EMILY LEES

Autistic Speech and Language Therapist

A BEGINNER'S GUIDE TO

ABLEISM

This free document has been created to support childminders, nurseries and schools in having necessary conversations about ableism.

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WHAT IS NEURODIVERSITY?

Neurodiversity is the diversity in human minds. Judy Singer, an autistic sociologist coined the term in the late 1990s and proposed that neurodevelopmental differences were in fact natural variations in how humans think, feel, and experience the world. Neurodiversity is an umbrella term which includes ALL types of brains: both neurotypical and neurodivergent brains.

THE LANGUAGE OF NEURODIVERSITY

Neurotypical
A person whose brain follows 'typical' development in regards to language, learning – the neuromajority.

Neurodivergent
Kassiane Asasumasu first described a person whose mind diverges from the dominant society standards of 'normal' neurocognitive functioning as neurodivergent – the neurominority.

Types of neurodivergence
Innate neurodivergence - autism, ADHD, dyslexia, dyscalculia, dyspraxia, Tourette's, epilepsy, stammering, dysgraphia. Acquired neurodivergence – trauma, mental health conditions, acquired brain injury.

Neurodiverse
A term often misunderstood. Neurodiverse describes all types of brains; neurotypical and neurodivergent. "We humans are a neurodiverse species" (to quote Nick Walker).

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Ableism is a type of discrimination which favours people without disabilities, and as a consequence, harms disabled people. It can present in many different forms such as policies, society values, people's beliefs, attitudes, and actions.

Here are some common types of ableism seen in education:

· An ADHD child is told off for fidgeting and not being able to sit still in class.

· A child with dysgraphia is told to try harder to improve "untidy" handwriting.

· A child with Down's Syndrome with unclear speech is asked to constantly repeat themselves and not given or supported to use an alternative way to communicate e.g. Makaton.

· An Autistic child who needs ear defenders due to their hypersensitivity to noise is told to wear them less so that they can 'get used to' the noise.

· A student with learning disabilities has adult support reduced to make them more independent.

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PRIVILEGE

Professionals wishing to reflect on their practice will benefit from understanding how privilege impacts their ability to identify ableist systems, values and attitudes. Privilege comes in many forms: race, gender, ethnicity. But, there is also the privilege of being a neurotypical, a member of the neuromajority group in society.

Neurotypical people do not experience the world with multiple barriers at all levels of society. Unlike neurodivergent people, they do not experience marginalisation or oppression by existing in a world which is not set up for them. Therefore, they are unable to empathise or put themselves in the shoes of the disabled person.

"Privilege is when you think something isn't a problem because it's not a problem for you" – David Gaider.

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CHALLENGING LANGUAGE AND TERMINOLOGY

"Autistic person" or "person with autism"

The way we talk about autism is important because language shapes our beliefs and attitudes. The preference in the autistic community is that they want to be referred to as "autistic" rather than "person with autism". The reasons for this are that being autistic is an inherent part of the person's identity and not something that is separate from them or something to be ashamed of.

Special needs

A term which is still widely used within education and is associated with stigma. It is a euphemism, used by the non-disabled, to describe disability without saying the word 'disabled.' This incorrectly implies that 'disability' is a stigmatised word. The term also suggests that neurodivergent and disabled children somehow have different needs than neurotypical children, when they have the same needs such as eating, going to the toilet, communicating, accessing education and transportation. One step to dismantle ableism is to talk about a child's needs without highlighting them as 'additional' or 'special'.

Challenging behaviour, behaviour that challenges

These place blame on the child for their unmet needs, instead of looking to the environment for the contributory factors to the person's distress. It is also a judgmental term because it draws conclusions based on the adult's interpretation of that 'behaviour'. Instead of talking about challenging behaviour, talk about the person's "distress".

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CHALLENGING LANGUAGE AND TERMINOLOGY CONTINUED

High/low functioning, mild/severe autism

Autism cannot be measured. These are misleading and stigmatising terms. Autistic children's needs can fluctuate hourly, daily, weekly, which is significantly impacted by the demands that are placed on them and how much support is provided by adults around them. It can also be dependent on the child's current sensory, physical, cognitive and emotional state in any given moment.

Being called "Low-Functioning" is potentially one of the most harmful labels. It can deny a young person the same opportunities as peers because professionals determine them incompetent assuming their skills cannot develop over time.

"High-Functioning" dismisses the child's struggles as they are perceived as 'not that bad' when masking.

Masking is when the autistic child essentially develops a mask and hides/ suppresses their autistic traits to protect themselves, having been conditioned to present as 'socially acceptable'.

And so functioning labels and categorising autism into low / mild / severe are value judgments and do not consider that all humans need different levels of support at different points in their lives. Sometimes we may have high support needs, other times we don't.

