In Pursuit of Truth and Care: Discourses of Autism Spectrum Disorder Diagnosis Among Psychologists in Ontario

by

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ABSTRACT

IN PURSUIT OF TRUTH AND CARE: DISCOURSES OF AUTISM SPECTRUM DISORDER DIAGNOSIS AMONG PSYCHOLOGISTS IN ONTARIO

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In the last half-century, members of the medical community have sought to establish a more valid method of diagnosing autism spectrum disorder (ASD). I argue that these methods, which have come to be predominantly rooted in a reductionist biomedical framework, obscure how ASD and its related experiences are necessarily mediated by social circumstance. Applying a social constructionist lens to the issue of ASD diagnosis, this thesis elucidates the discursive construction of ASD and its diagnosis in eight semi-structured interviews with Ontario-based psychologists who diagnose ASD. I demonstrate that psychologists’ talk about ASD diagnosis shifts around the notion of clinical impairment. Diagnosis is, on the one hand, a hypothetico-deductive process that is concerned with the accurate determination of an innate and discrete ASD and, on the other, an act of care concerned in which ASD is a diffuse and pragmatic label. I argue that while the variability in psychologists’ talk legitimizes diagnosis at the limits of biomedical discourse, ASD is ultimately constructed as a deficit.
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1 Introduction

This thesis focuses on Ontario-based psychologists’ talk about autism spectrum disorder (ASD) diagnosis and seeks to situate such talk in broader cultural discourses of disability and normality. In this thesis, I choose to use the term “autistic people” or “autistic individuals” in reference to those with ASD diagnoses rather than the person-first language preferred by the American Psychological Association (American Psychological Association, 2010). Person-first language is regarded as politically correct terminology in much of the academic community as it places the individual rather than their disorder at the discursive forefront, hence the term “person-first” (American Psychological Association, 2010; Dunn & Andrews, 2015). However, Jim Sinclair – an autism-rights activist and founder of Autism Network International – criticized person-first language for its suggestion that autism can be “separated from the person” and, “that even if autism is a part of the person, it’s not a very important part” (Sinclair, 1999). Further, Sinclair (1999) states that such language suggests that autism is “something bad-so bad that it isn’t even consistent with being a person” because, “nobody objects to using adjectives to refer to characteristics of a person that are considered positive or neutral.” Such a claim may seem controversial given widespread regard for person-first language as politically correct. However, similar sentiments are echoed by other members of the autism community. In an ethnography of the autism rights community, Bagatell (2010) found that although some members of the ASD community were indifferent about the use of person- or autism-first language, others concurred with Sinclair. Based on this expressed indifference and preference within the autism community itself, I will use autism-first language in this thesis.
ASD is currently categorized in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) – the criteria that Autism Canada names as being used by North American “medical professionals” to “evaluate autism spectrum disorder” (Autism Canada, 2018a) – as a neurodevelopmental disorder characterized by, “persistent deficits in social communication and social interaction” and “restricted, repetitive patterns of behavior, interests, or activities” (American Psychiatric Association [APA], 2013, 299.00 F84.0). Current data suggests that rates of ASD diagnosis across Canada and elsewhere are on the rise. Between 2003 and 2010, prevalence rates of ASD among children between the ages of 2 and 14 increased from 47.2 to 90.6 per 10,000 in Prince Edward Island, 45.6 to 83.0 per 10,000 in Newfoundland and Labrador, and from 52.7 to 129.2 per 10,000 in parts of southwestern Ontario (NEDSAC, 2012). In 2015, approximately 151.5 in 10,000 children between the ages of 5- and 17-years-old were diagnosed with ASD in Canada, with 72 percent of cases being diagnosed prior to the age of 8 and less than 10 percent being diagnosed after the age of 12 (Public Health Agency of Canada, 2018).

This rise in rates of ASD diagnosis has garnered widespread public attention and led to a proliferation of research around its potential cause(s). Explanations for the rise in ASD diagnosis in various countries tend to focus on increased awareness and/or reporting of symptoms related to ASD (Kogan et al., 2009; Russell, Collishaw, Golding, Kelly, & Ford, 2015; Saracino, Noseworthy, Steiman, Reisinger, & Fombonne, 2010), a rise in pathogenic triggers or conditions that lead to ASD (Mari-Bauset et al., 2018; Rogers, 2008; Theoharides, Doyle, Franis, Conti, Kalogeromitros, 2008), changes to the diagnostic criteria of ASD and related conditions (King & Bearman, 2009; Shattuck, 2006; Saracino et al., 2010; Fombonne, 2005), improved recognition
of ASD among clinicians (Gillberg, 1999; Saracino et al., 2010; Fombonne, 2005), and/or the use of different estimates of ASD between epidemiological studies (Basu & Parry, 2013; Posserud, Lundervold, Lie, & Gillberg, 2010; Wazana, Bresnahan, & Kline, 2007). However, no explanation conclusively accounts for the increase and so the body of research dedicated to ASD and its diagnosis continues to grow.

