminal actions of Lanza:

(ON3-a, Line 31) *'...we would urge everyone not to jump to conclusions or to conflate the actions of one disturbed individual with a whole section of society, or to make judgements about people with the condition.'*

The above statement appeals for readers not to judge all AS people as potential gunmen. The NAS author describes the collective of AS as a 'whole section of society' in order to contrast this with 'one disturbed individual', suggesting that it would be a miscalculated 'jump' to associate the two given the huge disparity in number between them. The article therefore acknowledges the basic human behaviour of stereotyping others. Such stereotypes are based on overly simplistic generalisations of isolated incidences, and once in the public consciousness, are a risk to the individuality of each AS group member.

As the above examples illustrate, the 'homogeneous identity' construction is likely to have various implications for the AS person in terms of subjectivity. Within this construction the AS person can be either an 'active acceptor', a 'passive acceptor' or a 'rejector' of this construction. For those who actively accept the 'collective' identity of AS, they may experience a positive group identity, shared support and interests. This may create a sense of acceptance or belonging within an AS community. This acceptance of a collective identity of AS, and the benefits experienced by people as a result, were discussed in the rationale of the Introduction chapter where the benefits of a diagnosis were considered.

Some AS people may accept this construction in a more passive manner – not deriving benefit or difficulty from this. There may be, however, a subset of AS people, for whom a collective identity may not be valued. It may be experienced as a compromise to their own individuality. This appears to be the case for some people who state that AS is not a 'disorder' but simply a 'difference' (as discussed in the Introduction chapter). The disabled assumption that accompanies the collective identity may conflict with their own individual sense of 'ability'. Therefore, subjectively, they may feel this is a limiting and inaccurate reflection of their own individuality, and it may become a source of frustration.

For Professionals and the general public the idea that AS people are mostly 'same' may assist to place AS people within some sort of understandable boundary. It also gives the impression that, in terms of support or intervention, what has *helped one* AS person is likely to *help them all*. This may provide them with a sense of control over the AS and a way in which to guide their action towards the AS person. Awareness of individuality appears not to be at the forefront of consideration when speakers deploy this construction.

Dominant Construction 7: A form of social dyslexia

(TV-b, Line 36) *RICHARD: There's a 'social dyslexia'. You can see other people but you can't read other people. You don't know what they are thinking. You don't know what they are thinking at all.*

**TV/FILM/
FICTION**

(TV-b, Line 26) *COMMENTATOR: Richard's Asperger's makes it hard for him to read other people. So when it comes to dating, he can put his foot in it (footage shows past examples of this).*

This construction was found to be particularly dominant within in one societal domain of the study: TV/Film/Fiction. It is a construction of AS as a form of 'social dyslexia', implying it was a type of 'social blindness' which could lead an AS person to be continually socially inappropriate, socially awkward, and unintentionally offensive to others. The construction suggested that a defining feature of the character of AS people is frequent social 'faux pas'. This construction may be related to societal perspectives of autistic people as 'odd' as well as an increasing awareness of the Theory of Mind (ToM) perspective of ASD. Both of these perspectives were discussed in the Introduction. The ToM perspective assumes that AS people have little understanding of the minds of others, and therefore may explain why they may act inappropriately across many social situations.

This construction, like several others above (difference, high intelligence, weirdness and homogeneous identity) appears to be a form of 'otherness', sometimes expressed by the AS person, and sometimes by other society members. It operated in a similar manner to the 'weird' construction in which it was the social behaviour of the AS person in particular that was of focus. It therefore draws on a discourse of social etiquette. Via deployment of this

construction, the AS person often became a source of amusement for others, with their 'social dyslexia' used for entertainment purposes.

The construction was seen to be deployed in several different ways. Firstly, this was achieved via the use of explicit terms within character dialogue, for example, using phrases such as he 'put his foot in it' (TV-b), being labelled 'blunt' (FIC-a) or being continually socially corrected by others. At other times, the AS person was shown within a social situation in which they noticeably made another person uncomfortable. The construction was mobilised by speakers to draw attention to the social difficulties of an AS person. Sometimes the AS person used the construction themselves in an attempt to explain their difficulties in social interaction, so as to increase understanding of these, as the following examples illustrate:

(TV-b, Line 36) *RICHARD: There's a 'social dyslexia'. You can see other people but you can't read other people. You don't know what they are thinking. You don't know what they are thinking at all.*

(FLM-b, Line 83) *TEMPLE: 'People. I don't understand people. At least the people at school know I don't understand them – and some of them are my friends anyway.'*

Sometimes the construction was deployed via an on-screen depiction which appeared to illuminate the AS person as being socially incompetent and socially unaware. Particular examples portrayed the AS person as the 'butt' of their own social errors, providing amusement for viewers or readers. Depictions appeared to exaggerate social difficulties for dramatic effect, along with the heightened dramatisation of the reactions of other characters. All depictions of AS people in film, TV and fiction were seen to include this construction, indicating that the entertainment industry may find the perceived social awkwardness of an AS person to be one of the most readily transferrable societal constructions of AS; translating effectively into visual or fictional formats. In 'The Undateables' TV programme, Richard's 'social dyslexia' is constructed against a background of past footage in which he had unwittingly offended his past dates. These depictions appeared to be displayed for comedic effect. We can also see how a further instance of 'social dyslexia' is portrayed for amusement purposes in the below excerpt from the film 'Adam':

(FLM-a, Line 11) *[Beth approaches the apartment building carrying many heavy shopping bags. Adam is sitting on the front steps. They have a brief conversation and Beth decides to go inside]*

BETH: Well, I'll just be hauling these enormous grocery bags upstairs now. [hinting at Adam to assist her]

ADAM: Okay. [Adam is completely unaware that Beth was hinting that he should assist her. This is portrayed as an amusing moment for viewers.]

Sometimes depictions within film, TV or fiction showed the AS person as being rejected due to their 'social dyslexia', as two following examples will demonstrate. In the TV show 'The Undateables' Richard's date decides to leave due to his inappropriate behaviour:

(TV-b, Line 29) *'...Was that a chip you pinched, Richard, was it? ...Richard I'm going to have to go, sorry.*

Again, in the film 'Adam' Beth decides to leave Adam's company due to his inappropriate sexual question. These examples illustrate how part of the deployment of AS as a form of social dyslexia involves the dramatic reactions of others who have taken offence to the behaviour of the AS person:

(FLM-a, Line 84) *BETH...I had a really nice time last night in the park.*

ADAM: Were you excited?

BETH: What?

ADAM: Sexually, when we were in the park?

BETH: Um – uh no, not exactly.

ADAM: Well, I ask because I was, and I wondered if you were too. (Beth looks noticeably unnerved by Adam's question)

BETH: Thank you so much for the glass of water. I-I should, I should be going now.

ADAM: Because I said that thing about being sexually excited?

As demonstrated in the examples above, when deployed, this construction mobilises a discourse of social etiquette, where speakers are assumed to know how to behave and communicate when they are in the company of others. Speakers generally know what they 'can' and 'cannot' say and hence when someone does not conform to such expectations it can lead to confusion, amusement and ridicule from others. In the example from the film 'Adam' above, Adam would potentially argue that he is simply being honest when he asks about sexual excitement. This is seen as inappropriate however due to the existing discourse around social decorum. Similarly, Richard (above) has also breached expected social etiquette, much to his date's surprise and displeasure.

When AS is constructed as a form of social dyslexia we can suggest there may be certain subjective implications for the AS person depending on who is deploying this and in what circumstance. If deployed by the AS person themselves, they may feel aided by having a shorthand way to explain, or construct, their difficulties for others. They may also feel that the phrase 'social dyslexia' provides a clearer and less stigmatising indication of their difficulties, avoiding use of the term 'disorder' or 'syndrome'.

For family members, we can posit that when AS is constructed as a form of social dyslexia, that they may act as a social bridge, and seek to educate the AS person regarding their social difficulties, while simultaneously inviting the patience of others. Richard's mother, from a scene in 'The Undateables' appears to act as a social bridge for Richard, who attempts to explain the potential thoughts of others to Richard, along with providing guidance on how he should interact as a result:

(TV-b, Line 134) RICHARD'S MOTHER: *If you think they're looking uncomfortable in any way, then don't carry on talking about what you're talking about.*

The use of this construction amongst the general public may however have varied implications for AS individuals. Rather than using this construction as a way to increase their own and other's empathetic understanding of the difficulties AS people may face, they may instead share in the curiosity and amusement of dramatised depictions of the 'social faux pas' of AS people. This may provide viewers/readers with a reassurance of their own social 'normality' in comparison

to the depicted AS person. It may also lead to a narrow and potentially disrespectful view of AS individuals, serving to further limit their societal opportunities and social experiences.

Dominant Construction 8: A trait of criminality

(ON3-a, Line 5) *'...leading many to cast the 20-year-old gunman as mentally ill or autistic'*

NEWSPAPERS

(BS1-a, Line: 3) *'Gary McKinnon, the British hacker who is diagnosed with Asperger's syndrome.'*

This construction was found to be particularly dominant within one type of newspaper within the Newspaper subdomain: Online News. Although not dominant within Broadsheets, this construction was noted to also have a minor presence within that type of societal text. Within such documents, the diagnosis of AS was seen to have an association in the media with several US shootings. As such, AS was associated with criminality and 'psychopathic-type' murderous actions. The construction implied that AS may be a contributing factor in criminal and violent acts. It created the AS person as someone who may be more likely, than the general population, to commit extreme violence or other illegal acts. The construction is likely to also be related to the societal stereotype of autistic people as 'lacking empathy' and potentially has also gained impetus since the development of the E-S theory of autism (both were discussed in the Introduction), which suggests AS people are low in 'empathising', hence making harmful acts towards others seem more likely.

The construction was noted to be commonly achieved via association, in which the crime was subsequently linked to a person who has been diagnosed with AS.

Although a direct statement was usually not made, there was an implication of a causal link between AS and the crime. This was usually achieved via a continual association between the crime and statement regarding the individual's AS diagnosis. This implied that the AS diagnosis could essentially be used to explain the criminal act. Diagnostic characteristics were deployed in a manner that aided in portraying the individual in a criminal light.

Like many constructions of AS discussed so far, the construction of AS 'as a trait of criminality' also appears to be a form 'otherness'. Within this construction, the person with AS becomes positioned as the 'potential criminal' and 'the other' who sits in contrast to the 'non-criminal' and 'at risk' general public. The construction also evokes a discourse of morality, placing the AS person as an 'immoral' character who could therefore be assumed to act in a harmful and unempathetic manner towards others.

This construction appears to have evolved due to a society-wide anxiety about violent crime. Often in instances of violence, the reason for its occurrence is unclear. Due to an absence of environmental explanations for the criminal act, characteristics of the criminal's psychology therefore come under scrutiny. Associating criminality with a diagnosed AS person can be seen as an attempt to assign a medical reason for inhumane criminal actions. Speakers were seen to employ this construction as a type of rationalisation; perhaps a desire to believe that people who commit crimes are not 'normal', and must do so due to being 'disordered' or 'ill'. As AS is considered to be a 'disorder' it therefore fits this societal need for an explanation: the 'disordered' construction of AS is used to make sense of the crime. Examples of AS being implied as an explanatory factor for criminal behaviour can be seen in the following examples:

(ON2-a, Line 5) *'What has emerged in the aftermath of the Sandy Hook shooting is a picture of an odd, withdrawn and troubled boy. One law enforcement officer has said that 20-year-old Lanza had been diagnosed with Asperger's, a mild form of autism characterised by social awkwardness.'*

(ON3-a, Line 11) *'As director of security for Newtown board of education for 16 years, Richard Novia came into contact with Lanza almost every day. "Adam had*

mental disorders. That's pretty much out there already. Asperger's syndrome was one we knew about," he told the Press Association.'

This construction casts all AS people as potential criminals. Speakers attempted to further strengthen and justify the link between AS and violence by referring to particular characteristics of the diagnosis, such as social interaction and sensory difficulties. These were seen to be a salient aspect of the person's character that may have indicated potential criminal behaviour. The presence of unusual personal characteristics became tied to the diagnosis and implicitly used as an explanation for the crime. Examples of journalists using speaker's words that focus on unusual personal characteristics to justify a connection to criminality are as follows:

(ON2-a, Line 3) *'Connecticut gunman Adam Lanza has been described as "socially awkward", "shy", "a nerd" and "super smart". As a teenager he would scuttle from class to class, pressing himself against walls and clutching a black briefcase...'*

(ON2-a, Line 15) *'But I could always tell he was a super smart kid, maybe just socially awkward, something just off about him.'*

(ON2-a, Line 9) *'Gunman Lanza "socially awkward".'*

Each of these examples implies that due to such unusual personal characteristics, that we could nearly have 'seen it coming'. In other words, speakers suggest that the person showed 'markers' of potential criminality well before the event. Speakers appeared to re-examine the AS person's past behaviour in an attempt to make some sense of the shocking event. This would result in certain statements inadvertently suggesting that the characteristics listed here are potential warning signs of imminent violent behaviour. As a result of such associations and attempts to 'make sense' of the crime, any smart, shy or socially awkward teenager is increasingly likely to become cast as a potential risk to others (in turn increasing their sense of social difference from others).

This construction can have serious practical consequences for AS people. It could lead to fear and mistrust of AS people, which could result in alienation, rejection

and denial of societal and social opportunities. For example, due to the presence of this construction, someone who discloses their AS to a potential employer, may not secure employment. Anti-discrimination laws can be easily subverted by the employer who can simply provide a different reason for rejection of the AS applicant. Similar difficulties in gaining other societal opportunities are likely to occur when this construction is frequently available in the media.

Recognition of the harmful effects of this association appears absent across societal texts, until a single statement from the National Autistic Society (NAS) was located. After repeated articles appearing in the press, in which associations between AS and mass shootings were made, the following statement was released. It appeared in an article by Channel 4 news online in December 2012 entitled 'What made Adam Lanza kill 27 people?'. In the article, the journalist quotes a spokesperson for the NAS:

(ON3-a, Line 31) *'Unconfirmed reports that the perpetrator had Asperger's syndrome, a form of autism, have been circulating... we would urge everyone not to jump to conclusions or to conflate the actions of one disturbed individual with a whole section of society, or to make judgements about people with the condition.'*

Here we see how there is an attempt to discredit this arising construction of AS people as potential criminals. The presence of this public address, and its deployment by the journalist, is evidence of the growing deployment of the 'criminal' construction within the media, provoking the NAS's concern for AS people and their families.

