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Autism and ‘disease’: The semantics of an ill-posed question

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ABSTRACT

It often seems incorrect to say that psychiatric conditions are diseases, and equally incorrect to say that they are not. This results in what would seem to be an unsatisfactory stalemate. The present essay examines the considerations that have brought us to such a stalemate in our discussions of autism. It argues that the stalemate in this particular case is a reflection of the fact that we need to find the logical space for a position that rejects both positive and negative answers. It then suggests one way in which we might find such space, by applying Michael Dummett’s notion of semantic disharmony.

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1. The question of disease

Philosophical work arising from the theory and practice of psychiatry has often been directed at the evaluation of psychiatry’s “medical model” (Claridge, 1985; Glackin, 2010; Guze, 1992; Klerman, 1977; Madduz, 2001; Small, 2006; Thomas, Bracken, & Timimi, 2012). It has therefore been concerned with the question of whether psychiatric conditions are properly thought of as diseases. We often avoid taking a stance on this question by employing the vocabulary of ‘service users’ rather than ‘patients,’ and of ‘disorders’ rather than ‘diseases.’ This tactic of avoiding “disease talk” is often prudent, but there are also occasions on which the question of disease is thought to be important. If we do need to dodge that question, we should like to be able to explain why.

The question of disease is particularly fraught when it is applied to the case of autism. As applied to that case, the question of disease has been addressed from a range of theoretical perspectives (Davidson & Orsini, 2013; Happé, 1999; Jaarsma & Welin, 2011; Ortega, 2009; Rapin & Tuchman, 2008). Compelling objections have been given against answering it in the negative. Equally compelling objections have been given against answering it in the affirmative. Both sets

of objections are reviewed below, and lessons are drawn from the existence of a stalemate between them.

The objections are not new. Nor is the existence of this stalemate a sign, by itself, of there being anything philosophically problematic in the foundations of this debate. Stalemates are something to which entrenched debates will always be prone, even when the questions that they address are perfectly good ones. The arguments that follow suggest that the stalemate in this particular case is, nonetheless, an indication of something that is philosophically problematic. It is not simply a result of vagueness. The question of whether autism is a disease is undoubtedly a vague one, since neither 'autism' nor 'disease' has sharp boundaries, but this vagueness does not seem to be the source of our present stalemate. Nor does this stalemate originate simply with the fact that autism is a poorly understood condition, although that too is undoubtedly the case.

Instead I argue that this stalemate originates in the fact that our question makes an illegitimate application of the concept 'disease.' The problem is not, as has sometimes been suggested, that there are no diseases in the psychiatric domain (Pickard, 2009; Szasz, 1960). It is, rather, that the disease concept warrants certain normative moves when we apply it and warrants certain other normative moves when we withhold it, and *neither* of these moves is a morally appropriate response to the autistic condition. We should not say that autism is a disease, but nor should we say that it is not one. We therefore need to find logical room for a response that rejects both of these positions. The second half of this paper explains one way in which that room can be found.

2. For and against the disease model

We would face a host of difficulties if we attempted to answer the question of autism's disease status in the affirmative. To answer in the affirmative is to say that autism *is* a disease. The literature on autism contains excellent reasons for rejecting such an answer. One theme of that literature is that, by treating autism as a disease, we would be treating as pathological a trait that makes a certain sort of person cognitively extraordinary (O'Neil, 2008). Possession of this trait may be disabling in a wide range of contexts, but the trait itself is not essentially a disability (Baron-Cohen, 2002): there are contexts in which the people who have it perform better than those who do not (O'Riordan, Plaisted, Driver, & Baron-Cohen, 2001; Shah & Frith, 1983). Even if the defining traits of autism proved to be disabling in every context that the autistic child normally encounters, it would still be a mistake to take this as a reason for treating autism as if it were a disease (Rapley, 2004). All sorts of extraordinary thinking styles will sometimes create difficulties for the people that have them, without these thinking styles being in the least bit disease-like. Such styles will be especially apt to create difficulties when the people that have them are expected to negotiate an educational environment that has been tailored to those who are not so extraordinary (Carnahan, Harte,

Schmacker Dyke, Hume, & Borders, 2011). Autism can be thought of as one such style. It does create difficulties for the people who have it, and it does present challenges to those who care for them, but in treating that condition as a *disease* we would be committing the elementary fallacy—long lamented in the field of disability studies—of treating that which is different and challenging as if it were *ipso facto* defective (Linton, 1998).