Research on ASD and its diagnosis has, to a large extent, focused on the identification of biological or genetic causes, which are not well understood (Nadesan, 2013), and the validity of current diagnostic criteria and procedures (see for example Schaefer & Mendelsohn, 2008; Wing, Gould, & Gillberg, 2011; Nassar et al., 2009). However, in this thesis, I argue that medical research and practice which are predicated on the assumption that ASD is solely biological or innate are misguided. Though perhaps ASD has a biological component, its reduction to biology alone obscures and naturalizes the shared cultural notions that give meaning to the disorder and its related experiences (O’Dell, Bertilsdotter Rosqvist, Ortega, Brownlow, & Orsini, 2016; Nadesan, 2013). Despite its cultural situatedness, research has yet to explore how practitioners who diagnose ASD – and are thus at the crux of articulating and reinforcing the cultural meanings of ASD – speak about the disorder itself.

This thesis thus focuses on practitioners’ talk about ASD diagnosis, with the goal of establishing transparency about its cultural situatedness. In the following sections, I will explore extant literature on psychiatric diagnosis and the history of ASD as a diagnostic category, current trends in research on ASD and diagnosis, and social constructionism in order to contextualize the present study. I will first discuss the history of ASD and explicate its emergence and evolution as
a diagnostic category in relation to broader trends in Western psychiatry. Then, I review the current orientation and objectives of research and medical practice around ASD diagnosis. After this, I will discuss social constructionism – the theoretical framework of this thesis – and the body of work that approaches the subject of ASD and ASD diagnosis from this perspective. Finally, I will outline the research questions that will be explored and addressed in this thesis: that is, how do practitioners discursively construct ASD? And how do practitioners discursively construct the diagnostic process?

1.1 The emergence and evolution of ASD

The evolution of autism is deeply entangled in the shifting Zeitgeist of Western psychiatry in the 20th and 21st century. In this section, I trace some of these shifts – particularly those related to diagnostic practice – and situate within them the emergence and evolution of ASD as a diagnostic category. In her book *Constructing Autism*, Majia Nadesan (2013) undertakes the task of contextualizing the history of ASD within broader social and historical processes. She states of autism’s emergence:

In the nineteenth century a child born with severe autism would very likely have been abandoned, neglected, or institutionalized. The biological psychiatry of Kraepelin had no interests in, or solutions for, such children. The "mildly" autistic child would have been regarded as "eccentric," if regarded at all. Such a child might or might not have mastered the rudimentary arts of living enabling him or her to survive independently in adulthood. But by the 1940s, psychoanalysis wrought significant changes (p. 87).

The emergence of autism as a diagnostic category was thus contingent on particular social and historical conditions in which autistic individuals were not just “neglected” or “regarded as ‘eccentric,’” but rather, recognized as suffering from a discrete pathology (Nadesan, 2013).
The term *autism* was then first used in reference to a discrete “disorder” when, in 1943, Austrian-American psychiatrist Leo Kanner described eight children’s, “obsessiveness, stereotypy, … echolia,” and “extreme aloneness from the beginning of life” (p. 248). Kanner (1943) appropriated the term autism from the writings of Eugene Bleuler (1911) on *dementia praecox*, what is today called schizophrenia, wherein it was used to describe “his psychotic patients' … withdraw from the world into fantasy” (Nadesan, 2013, p. 11). However, Kanner (1943) maintained that autism – and specifically *early infantile autism* – was distinct from schizophrenia: while schizophrenia was characterized by a delayed onset – occurring at least two years after birth – autism was evident from the “beginning of life” (p. 248). Despite Kanner’s (1943) claim, autism remained a descriptor of “schizophrenic reaction, childhood type” in the first two editions of the Diagnostic and Statistical Manual of Mental Disorders [DSM] (APA, 1952; APA, 1968; Nadesan, 2013).

From the 1940s to the 1960s – the time during which the American Psychiatric Association published the first two editions of the DSM (APA, 1952; APA, 1968) – Western psychiatry was predominantly informed by psychoanalytic thought. Central to psychoanalytic theory is the premise that adaptive and maladaptive psychological responses emerge in the presence or absence of particular environmental stimuli, most notably during childhood (Nadesan, 2013). At the time, psychoanalysis was occupied not with diagnostic categories, but explicating causes and developing treatments for maladaptive psychological responses (Decker, 2013). Nadesan (2013) therefore notes that although Kanner (1943) posited autism to be, “caused by a variety of environmental, constitutional, and hereditary factors,” as psychoanalysis emerged as the dominant paradigm within Western psychiatry, his view, “was overshadowed by the idea that
both childhood autism and childhood schizophrenia were most significantly affected by the social dynamics of parental influences, particularly maternal influences [Bender 1991]” (p. 73).

Perhaps the most notable psychoanalytic theory of autism came in 1967 with the publication of Bruno Bettelheim’s *The Empty Fortress: Infantile Autism and the Birth of the Self* in which he states:

The infant, because of pain or discomfort and the anxiety they cause, or because he misread the mother’s actions or feelings, or correctly assesses her negative feelings, may retreat from her and the world. The mother, for her part, either frustrated in her motherly feelings, or out of her own anxiety, may respond not with gentle pursuit, but with anger or injured indifference. This is apt to create new anxiety in the child, to which may now be added the feeling that the world (as represented by the mother) not only causes anxiety but is also angry or indifferent as the case may be (p. 72).