This construction also has serious implications for AS people in terms of subjectivity. Being cast as a potential criminal may lead to anxiety, and a sense that they are further misunderstood, ridiculed and rejected by others. The AS person may fear persecution and unfair judgement due to their diagnostic status evoking distrust in others, whether or not this leads to a noticeable change in the behaviour of others towards them. Similarly, this association is likely to be very concerning for parents who may become anxious that their child may be feared and avoided, due to AS being perceived as potentially deterministic of psychopathic, anti-social and dangerous behaviour. Respect and acceptance of an AS person is unlikely when this construction is prevalent.

Finally, when deploying this ‘criminal’ construction, society becomes cast as the passive potential ‘victim’ of the AS person. This construction casts many potential gunmen among us. It is an anxiety-provoking construction that evokes distrust and fear of AS people. Therefore when deployed, it may lead to a subjective sense of anxiety for general members of the public. This may arise when directly interacting with an AS person, or indirectly by simply knowing that AS people exist. This construction creates AS as an unpredictable ‘risk to the public.’

1c) Constructions unique to Community Interviews

Within the study, there were two constructions that were found to be unique to the Community Interviews master domain: AS as ‘an acceptable difference’ and AS as ‘an individual experience’. See figure 16 below. Each of these Community-unique constructions will be discussed in turn.



Figure 16: Constructions unique to community interviews.

Dominant Construction 9: An Acceptable Difference

(PAR-a, Line 190) *'I would love also for, you know, the world's changing a lot and I would...I feel grateful that we are living in that time whether what's normal is being broadened out really...or people who aren't normal .hh are much more accepted for who they are and so I'm hoping the world will turn...so I'm hoping that change in society will continue and his confidence will grow, that he will be happy with who he is'*

(PAR-b, Line 110) *'Um I think in the States now they're making big strides in terms of the neurodiversity movement, [yeah] (2) and autistic advocates that're really trying to change the conversation around in society and I I think they're doing remarkable work and I, and I'm very appreciative of the fact that they're sort of laying the foundations you know.'*

COMMUNITY INTERVIEWS

(TEA-b, Line 413) (TEA-b, Line 395) *'...there's a whole group who just love him for him, who play with him, who have an expectation of him which is quite good, because they, they don't treat him differently...There's a **real phenomenal** acceptance in **this** class in the way there wasn't in the other class.'*

This dominant construction was unique to Community Interviews. It was used in all interviews to varying degrees, with all participants indicating some form of 'acceptance' of AS. This construction did appear also on one occasion within the Psychology type (Professional Articles) but as it was not a major construction shared across types, it was not considered representative of the Professional Article domain (but possibly emerging).

This appears to be an impassioned construction, which was used in a very conscious and active manner by the participants – indicating it was a construction that participants had thought a great deal about, and that they may wish to contribute to increasing its prevalence. It was a very prominent and unique construction, within Community Interviews, making these distinctly different from Societal Texts. (Potential reasons for this will be explored at the end of the chapter in the Summary of Analysis). This construction appeared to be related to the views of some autistic people and advocates, as discussed in the Introduction chapter: neurodiversity and the social model of disability.

The construction was deployed via several means. Firstly there were direct statements describing ‘acceptance’ (TEA-b) and ‘appreciation’ (PAR-b) of the differences found within the AS person. Deployment was also achieved indirectly via a general attitude that rejects an adherence to ‘normality’, and discussion of society’s potential to ‘broaden’ (PAR-a) what is and is not considered to be ‘normal’. Finally, this construction was also deployed via participants’ discussions of the wider political neurodiversity movement.

This construction was unlike any of those in the study so far, strongly drawing on a wider discourse of neurodiversity as well as the discourse of the social model of disability. In the examples provided above, participants were observed to specifically construct the ‘difference’ in the AS person as ‘acceptable’. The purposeful deployment of this construction suggested that some speakers considered differences in neural development or functioning to be part of ‘natural human diversity’, which did not necessarily need to be seen as a ‘disorder’. As the Introduction outlined, this discourse has direct links with civil rights movements, which seek to establish neurodiversity as a protected aspect of personhood. Use of the neurodiversity discourse was particularly apparent with parents and was seen to actively encourage respect for AS people, as the following example from an interview with a parent illustrates:

(Par-b, Line 122) *‘... so that childhood isn’t over-medicalised you know...hh that there’s, scope for difference. And not just tolerance but a real fundamental .hh appreciation, beyond just acceptance.’*

For other participants, especially speech and language therapists, the 'acceptable difference' construction appeared most related to a similar discourse - the 'social model of disability'. As the Introduction discussed, this is a discourse that has come into public awareness due to research and changing practice within the 'disability' field (Oliver, 1983). In this discourse, the disability (or difference) observed in the person, is due to difficulties present in the environment. This discourse seeks to recognise that disability only occurs in certain contexts where the needs of the person are in contrast to what the environment can offer. It puts the responsibility on all members of society to meet the needs of the person, and hence resolve the disability. This willingness to 'accommodate' the persons' needs, and 'make it work for them' was especially observable in the 'talk' of the speech and language therapists who took part:

(SLT-b, Line 314) *'...all the children I've worked with, high functioning, they're functioning quite well...as long as **we** as a society adapt **our** way of thinking I think...to allow everyone to live their lives.'*

When this construction was deployed within a 'social model of disability' discourse, it assumed that all parties had a responsibility for addressing the aspects of the environment that may disable another person: AS becomes a 'shared responsibility': removing responsibility for any difficulties the AS may bring, away from the individual and instead placing it on all members of society. Constructing AS as a shared disability was then seen to direct the actions of individuals who are expected to actively reflect this 'sharing'. This was demonstrated in the following examples from an interview with a speech and language therapist:

(SLT-b, Line 354) *'I, I think it's about **us** as the **society** to bend over backwards to accommodate people's differing needs... and making it work for **them**.*

(SLT-b, Line 378) *I just think that doesn't take much*

NW. *No, it doesn't*

SLT-b: *On our behalf really.*

NW: *Yeah*

SLT-b: *You would do the same for a person in a wheelchair.*

NW: *Yeah, exactly, yeah, that sounds like, you know*

SLT-b: *That's my ideal vision.*

This construction, situated in either discourse, attempts to create a subject position for the AS person as an 'equal other'. The construction therefore seeks to explicitly address the negative aspects of 'otherness' that may be experienced by AS people. When deployed, this construction has the potential to remove barriers and limitations across many societal domains, for AS people. It also has the potential to do the same for all people with other neurological differences or disabilities. When the construction is drawn from a neurodiversity discourse it appears to actively seek respect for the AS person as a 'natural' human being. By doing so it may ensure that AS people are entitled to all the same rights and privileges as all members of society. Earlier in this chapter, an example was given from a BBC article which reported that a Mexican man had to fight for many basic societal rights that other members of society were entitled to:

(ON1-b, Line 6) *'It [governmental legislation] banned him from doing simple tasks by himself, such as applying for a passport, because of his condition....Mexican legislation makes straightforward tasks, such as buying a mobile phone, enrolling in university or applying for a driving licence, very difficult for people with Asperger's syndrome or other forms of autism.'*

After a lengthy court battle some rights were restored to the man. This was achieved via a demonstration that Mexican legislation had violated the United Nations Convention on the Rights of Persons with Disabilities. The disability rights movement is closely related to the autistic rights movement, which aims to see the autistic community is recognised as a minority group, as the following examples illustrate:

(ON1-b, Line 8) *'The groundbreaking ruling is expected to have wider implications for the rights of people with autism in Latin America, says the BBC's Will Grant.'*

(ON1-b, Line 17) *'They [the lawyers] have asserted our rights and I believe this is a great step forward', he said.'*

There are other practical implications for the AS person when AS is constructed in terms of a neurodiversity view. It encourages the acceptance of autistic behaviours, rather than expecting autistic individuals to learn to imitate others.

When applied therapeutically, the neurodiversity model assists individuals to develop ways to live in society as they are. As discussed in the Introduction chapter, this would be more inline with a TEACCH model rather than an ABA model of therapy. In the following interview, we can see the neurodiversity view in practice when a parent speaks about their concern over certain autism therapies:

(Par-b, Line 156) *'um and I, yeah I sometimes I, I wonder about the sort of therapies that we, like, ABA, something that's very sort of intensive, that may in some ways, in some respects help, and in some respects actually drum out the uniqueness, the soul, the vibrancy of the individual. And I can understand why parents rush towards these, you know, therapies that are more standard like ABA and also you know, things that are really wacky and I'm absolutely against, you know, the idea of using our children as sites for experimentation just because we can't deal with the fear of our child having a diagnosis.'*

When the construction is deployed within the social model of disability there are likely to be other practical benefits for AS people, such as creating inclusive and accommodating environments, as advocated by the speech therapist when she speaks about 'bending over backwards' in example above.

The 'acceptable difference' construction may therefore lead to some positive subjective experiences for the AS person. Rather than being considered an out-group member, the concept of out-group becomes irrelevant, as despite any differences, all are considered 'equal'. Under this construction, any difference that was noted in the AS person, was not related to negative self-worth, and therefore did not warrant rejection or ridicule from others. Hence, subjectively speaking we can posit that for an AS person, to exist within this construction may be greatly de-pathologising, as concepts of normality do not define their worth, value or social acceptance. Within this discourse the AS person may experience freedom and acceptance by others, and once internalised, there may be a greater likelihood of genuine acceptance of oneself.

For members of society, this construction can encourage diversity while also disallowing fear, ridicule and rejection of others. Under this discourse, people may exist 'as they are' and to be accepted on a deeper, more fundamental level of humanity. Subjectively this may enable feelings of self-acceptance and care for all members of society, regardless of their form of difference.

However, there may be potential difficulties when a neurodiversity discourse is deployed, especially for those who most strongly advocate a medical/disordered approach to AS. If AS is considered to simply be part of human diversity, will the same level of support continue to be available for those with AS who feel they need this? The idea that someone's 'way of being' is part of natural diversity can perhaps create situations in which a person's experience of disability may not be recognised or acknowledged and therefore appropriate support may not be provided. Subjectively speaking, if medical discourse is entirely abandoned in favour of a purely neurodiverse approach, for some AS people and their families this may create feelings of vulnerability in terms of obtaining support and understanding regarding the difficulties and sense of disability an AS person may face on a daily level.

Dominant Construction 10: An individual experience

(PAR-b, Line 38) *'Yeah as soon as I got the, as soon as we had the diagnosis confirmed yeah, I mean for me it was right, let's buy all the books in the world (laughs), just you know find out as much as we can so that we can support him. (1) And I think then it became a balancing act of um (1) of ah sort of having that information but not viewing everything that he did through that lens.'*

COMMUNITY INTERVIEWS

(GP-a, Line 44) *'...um because I think even within Asperg- Asperger's they have different, people have different levels of functioning.'*

Within Community Interviews AS was commonly seen to be constructed as 'an individual experience'. Although participants were aware of the diagnostic criteria

and typical characteristics related to the diagnosis, these seemed to remain in the background of the interview, and were barely spoken of. Each interviewee was asked what they '*knew about Asperger's*', providing them with a place to speak about AS generally. I was interested to see to what degree they spoke of AS in a 'collective' or homogeneous sense. Each participant briefly outlined the diagnosis, but very quickly moved on to individual idiosyncrasies of the person they knew, and particular instances they had experienced with them. They spent very little focus, if at all, on collective conceptions of AS. Participants appeared to speak about the person they knew, while holding the diagnosis 'lightly'.

This construction was deployed in several ways: via explicit statements describing AS people as 'individual'; as well as a noticeable preference to avoid responses to interview questions that involved generalised statements about AS people. For the participants, the construction of the person as 'an individual' was much more at the forefront of their responses than any form of 'homogeneous/collective construction'. This made data from participants in Community Interviews very different from any form of data obtained from Societal Texts. Possible reasons for this will be explored at the end of the chapter in the Summary of Analysis. Deployment of the 'individuality' construction did not appear to be related to any form of denial of AS, but rather conscious assertion that AS people vary greatly in their characteristics and experiences.

The construction of AS as 'an individual experience', like the 'acceptable difference' construction, appeared to draw on a different discourse than seen in the study so far – a discourse of 'individuality'. It was a discourse in complete contrast to the homogeneous constructions that created forms of 'otherness'. Here the individual view of a person held sway over homogeneous group membership. It acknowledged, that although people may share a diagnostic label, their experience of this was also very individual. This 'individuality' discourse appears most related to the 'internal views on ASD' discussed in the Introduction chapter. In the below example we can see how a parent showed awareness of the individual autistic experience of their child:

(PAR-b, Line 68) '*He's his own person, he'll uh .hhh uh he creates sort of **fascinating** words, he's you know, his own words that will describe things that*

*don't exist already, you know what I mean **that actually**, it's like "oh yes, that's a very particular thing and it's **right** that there should be a word for this", you know.'*

Similarly, a speech and language therapist acknowledges that each AS person is different:

*(SLT-b, Line 66) '...I would feel that this child I'm thinking about would think, "well there's nothing wrong with me thinking like that. That that is annoying me, I want that cleaned up before I can (1) come into the classroom and work" ...Yeah, but then I know **other** children that would get quite cross with themselves for doing that.'*

As the above examples demonstrate, this construction of AS attempts to seek understanding of the unique aspects of the AS person and by doing so counteracts conceptions based on group membership alone. It actively limits the risk of someone's identity being consumed by stereotypes associated with a diagnostic label. Speakers using this discourse appear to value, and assert individuality above subscription to a label. There was a sense that the differences between people sharing a label are just as important as any similarities.