These objections to the disease view of autism are at least as normative as they are descriptive: they claim that the vocabulary of ‘disease’ misdescribes the autistic condition, in part because the application of that vocabulary mistakenly situates autism within a set of norms concerning the way in which diseases should be treated. A parent who was indifferent to their child’s diseases would be, *ipso facto*, a negligent parent. To classify autism as a disease would therefore be to imply that any non-negligent parent ought to be concerned with the alleviation of their autistic child’s condition. That would leave no room in which to recognize the laudability of an autism-embracing attitude, such as those with autism have themselves often advocated (Wolman, 2010). The writings of high-functioning autistic persons often give voice to the concern that “the autistic person is who they are and so to wish away the autism is to wish them away” (Glover, 2014, p. 232). To simply say that autism is a disease is to lose one’s grip on the extent to which, rather than being something that we might hope to eradicate, or might think of as a candidate for being cured, an autistic style of thinking can be integral to the identity of those people whose lives are dominated by it (Cascio, 2012).

Taken together, these considerations make a straightforwardly affirmative answer to the disease question unacceptable. If that question were well-formed then they would be considerations that thereby motivate the giving of a negative answer. But to give a negative answer is to say that autism is *not* a disease, and this too seems wrong. Writing about her experiences as the mother of an autistic child, and as the daughter of an autistic mother, Judy Singer gives one salient articulation of the idea that classifying autism as a disease might give welcome recognition to the experience of people living with autism. Although Singer takes account of the medical model’s limitations, she also writes that “Whereas the traditional image of ‘diagnosis’ is of something reluctantly sought, dreaded, resisted, and imposed from outside, people with ‘marginal’ neurological differences clamour at the gates, self-diagnosed, and demanding to be let in” (1999, p. 65). To deny that autism is a disease would be to deny that it is an appropriate topic for diagnosis, and so would be to withhold the recognition that Singer here describes.

It would also restrict our application of the term ‘disease,’ despite the presence of symptoms that would usually seem to be sufficient for its application. The autistic syndrome can be unequivocally detrimental to the flourishing of those who are affected by it. It has several deleterious consequences affecting the gastro-intestinal system (Molloy & Manning-Courtney, 2003), the immune system (Heuer et al., 2008), and the various processes involved in inflammation (Depino, 2013). The DSM’s diagnostic criteria give necessary conditions for a diagnosis of autism

that include psychological features specified to be *deficits* (American Psychiatric Association, 2013, pp. 50–51). What we have here is a syndrome of physiological and cognitive impairments, originating in part from some sort of genetic malfunction (Freitag, Staal, Duketis, & Waltes, 2010; Ozonoff et al., 2011; Polleux & Lauder, 2004). To deny that such impairments constitute a disease is to lose touch with the fact that, even if there are certain contexts in which the cognitive aspects of this syndrome can usefully be exploited, the traits associated with it are typically a source of impairment, isolation, and suffering.

As with the affirmative answer, the flaws in a negative answer to our question are partly descriptive and partly normative. The negative answer would rob the autistic child of certain social entitlements that ought properly to be his (Ryan, 2013). These include entitlements of access to certain publicly funded resources (Feinberg & Vacca, 2000), but they also include certain informal entitlements to everyday social accommodations. It is a conspicuous part of the autistic condition that, when faced with a situation in which social niceties need to be observed, the behavior of an autistic person can sometimes appear rude. To treat such instances of autistic incivility as a *symptom* is to provide some mitigation for them. It obliges us to make certain accommodations in the interests of fairness. Considerations of fairness do not create any obligation to accommodate the incivility of healthy people whose thoughtlessness is just a fundamental part of who they are. A negative answer to the disease question therefore fails to recognize one of the ways in which the social isolation of autistic people warrants special sympathy and special accommodation. It also fails to give a straightforward account of the autistic child's entitlement to help with that isolation, as a part of their right to the provision of basic health care (Orsini, 2012). Taken together, these considerations make a straightforwardly negative answer to our question just as unacceptable as a straightforwardly affirmative answer was found to be. They are particularly important for the argument that follows.