Infantile autism is here said to result from the dynamic between child and mother, wherein each retreats due to their own anxieties and the perceived anger and/or apathy of the other: the child, within such a dynamic, “may be caught in a vicious cycle, where anxiety leads to retreat from reality, retreat to still greater anxiety, and in the end to more permanent withdrawal” (Bettelheim, 1967, p. 74). Although psychoanalytic theory had, from the 1940s to 1960s, expounded autism as a psychological response to insecure attachment between child and parent – particularly the mother – this theory became widespread in public discourse following Bettelheim’s (1967) publication (Nadesan, 2013). The *refrigerator mother* theory of autism, wherein it is thought to be a product of a mother’s lack of warmth towards her child, largely dominated public and academic discourse about autism until the decline of psychoanalysis (Nadesan, 2013).

In the 1970s, however, the field of mental health fragmented as psychoanalysis lost its footing as the dominant framework. Members of both public and professional spheres began to question the efficacy of psychoanalytic treatments and, as the number of clinical psychologists
and social workers within the field diversified, so too did the theoretical perspectives (Strand, 2011). In 1974, in the midst of this schism, Robert Spitzer, an American psychiatrist, was hired by APA to fulfill the World Health Organization’s requirement of a “classification of mental illness” that was “compatible with the taxonomy produced in the International Classification of Diseases, at the time in its 9th edition (ICD-9)” (Strand, 2011, p. 288). Spitzer recruited a team of psychiatrists – many of whom were psychiatrists from Washington University deemed “neo-Kraepelinian,” a reference to early twentieth-century German psychiatrist Emil Kraepelin who advocated for a typology of psychiatric disorders (Decker, 2013) – and together, sought to establish a standardized diagnostic system based on observable symptoms that would facilitate consistency in psychiatric diagnoses and treatment (Strand, 2011). In 1980, the product of this pursuit, the DSM-III, was published by APA. However, as Strand (2011) points out of the publication:

the DSM-III keeps psychiatry medical by connecting illness-types to syndromes and inferring that the syndrome results from the illness-type, even though illnesses are understood according to symptoms whose grouping also constitutes the syndrome. In other words, everything becomes a matter of symptoms: the syndrome, the diagnostic criteria, the illness itself (p. 298-299).

With the widespread adoption of the DSM-III, symptom-based criteria thus came to constitute and also signify what were (and still are) assumed to be etiologically distinct pathologies.

With the decline of psychoanalysis and the publication of the DSM-III (1980), infantile autism was, for the first time, categorized as a Pervasive Developmental Disorder (PDD) distinct from schizophrenia. The DSM-III included as the criteria for infantile autism, “onset prior to the age of 30 months, a failure of responsiveness to others, gross deficits in language development, and bizarre responses to environmental stimuli, with an absence of schizophrenic symptoms”
In 1987, APA published a revision to the DSM-III. In the DSM-III-R, infantile autism became autistic disorder and its criteria reflected three areas of impairment, “(1) reciprocal social interaction, (2) communication (verbal and non-verbal), and (3) repetitive, stereotyped or ritualistic behavior” and “allowed children with more subtle symptoms to be diagnosed with autism and related disorders such as ‘high functioning Autistic Disorder’ or ‘Pervasive Developmental Disorder Not Otherwise Specified’ (PDD-NOS).” The age of onset was also revised as prior to 36 months (Nadesan, 2013, p. 11).

As autism was solidified as a discrete disorder with these editions of the DSM and the medical model made its return to psychiatry (Kleinman, 1988), researchers began investigating its cause. In the late 20th century, cognitive psychology emerged as the dominant paradigm of psychology at large and, as such, of autism. As Nadesan (2013) reflects, “the goal of cognitive research on autism is to identify the specific cognitive deficiencies in people with autism and, ultimately, link those deficiencies to the specific problems in the neural-anatomy of autistic people” (p. 214-215). Some notable cognitive theories of ASD posited deficiencies in an individual’s: *theory of mind*, or ability to imagine and respond to the perspectives and emotions of other people (Baron-Cohen, 1995; Nadesan, 2013); *executive function*, or higher order cognitions though which people organize themselves and respond to unexpected situations (Hill and Frith, 2003; Nadesan, 2013); *central coherence*, or the ability to “process information contextually” (Hill and Frith, 2003; Nadesan, 2013, p. 122); and/or *joint attention*, wherein a child, “shar[es] the same perceptual focus with others in their social environment” and thus “acquires mental structures and/or relational interaction patterns enabling it to inhabit a shared social world” (Baron-Cohen, 1989; Nadesan, 2013, p. 119). Regardless of the precise theory,
however, ASD is, from such a perspective, a deficit in the “affected” individual’s cognition caused by “problems” in their neurology (Nadesan, 2013, p. 215).

In *Rethinking Psychiatry* (1988), Arthur Kleinman describes this period in which the DSM-III was published as psychiatry’s return to the, “medical model, with its emphasis on delineating discrete diseases and their equally specific pathological underpinnings” (p. 16). This shift, Kleinman states:

Transformed psychiatric epidemiology from a marginal discipline concerned with measuring symptoms of general distress … into a robust program of disease-specific studies… and opened up opportunities for remarkably innovative research into the genetic and other neurobiological causes of disease” (p. 17).

“Mental disorders” had thus become the domain of cognitive, biological, and neurological researchers who have since sought physiological explanations for pathology. In the late 20th century and into the 21st century, psychiatry had entered what has been deemed the “Decades of the Brain,” wherein we assume, “causal relationships between psychology and biology” (Miller, 2011, p. 717) and thus conceive “mental illness as… biological illness” (Miller, 2011, p. 719). This research and theoretical perspective continues to dominate the discipline today.