This construction was observed to position the AS person as an autonomous member of society, who, like all others, is not defined by a diagnostic conception or stereotype alone. By doing so the AS person may be less likely to be at risk of having their needs and difficulties 'assumed' by others. Interviewees also mobilised the construction when they spoke about how the individuality of the AS person they knew was often not acknowledged, which resulted in certain practical consequences. In the below example, a parent discusses how the diagnostic label can sometimes get in the way of the recognition of the child's individual needs:

*(Par-b, Line 172) '... I've always been very um, .hhh just very um (1) on top of things when it comes to sort of meeting the practitioners that he's going to be working with, you know there are times where I've absolutely, you know, stepped in and said that this is not the person that he **needs** you know, because of the way that .hhh they may be with him, you know, don't patronise with him, don't do Makaton with him, he can speak. [Laugh] Not, well you know, it's just kind of*

*instead of seeing the person in front, they're like, oh right, this kid is autistic, this is how I will **be** with this child.'*

In a similar example, a speech and language therapist expresses how, due to their diagnosis, some professionals in the past had utilised a standard approach towards the treatment of AS children at school:

(SLT-b, Line 234) *'And I think you know in the past...children on the spectrum would be **forced** to go out and make friends in the playground, which is like their ultimate worst **nightmare** in often .hh cases, and actually (1) is that really helpful? Mmm no, probably not.'*

We can also identify the effect this discourse can have, at a societal level, when we consider what can occur for AS people when it is completely absent. On Dec 29th 2014, the Russian government sparked outrage when it decided that a diagnosis of a 'mental and behavioural disorder' (as listed in the World Health Organisation's ICD-10) was a justifiable reason for disqualifying individuals from having a driving licence. Asperger's was included.

Such examples show how considering people to be defined by group membership has the potential to create situations in which their opportunities are limited, their needs assumed, and their human rights can be interfered with. This was also the case with the Mexican AS man (referred to in construction 1: a disorder.) He had automatically lost his societal rights due to his diagnostic group membership. Therefore the construction of 'individuality' removes barriers to opportunities that would have otherwise been compromised due to a diagnosis of AS. This construction allows the AS person to partake in society as an autonomous individual. Therefore recognition of individuality would ensure 'personalisation' of support and make 'blanket' removal of civil rights unlikely.

Subjectively speaking this discourse is likely to remove the limiting assumptions an AS person may often experience due to their diagnostic status. This may therefore be a very freeing discourse for AS people, in which they are less restricted by limiting stereotypes attached to the label. They may feel that others are able to 'see them for them' rather than a collection of well-known diagnostic stereotypes. Utilising this discourse may also have benefits for general members of society. Within this discourse, each person's individual needs, as well as their

strengths, are acknowledged. Assumptions are not made on behalf of others due to group membership of any kind: each person can be met on his or her own terms.

However, for some AS people, there may also be certain difficulties that accompany this discourse. Some AS people may take most comfort from collective conceptions of AS, therefore being identified primarily as an individual may create a sense that they are personally responsible for the particular disabling aspects that they may experience. This may create a sense of personal responsibility for their AS, that may lead to some stress and difficulties with self-esteem.

Summary of Analysis

By applying FDA, via Willig's six steps, analytic findings have highlighted four dominant constructions that were shared between the master domains of Societal Texts and Community Interviews. AS was constructed as: 'a disorder', 'a difference', 'a predisposition for high intelligence' and 'a problem'.

When constructed as a lifelong 'disorder' we could see that help and support could be provided; however this was also accompanied with the potential restriction of human rights and certain forms of social control. When constructed as 'a difference', this could have varied affects for the AS person. Although speakers in interviews did not negatively evaluate the 'difference' this was not the case in societal texts where AS people were sometimes cast as the 'other' and the 'out-group' and placed in an unequal position of power. The construction of AS as 'a predisposition for high intelligence' was another form of 'otherness' with which 'high intelligence' was used by speakers to counterbalance the perceived difficulties associated with AS. When constructed as 'the problem' the AS person, their family, and those around the AS person became 'a victim' engaged in a 'struggle' or 'challenge'.

The analysis also revealed several constructions unique to each master domain. Within Societal Texts there were four unique constructions. AS was constructed as: 'an observable weirdness', 'a homogeneous identity', 'a form of social dyslexia' and 'a trait of criminality'. Within Community Interviews there were two unique constructions: AS was constructed as an 'acceptable difference' and as an 'individual experience'. A diagrammatic representation of the main findings is provided again below in Figure 17.

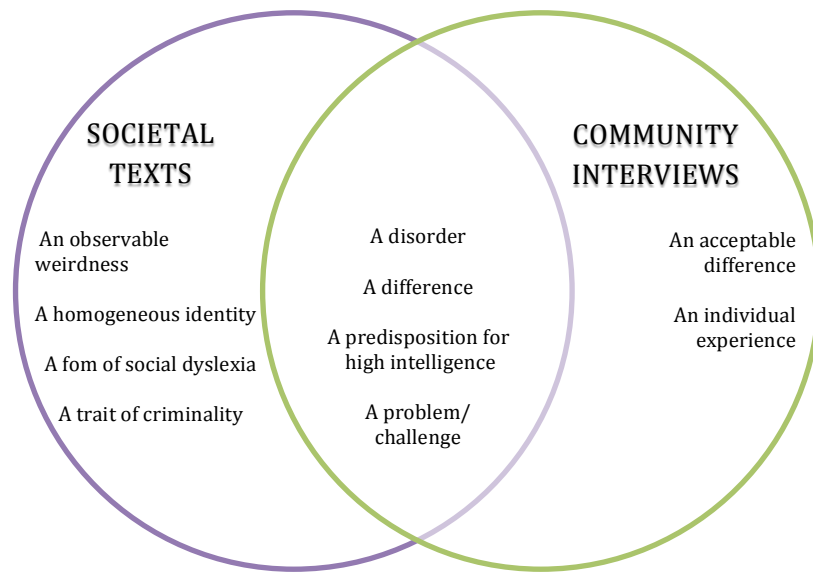


Figure 17: Shared and unique constructions. A diagram showing which constructions were shared with Societal Texts and Community Interviews, and which were unique to each master domain.

An overview of these findings therefore indicates that there were unique constructions within each master domain. Despite the medical model of AS being at the core of each domain (sharing the 'disordered' construction), it was the additional accompanying constructions within each domain that shaped how it was used. It was noted that constructions unique to Societal Texts involved 'homogeneous' views of the AS person, with forms of 'otherness' that were likely to contribute to limited possibilities for action, and subjective experiences of disempowerment, for the AS person. Within newspapers especially, constructions of the AS person as 'weird' and 'criminal' were common. Speakers often utilised the medical model of AS as 'proof' of an inherent 'biological fault' that justified certain forms of alienation, ridicule, denial of human rights, or associations with criminality.

In contrast, within Community Interviews, the medical model view of AS was not accompanied by negative evaluations of the AS person, and did not justify potentially forms of action that could limit opportunities for AS people. Community interviews also involved two constructions not yet observed in the other master domain. The constructions of AS as 'an acceptable difference' and as 'an individual experience' appeared to offer the potential to counteract many of the

negative and limiting effects of the 'homogeneous group', 'weirdness' and 'criminal' constructions. These actively respectful constructions were seen to have the potential to serve in an empowering and protective manner for the AS person.

The difference in the unique constructions found within the two master domains was a surprising result. I had expected to find the unique societal constructions to also be present, at least to some degree, within interviews. Similarly, after analysis I could see that neurodiversity and individuality discourses were strongly absent from societal texts. The reason for this difference could be related to several factors. Firstly, societal texts, by their nature, are very different to personal interviews in that they more frequently deal with societal wide concerns and interests. This may invite more 'homogeneous' views of AS. Secondly, community interviews were conducted with people who 'know someone with a diagnosis of AS' and therefore this may invite more focus on a particular individual and their unique idiosyncrasies. However, questions about AS as a collective were also equally present within interview questions. These aspects of the design alone are unlikely to explain the stark difference between the two domains, as it would be likely each domain would have also reflected some use of the other constructions, even to a small degree. This was not the case. Concepts of neurodiversity, in particular, were clearly absent within societal texts.

Such findings indicate, within the texts collected here that AS people were commonly described in terms of unhelpful stereotypes within wider society, and that via such sources, AS people are more at risk of reduced opportunities and negative subjective experiences. Within the community however, participants' talk indicated that they had found ways to counter-balance these concerns. Although they were aware of societal constructions, they chose to draw on those that were considered less limiting, supplementing the shared societal constructions with particular discourses focussing on care and respect.

Discourse development

When looking at the pattern of discourses deployed across the study, there appeared to be a 'developmental' relationship between certain discourses. What

first began with constructions of 'weirdness' and 'difference' often became reconstructed as 'disorder'. The medical model was mobilised in order to 'make sense' of difference or weirdness. It appeared to often come into use to address the rejection and ridicule that results from the 'weirdness' construction. Once 'made sense of' in medical terms, rather than ridicule and rejection, treatment and support was invited. But the development of discourses of AS then continued further. Newer discourses of 'acceptable difference' and 'individuality' appeared to arise when speakers wished to address the limitations of the medical 'disordered' construction. Therefore, the pattern of discourse 'development' noted in the study was as follows:

Weird/different → disorder → acceptable difference/individuality

Observation of this pattern across the study suggests that certain discourses have arisen in response to others. In which case, 'acceptable difference' and 'individuality' constructions exist 'because' of and 'in response to' the 'disordered' construction. Similarly, it may follow that the 'disordered' construction arose in response to an older 'weirdness/eccentricity' construction that would likely have been common throughout the first part of the 20th century, before the diagnosis of AS had emerged. Each newer discourse was defined by, and in opposition to, an earlier discourse.

A pattern such as this shows us that any 'one' construction inevitably has its limitations. No one construction located here has appeared to offer both justification for support and treatment, as well as full consideration of individuality and acceptance. Speakers across the study appeared to mobilise multiple discourses in order to most suitably construct AS for their desired purposes. The development of discourses appear to reflect the changing attitudes to AS, and an increasing need for the recognition and relief from the limitations of older discourses.

Overall, reflection on the findings revealed that participants in the community were observed to draw on a wider collection of discourses, compared to individual societal texts. Each participant referred to multiple shared societal constructions, representing different 'truths' on AS. Participant's talk therefore appeared to represent a pluralistic awareness, and mobilisation, of constructions.

Participants also purposefully mobilised particular discourses that were perceived to be the least limiting and had the most potential to be empowering for the AS person. By considering the potential subjective experiences related to each construction, this pluralistic approach employed by participants was seen to provide the AS person with multiple subject positions which would therefore enable access to both support and a sense of empowerment, alongside recognition of their individuality.

5. IMPLICATIONS AND CONCLUSIONS

How is AS currently constructed?

The research question of this study asked: how is AS constructed currently, and how does this shape the 'package deal'? It was proposed against a backdrop of 21st century professional perspectives and societal stereotypes of ASD, along with further consideration of the 'difference' versus 'disorder' debate surrounding AS and HFA. Qualitative research and social constructionist perspectives on AS were also considered. Via a two-level design, this discourse analysis has resulted in 10 dominant constructions of AS considered to be prevalent in the UK currently. These constructions will now be discussed in light of the research on AS presented in the Introduction chapter, exploring how these findings may have challenged or corroborated past research. Before doing so, it must first be noted that, as is the case with qualitative research, the findings here have not derived from a generalisable sample and therefore may not necessarily be representative of all community populations or all societal texts. However, these findings may be considered to contribute to a richer picture of AS; being one of many possible interpretations of the particular data that was collected.

From the interpretation of data gathered here, AS appeared to be many things, to many different people, usually depending on what the speaker sought to achieve. When seeking to communicate the difficulties that AS people experience, the diagnostic criteria was often referred to, mobilising the 'disordered' construction of AS. These diagnostic terms were drawn from the professional perspectives discussed in the Introduction. Speakers were seen to use this construction to 'make sense' of an unexplainable difference. This finding linked to the rationale at the beginning of the thesis, in which the benefits and difficulties of a diagnosis were discussed. Speakers reported a sense of 'relief' accompanying their diagnosis. Hence the data here appeared to corroborate other reports that a diagnosis can have a beneficial 'sense-making' function for the AS individual and family.

Similarly, analysis of the 'disordered' construction indicated that the term 'disorder' created negative forms of 'otherness' that carried some risk for stigma. The rationale of the thesis discussed stigma as a potential difficulty that a diagnosis can bring. The data seemed to corroborate this concern and further

illustrate that when an AS person is judged as 'deficient' certain societal rights and limitations could be imposed. Consideration of the 'disordered' construction also illustrated how the diagnosis may not always solely serve the AS person, as social constructionist critiques cited in the Introduction had suggested. A parent within a newspaper article indicated feeling relief once their child was diagnosed. The child's behavioural difficulties could now be considered to be due to the 'child's disorder' rather than a failure in parenting. Therefore the reported benefits and limitations taken together support the concept of the diagnosis of AS being a 'package deal' (Link and Phelan, 2013), the effects of which appeared to vary for each individual.

Across the study, speakers described the AS person as 'different'. When taken in light of our discussion in the Introduction chapter regarding the 'disorder' versus 'difference' debate, AS appeared to be constructed as both. Both of these constructions were common to each master domain across the study, although the 'disordered' view was most widely in use. The deployment of the 'difference' construction in societal texts did not appear to offer any particular benefit to the AS person, as often it was associated with a negative judgement. However, in community interviews, the 'difference' construction was not related to a devaluing of the person. Participants spoke about supporting the difference rather than trying to resolve or change it. This was reminiscent of the desire expressed by some AS people observed in online blogs, who were frustrated by assumptions that AS was a disorder that needed to be remedied. When used in this explicitly supportive way, the 'difference' construction could be seen to offer some relief from a pathologised view of AS.

Analysis also indicated that when seeking to share a personal narrative of struggle, a construction of AS as a 'problem' was deployed. AS people were seen to share their struggle, attempting to increase the understanding of others. Their descriptions of individual sensory and social difficulties resembled the internal views of ASD as offered by autistic writers, as well some findings from several qualitative studies that were presented (each discussed in the Introduction). For professionals, the way the problem was defined guided specific actions towards the AS person. For example, texts suggested that, in psychology, AS was constructed in line with the weak central coherence theory (as discussed in the Introduction). AS was a 'problem seeing the big picture'. By constructing the problem in this way, particular interventions aimed at improving wider-context

focus (zoom in, zoom out guidance), were proposed.

The construction of AS as a form of 'social dyslexia' was seen to contain descriptions of AS in terms of the professional perspectives that were discussed in the Introduction; notably that AS is a deficiency in Theory of Mind. Interestingly, rather than being described by professionals, this construction was often mobilised from an internal perspective, by the AS person who may be seeking support and understanding for their difficulties in reading other's minds.