2.1. Responses to the stalemate

We have seen that there are reasons to reject both positive and negative answers to the question of whether autism is a disease. When faced with a stalemate of this sort, several responses are possible. Our inability to answer a question can always be taken as a sign of our ignorance regarding that question's subject matter, especially when the question is one that concerns a subject about which our ignorance is profound (as, in matters of philosophy and psychiatry, it often is). Our inability to answer a question might also be taken to indicate that the question is vague, or intractable, or ambiguous. Each one of these stalemate-producing factors plays a role in the present case, but I hope to show that they do not give us a complete account of the way in which the stalemate concerning autism has come about. To assess these diagnoses of that stalemate, consider first the response that blames our inability to find an answer on our ignorance.

A great many facts about autism remain unknown. It should nonetheless be clear that the considerations rehearsed above do not depend on those facts. The considerations raised above were ones that depended only on some uncontroversial features of the autistic condition: that autistic children suffer, that they experience a range of physiological and social impairments for which there is a partially genetic cause, that they think in extraordinary ways and so fail to cope with the demands of what is a currently typical developmental environment, and that their condition is one that warrants special treatment. None of these claims needed to be derived from any untested empirical hypothesis, nor from any contentious philosophical theory. Insofar as they are claims that require empirical support, the evidence for them is well established. Better theories of autism would, of course, be good to have, but having them would not enable us to break the stalemate regarding the question of whether autism is properly thought of as a disease.

Nor does the unanswerability of that question result merely from the fact that autism falls on the borderline of a vague classification. It is almost inevitable that our natural language classifications will be vague, and so will admit of borderline cases. It should therefore be no surprise that the classification of conditions into diseases and non-diseases is a vague matter. That classification is susceptible to different precisifications in different contexts. One consequence of this is that some questions of the form “Is x a disease?” will be unanswerable until a specific context for their interpretation has been fixed. It is for this reason that there would be no clear answer if we were to ask whether, for example, a chronic proneness to hiccups should be counted as a disease. Stringent standards would rule it out. Laxer standards might rule it in. The vagueness of ‘disease’ means that conflicting answers to this question can be made to seem equally correct. But the difficulties we face in answering the question “Is autism a disease?” did not arise in this way. The objections to treating autism as a disease did not depend on the idea that this would be inappropriately loose talk, in which the vague word ‘disease’ was applied in accordance with too lax a definition. When those who live with autism object to their condition being characterized as a disease they are not complaining that this exaggerates their impairment. They need not be denying that autism causes a degree of debilitation that falls within the range calling for clinical intervention. The injustice done by the label ‘disease’ is not a matter of exaggeration. It is an injustice that is associated with the rhetoric of ‘sickness’ and of ‘cure’ (O’Neil, 2008; Pellicano & Stears, 2011). And, on the other side of our debate, the injustice done by *denying* the application of the disease label is not the injustice of excessive semantic stringency. It is, as we have seen, an injustice associated with denying the norms of mitigation and of entitlement to care (Grinker, 2007; Singer, 1999). Like most questions that are framed in normal language, the question of whether autism is a disease is vague, but the reasons for that question’s unanswerability cannot merely be owing to this vagueness.

Nor should our difficulties in giving a straight answer to this question be thought to indicate that the question is in some other way ambiguous, so that our

answer to it should in some cases be “yes” and in others “no.” This last response is a tempting one—and it draws attention to some important features of the autistic syndrome—but again this cannot be a complete account of the reasons for the stalemate that we have observed.