Today – firmly in the Decades of the Brain – biological explanations of ASD predominate Western medicine. While in the DSM-IV (APA, 1994), autistic disorder featured much of the same criteria as the infantile autism of the DSM-III-R (APA, 1987) and was still categorized as a PDD, with the publication of the DSM-V (APA, 2013) autism – now autism spectrum disorder due to its subsuming of what were once discrete PDDs in earlier editions of the DSM (Autistic Disorder; Asperger’s Disorder; Rett’s Disorder; Childhood Disintegrative Disorder; PDD-Not Otherwise Specified [PDD-NOS]) – is conceived as a neurodevelopmental disorder (APA,
2013). However, despite its classification as a neurological disorder within the DSM-V, researchers have yet to establish a neurological, biological, and/or pathogenic basis of ASD. While particular genes (e.g., the presence of two variants of HOXAl, interactions between MAOA-uVNTR and uVNTR), neurological irregularities (e.g. enlarged cerebellums, abnormal activation in the amygdala), genetic disorders (e.g., fragile X syndrome) are associated with an increased likelihood of certain behavioural symptoms of ASD, there is, as of yet, insufficient or inconclusive evidence about the nature of these associations (Nadesan, 2013). What we are thus left with is the assumption that symptoms which constitute the diagnostic criteria of ASD are caused by and reflect an underlying pathology.

1.2 Current trends in research and medical practice around ASD

The current state of knowledge about the cause of ASD and the increase in rates of ASD diagnosis in the Decades of the Brain have, for several reasons, fostered widespread and persistent concerns about ASD and its diagnosis within the medical community. First, absent the existence of reliable biological markers for ASD – let alone any clear understanding of its purported underlying biological pathology – ASD can only be recognized by its behavioural criteria (Nadesan, 2013). Behavioural manifestations of ASD are, however, markedly diverse given current understandings and definitions of the disorder (Solomon, 2010; Lenne & Waldby, 2011). The DSM-V, for example, states that those with ASD will demonstrate, “persistent deficits in social communication and social interaction” (APA, 2013, 299.00 F84.0) in the form of:

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced
sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers (299.00 F84.0).

While such examples encompass the diverse manifestations of ASD, there is concern within the medical community about the ways in which a lack of specificity in the diagnostic criteria might contribute to inconsistent understandings of, and diagnostic decisions related to, ASD amongst practitioners (Lenne & Waldby, 2011).

Second, there exists no standardized process or definitive tool for ASD diagnosis. In describing the process of diagnosing ASD, the Government of Canada (2018) states that an, “individual will most likely go through a series of simple procedures designed to allow the diagnostician to observe their behaviour” (para. 18) and that, “health professionals specializing in diagnosing ASD may use any number of standardized tests…in combination with their clinical judgment” (para. 16). This description, while non-specific in itself, becomes even more complicated in practice when one considers the multitude of diagnostic tools that are available for use in ASD diagnosis. Autism Canada, for example, provides a non-exhaustive list of eight screening tools that might be used to make a diagnosis: the Autism Diagnostic Observation Schedule (ADOS), Ages and Stages Questionnaires (ASQ), Communication and Symbolic Behavior Scales (CSBS), Parent’s Evaluation of Development Status (PEDS), Modified Checklist for Autism in Toddlers (M-CHAT), Screening Tool for Autism in Toddlers and Young
Children (STAT), Autism Diagnostic Observation Schedule (ADOS-G), The Childhood Autism Rating Scale (CARS), and the Autism Diagnostic Interview – Revised (ADI-R) (Autism Canada, 2018b). A recent study of Canadian practitioners – the majority of whom were based in Ontario – found that psychologists and physicians most often reported using the ADOS, ADI-R, and unstructured observations when making ASD diagnoses (Estevez, 2018). Both groups of professionals also reported using the CARS in cases where the individual being assessed demonstrated below-average levels of cognitive functioning (Estevez, 2018). Less commonly, though also reported, was clinicians’ use of the Social Responsiveness Scale (SRS), Social Communication Questionnaire (SCQ), and Autism Spectrum Rating Scale (ASRS) (Estevez, 2018). Lenne & Waldby (2011) point out that such a variety of available approaches to ASD diagnosis, “is frequently explained as the result of a lack of good, randomised controlled trial (RCT) evidence, supporting diagnostic techniques” (p. 72).

The present state of knowledge about the biological nature of ASD and current diagnostic standards have raised concern in the medical community about practitioners’ abilities to accurately determine whether an individual is autistic, particularly as rates of ASD diagnosis in Canada and elsewhere continue to increase (Lenne & Waldby, 2011, p. 72; Solomon, 2010). Consequently, researchers from various disciplines — including psychology, psychiatry, biomedicine, and neuroscience — have sought to refine and validate diagnostic criteria and tests and to identify biological and/or genetic markers of ASD (see for example Hellmer & Nyström, 2017; Ngounou Wetie et al., 2015; Mcpartland, 2017, Levin & Nelson, 2015). These pursuits are intended to standardize ASD diagnosis and treatment and facilitate clinicians’ abilities to
conclusively determine the presence or absence of the “disorder” within an individual based on their behaviours/traits or biology (Solomon, 2010).