Analysis of texts also suggested there were several prevalent constructions that are likely to shape the 'package deal' of AS further. Speakers in societal texts were seen to construct certain undesirable AS characteristics or unsocial behaviours by deploying a construction of 'weirdness' or 'criminality'. These constructions appeared to be related to the societal stereotypes discussed in the Introduction i.e. people with autism are 'odd' and 'lack empathy'. Hence the presence of these constructions indicated that these societal stereotypes are indeed in action across society currently. In fact there may be a possibility that the criminality construction gained impetus with the introduction of the E-S theory of Autism (also discussed in the Introduction). In contrast to these constructions of AS in terms of undesirable characteristics, a construction of AS as being a 'predisposition for high intelligence' was noted. This indicated that the societal stereotype of the AS person as possessing savant or genius abilities is clearly prevalent at this time, and is considered as a positive 'upside' to AS.

Finally, the 'acceptable difference' construction identified in community interviews drew on neurodiversity and the social model of disability, as discussed in the Introduction. This construction was not present within societal texts, but was very prevalent at a community level. This suggested that people in the community had a strong need for these discourses, but that this may currently be under-represented on a wider societal level. Although the interviews were drawn from only one community, it means that they are non-generalisable, however, it does not mean that they are unimportant. It is hoped that these more empowering discourses of AS may be something that newspapers and professional articles will soon begin to reflect and incorporate into the societal-wide 'speak' of AS.

How do these constructions shape the 'package deal'?

The nature of various discourses surrounding AS/HFA have important real world implications. Discourses were viewed to be intimately intertwined with societal power, civil liberties and social respect. However, limiting discourses do more than just limit our societal opportunities, they may also structure our subjectivity. Harré and Gillet (1994) pointed out that discourses can be both public (expressed within a social context), and private (as thought). By this reasoning, subjectivity is created within public discourse. As discourses become internalised, they come to constitute and structure our thought, and hence our subjectivity. In the case of an AS person, these discourses shape what they come to learn and feel about themselves. It is therefore these discourses that inevitably shape the experiences of people who hold an AS diagnosis.

Holloway (1984; 1989) argues that the subject positions within a discourse not only guide social action, but also shape internal experiences. She looked at positionings available within discourses and the implications of these on subjectivity. She demonstrated how speakers are 'placed in relation to each other through the meanings which a particular discourse makes available' (as cited in Harré & Langenhove, 2003, p. 16). Therefore, in essence, subjectivity becomes a property of discourse. Similarly, Burr (1995) describes how subject positions, when permanent and enduring can become internalised. Therefore the ways in which we position others, and ourselves within discourse is integral to subjective experiences.

In this study, the AS person was primarily positioned as the 'disordered', passive recipient of services and support. When positioned as 'disordered' help and support was available, but when translated outside of 'helping professions' there were also real world limitations in terms of power and civil rights. Therefore, subjectively speaking, when situated within a medical discourse, an AS person may feel supported but equally disempowered and 'faulty'.

The AS person was then shifted through various other subject positions, by speakers seeking to achieve further aims. Within interviews, speakers sought to care and protect the AS person, re-positioning them as 'acceptably different'. This enabled a potential sense of self-acceptance and empowerment for the AS person. In some societal texts however, AS people became re-positioned as

potential criminals. This had the potential to be damaging to all who share this label, evoking distrust and fear in others. Subjectively, this positioning this may create a sense of alienation and rejection.

Via recognition of these various subject positions, an intimate link with subjectivity can be seen. As discussed in the Introduction, Mead (1934) was among the first to note how our 'self' develops via understanding how one is treated, or we could say positioned, by others. Scheff (2005) called this the 'self looking glass' through which we can view how we are evaluated by others. Limiting views and stigmatising societal perceptions are likely to become internalised by the individual (Martz, 2004), compromising well-being and psychological security. Limiting discourses can therefore not be dismissed: they should be recognised and addressed. From this point onwards this thesis will consider potential ways to do so.

Where do we go from here? From observer to action

A social constructionist discourse analysis may assist us to 'deconstruct' dominant discourses. We can expose previously hidden power relations and illuminate the effects of these for subjectivity. As we can now see that it is the available subject positions that shape subjectivity, we are in a better position to address this. It seems clear to see that we must work to challenge unhelpful positionings. But what do we offer in their place? Which discourses should we ourselves make available, and work to advance within society? How do we know the best course of action to take?

As it is us as human beings who construct ourselves, then in theory it would be possible to re-construct ourselves and others, enabling more facilitative constructions (Burr, 1998, as cited in Parker, 1998), but in practice it is difficult to simply discard unhelpful and limiting constructions. In fact, translating social constructionism into action has always been difficult. Potter (as cited in Parker, 1998) suggested relativism is a kind of non-position, a radical form of scepticism in which reality can never be determined and where all claims to truth are challenged. This can lead to a form of paralysis, or non-action, where one way of talking is considered no more valid than another. So if relativism is the pitfall of

applying social constructionist thinking, where do we go from here?

The data obtained from participants in the study has provided a useful starting point for reflection. Interviewees were seen to use multiple discourses, taking many different perspectives on AS: a pluralistic conception of AS. This is not dissimilar to a social-constructionist approach to knowledge. Although each participant referred to many shared societal discourses on AS, they favoured discourses that created strongly empowering subject positions for the AS person. Therefore, participants appeared to be 'pragmatic' in their preference for mobilising certain empowering discourses. They consistently focussed on discourses that could subjectively benefit and 'work best' for the AS individual. Pragmatism as applied here was seen to have great benefit in terms of subjectivity for AS people. Similarly, a social constructionist stance on knowledge could find relief from a paralysed non-position via the application of pragmatism. Rather than withholding from all forms of action due to a complete abandonment of any 'ultimate truth', we can instead choose to apply a 'pragmatic truth' i.e. a truth that works. By doing so, a social constructionist critique can move from 'observer' to 'action'.

What also became evident from community interviews, was that the constructions chosen pragmatically, and in benefit of AS people, were also those based on a strongly ethical stance. Discourses of 'neurodiversity' and 'individuality' indicated strong humanistic undertones, which prized the AS person, undefined by objective concepts of 'normality'. An actively non-pathologising and humanistic stance is also at the core of counselling psychology's value base and would therefore also be required to inform any course of action we choose to take.

The ethical stance reflected by participants here is particularly well articulated by Levinas' (1969, 2003) concept of 'welcoming the other ' (as cited in Cooper, 2009; Cooper & McLeod, 2011). Levinas considers that the essence of any ethical relationship is openness to the diversity of others. This goes beyond willingness to accept the other, to develop a prizing of and a deep respect for all people in their uniqueness. We must recognise that we cannot make people 'same' and will therefore not attempt to squeeze them into constructs and beliefs that may problematise their differences. Participants in the study were clearly observed to 'welcome the other' and had sought out and mobilised discourses in aid of this ethical position.

And so, by starting with a social constructionist critique, I have now chosen to apply both pragmatism and humanistic ethics, to guide these findings towards action. The following section will attempt to bring the findings of this study into recommendations for counselling psychology clinical practice.

Recommendations for practice

Pluralistic discourses deployed in the community, involving neurodiversity and recognition of individuality, appeared to offer the AS/HFA person multiple subject positions which provided them with the best potential for support and empowerment. For clinicians, and wider society, using a pluralistic and ethically grounded approach, such as this, could provide individuals with access to multiple helpful discourses while also supporting and respecting individuality and acceptance of difference. By providing access to multiple discourses, and favouring a 'pragmatic truth', practitioners can ensure AS people can take up subject positions that 'work for them'.

In addition, a pluralistic approach to practice emphasises a humanistic ethical stance to 'welcome the other', ensuring that what is chosen 'pragmatically' is also done so in ethical service of the client. This thesis therefore makes a recommendation for a pluralistic approach to practice as a potential way in which to address 'the package deal' of AS. As was demonstrated by participants in community interviews, pluralism encompasses a philosophically 'pragmatic truth' alongside an ethical approach to 'welcoming the other'. See Figure 19 below.

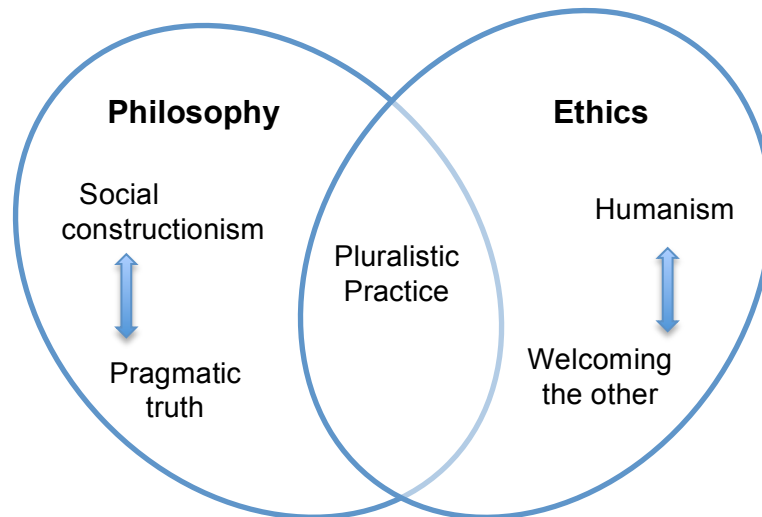


Figure 18: Philosophy, ethics and the findings: the findings of this study have been considered in terms of both philosophy and ethics, leading to a recommendation of pluralistic practice.

By working pluralistically, rather than prioritising our own dominant discourses, it is hoped that we as practitioners, could assist AS people (and perhaps those with other diagnoses) to best negotiate the ‘package deal’. A pluralistic approach to practice, in relation to these findings, will be outlined below before further recommendations will be made for work to improve the ‘package deal’ at a societal level.

A pluralistic perspective to practice

As the findings of this study show, different ‘truths’ and ways of speaking have consequences. What discourses achieve support, and get things done? What discourses are protective and empowering when that is what is required? For each person, and within each context, the discourse that could most benefit them will differ. Recognising this is key. What is a ‘useful truth’ for one person may need to be very different for another. It is by adopting this recognition of diversity, and facilitating access to ‘truth’ based on our clients’ values, that we could be most effective within our practice.

The practice of holding and utilise multiple discourses, and 'truths' can be described as a 'pluralistic perspective' to practice. Cooper and McLeod (2011) state that there are two underlying principles required to apply a pluralistic philosophy to practice:

1. Lots of different things can be helpful to different clients
2. If we want to know what is most likely to help clients, we should talk to them about it (p. 6)

A pluralistic perspective therefore suggests that any one question can have multiple plausible, but also conflicting answers (Rescher, 1993). Inline with social constructionist thinking there is a 'belief that there is no one, privileged perspective from which the "truth" can be known' (Cooper & McLeod, 2011). Pluralism therefore supports multiple discourses. Practitioners are encouraged to work pragmatically, basing their therapeutic decisions on what works best for the client, while also utilising a strongly humanistic and ethical stance. It is therefore a good fit in terms of this study's findings.

At its most simple, pluralism is a move away from 'black and white' thinking, towards an acceptance of a 'messy universe' (James 1996, as cited in Cooper & McLeod, 2011). 'Disorder' or 'not disorder', 'normal' or 'not normal' are binary ways of thinking. As therapists we encourage our clients away from these simplistic of thinking, as they can be limiting and unhelpful. Therefore how can we advocate for black and white thinking within our own theories, concepts and practices? This does not mean to say that we cannot practice within one modality alone, but that when doing so we must remain always open to the needs and values of our client – ensuring they have access to multiple versions of 'truth'. And so, rather than practicing via a theory that mostly meets our own requirements, or framework of understanding, we must match our therapy goals, techniques and practices to the needs and values of our clients.

Similarly, Burr (cited in Parker 1998) suggested that that 'practitioners aim to provide their clients with alternative constructions of their experience which do not necessarily position them in unhelpful ways' (p. 17). This encourages us, as practitioners, to not position ourselves as the ultimate holders of truth, but to be open to many 'truths', and guided by the client towards that which is useful.

Similarly, the British Psychological Society (2000) stated that ‘professionals and other mental health workers should not insist that all service users accept any one particular framework of understanding’ and ‘should respect and work collaboratively with the service user’s frame of reference’ (p. 19; p. 59). Such statements indicate that the benefits of a pluralistic approach to practice is increasingly recognised.

Recommendations for work at a societal level

Via a pluralistic approach we can bring individualised support and empowerment to AS people (and possibly other individuals with diagnostic labels). However, we become limited in creating space for empowering subject positions, if the environment limits us from doing so. People exist within a social context. Therefore we need to manipulate context within the wider community, to ensure the creation of environments in which multiple ‘truths’ and multiple possibilities are available to our clients. For those who experience a sense of difference, our work as psychologists in the community can assist to increase societal awareness regarding the respect of difference. Via our interactions and professional presence we can promote the idea that *different* does not mean *less*.

Counselling psychologists have many opportunities to affect society. Here I will borrow on a concept from Community psychology where the metaphor of ecology is used to describe the interaction of people at various societal levels as ‘an eco-system’ (Kelly, 1996; Trickett, Kelly & Todd, 1972). Via this analogy, at various levels of society, various aspects of work can be done. At the macro level we can strive to create policies that promote inclusion and seek to widen societal norms (Nelson & Prilleltensky, 2010). At meso levels we can work within schools, workplaces and community groups, running education and support programs. Alongside this work at both macro and meso levels, we can also work within our micro-level client work to open up limited discursive practices, allowing new discourses, and ‘truths’ to emerge.

Within new discourses there are new possibilities for more helpful and empowering subject positions. This is what was observed at a community level in this study. Interviewees in the study created a wonderful example of applying a

'truth' or a construction of AS that opened up opportunities, recognised strengths, and provided a genuine acceptance of diversity. It is therefore this example that I will also utilise here to guide recommendations for our work on a community level. Participants appeared to have a need for these more accepting discourses; they sought them out, and brought them into action. The fact that this was observed to occur, means that it can be done. Driving this forward within our community work is now the next step. By allowing empowering discourses to be present within our public psychological 'speak', and within our interactions at all levels of the community, counselling psychologists can actively assist to further propagate ASD as a natural and acceptable part of human nature; one of the many myriad of ways to be human.