On being asked whether autism is a disease, the motivation for answering “sometimes yes and sometimes no” is clear: having taken the correct step of treating autism as corresponding to a *spectrum* of functioning, and not as a categorical diagnosis, it is tempting then to take the further step of thinking that the disease question should be answered by saying that the lives of people at one end of this spectrum are sufficiently disrupted to count as diseased, whereas the lives of those with only a milder form of the condition are not. This further step would be a mistake. The position that it would bring us to would be one in which the disease status of autism was treated as if it were analogous to the disease status of obesity. Much as those who are morbidly obese might qualify as diseased on account of their obesity, while those who occupy a less extreme position on the spectrum of weight do not, this suggestion treats the severely autistic person as having a disease on account of his autism, whereas the high-functioning autistic person does not: she has a condition that is just one position on a spectrum of normal human variation (albeit a position that might put her *at risk* for disease, in various ways).

Although this approach to the disease question has much to recommend it, it does not make a sufficient concession to the arguments that were given against answering the disease question negatively. One of those arguments depended on the thought that rejecting the disease label commits us to regarding autistic symptoms as traits that are integral to the autistic person’s identity. This was taken to be problematic because it prevented considerations of fairness from obliging us to overlook the antisocial manifestations of those traits. Our worry was that the refusal to classify autism as a disease leaves the autistic person without the correct sort of exculpation for his social awkwardness (and without any medical entitlement to specialist care in overcoming it). If we recognize severe autism as a disease, but not high-functioning autism, then we grant an exculpation only to the severe sufferer. The problem is that this seems arbitrary. It is not the *severity* of the autistic person’s suffering that requires us to regard his social ineptitude as mitigated. Some non-autistic person whose social behavior was consistently insensitive to the needs of others might suffer quite severely from his resulting lack of friends, and yet this person may simply be an unmitigated boor, without any excuse for his boorishness, nor any special claim on our sympathies. Sympathy is not granted to the correct range of cases, or for the correct reasons, if we treat mild autism as a non-medical matter of character, while treating autism as a disease when the suffering that it causes is severe.

The foregoing arguments suggest that, although ignorance and vagueness are present here, the stalemate between positive and negative responses to our question cannot be understood as being the result of ignorance or vagueness, and cannot be taken as a sign that a distinction needs to be drawn between different

cases on the basis of their severity. They therefore suggest that some alternative account should be given of that stalemate's origins. In order to make logical room for the possibility that the answer to our question should be neither "yes" nor "no" (nor "sometimes," nor "depends"), I suggest that this stalemate should instead be understood as arising from a defect that is built into the semantics of the term 'disease.' To see how this might be the case, it will be helpful to consider one of the ways in which a *question* can have a semantic defect.

3. Dummettian harmony

In a classic discussion of truth definitions, Michael Dummett noted that one may fail to grasp the meaning of a term, even if one knows when the term can be correctly applied (Dummett, 1981, pp. 452–456). We can see his point by elaborating on a line of thought that Dummett himself introduced, imagining a child who has been taught to recognize whether a text is a sonnet, a recipe, or a logically valid argument. Imagine that this child has been taught this via some thoroughly unimaginative pedagogical drill. The child might have learned to recognize these things purely on the basis of the fact that each of them has a distinctive *syntax*, and so makes a recognizable shape on the page. This child might apply the terms 'sonnet,' 'recipe,' and 'logically valid argument' with a high degree of reliability—always recognizing these things when they see them and never misclassifying one as if it were another—but they might apply these terms without having any appreciation of the fact that, once something has been classified as being a sonnet, a recipe, or a valid argument, there are consequences for the sorts of uses to which it can be put. The child who can correctly *apply* the term 'recipe,' but who does not know what recipes are *for*, does not fully understand the meaning of that word.

This thought experiment suggests that, in order to fully understand the meaning of a term, one must have a grasp on some criteria for applying the term, but must also grasp the consequences that follow from its application. Because our understanding of a term can have these two components, our terms can become semantically defective if these two components are out of joint. There is, as Dummett says, a "demand for harmony" between them.

Dummett illustrates the possibility that this demand might fail to be met by using a relatively simple example, given by the case of racially pejorative epithets.¹ Such epithets can be offensive, even when they are being mentioned in the service of a philosophical argument. To avoid offense, I follow Dummett in taking for an example the somewhat quaint pejorative 'Boche,' as employed by the English when insulting the Germans. Readers may find that silently substituting some more incendiary racist term makes the force of the following discussion clearer.