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MODELS OF PRACTICE IN HEALTH, EDUCATION AND SOCIAL CARE

The Medical Model

In terms of models of practices in health, education and social care, the Medical Model of Disability has been the dominant model for the past 200 years. It focuses on reducing deficits, symptoms, treating and curing. People are viewed as either healthy or unhealthy, normal or disordered. The influence of the medical model has infiltrated education, seen in standardised tests which set students at points on the bell curve of 'normal distribution' of academic performance which disadvantage and discriminate neurodivergent children with their neurocognitive differences. In this deficit model, students are described as "aloof", "rigid", "own agenda", and having "rigid, inflexible thinking". The model reinforces the curative notion that an autistic child needs to 'look less' autistic to be successful in the "real world" e.g. reducing repetitive behaviours (stimming) and teaching eye-contact, speak at an 'appropriate' volume, use 'appropriate' body language.

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The Neurodiversity Model

The Neurodiversity (ND) Model is a radically different model of practice and an antidote to The Medical Model. It focuses on empowering neurodivergent children by accepting and celebrating their differences in thinking, feeling, and communicating and not attempting to change or shape them into meeting neuromajority norms. It does not use behavioural-based approaches which seek to improve behaviours which are deemed as 'challenging' and 'inappropriate'. For example: using positive reinforcement to improve behaviour such as rewards, taking away toys and snacks and making the child earn them, and using visuals to compel compliance such as using a "First/Then" tool for compliance, not to give information or using visuals to control the student, "sit down, stop, check schedule, use your inside voice".

It addresses the child's underlying emotional and sensory distress by using a compassionate, stress-reduction and environmental approach such as the Low Arousal Approach (Professor Andrew McDonnell). The approach honours sensory differences and strives for sensory-safe environments, avoiding goals such as tolerance e.g. not taking away a child's ear defenders, not forcing a child to eat a food which they are aversive to, having fidget toys available at all times, not taking away a child's speech device because they are pressing buttons repeatedly during a lesson. The ND model honours diversity in social intelligence and does not use Social Skills Training. Autistic communication is understood and accepted. For example: info-dumping (talking a lot about a topic), low levels of eye-contact, echolalia (repeating words and phrases). It honours attention and learning differences, allowing the child to pay attention in the way they prefer (allowing the child to move around the room, fidget, not look directly at the teacher to show they're listening). The ND model uses a child-led approach which means using the child's interests to facilitate learning activities which sparks their intrinsic motivation, enabling them to engage in the activity in order to help them learn and grow. The ND model avoids stigmatising terminology such as: deficits, challenging behaviour, symptoms, restricted interests, functioning labels, and impairments.

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GLOSSARY OF TERMS

Ableism
A type of discrimination which favours people without disabilities
Privilege – An advantage that one person or group of people has over another.

Neurodiversity
Differences in brains; how people think, feel, learn.

Neurotypical
A brain that follows typical development. A neurotypical person is not autistic, ADHD, dyslexic, dyspraxic etc. E.g. "this child is neurotypical".

Neurodivergent
A brain that does not follow typical development. A neurodivergent person can be autistic, dyslexic, dyspraxic etc. E.g. "this child is autistic and so they are neurodivergent".

Neurodiverse
Encompasses neurotypical and neurodivergent brains. We are all part of a neurodiverse group. E.g. "This class of children is neurodiverse because there are both neurotypical and neurodivergent children in it".
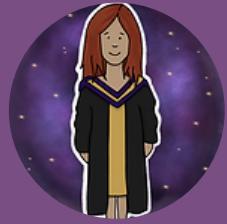
Neurodivergence
E.g. "types of neurodivergence are autism, dyslexia, dyscalculia, epilepsy".

Ableist / Medical Model terminology
Deficits, impairments, disorder, high / low functioning, symptoms, tantrum, challenging behaviour, mild/severe autism.

Neurodiversity-affirming terminology
Strengths, needs, difficulties, autistic, characteristics, distress, meltdown, sensory overload.

WHAT EDUCATORS CAN DO TO BE AN ALLY FOR NEURODIVERGENT CHILDREN:

· Use neurodiversity-affirming terminology in day-to-day practice
· Accept differences in communication and attention
· Lay aside judgments and assumptions about behaviour
· Empower children by encouraging self-advocacy and autonomy

FURTHER READING

"What is autism?" - Neuroclastic
https://neuroclastic.com/autism/what-is-autism/

Masking - The Autistic Advocate
https://theautisticadvocate.com/autistic-masking/

"Nothing about social skills training is neurodivergence affirming" Therapist Neurodiversity Collective
https://therapistndc.org/nothing-about-social-skills-training-is-neurodivergence-affirming/

"Neurodiversity terms and definitions" - Nick Walker
https://neuroqueer.com/neurodiversity-terms-and-definitions/

"Identity-first language" - Autistic Self-Advocacy Network
https://autisticadvocacy.org/about-asan/identity-first-language/

A Guide to SEND in the Early Years - Kerry Murphy
https://www.bloomsbury.com/uk/guide-to-send-in-the-early-years-9781472981011/