This study did not just illuminate empowering discourses however. It was clear that certain limiting discourses were prevalent among certain societal texts. A construction of AS people as 'criminal' was prevalent in newspapers, and a construction of 'weirdness' was common to TV, film and fiction. These constructions positioned AS people as 'others', negatively evaluated and separated from the dominant social majority. How can we best address this? Community psychologist Ingrid Huygens (1997) argued that 'disadvantaged groups do not want professionals or dominant social groups to empower them; rather they want these dominant groups to 'depower' themselves' (Nelson & Prilleltensky, 2010, p. 41). As such, counselling psychologists are recommended to intervene in the proliferation of certain constructions mobilised by majority groups who assert their dominant status at the cost of others. We must assist in 'depowering' limiting discourses such as these that are prevalent across society currently.

There are several ways in which this can be achieved. When authors engage in propelling harmful and limiting stereotypes they often do so from the safety and ignorance of their majority group, unaware of the damage resulting from such actions. For such authors, their social responsibility towards fellow members of society appears unrecognised. Levinas (1969, 2003) points out that all members of society have a moral responsibility to 'the other'. He proposed that self-dignity arises from 'moral responsibility to and for the other person' and by doing so 'care for the other' is ultimately 'care for the self' (Cohen, 2006, p. xxvii). This therefore goes beyond 'love thy neighbour as oneself' in which self-love proceeds

the love of the other, but rather 'love thy neighbour *is [loving] oneself*' (Cohen, 2006, p. xxvii). This 'moral responsibility in welcoming the other leads 'to the demand for justice...for all others, all humanity' (Cohen, 2006: xxvii).

Therefore, with this in mind, bringing awareness to authors about their social responsibility when they engage in propelling limiting discourses must become a priority. As psychologists, our work at a societal level may therefore include contacting editors or authors of societal texts directly, and in our professional capacity, bringing awareness to those for whom it is clearly lacking. It may also be possible to seek the support of umbrella organisations, such as the National Autistic Society (NAS) to create a clear and direct message to media organisations regarding the harmfulness of perpetuating certain constructions. Co-ordinating this on a wider scale, releasing statements more consistently, and discussing ethical responsibility with newspaper editors, and other media professionals, may be an effective way forward. Such action may assist to prevent further negative misconceptions of AS people, which, without sufficient intervention have already undoubtedly contributed to increasing stigma.

Conclusions and Evaluation

This research has attempted to produce a reading and analysis of the current constructions and discourses surrounding AS. This diagnostic label was chosen as part of a wider interest in exploring how the difficulties with psychological diagnoses can be better addressed. This thesis began with a wider focus on the benefits and difficulties of holding a diagnosis (the 'package deal'), in order to provide a strong rationale as to why a study such as this was necessary. This was then explored further in relation to ASD. A discourse analytic design then attempted to ground this discussion in real-world data so that practical recommendations, geared towards improving the 'package deal', could be generated. This thesis was ambitious, attempting to take a conceptual discussion that required addressing, ground it in real data, and make useful recommendations for change. Here I will attempt to reflect on the execution of the study overall, considering potential ways in which it could be evaluated. I hope this may assist the reader to decide whether what has been generated is both coherent and useful.

The manner in which diagnosis has been explored here has been complex, and the research methodology used to address this has included a very detailed design, involving both societal and community levels of data. This was a complex design, which generated vast amounts of text for analysis. This level of detail and design has however been necessary. Diagnosis is a complex issue. It cannot begin to be explored with anything less than the breadth and depth of design attempted here. People holding diagnostic labels are surrounded by discourses about these. It is only by gauging what currently exists across several plains that we can even begin to understand what holding such a label entails. Individuals are embedded in communities, which are embedded in societies. Via application of this design, we could see what constructions were available societally, and attempt to see how these may also be applied 'on the ground' within the community. By doing so, we have a better chance of understanding the potential subjectivities for AS people, and the potential ways in which the 'package deal' *can* be experienced.

Unlike positivist designs, which are generally evaluated in a standardised manner (reliability, validity, generalisability and objectivity), there appears to be no consistent agreement as to how qualitative discourse analysis can be evaluated. Several sets of criteria to evaluate qualitative research have been proposed (Elliot, Fischer, & Rennie, 1999; Henwood & Pigeon, 1992) but some of these are not always appropriate to particular forms of qualitative research. Willig (2000) reminded us that each form of qualitative research has different philosophical roots and asks different types of questions. Willig states that 'different methodological approaches are based upon different assumptions about the nature of the world, the meaning of knowledge and the role of the researcher in the research process' (p. 152). Therefore we need to become aware of the relationship between the epistemology employed and the way in which this can be appropriately evaluated.

Therefore utilising evaluation criteria that is matched to a constructionist approach to knowledge is necessary here. This study aimed to observe how AS people are constructed currently. It does not offer a view as to which of these constructions may be considered a 'true' representation, and therefore there will be no examination of the constructions in terms of their accuracy or fit to ontology; the data here is not considered to be an objective representation of

truth. In addition, the role of the researcher is clearly acknowledged: the constructions observed here have been interpreted from one individual's social constructionist perspective. Therefore this interpretation does not claim to be an ultimate reading of truth – it may be one of many. Therefore what will be assessed here is not 'validity' but 'quality'.

And so, consideration of what would constitute 'quality' in a discourse analysis study is where I shall now focus. Exploration of potential criteria to assess 'quality' has been suggested (Henwood & Pigeon, 1992; Elliot et al., 1999, Madill et al., 2000). Potter and Wetherell (1987) argue that discourse analyses must be assessed with reference to the 'coherence' and 'fruitfulness' of the findings (cited in Taylor, 2013, p. 321). This is also supported by Riessman (1993). Consideration of each of the suggested criteria above indicates that 'quality' is most often assessed in terms of 'internal coherence' and 'usefulness'. Therefore I shall offer these as the criteria upon which to evaluate the study at hand. A discussion of this research in terms of each will assist the reader to establish if these have been met.

Quality and internal coherence

Internal coherence refers to how well the research is put together, and whether it traces a 'coherent' journey from the research question through to its findings and conclusions. Discourse analysis needs to be evaluated as a 'discursive construction in its own right, on the basis of its internal coherence, theoretical sophistication and persuasiveness' (Willig, 2000, p. 156).

This study firstly attempted, in the Introduction, to give a strong rationale as to why this research was conducted (the 'package deal'). The Introduction then stated the research question the study wished to explore (constructions of AS) as well as the type of knowledge it has sought to produce (a social constructionist critique, with potential for empowerment and change). The next step involved a clear justification for the methodology employed:: discourse analysis. Via a clear and logical progression from our research focus to our methodology I have attempted to create a 'coherent' backdrop on which the rest of the study would unfold.

There was a degree of theoretical sophistication in the two-level design (focus 1: texts; focus 2: interviews). In addition, each of these consisted of various levels of data to ensure both a sufficient depth and breadth of data to address the research question adequately. An extensive method section then gave a very detailed account of how both data collection and analysis was conducted. Taylor (2013, p. 321) stated, that ‘in discourse analysis, rigour can be linked on one hand to the richness of *detail* present both in the data and in the analysis presented to the reader, and on the other [hand] to the *explication* of the process of analysis’. Therefore, this section was integral to the study for several reasons. Firstly, it provided a strong backbone to my own research process. Secondly, it was intended to provide ‘reader assurance’ that any interpretations made would be evidenced by a clearly accountable and methodical process. By providing as much transparency as possible, the reader has been provided with a detailed view as to how each stage of the research was conducted, and the process by which dominant constructions were extracted. Coherence within the methodology section is integral to the coherence of the study as a whole. A transparent, detailed and methodical account of the research process also provides an opportunity for the research to be replicated if so desired.

In addition, I have attempted to present findings in a clear and consistent manner so that the reader can evaluate such findings for themselves. The 10 dominant constructions discussed in the Analytic Interpretations chapter were each entitled individually by using words or phrases taken directly from the data, wherever possible. For example ‘social dyslexia’, ‘weird’, ‘different’, ‘highly intelligent’, ‘disorder’, ‘a problem’ were all explicit speaker references. ‘Homogeneous group’, ‘criminal’, ‘acceptable difference’ and ‘individuality’ were entitled as such via the collection of phrases describing such concepts. Evidence of each are provided via the accompanying excerpts of dialogue and text. Overall, across the Analytic Interpretations chapter, a sizeable amount of data was provided, allowing the reader direct access to a range of data from the study. I have also attempted to provide as much transparency as possible in regards to my presentation of the data and the inferences I have made. This was intended to allow readers to gauge for themselves as to whether my interpretations are coherent and convincing.

Finally, the Discussion section has sought to 'coherently' pull this research journey together. Firstly I have revisited the research, theories and debates presented in the Introduction, considering whether the findings of the study either challenged or corroborated these. The chapter then traces my original philosophical position (social constructionism) through to recommendations for action, both in practice, and in the community. This 'pulling together' has come from considerable reflection on the findings itself, along with careful consideration of counselling psychology's own position in terms of philosophy, ethics, and current theoretical approaches to practice. It is hoped that the findings of this study, the interpretation of these, and the recommendations for action will result in a better 'package deal' for AS people, and by extension, others who hold a psychological diagnosis. Together the chapters of this thesis have attempted to carry a clear and coherent line of thought, which travels from the opening Introduction through to the final conclusions.

Usefulness

The research at hand seeks to provide a rationale as to why both the costs and benefits of holding a diagnosis should be considered. It argues that we have a clear ethical responsibility to our clients to do so. By undertaking such a study and providing convincing findings and recommendations for change, it is hoped that this will stimulate other practitioners or researchers to not be so passive in allowing this compromising 'package deal' to persist in the way it does currently. Therefore this research provides a starting point from which other diagnostic labels could be studied in relation to the 'package deal', so that greater support will enable such recommendations to take hold. It is not only social constructionist studies on various diagnoses that are required, but it is also a clear tracing of the implications of these through to recommendations for change which is hoped for here.

It must be acknowledged again, as with many qualitative studies, the knowledge gained here, which informs the recommendations, is not neutral, objective or necessarily generalisable. It is for such reasons that the application of qualitative research has been debated. Some suggest qualitative research has 'the relatively modest aim of understanding and exploring meanings, rather than

changing society' (Wetherell, et al., 2012, p. 325) and therefore is best considered to be a preliminary 'pilot' study on which to base future quantitative research. However, Wetherell et al. (2012) pointed out that 'the change from qualitative to quantitative methods seems to involve a corresponding change of assumptions, which seems illogical' (p. 325). Hammersley (1992) suggested that from a subtle realist position we can accept that our findings are partial and situated while still having implications for change.

Some discourse analytic studies state that 'critique' can lead to both practical and significant change. This study has served as a social critique, to question the status quo, but has also aimed to be a tool to aid empowerment and potential change. It has made direct recommendations for clinical practice in order to address the inherent power imbalances within our professional discourses and discursive practices. In addition it has suggested practical ways in which counselling psychologists could use this knowledge in terms of our community work to affect change on a wider level. The findings of the study indicated that media representations of AS people could be a useful place to focus. When an AS person is not known personally, limiting constructions appeared more likely to be mobilised. Such writers are likely to be unaware of the ethical effects of their actions. Questioning the status quo of such representations, and introducing concepts of neurodiversity and individuality, could improve the situation. And so, as recommended earlier in this chapter, attention could be drawn to the authors of articles where limiting constructions are reproduced and unchallenged.

Finally, Bloor (1997) suggested that an important application of research is to influence practitioners directly. Therefore presentation of these findings to other practitioners, who in turn may follow the recommendations for pluralistic practice, may be an important application of this research. By raising awareness among professionals of the negative aspects of the 'package deal' of diagnosis it may serve to encourage depowerment of those of us who hold power, allowing for wider emergence of more positive subject positions and identities for people who hold diagnostic labels.

Limitations and future research

It must be recognised that any one study alone cannot do justice to a complex research interest such as this. This study does not assume that it has considered all that can be known, but it is hoped that it will provide a strong basis for more explicit consideration of this 'package deal', and with the recommendations made above, serve to guide practice in ways that actively address this. Several general limitations to qualitative research, in terms of generalisability, neutrality and objectiveness have been addressed above. In addition, several factors regarding the limitations of the current study will be considered here. Firstly, although hoping for a diverse spread of culture, economic status and gender, the sample of interview participants were mostly white, middle class and female. Although this was not ideal, it was also not a choice. These were the people who responded to my advertising, and responses were not numerous enough to be selective. I acknowledge the limitations of this, and therefore the limitations regarding generalisability to other communities.

Since analysis I have also reflected on other limitations in regards to my interviews. Harré and Langenhove (2003) argue that we should always start by analysing '1st order' positionings (p. 29). In the case of interviews, '1st order' positions are said to most often occur before we, as scientists, start to converse with people about the research topic. Therefore in order to get closer to '1st order' positionings, we could ask participants more about how their thinking on the particular topic changes over different occasions, as well as what they think about our interest in their thoughts.

A move to capturing natural conversations may also address this. When conducting interviews I have come to realise that we, as researchers, 'set the agenda', and thus are already likely to be constructing the forthcoming constructions. Our interview questions will inevitably invite responses from certain subject positions over others. When a teacher, parent or therapist wishes to speak from a securely 'caring' subject position, particular discourses are drawn on to aid this. They will be putting forward one part of themselves, that is, certain subject positions, over others. How they may feel and speak about the AS person may change at different times and across different occasions: we can only see the way they position themselves on this occasion, and with us, the researcher.

Access to more natural talk about AS may provide a different collection of constructions than have been considered here.

Future studies have the opportunity to address the limitations noted above, firstly by adjusting our interview questions, or secondly, by seeking to capture natural conversation regarding the topic of interest. Each of these adjustments would more openly account for the researcher/participant power differential, and thus might give rise to different constructions and accompanying subject positions. A focus on natural conversation in research is growing, and this move goes beyond the boundaries of psychology. Here I will borrow a concept from anthropological research, which may offer some interesting insights for psychology. Influential American anthropologist Clifford Geertz (1998) coined the term 'deep hanging out' as a research method in which the researcher immerses themselves in a social experience, culture or group, but does so in an informal way. It is a form of participatory observation, involving longer periods than interviews would normally take. Applying this within psychology would not be difficult. By taking part in a support group or away weekend participants could become more comfortably acquainted with the researcher. This would undoubtedly provide rich and detailed data, which may provide a more detailed collection of participants' discourses, and varying subject positions, regarding the topic of interest.