However, behaviours and psychological phenomena – like those that are associated with ASD – cannot be reduced to biology. First, while biological or neurological research might establish a correlation between certain genetic, cognitive, or neurological structures and psychological experiences or behaviours, this research tells us little about the mechanisms of these structures or processes (Miller, 2011): correlation, in other words, cannot explain how genetic, cognitive, or neurological structures and/or processes manifest as an experience or behaviour. We cannot, given this lack of knowledge, deduce the presence of a “disorder” from or reduce a “disorder” to a genetic, cognitive, or neurological process or structure alone (Miller, 2011). Second, and related, the interpretation of an individual’s experiences and behaviours are unavoidably entrenched in a particular social and historical context (Stier, 2013). What we view as disordered behaviours or experience – like those that presuppose ASD as a disorder – are not inherently abnormal but, rather, become recognized as such when contrasted against socially and historically situated assumptions about normal conduct and functioning (Stier, 2013). Crowe (2000), for example, examined the DSM-IV criteria and situates its construction of mental disorders within Western normative expectations of productivity, based in neoliberal ideals that emphasize individual contributions to and responsibility for economic gain; unitariness, based in views of a consistent individual subjectivity; moderation, based in the value of “self-control” which is rooted in governmental surveillance; and rationality, based in the notion that there is only one version of reality that emerges from scientific rationality. She concludes that, “the DSM-IV (APA 1994) definition of mental disorder is based on particular assumptions as to what
constitutes normality,” and, as such, an “Uncritical acceptance and utilization of this classification system excludes the possibility of more innovative research and treatment for people experiencing mental distress” (p. 75). Disorder, from such a perspective, cannot and should not be reduced to an individual’s biology, as cultural and historical norms will always mediate the pathologizing of behaviour and/or experiences. As emphasized by Stier (2013):

if the boundary between normality and mental disorder is a social construction such that the question of whether a certain kind of behavior is a disorder can only be judged against the background of this very convention, then the “disorderedness” of a condition cannot be found on—and hence not be reduced to—the neuronal level (p. 3).

This point is further emphasized by Nadesan (2013) who argues that research endeavours that seek to identify a biological or genetic marker of ASD fallaciously restrict the cause of a socially bound and heterogeneous disorder to one’s biology. Research pursuits that focus on the determination of the biological presence or absence of ASD are thus misguided: these pursuits reduce ASD to an individual’s biology and, in turn, obscure the cultural situatedness of experiences and interpretations of the “disorder.”

1.3 Theoretical framework

I do not dismiss the persisting concerns that surround ASD diagnosis and the foundations on which practitioners make diagnostic claims. However, unlike biomedical pursuits which problematize diagnosis as potentially inaccurate, I, like Stier (2013) and Nadesan (2013), maintain that the “disorderedness” of ASD cannot be reduced solely to the biology of a diagnosed individual, but is necessarily mediated by cultural and historical norms against which concepts of abnormality and ultimately ASD emerge (Stier, 2013, p. 3). From this perspective,
improving the diagnostic process means also facilitating an awareness of and establishing transparency about the meaning of ASD that informs and is established by practitioners’ processes and claims – a clarity which is currently lacking from the literature on ASD diagnosis. The objective of this thesis is thus to explore constructions of ASD in practitioners’ talk about the diagnostic process in order to make evident the cultural situatedness of this talk. Specific attention will be paid to how practitioners’ discursive constructions of ASD establish and naturalize boundaries between concepts of normality and disorder.

This thesis therefore employs a social constructionist framework. Social constructionism maintains that people understand and express their understandings of reality within the context of the interpretations that are available to them within their particular historical and social circumstance (Edley, 2001). Ontologically, this claim does not mean that there is not a material basis of reality or experience, but rather that our understandings of this reality are inescapably, “mediated historically, culturally and linguistically” (Willig, 2013, p. 48; Edley, 2001).

Research on the social construction of disability — which has flourished in fields such as psychology, anthropology and sociology within the last three decades — focuses specifically on how constructions of particular disabilities come into being and gain meaning in certain cultural and historical contexts (Conrad & Barker, 2010). Like social constructionism more generally, this theoretical perspective does not uphold that disabilities are necessarily without physiological bases or exist only in discursive constructions, but rather that physiological differences are only understood as disordered or disabbling in relation to cultural assumptions about normality and functioning (Conrad & Barker, 2010).
1.4 The social construction of ASD

Particularly relevant to this study is social constructionist research that examines the implications of different cultural discourses of ASD for the medical treatment of those diagnosed. This body of work draws on social constructionist notions of dominant and counter discourses. Dominant discourses are those that, “privilege those versions of social reality that legitimate existing power relations and social structures,” whereas counter discourses diverge from dominant social constructions (Willig, 2013, p. 380).