It is clear that grasping the meaning of an insulting term like 'Boche' requires one to grasp both of the components that Dummett identifies: it involves a grasp of the criteria for this word to be correctly applied, and it involves a grasp of the consequences that follow from its application. A competent user of English will

know that ‘Boche’ is applicable to Germans (they would have gone wrong if they thought that it applies only to Bavarians, or if they thought that it applies also to Italians). They will also know that the identification of someone as Boche is intended to indicate that that person is an appropriate target of fear and contempt. Grasp of both these components is essential to a correct understanding of the term. The term has been misunderstood if it is thought merely to be a word for Germans, with no insulting connotations. It has also been misunderstood if it is thought merely to be a generic insult.

Both components of meaning need to be grasped, but only a speaker who has a racist attitude to Germans would think that these two components belong together. The rest of us will think that the term exhibits a failure of “harmony,” in Dummett’s sense: we will reject such slurs because we think that consequences pertaining to fear and contempt ought not be derivable from attributions of race (Brandom, 1994, pp. 126–127). We take ‘Boche’ to be inappropriate vocabulary, even if the Germans about whom we are talking are, as it happens, fearful and contemptible ones. The flaw embodied by such vocabulary is, therefore, in where its normative commitments come from, not in what those commitments are. Dummett is not making the banal ethical point that we shouldn’t be beastly to the Germans. He is illustrating a substantive point about the way in which our choice of vocabulary can carry commitments, including normative commitments. We sometimes employ a vocabulary in which normative consequences are derivable from terms that are applicable on what are not explicitly normative grounds. Our choice of such vocabulary can already commit us to a normative position, even before we have put that vocabulary to use in the making of any normative claims.

It is crucial for our present purposes that, when a term’s normative commitments are out of harmony with its conditions of application, that term will be unfit for the asking of questions, just as it is unfit for the making of assertions and denials. The person who *asks* “Is Thomas a Boche?” has already incurred a normative commitment, just as much as the person who asserts that he is. A person using racist vocabulary when asking who was in attendance cannot excuse themselves from accusations of racism by saying that they were only *asking*. Even the person who says “Thomas is *not* Boche” incurs a normative commitment (although that commitment might sometimes be canceled by features of the context).

Like other natural languages, English has a large vocabulary for the expression of “ethically thick concepts” (Williams, 1985). The consequences of applying such vocabulary can be both positive and negative, and the vocabulary can be used to praise, commend, encourage, and cajole, as well as being used to blame, insult, deplore, and condemn. The consequences of applying this vocabulary can be problematically out of harmony with the criteria for the vocabulary’s application, whether those consequences are negative ones (as in case of racial pejoratives) or positive ones (as in the case of terms that commend class-loyalty, or imperial pride, or a verecund attitude to the priesthood). Disharmony does not only occur in contexts where the disharmonious term is used insultingly. It depends only

on its consequences being inappropriate to its conditions of application, where this inappropriateness might be a matter of the vocabulary's consequences being inappropriately positive, given its criteria of application; or on those consequences being inappropriately negative, given those criteria, or on their being inappropriate due to some more subtle failure of fit between the criteria for a term's application and the consequences that follow from its being applied. Terms that condemn blasphemy, or that commend machismo, illustrate disharmony of this latter sort. A behavior that we hear being described as "blasphemous" may be one of which we do disapprove, even if we do not want to express our disapprobation in these terms. And a behavior that we hear being described as "macho" may be one that we do want to commend, even if these are not the grounds on which we wish to commend it. Disharmony is not a matter of being positive when we should be negative and vice versa. It is a matter of normative consequences being derivable on the wrong basis.

3.1. *The disharmony of 'disease'*

I want to suggest that the normative consequences of the vocabulary of disease are out of harmony with the criteria for that vocabulary's application when the vocabulary is applied to a case such as autism. The disharmony of 'disease' is not so straightforward as the disharmony of racist pejoratives, but the two cases do both fit the same Dummettian model. In each case there are two components of meaning that need to be grasped in order for the term to be properly understood. The first of the components is a grasp of some criteria for the concept's application. The second is a grasp of the consequences of its being applied. In each case, a problem arises from a mismatch between these components. To bring the disharmony of 'disease' into view, we shall need to consider its two components in turn.