In addition, if time and other practical constraints were not as present, I would have liked to include community interviews with people who 'do not know' an AS person. I have wondered as to what constructions these would have revealed. I am curious to know whether interviews with people who 'do not know someone with AS' would yield different findings to the interviews analysed here. Was it the 'knowing someone' that was behind the mobilisation of participants' empowering discourses? When interviewing people who 'do not know' an AS person, would we find more frequent use of 'weird', 'homogeneous group' or 'criminal constructions'? Are people who 'do not know' an AS person any less accepting of difference at all? AS people are not only affected by those who know them, but also those who do not, so further interviews along this line would provide an increasingly richer picture.

It is also important to note here that the design of this study resulted in the absence of the voices of autistic people. This design, as discussed in the methodology, was purposefully chosen to study the constructions surrounding AS people, but by doing so leaves a gap in terms of the constructions AS people may use themselves. Some indications were suggested via the quotes authors chose to reproduce in newspaper articles, but as these were ultimately re-voiced and presented by journalists they are best not considered to be a direct autistic voice. The implications of this absence overall could mean that there may be some disparity between the discourses of various sectors of society and autistic people themselves. It could also contribute to a sense of under-representation in research in terms of autistic views. A future study could address this limitation by actively recruiting autistic participants and sourcing material written by autistic people capturing dominant constructions and discourses around AS.

Finally, as previously noted above, qualitative research such as this is often considered to be a first step to encourage further quantitative studies such as a pilot study. Studies that employ quantitative measures of public attitudes towards ASD, or views of autistic individuals themselves, may aid in providing more traditionally 'valid, reliable and generalisable' accounts of the current attitudes surrounding ASD. Future research could also investigate this topic via different epistemological and methodological perspectives. For example, phenomenological methods may provide insight into the 'lived experience' of this 'package deal'. A variety of different qualitative methodologies would provide us with an increasing number of perspectives, or 'truths', allowing us to build a richer picture of our subject of interest.

Reflexivity and Closing

Prior to the commencement of this thesis, I was unsure as to how I felt about the medical model within psychological practice. Not only was I unsure as to whether I wished to refer to diagnostic conceptions of my clients, but I was also unsure as to whether holding a diagnosis contributed to more risk than benefit for each individual. This thesis has aided my exploration of this topic, enabling a detailed consideration, which has provided me with a more complex and potentially informed viewpoint than I had held previously. I can now see that black and white opinions on such matters are not useful. The data has shown me that the aspects

of psychological diagnosis that concern one person may derive benefit for another. Therefore a global decision, made on the behalf of all clients, seems too simplistic. I have come to see that holding a diagnosis is indeed a 'package deal' and that, as practitioners, it is our clients that are our best guide as to how this can best be negotiated. My views, on the whole, still remain largely critical, as the evidence regarding the risks of diagnosis are concerning, but the indication of certain benefits has lead to a conclusion that a pluralistic perspective may be the most pragmatic and client-centred manner in which to proceed from here.

In conclusion of this work, I will offer a personal reflection on the overall identity of this thesis. Many elements of the thesis, the contents of the Introduction, the Methodology and even the form of analysis, could be similarly represented in many psychology theses. However, what I have *made* of the findings, and the recommendations for practice that result, have come from a particular perspective that strongly identifies with the counselling psychology division. These recommendations have drawn together many ethical and theoretical elements that are strong represented within counselling psychology. Humanism is found at the foundational core of both our theory and practice, and pluralistic practice enables practitioners to embody multiple philosophical perspectives, making this a defining aspect of the counselling psychology identity.

The incorporation of these philosophical, ethical and clinical elements has presented a fascinating and stimulating challenge, while also simultaneously enabling a strengthening of my own identity as a counselling psychologist. My doctoral training has encouraged me to explore and question many realms of philosophy, ethics and practice, and this thesis has drawn these many strings together. Via this process, I have a felt a growing sense of 'knowledge synthesis', and as a result I now prepare to end my doctoral training with a confident counselling psychologist identity. Finally, to close, I hope that sharing this journey will also be beneficial to other trainees and colleagues within the division, as well as a wider selection of practitioners with an interest in psychological diagnosis or ASD.

APPENDIX 1: Societal texts data references

1. Newspapers x 14

a) Broadsheets:

(BS1-a) **Reference:** The Guardian 2 December 2012

Title: Asperger's syndrome dropped from psychiatrists' handbook the DSM

(BS1-b) **Reference:** The Guardian, Saturday 17 May 2014

Title: A letter to ... My son, whose flat is filthy

(BS2-a) **Reference:** The Independent, Friday 12 September, 2014

Title: Susan Boyle's presence in popular culture is more important than ever after revealing she has Asperger's Syndrome

(BS2-b) **Reference:** The Independent, Adam Witnall, Sunday 08 December 2013

Title: Susan Boyle 'relieved' after Asperger's Syndrome diagnosis

(BS3-a) **Reference:** The Telegraph 31 Aug 2011

Title: Woman's hour psychologist's autism evidence 'used as weapon' in divorce case

(BS3-b) **Reference:** The Telegraph Daphne Lockyer 11:58PM BST 09 Apr 2011

Title: Paddy Considine: Knowing I have Asperger's is a relief

b) Tabloids:

(TB1-a) **Reference:** 31 May 2012, By Rob Waugh, Mail Online (Part of Daily Mail and Mail on Sunday group)

Title: Are autistic people 'unable' to believe in God? Ability to think 'inside' other people's heads is key to religious feelings

(TB2-a) **Reference:** By Adrian Monti, Daily Mirror, June 19, 2012.

Title: 'We thought Oliver was eccentric...until doctors said he had autism': Sally Bercow on how her son inspired her Celebrity Big Brother appearance

(TB2-b) **Reference:** 4th September, 2014, By Jason Beattie, Mirror online

Title: Tory MP tells autistic man: Keep quiet if you have mental issues

(TB3-a) **Reference:** 19th August 2014, Daily Star

Title: Autistic schoolboy becomes top fashion designer at just 16

c) Online news:

(ON1-a) **Reference:** 11 October 2010 BBC News Online, By Thelma Etim

Title: Coping with a child with Asperger's

(ON1-b) **Reference:** 17th October 2013 BBC News Latin America and Caribbean

Title: Mexican man with Asperger's syndrome wins court battle

(ON2-a) **Reference:** Monday 17 December 2012, Sky News online
Title: Adam Lanza: School Gunman 'Socially Awkward'

(ON3-a) **Reference:** Channel 4 news online, 18 dec 2012
Title: What made Adam Lanza kill 27 people?

2. Professional Articles x 10

a) Medicine:

(AC-MED-a) **Reference:** Pulse, 15 March 2012
Title: Key questions on Autism and Asperger's

(AC-MED-b) **Reference:** www.thelancet.com Vol 373 May 9, 2009
Title: Does autism need a cure?

b) Education:

(AC-ED-a) **Reference:** Roud, Paul, Education Digest, April 2013, Vol.78 Issue 8, pg 39-44.6p
Title: Asperger's Syndrome: The Hidden Disability

(AC-ED-b) **Reference:** SEN Magazine, Issue 41, August 2009.
Title: Asperger's syndrome

c) Speech and Language:

(AC-SLT-a) **Reference:** Speech & Language Therapy in Practice, Winter 2010, pg 4-6.
Title: Best of Pals

(AS-SLT-b) **Reference:** Speech and Language Therapy in Practice, Spring 2010, pg 8-10.
Title: Talking Matters

d) Occupational Therapy:

(AC-OCC-a) **Reference:** OT News, May 2011, Feature: mental health
Title: Sensory integration in an adult mental health setting

(AC-OCC-b) **Reference:** Occupational Therapy Evidence: Fact Sheet, College of Occupational Therapists Limited, Jan 2014
Title: Occupational therapists help children and young people with autistic spectrum disorder to participate in everyday tasks and cope with busy environments

e) Psychology:

(AC-PSY-a) **Reference:** The Psychologist, February 2011, Vol.24 (pp.114-117)
Title: Asperger's syndrome – Difference or disorder?

(AC-PSY-b) **Reference:** The Psychologist, Vol 27, no 10, October 2014
Title: A creative, interpersonal, social scientist

3. TV/Film/Fiction x 6

a) Fiction:

(FIC-a) **Reference:** Hornung, C.S. (2013) *Asperger Sunset*, Amazon.co.uk. Ltd, UK: Marston Gate.

Title: Asperger Sunset, Chapters 1 and 2, pg 1-81.

(FIC-b) **Reference:** Hawkes, H. (2012) *Jay in the Journey*, Strawberry Jam Books: UK.

Title: Jay in the Journey

b) Film:

(FLM-a) **Reference:** Adam (2009) Twentieth Century Fox, Starring Hugh Dancy, Rose Byrne.

Title: Adam: Two different worlds. One special connection

(FLM-b) **Reference:** *Temple Grandin: Autism gave her a vision, she gave it a voice*, HBO home video: US.

Title: Temple Grandin

c) TV:

(TV-a) **Reference:** Sherlock, Series 2, episode 2: The Hounds of Baskerville. First aired 8th January 2012, BBC

Title: Sherlock: Series 2, Episode 2

(TV-b) **Reference:** The Undateables – series 3 episode 4. Channel 4. First aired 30 Jan 2014. Online at: <http://www.channel4.com/programmes/the-undateables/on-demand/56967-004>

Title: The Undateables – Richard's Story

APPENDIX 2: Individual Article Analysis Template

This template is based on Willig's six steps. Some possible constructions have been added here in order to give an impression as to how the document functions.

Analysis Template

Reference:

Title:

CONSTRUCTIONS OF ASPERGERS CONTAINED IN THE ARTICLE:

How is Asperger's constructed through language?
What type of object is being constructed?

Highly intelligent/smart/genius

Discursive Employment 1:
Line

Discursive Employment 2:
Line

Weird/Eccentric/Odd

Discursive Employment 1:
Line

Discursive Employment 2:
Line

A Disorder

Discursive Employment 1:
Line

Discursive Employment 2:
Line

Different:

Discursive Employment 1:
Line

Discursive Employment 2:
Line

An impact statement from the text that has provoked much thought or emotive response. It illustrates key constructions and discourses employed to achieve certain aims.

Line

Comment:

WIDER DISCOURSES THESE CONSTRUCTIONS ARE SITUATED IN:

What discourses are drawn upon?

Medical

Line:

Key words indicating this discourse:

Neurodiversity

Line:

Key words indicating this discourse:

ACTION ORIENTATION

What do each of these constructions of Asperger's achieve?

What is gained from this construction? Who gains?

What is the speaker/writer doing?

Who loses?

POSITIONINGS

What subject positions are made available by these constructions?

PRACTICE

What possibilities for action are mapped by these constructions of Aspergers?
What can be said and done from within the different discourses?

SUBJECTIVITY

What can be felt, thought, experienced from the various subject positions?

Additional Questions

What is absent?

What could the speaker/writer have said that would have been different?
What is left unsaid?

What is the evidence?

These analytic questions were adapted from: Willig (2008) and Vingoe, L (2007).

APPENDIX 3: Newspaper subdomain analysis example

Frequent constructions ordered by type: A simple count indicates how prominent each construction was both within and across articles.

BROADSHEETS

(BS1-a) The Guardian – Asperger's syndrome dropped from psychiatrist's handbook the DSM

- Criminal x 2
- The other x 2
- Smart x 2
- Weird/misunderstood x 2
- Social skills problem x 1
- Homogeneous group x 2
- **A disorder x 3**
- Financial problem x 1
- Parental problem x 1

(BS1-b) The Guardian – A letter to....My son, whose flat is filthy

- **The other x 5**
- Smart x 1
- Homogeneous group x 3
- A disorder x 3
- **Parental problem x 5**

(BS2-a) The Independent – Susan Boyle's presence in popular culture is more important than ever after revealing she has Asperger's Syndrome

- The other x 4
- Smart x 1
- **Weird x 7**
- Homogeneous group x 1
- A disorder x 3
- Societal problem x 3
- Human diversity/acceptable difference x 2

(BS2-b) The Independent – Susan Boyle 'relieved' after Asperger's Syndrome diagnosis

- Smart x 1
- Weird x 1
- **Homogeneous group x 2**
- Mental illness x 1
- A disorder x 1
- **Parental problem/dependent x 2**

(BS3-a) The Telegraph – Woman's hour psychologist's autism evidence 'used as a weapon' in divorce case

- **Incompetent/less than x 3**
- Unwelcome pathologisation x 2
- Makes you unsocial/withdraw x 2
- Less capable parent x 1

- Mental illness x 1
- Parental problem x 1

(BS3-b) The Telegraph = Paddy Considine: Knowing I have Asperger's is a relief

- **Personal problem x 4**
- The other x 3
- Smart x 1
- Homogeneous group x 1
- A disorder x 3

Frequency of constructions found within broadsheets:

| | |
|---------------------------|----------------|
| Criminal | 2 |
| The other | (2+5+4+3) 14 |
| Smart | (2+1+1+1+1) 6 |
| Weird | (2+7+1) 10 |
| Social skills problem | 1 |
| Homogeneous group | (2+3+1+2+1) 9 |
| A disorder | (3+3+1+1+3) 11 |
| Financial problem | 1 |
| Parental problem | (1+5+2+1) 9 |
| Societal problem | 3 |
| Human diversity | 2 |
| Mental illness | (1+1) 2 |
| Incompetent/less than | 3 |
| Unwelcome pathologisation | 2 |
| Unsocial/introverted | 2 |
| Bad parent | 1 |
| Personal problem | 4 |

Top 6 most frequent constructions in broadsheets:

1. The other (2+5+4+3) 14
2. A disorder (3+3+1+1+3) 11
3. Weird (2+7+1) 10
4. Homogeneous group (2+3+1+2+1) 9
5. Parental problem (1+5+2+1) 9
6. Smart (2+1+1+1+1) 6

TABLOIDS

(TB1-a) Mail Online – Are autistic people 'unable' to believe in God? Ability to think 'inside' other people's heads is key to religious feelings

- Homogeneous group x 1
- A disorder x 2
- **Disabled x 2**
- **Non-religious x 3**