Dominant discourses of ASD in Western culture are those that draw on the biomedical model of disability and construct ASD as a biological disorder (O’Dell et al., 2016). Like the DSM-V and research on the biological basis of ASD, biomedical discourses of ASD locate the disorder within the “affected” individual rather than social constructions of normality against which notions of disorder emerge (O’Dell et al., 2016; Stier, 2013). These discourses construct ASD “as a deficit to be fixed, cured or prevented through clinical, genetic, or biomedical intervention” (Gruson-Wood, 2016, p. 39). For example, Waltz (2005) reviewed case studies of ASD diagnosis to demonstrate how, by drawing on biomedical discourse and positioning themselves as the knowing “observer and healer,” medical practitioners legitimized their own claims (p. 427). Further, Waltz (2005) argued that practitioners’ used reductionist language wherein, “children have become disembodied brains: ‘cases’ without names or faces” (p. 428), which obscures the personhood of the patient. In such reductionist language, wherein individuals are reduced to their biology, autistic people’s behaviours becomes a matter not of their own intention but rather of their body’s doing (Yergeau, 2018). Within such discourse, the autistic person therefore comes to lack agency and personhood (Yergeau, 2018).
Counter discourses – those that diverge from dominant social constructions (Willig, 2013) – are being articulated, in particular, in ASD patient communities. For example, autism rights advocates have taken issue with biomedical constructions of ASD as a disability and, instead, advocated an alternative understanding of the disorder as one of neurodiversity – with autistic individuals being described as “neurodiverse” and those without as “neurotypical” (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002). Where dominant biomedical discourses of ASD construct its behavioural manifestations as disordered and ultimately abnormal, these counter discourses criticize the idea of normality (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002). Here, the behaviours associated with ASD are not understood as disordered or abnormal, but instead reflect the diversity that can exist between people (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002). Proponents of these alternate understandings of ASD have argued that people with ASD often possess skills that are in some ways superior to those who have been deemed neurotypical (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002). For example, so-called abnormal behaviours, like communicating in a blunt manner, have instead been reframed as strengths, like clarity and directness in one’s speech (Brownlow & O’Dell, 2006). As such, ASD is here understood as indicative of neurodiversity rather than of disability.

Similar counter discourses have also been deployed in the sociological, anthropological, and psychological constructionist literature in which this thesis is grounded. Constructionist approaches to disability aim to deconstruct and denaturalize taken-for-granted disability discourses and, in doing so, offer alternate discourses of disability (Conrad & Barker, 2010). For example, the social model of disability distinguishes impairments — differences in an individual’s biology — from disabilities (Molloy & Vasil, 2002). Although individuals might
have impairments, like the loss of a limb or delayed cognitive functioning, these impairments only become disabling in the context of a society that expects and values skills that require the use of these facilities (Molloy & Vasil, 2002). From this perspective, ASD might be associated with one or multiple biological impairments, however, these impairments do not explain why ASD is labelled as a disorder. For an impairment to be recognized as a disorder, as is the case with ASD, there must exist certain cultural assumptions about functioning and normality that value the unimpaired performance of particular behaviours or skills (Molloy & Vasil, 2002). Molloy and Vasil (2002) exemplify the distinction between impairment and disability within the social model: “the inability to hear, exist[s] in the world, but deafness, as a disability, is socially constructed” (p. 663). As such, the social model of disability situates disability within the social systems that necessitate unimpaired performance or behaviour, rather than in the physiology of an “affected” person.

Like dominant discourses of disability, counter discourses carry their own set of implications. Neurodiversity discourse, for example, challenges biomedical assumptions that ASD necessitates a cure or even intervention: by positioning those with ASD within the bounds of normality, this counter discourse of ASD does not necessitate the marginalization, medical treatment, or passivity of those diagnosed (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002). While autistic individuals might, within this framework, make use of services or supports, such intervention is not imperative. Similarly, by situating the cause of disability in social structures and institutions, the social model of disability shifts the target of intervention from the “affected” individual that is established through biomedical discourse to the disabling society (Molloy & Vasil, 2002). Following from Molloy and Vasil’s (2002) example, interventions for deafness
would not focus solely on an individual’s “inability to hear” but, rather, on the ways in which society excludes those with this inability from full participation and thus renders them “deaf” (p. 663).

Dominant and counter discourses of ASD have, however, not been taken up neatly or advocated for exclusively by medical or ASD communities. Biomedical discourses of ASD that construct ASD as abnormal and “disordered” have, for instance, also been taken up outside of medical practice. Huws and Jones (2010) found that individuals who had little or no direct contact with autistic people often described the disorder as a divergence from societal norms in development and behaviour, an inability to function independently in adulthood, existing within the mind, and being caused by one’s genes. Such descriptions of ASD reify biomedical discourses that locate the disorder and its manifestations within the “affected” individual. Likewise, in Western media (i.e., film, television, televised and printed news), fictional autistic characters are overwhelmingly portrayed as savants, possessing extraordinary intelligence and/or abilities in a specific area (Nordahl-Hansen, Tøndevoid, & Fletcher-Watson, 2018; Garner, Jones, & Harwood, 2015; Nordahl-Hansen, 2017), while news media has been demonstrated to overemphasize negative traits and experiences as being symptomatic of ASD (Holton, Farrell, & Fudge, 2014; Jones & Harwood, 2009; Mann, 2017). Rubin (2012) and O’Dell et al. (2016) argue that dominant discourses of ASD in the media establish autistic individuals as the other in a way that solidifies boundaries of normality, while simultaneously oppressing autistic individuals by situating them outside of this established norm.