Criteria for the application of the concept of disease are controversial (Boorse, 1997; Wakefield, 2014). However those criteria should eventually be specified, it does seem to be sufficient for this concept's application that the condition be one that involves a range of physiological and psychological deficits, leading to significant impairments in human flourishing, and having a genetic malfunction as some part of its cause. These several criteria may not be individually necessary for the term 'disease' to be applied. Considered individually, they may not be equally important. It may be, as an anonymous reviewer for this journal suggests, that impairments to flourishing carry special weight when we are determining whether some condition qualifies as being a disease. That possibility can be acknowledged without retreating from the claim that, when taken together, these criteria are jointly sufficient for an application of the term 'disease' to be correct. Autism satisfies all of these criteria. It was for this reason (but not only for this reason) that it seemed mistaken to deny that the disease concept should be applied to it.

The second component in our understanding of the disease concept is our grasp of the consequences that follow from the application of this concept, where these

must, as Dummett notes, “include both the inferential powers of the statement and anything that counts as acting on the truth of that statement.” Here again there is room for controversy, but again the present point does not require us to resolve all of the controversies that might arise in this connection. However these consequences of application should ultimately be specified, they do at least seem to include some consequence to the effect that, once a condition has been recognized as being a disease, the taking of available steps towards the curing of it will be appropriate, and may be obligatory (in situations where there is some relationship that creates a duty of care). We have said that in the case of autism this cure-seeking attitude sometimes seems not to be appropriate. It was for this reason (but, again, not only for this reason) that the application of the disease concept seemed like it must be resisted.

The above considerations suggest that the disease concept’s criteria of application do apply to the case of autism, and that that same concept’s consequences of application do not. The stalemate that results from this mismatch lends itself very naturally to explanation in Dummett’s terms. This is not yet a complete account of the conditions that produced this stalemate, but it does suggest that the Dummettian framework is not out of place when we are attempting to account for it. To complete our account, we must show that the complications to this picture can also be understood in Dummett’s terms.

One of the complicating factors here is the idea that, in addition to consequences concerning the appropriateness of cure-seeking, applications of ‘disease’ also have consequences that oblige us to mitigate whatever shortcomings can be attributed to the occurrence of a disease. The relevant shortcomings in the case of autism include social ones. It would, as we emphasized above, be unfair to hold the autistic person to the same social standards as those who are not autistic, but it would not be unfair (or, at least, it would not be unfair in the same way) if we were to hold some habitually thoughtless person to those standards. Our explanation for this difference seemed to depend on the fact that autism is a disease, whereas the condition of habitual thoughtlessness is not. This explanation traded on the normative consequences of the disease concept’s application.

These normative consequences are distinct from those that we considered previously. It is one thing to say that the recognition of a disease makes the seeking of a cure appropriate, and it is something else to say that the recognition of a disease makes the mitigation of shortcomings appropriate. The concept of disease bundles these two sets of consequences together, and associates both with certain conditions that limit human flourishing. This semantic bundling can be appropriate in discourses that concern bodily conditions of a non-psychiatric sort. This bundle of normative consequences can be a harmonious one in those cases, because they are cases in which the presence of an impairment to flourishing *explains why* the search for a cure would be appropriate, while also explaining why it is that an application of normal standards would be unfair. The presence

of a flourishing-preventer lowers the attainable standards, *thereby* making the expectation that normal standards will be met unreasonable, and *thereby* justifying the search for a cure, in order that normal standards of flourishing can be reinstated. In the case of autism, this bundle of normative and non-normative commitments begins to unravel.