(TB2-a) Daily Mirror – ‘We thought Oliver was eccentric...until doctors said he had autism

- The other x 2
- Smart x 1
- Weird x 4
- Disabled x 1
- A disorder x 2
- Personal problem x 2
- Societal problem x 1
- **Parental problem x 11**
- Educational problem x 1

(TB2-b) Mirror Online – Tory MP tells autistic man: Keep quiet if you have mental issues

- **Mental illness x 5**
- Sob story x 1
- Inadequate member of society/less than x 2
- Oppressed group x 1

(TB3-a) Daily Star – Autistic schoolboy becomes top fashion designer at just 16

- **The other x 3**
- **Smart x 3**
- Weird x 1
- **Special skills x 3**

Frequency of constructions found within tabloids:

| | |
|------------------------------|---------|
| Homogeneous group | 1 |
| A disorder | (2+2) 4 |
| Disabled | (2+1) 3 |
| Non-religious | 3 |
| The other | (2+3) 5 |
| Smart | (1+3) 4 |
| Personal problem | 2 |
| Societal problem | 1 |
| Parental problem | 11 |
| Educational problem | 1 |
| Sob story | 1 |
| Inadequate member of society | 2 |
| Oppressed group | 1 |
| Weird | 1 |
| Special skills | 3 |

Top 5 most frequent constructions in tabloids:

1. A problem (1+11+1) 14
2. The other (2+3) 5
3. A disorder (2+2) 4
4. Smart (1+3) 4

Most frequent constructions that occur across more than one article:

- | | |
|---------------|---|
| 1. the other | 5 |
| 2. A disorder | 4 |
| 3. disabled | 3 |
| 4. smart | 4 |

ONLINE NEWS

(On1-a) BBC News Online – Coping with a child with Asperger's

- Weird x 1
- **Homogeneous group x 2**
- **A disorder x 2**
- **Societal problem x 2**
- **Parental problem x 2**

(ON1-b) BCC News – Mexican man with Asperger's syndrome wins court battle

- Legal issue x 3
- Homogeneous group x 2
- A disorder x 3
- Disability x 2
- **Oppressed group x 6**

(ON2-a) Sky News Online – Adam Lanza: School Gunman 'Socially Awkward'

- The other x 1
- Smart x 3
- **Weird x 4**
- Homogeneous group x 1
- A disorder x 1
- Parental problem x 3
- Educational problem x 1

(ON3-a) Channel 4 News online – What made Adam Lanza kill 27 people?

- **Criminal x 4**
- The other x 1
- Smart x 1
- Weird x 1
- Mental illness x 1
- A disorder x 2

Frequency of constructions found within online news:

| | |
|-------------------|-------------|
| Weird | (1+4+1) 6 |
| Homogeneous group | (2+2+1) 5 |
| A disorder | (2+3+1+2) 8 |
| Societal problem | 2 |
| Parental problem | 5 |
| Legal issue | 3 |
| Disability | 2 |
| Oppressed group | 4 |

| | |
|---------------------|---------|
| The other | (1+1) 2 |
| Smart | (3+1) 4 |
| Educational problem | 1 |
| Criminal | (3+4) 7 |
| Mental illness | 1 |

Top 6 most frequent constructions in online news:

| | |
|----------------------|-------------|
| 1. A disorder | (2+3+1+2) 8 |
| 2. Criminal | (3+4) 7 |
| 3. Parental problem | 5 |
| 4. Homogeneous group | (2+2+1) 5 |
| 5. Oppressed group | 4 |
| 6. Smart | (3+1) 4 |
| 7. The other | (1+1) 2 |

Most frequent constructions that occur across more than one article

| | |
|----------------------|---|
| 1. A disorder | 8 |
| 2. Criminal | 7 |
| 3. Homogeneous group | 5 |
| 4. Smart | 4 |
| 5. The other | 2 |

APPENDIX 4: Recruitment flyer



**Department of Psychology
City University London**

PARTICIPANTS NEEDED FOR RESEARCH ABOUT THE AUTISTIC SPECTRUM

We are looking for volunteers to take part in a study about their thoughts, experiences or perceptions of someone they know with a diagnosis of Asperger's Syndrome/High-functioning autism (HFA). The study aims to explore how people talk about and understand Asperger's syndrome/High-functioning autism.

We are specifically looking for people who 'know someone' who has an Asperger's Syndrome/HFA diagnosis. Your participation would involve approximately 40 minutes of your time and would take the form of a semi-structured interview, asking you questions about your thoughts and experiences of someone with an Asperger's (HFA) diagnosis. The study is strictly anonymous and you will be paid £20 in appreciation for your time.

For more information about this study please contact:

Niah Wilson (supervised by Dr Pavlos Filippopoulos)

Psychology Department, City University

Email: [REDACTED].

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London.

APPENDIX 5: Participant Consent Form



Title of Study: The Discourse and Social constructions of ASD

Please tick box

| | | |
|----|---|--|
| 1. | I agree to take part in the above City University London research project. I have read and understand the participant information section. I understand this will involve: <ul style="list-style-type: none">• Taking part in a semi-structured interview of approximately 40 minutes in length. | |
| 2. | This information will be held and processed for this study. I understand that any information I provide is confidential and anonymised, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. | |
| 3. | I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way. | |
| 4. | I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. | |
| 5. | I agree to take part in the above study. | |

Name of Participant _____ Signature: _____

I give my permission to take part in this study. Please tick: Yes _____ No _____

Date: _____

APPENDIX 6: Study information for participants



Title of study The Discourses and Social Constructions of ASD

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This study is being conducted as part of a DPsych program at City University, London. It aims to look at how people talk about and understand people with a diagnosis of Asperger's syndrome or high-functioning autism.

Why have I been invited?

You have been invited to take part in this study because you meet our eligibility criteria: you know someone who has a diagnosis of Asperger's syndrome or high-functioning autism.

Do I have to take part?

Participation is voluntary and you may withdraw at any stage. You do not need to answer any questions which you feel are too personal or intrusive. This will not affect any future treatment or penalize you in any way if you choose to withdraw.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

The researcher will invite you to take part in a semi-structured interview which will take about 40 minutes. There will be several open-ended questions which you may answer however you wish.

Expenses and Payments

- £20 per participant

What do I have to do?

Just be yourself and answer whatever questions you feel comfortable with. They will be open-ended questions so you can answer these any way you choose.

What are the possible disadvantages and risks of taking part?

Risk of harm or possible side effects are highly unlikely. If you feel concerned about anything after the interview please let the researcher know and advice and support will be provided.

What are the possible benefits of taking part?

By taking part you will be contributing to our knowledge around ASD. You will also be contributing to knowledge regarding well-being and the role of psychological diagnosis.

What will happen when the research study stops?

All anonymised data will discarded when the study is complete.

Will my taking part in the study be kept confidential?

- *The researcher and supervisor will have access to data, which will then be anonymised and stored securely.*
- *The only restrictions on confidentiality would include incidences such as you reporting any violence, abuse, self-inflicted harm, harm to others or criminal activity to us.*
- *Data will be stored and securely protected on the researchers' computer.*

What will happen to the results of the research study?

This study will be published as a thesis. Any further publication that may arise would adhere to the same obligation of ensuring anonymity and confidentiality of participant data. If you would like to know more about this please contact

[REDACTED]

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study at any time without an explanation or penalty.

What if there is a problem?

If you experience any sort of problem before, after or during the interview, please let the researcher know.

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone [REDACTED]. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is *The Discourse and Social Constructions of ASD*

You could also write to the Secretary at:

[REDACTED]
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square
London
EC1V 0HB
Email: [REDACTED]

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee.

Further information and contact details

Please contact Niah Wilson on [REDACTED] if you have any other questions or concerns. Supervisor: Pavlos Filippopoulos, Psychology Department, City University.

Thank you for taking the time to read this information sheet.

APPENDIX 7: Interview Schedule

1. With someone you know with Asperger's in mind, please tell me what you know about Asperger's.
2. With the person you know, how do you make sense of their behaviour?
3. How do you think this person with Asperger's sees themselves?
4. When you compare them to other people you know, what comes to mind?
5. How do you think other people see people with Asperger's?
6. Do you think if someone could choose not to have Asperger's, would they? Why or why not?
7. Do you think their Asperger's will play a role in their future?
8. How do you think this person with Asperger's feels about their Asperger's?
9. How do you feel about their Asperger's?
10. Do you have any other thoughts about Asperger's you'd like to share?

APPENDIX 8: Transcription Symbols

Jefferson's (1985) symbols from Wetherell, Taylor & Yates (2013, p. 62) adapted and presented here in a simplified form.

- ? Indicates questioning intonation
- . Full stop indicates a pause of less than 1 second
- (5) If larger than 1 second, brackets indicate the time gap in seconds
- () Empty brackets indicate an inaudible section of the recording
- (?) Words inside the bracket indicate the transcriber's best guess at an unclear word
- bold** Indicates speaker's emphasis. (in Jefferson's this is underlined)
- ↑↓ A rise or fall in intonation, placed directly before the shift
- [] Indicates the onset and end of overlapping talk
- .hh In breath
- hh Out breath

APPENDIX 9: Ethical Clearance Form

Appendix 5: University Ethics form to be signed

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc M.Phil M.Sc D.Psych ✓ n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

The Discourse and Social constructions of ASD: Diagnostic labels and their implications for psychological development

2. Name of student researcher (please include contact address and telephone number)

Niah Wilson, DPsych Yr 2 City University

3. Name of research supervisor

Pavlos Filippopoulos

4. Is a research proposal appended to this ethics release form? Yes ✓ **No**

5. Does the research involve the use of human subjects/participants? **Yes** ✓ No

If yes,

a. Approximately how many are planned to be involved?

8

b. How will you recruit them?

Via ASD organisations, local charities and the local community using both paper and online advertising.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Recruiting adult members of the general public who know someone with Asperger's syndrome.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? Yes No ☒

d1. If yes, will signed parental/carers consent be obtained? Yes No

d2. If yes, has a CRB check been obtained? Yes No

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Each participant will be invited to take part in a semi-structured interview which will take approximately 40 minutes.

7. Is there any risk of physical or psychological harm to the subjects/participants? Yes No ☒

If yes,

a. Please detail the possible harm?

b. How can this be justified?

c. What precautions are you taking to address the risks posed?

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes ☒ No

Yes an information page describing the study, along with contact details, will be displayed before the questionnaire and a copy can be sent on request.

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes

No ✓

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes ✓

No

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Digital tape recordings will be kept for analysis, transcribed and after the study is fully complete they will be deleted.

12. What provision will there be for the safe-keeping of these records?

All recordings will be anonymised and stored in an electronic password protected file on the researchers computer, which is also password protected.

13. What will happen to the records at the end of the project?

They will be discarded at the end of the project.

14. How will you protect the anonymity of the subjects/participants?

Participants will be assigned false names and only referred to by this.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be offered time to debrief, speaking personally with the researcher, and will also be provided with details of local psychological support organisations if required.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher ----Niah Wilson----- Date 14.03.14

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal
Recruitment Material
Information Sheet
Consent Form
De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes No ☒
If yes,

a. Please detail possible harm?

b. How can this be justified?

c. What precautions are to be taken to address the risks posed?

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature

Date

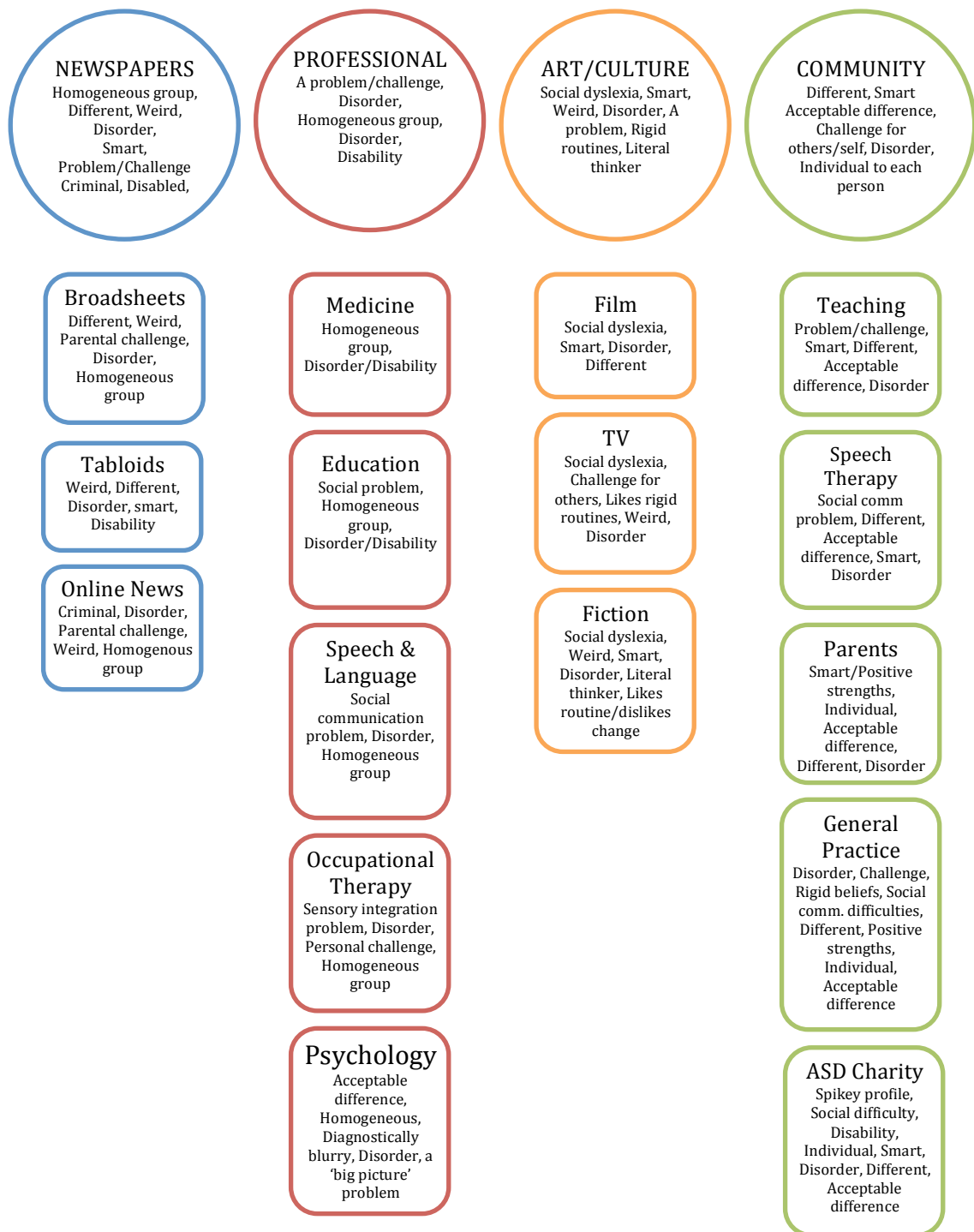
Section D: To be completed by the 2nd Departmental staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature

Date

APPENDIX 10: A full list of major constructions across the study



Appendix 10: A list of constructions found within each domain, further subdivided by type. All constructions are listed in order of their frequency of deployment, with very frequent constructions beginning each list.