Dominant biomedical discourses of ASD are also, at times, reified by autistic individuals themselves. For example, in one case study, Bagatell (2007) describes Ben, a 21-year-old autistic
man, who is struggling to reconcile pressure from the neurotypical world to adjust his behaviours and conform to dominant understandings of normality, with the pressure he receives from the “Aspie world” (p. 421) to just be himself. Consequently, Bagatell (2007) argues that the process in which an individual makes sense of their identity after being diagnosed with ASD is often ongoing and involves negotiating various and often conflicting cultural understandings of the disorder.

Additionally, some autistic people and/or their family members have outwardly criticized the neurodiversity movement’s claim that ASD is not in need of a cure (Bagatell, 2010). These people instead align themselves with dominant biomedical discourse and maintain that ASD is a disabling condition that would benefit from a cure because it can prevent, “a fulfilling life” – especially for those who are low functioning (Bagatell, 2010, p. 47). While other autistic people align themselves with the neurodiversity movement and state that they are anti-cure, they are in favour of biomedical interventions that might help them to cope with their symptoms – notably their sensory sensitivities that are a source of anxiety (Bagatell, 2010).

As ASD has, of late, become the subject of significant public and political conversation in Ontario particularly, we can see how discourses of ASD permeate social boundaries and carry with them particular effects. In 2019, Premier Doug Ford announced changes to the Ontario Autism Program – through which families receive funding for autism-related services – from a needs-based program to an age- and income-based program. Within the new program, children under six-years-old would, at most, receive $20,000 per year and children between six- and eighteen-years-old would receive a maximum of $5,000 per year. All children would be capped
at $140,000 of lifetime funding. Although these changes were meant to reduce the number of children on the waitlist for autism therapies and assessment – which are estimated to be 23,000 and 2,400 respectively – they have come under fierce criticism from the public, particularly from the parents of autistic children. These critics maintain that autism services, “can cost between $50,000 and $80,000 annually” and the proposed changes would necessitate that many families bear the expense of these services themselves (Powers, 2019). While the proposed changes have been since suspended and the Ontario Government plans to collaborate with families of autistic children on the new program, characterizations of ASD have proliferated in Ontario’s public and political discourse in the midst of this contention.

Amongst parents, autistic people tend to be characterized as in need of supports but not a cure. These sentiments echo those of autistic individuals discussed by Bagatell (2010) who were characterized anti-cure but wanted support for some of their more pressing challenges. One father, for instance, said that “denying” autistic children, “as the government continues to do with its budget caps and age cut-offs, is like denying glasses to a kid with fuzzy vision or university access to an impoverished genius. Kids with autism are brilliant. They deserve respect. And compassion. And a shot at greatness” (Rubinoff, 2019). The autistic child is, here, “brilliant” (Rubinoff, 2019) and, at the same time, in need of resources like “glasses” or “university” (Rubinoff, 2019). This discourse around ASD, here, effectively necessitates publicly funded autism-related services – by constructing services as beneficial and positioning the Ontario lack of funding as “failure” – while mitigating stigma by producing a positive account of autism (Goffman, 1963).
Members of the Ontario Government have produced similar, though somewhat less positive, images of ASD in the midst of this debate. For instance, Ontario’s Minister of Children, Community, and Social Services, Lisa MacLeod, stated of the current service waitlist that, “unfortunately no one can tell these families how long that wait will be for their child, or when they can expect desperately needed support” (CTV News, 2019). MacLeod emphasized when she, “met with families,” she “heard their struggles, but most of all… saw the potential and the possibilities in their children.” Autistic people are here represented as “struggling” and “desperately” in need of services in order to reach their “potential”, a representation that serves to emphasize the purported failure of the current Ontario Autism Program and necessitate a new, more effective means of allocating funding. This necessitation is further achieved through the characterization of service provision as a moral and ethical obligation, with one government official stating that, “We’re prepared to face whatever criticism they throw at us because it was quite frankly utterly morally and ethically unacceptable to us to leave those 23,000 kids on the wait list” (Crawley, 2019). ASD has thus been reflected in Ontario’s debate as in pressing need of services, the provision of which are a moral imperative. While accounts of autistic individuals are notably absent from the debate, it should be noted that the services associated with the Ontario Autism Program – like behavioural therapies – have been criticized by autism rights advocates as denying the legitimacy of an autistic way of being by attempting to curb autistic behaviours and, instead, foster those behaviours deemed normative (Yergeau, 2018).

These examples demonstrate that while cultural discourses may emerge within particular communities, these ways of speaking and their implications transcend and permeate broader social constructions and manifest in material experiences and consequences. I would like to
emphasize while dominant discourses in general and of ASD specifically reflect persisting worldviews, their predominance does not mean that members of society reproduce discourses intentionally. In contrast, it is because of their predominance that individuals may, despite their best intentions, inadvertently position themselves within and produce the outcomes associated with dominant cultural discourses. It is for this reason that critical reflections about the reproduction of discourse and its implications are essential: these reflections hold the potential to foster broader cultural awareness of the ways in which talk can and does mediate experience.