In order to see the reasons why it does so, consider the way in which the autistic entitlement to social mitigation is to be explained. Social interactions in which autistic people are treated with respect differ from respectful interactions between the non-autistic. The social mitigation to which an autistic person is entitled is an acknowledgment of the need to accommodate this difference. It is a recognition of the fact that normal standards of respect will here place special demands upon us. It is not simply a lowering of those standards. We *do* expect our autistic interlocutors to respect us, just as we do when our interlocutors are not autistic. We are entitled to hold it against them if they do not, just as they are entitled to hold a corresponding failure of respect against us. We go wrong in thinking of this case as if it were one in which the presence of a flourishing-preventer lowers the attainable standards, *thereby* making it unreasonable to expect that normal standards will be met, and *thereby* justifying the search for a cure, in order that the normal standards of flourishing can be reinstated. Such ‘therebys’ would be spurious. In accommodating the social awkwardness of the autistic person, we are not temporarily lowering our standards on account of some extraneous factor that prevents those standards from being met. We are instead finding a new way to negotiate the demands that these standards make.

The rhetoric of disease goes wrong, when we apply it to a condition such as autism, by leading us to take the matter of mitigation and cure to be settled by the facts about genetic or neurochemical malfunction. The problem is not that mitigation and cure are inappropriate. The problem is that the ‘therebys’ are spurious: mitigation and cure are not made appropriate simply by the presence of a malfunction. It is for this reason that the set of normative commitments that is bundled into the concept of disease becomes inharmonious when that concept is applied to the autistic condition. We said above that a racial pejorative like ‘Boche’ is the wrong vocabulary to be using, even when the Germans in question are, as it happens, cruel and contemptible ones. Use of such a term leads us to go wrong, whether we use the term affirmatively, or negatively, or in the posing of a question. It does so because the semantic profile of the term takes the matter of cruelty and contempt to be settled by the facts about race. Its normative consequences are derived from the wrong basis. When the vocabulary of disease is applied to the case of autism the problem is again that normative consequences are derivable on the wrong basis. We can recognize this as a case of disharmony—as we do in the case of terms that condemn the blasphemous, or praise the macho—without thereby saying that the normative consequences are of the wrong sort.

4. Conclusion

The point of the preceding argument is not to suggest that we insult autistic people by treating them as if they were victims of a disease. An argument to that end would merely show that we ought not to apply the concept of disease in this case, and so it would be an argument for rejecting the medical model. The current argument rejects something that is more fundamental.

If we were faced by someone who claimed that chastity is becoming to a lady it would be misleading—although not wholly false—to complain that this was *insulting*. One can easily imagine the terms in which the person making such a claim would protest against this complaint. In rejecting the claim that chastity is becoming to a lady, we do not want to be saying that chastity is *unbecoming*. Nor do we want to say that the answer must wait on a further precisification of ‘becomingness,’ or on a more detailed theory of chastity. Still less do we want to say that it depends on the lady in question. We want instead to reject the set of norms that have been bundled into this discourse. My suggestion here is that we regard should the question “Is autism a disease?” in the same way. The rules governing our application of the disease concept belong to a language game that we ought to refrain from playing when autism is at issue. Rather than rejecting the medical model, the above argument suggests that we should reject the question of that model’s applicability. It provides grounds for thinking that our current tactics for dodging the question of disease are well motivated, and are not mere evasiveness.

Making progress in our understanding of autism requires a compassionate and rigorous enquiry, informed by every scientific method that is found to be applicable. In rejecting the question of whether autism is a disease, I am not attempting to curtail this enquiry. The intention is to free up the logical space in which this enquiry can avoid what would otherwise be an invidious dilemma.

Other psychiatric cases may display a similar pattern (so too may certain cases from outside of the psychiatric domain). When we ask whether addiction is a disease, whether post-traumatic stress disorder is a disease, whether reactive depression is a disease, or whether the conditions classified by the DSM as conduct disorders are diseases, we consistently find ourselves wanting to make logical room for an answer that is neither straightforwardly yes nor straightforwardly no. As with autism, this is not (or not just) a matter of vagueness or ambiguity. Straight answers to these questions would not merely be imprecise; they would be misleading in some more fundamental, and more morally pertinent, way. The Dummettian notion of disharmony enables us to analyze this.

Note

1. The claim that it is a failure of “harmony” that explains the badness of such epithets is controversial (Hom, 2010; Williamson, 2009). We do not need to take any particular stance on that controversy here in order for Dummett’s discussion of the pejorative case to provide us with a useful model for our situation regarding the question of whether autism is a disease.

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