APPENDIX 11: Subdomain Analysis

Each subdomain will now be considered in turn; illustrating where certain unique constructions originated. This allows exploration as to whether certain forms of societal text, or certain parts of the community may favour some constructions over others. A full table of major constructions across the four domains can be seen in Appendix 10.

11a) Subdomain Analysis: Newspapers

The Newspaper subdomain contributed one unique construction to the study: AS as ‘a trait of criminality’. This was described above in the Analysis chapter. The other constructions found in the Newspaper domain were common to other main domains within the study. See Figure 19 below for an illustration of how these constructions were distributed among the different types of newspapers within this subdomain.

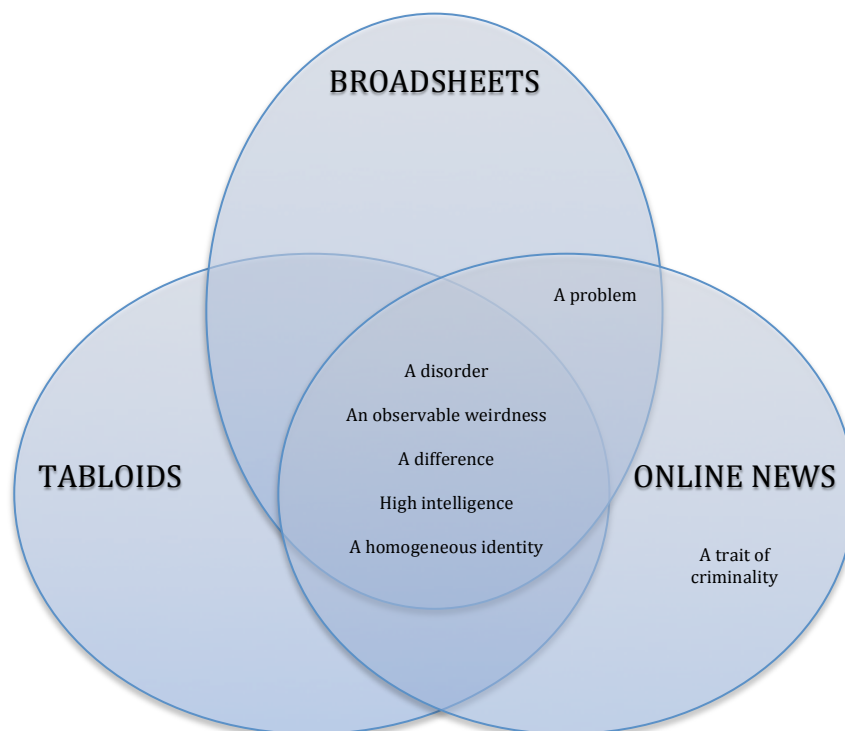


Figure 11a: Newspaper subdomain analysis. A diagram indicating which constructions were shared and which were unique to each newspaper type.

11b) Subdomain Analysis: Professional Articles

The constructions present within each type of the Professional Article domain were collapsed, and came to form dominant construction 4: A problem. Overall, there were no unique dominant constructions from this subdomain. Within professional articles AS was considered 'a problem' for each type. Text examples were given above in Analysis Part 1. See figure 20 for an illustration of how 'the problem' was further constructed within each type of Professional Article.

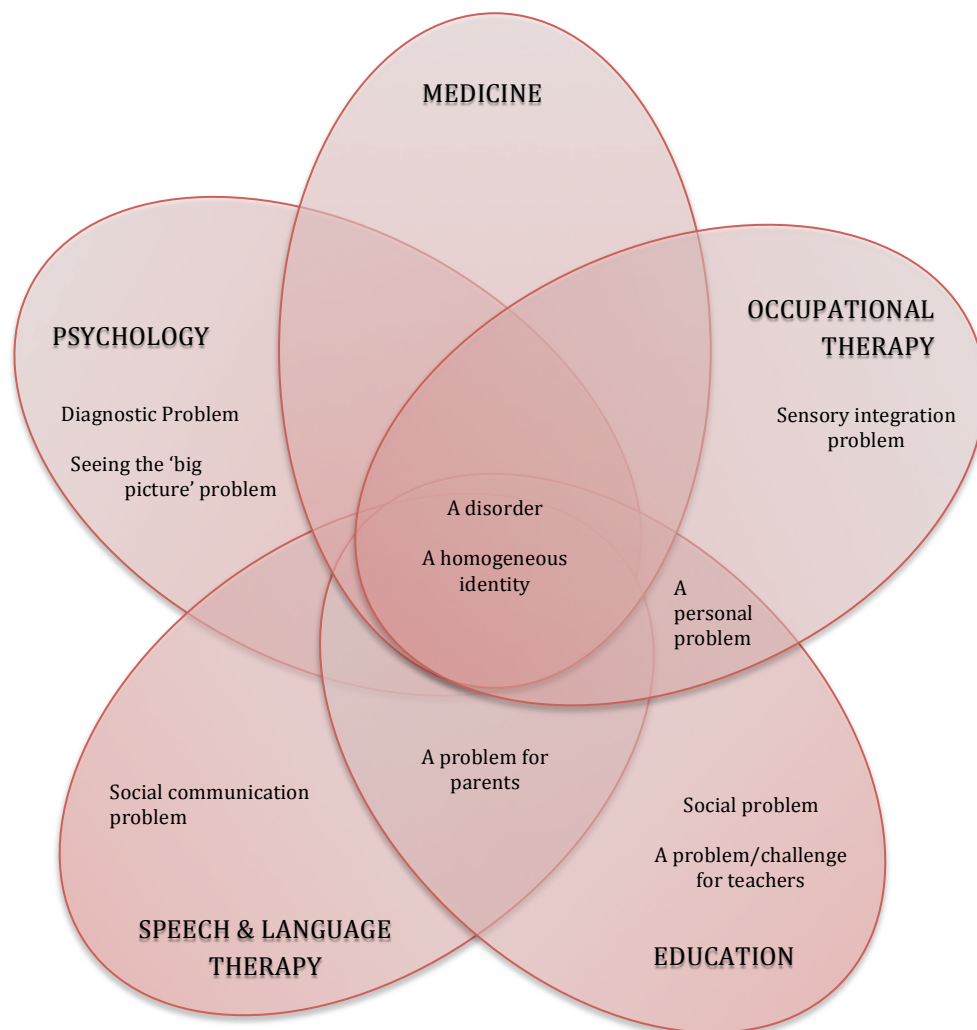


Figure 11b: Professional Article subdomain analysis. A diagram indicating which constructions were shared, and which constructions were unique to each type within the Professional Articles subdomain.

11c) Subdomain Analysis: Constructions Unique to TV/Film/Fiction

The TV/Film/Fiction subdomain contributed one unique dominant construction: AS as a 'form of social dyslexia'. This was described above in Analysis Part 1. There were several 'major' constructions identified within this subdomain. Some of these were not prevalent enough to become 'dominant' constructions in the study. See Figure 21 below for an illustration of how these constructions were distributed among the different types within this domain.

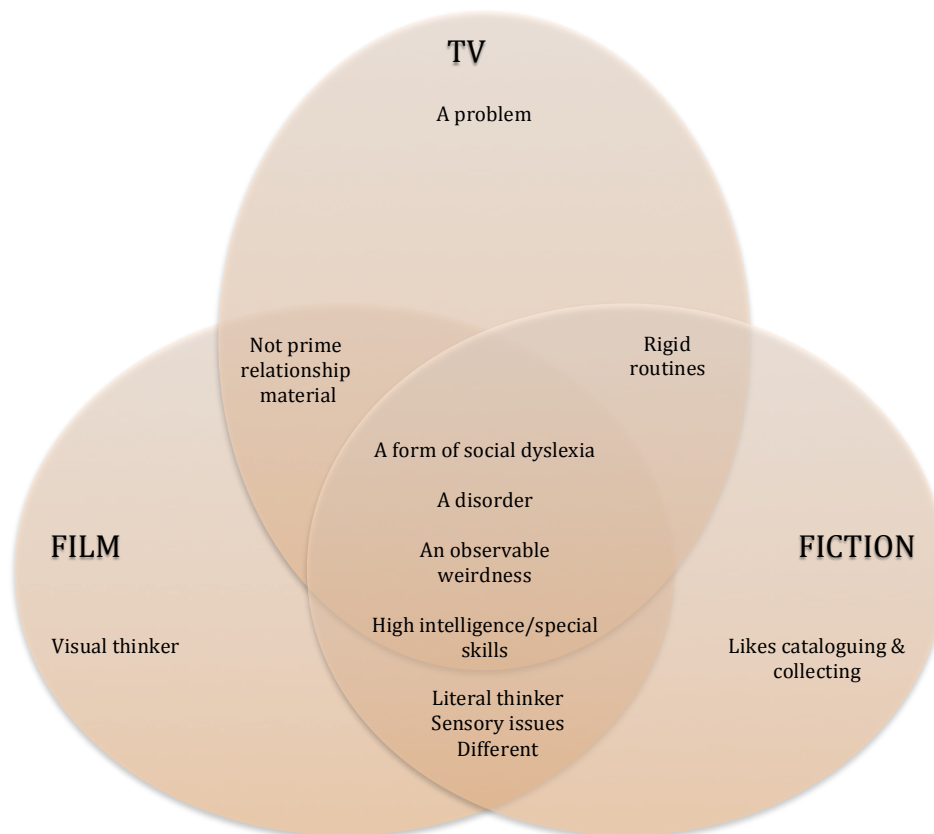


Figure 11c: TV/film/fiction subdomain analysis. A diagram indicating which constructions were shared and which were unique to each type.

11d) Subdomain Analysis: Community Interviews

The dominant constructions unique to the Community Interview domain have been discussed above in Analysis Part 1. There were several ‘major’ constructions that were not prevalent enough to become ‘dominant’ constructions. These have been illustrated below to allow a more detailed understanding of how constructions varied across community members. It must be noted however, that these findings are not derived from a generalisable community sample. See Figure 22 below.

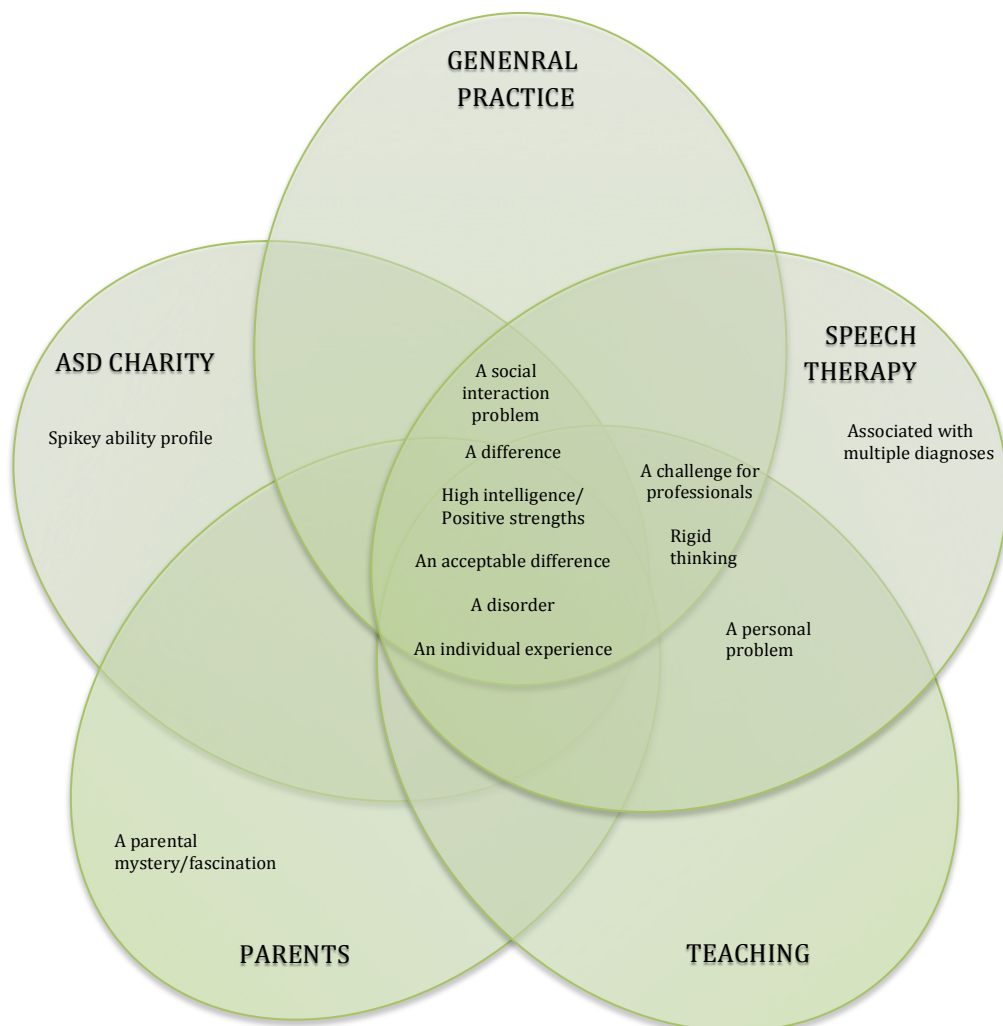


Figure 11d: Community Interviews subdomain analysis. A diagram indicating which constructions were shared, and which constructions were unique to each type.

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