1.5 Navigating cultural discourse in medical practice

Such critical reflections are particularly essential when it comes to those individuals who are afforded expert or authoritative status, for it is these individuals who, given their social influence, are so often at the crux of articulating and enacting cultural discourse with material consequence. Medical practitioners are attributed expert status in Western culture (Romelli, Frigerio, & Colombo, 2016) and, in Ontario, are centrally involved in discursive practices that have material consequences: it is clinicians who diagnose ASD, recommend courses of treatment, and facilitate the provision of services that are so embroiled in debate. How then might medical practitioners navigate such diverse cultural discourses of ASD in medical practice? In recent years, literature on medical ethics – and in particular, the ethics of medical practice – has disputed whose values should underlie and inform medical practice and the implications of different approaches to practice. This research bears a direct relation to the question of how practitioners might navigate broader discourses of ASD: that is, in light of divergent discourses of ASD, which notions of ASD should guide medical decisions and what are the potential effects of such medical practices?
Medical practice in which clinicians make decisions on behalf of their patients are often referred to as *paternalistic*. Paternalistic practices are founded on the assumption that the clinician, as a trained medical professional, knows what is best for a patient and has a responsibility to make decisions accordingly related to their care (Rodriguez-Osorio & Dominguez-Cherit, 2008). These notions find their roots in biomedicine: As Marcum (2008) points out regarding biomedicine’s treatment of expert knowledge, “The physician is the authority figure with the knowledge and power... Thus, the physician’s relationship to a patient is one of dominance” (p. 13). Biomedicine thus lends itself to paternalistic practice. Overall, while there are varying degrees of paternalism, these practices have been criticized as denying patient agency in the course of their own healthcare (Rodriguez-Osorio & Dominguez-Cherit, 2008).

Paternalistic practice defined much of Western medical practice in the first half of the twentieth century (Marcum, 2008). However, in the latter-half of the century, advocates of patient choice began to argue in favour of *patient-centred* or *autonomous* practice (Marcum, 2008). This type of practice prioritizes individual choice and a patient’s right to make their own health-related decisions (Rodriguez-Osorio & Dominguez-Cherit, 2008). In patient-centred or autonomous approaches to medicine, health-related decisions are guided by the patient’s decisions and values, and centre on their right to make informed choices about their own care, what Annmarie Mol (2008) calls the “logic of choice”. According to Mol (2008), “The autonomy that (competent) individuals are entitled to within the logic of choice is precisely the autonomy of attaching their own value to just about everything (except autonomy)” (p. 75). In such a practice, *choice* is the moral imperative and guiding principle of medical practice (Mol, 2008).
However, like paternalistic practices, a patient-centred or autonomous approach to healthcare also has particular implications for those involved. More specifically, when *choice* is the moral imperative that directs medical practice, healthcare outcomes become the patient’s responsibility (Mol, 2008). Ultimately, while in patient-centered or autonomous practice individuals may have a greater sense of autonomy and control over their care, “having a choice implies that one is responsible for what follows” (Mol, 2008, p. 80).

In light of the questions and criticisms that surround paternalistic and autonomous approaches to healthcare, some academics – particularly bio ethicists and medical geographers – have turned their attention to models of practice that instead focus on shared and ongoing decision making between clinicians and patients. Challenging “ideals of self-sufficiency” and independence that are embedded in ethics of *autonomy* and Western society more broadly, an ethics of *care* emphasizes values of interdependence and mutual consideration (Ververk, 2001, p. 291; Mol, 2008). In this sort of practice, “the fact that the patient has a disease affects what needs to be done, but it does not absolve the patient from playing an active part in the doing” (Mol, 2008, p. 81); responsibility is ultimately shared by those enacting and receiving care (Mol, 2008). “Good” care in this framework is therefore not a matter of administering a certain treatment or intervention, or even a matter of the effectiveness of the care, but rather of engaging in an ongoing, collaborative, and contextually sensitive practice. An ethics of care, in other words, is not governed by an external morality but is itself the moral act (Mol, 2008).

Care is, by definition, a non-specific practice – as previously stated, what is considered “good” care is decided on a case-by-case basis (Mol, 2008). However, this inability to provide a clear set of actions that are involved in providing care – when combined with its positioning as a
moral act in itself – has raised some concern within the medical community about the way in which framing medical practice as an act of care may obfuscate the values that underlie judgements of “goodness” throughout the practice (Rudnick, 2001). For example, in an analysis of applied behavioural therapies in Ontario, Gruson-Wood (2016) showed that among some therapists, “autism is considered a problem of behavioural dysfunction, and care is understood as increasing functionality” (p. 54). Gruson-Wood (2016) argues that these acts of “care” are informed by and reinforce a “psychocentric framework” which renders invisible the contextual factors that shape experiences and perceptions of health, and in doing so, places the sole responsibility for well-being on the individual deemed ill or dysfunctional (Gruson-Wood, 2016, p. 42). Superficially, acts of care such as these might therefore appear to be benevolent. However, upon closer scrutiny, it becomes evident that positioning these practices as such could obscure and naturalize the problematic effects of underlying discourse (Gruson-Wood, 2016).

1.6 Cultural discourse and ASD diagnosis

As has been demonstrated thus far, ASD and medical practice inform and are informed by broader cultural discourses; and yet, as public and academic concern engulfs ASD and its diagnosis, particularly in Ontario, research has predominantly pursued the topic through a reductionist biomedical lens – seeking out valid means of identifying an ASD pathology. Such research further naturalizes taken-for-granted notions of ASD as an innate “disorder” and, in turn, obscures the cultural entanglement of ASD and medical practice I have detailed thus far. While the naturalization of biomedical discourse is problematic in and of itself as it perpetuates its dominance in Western culture, it is particularly problematic in the practice of diagnosis, wherein the meaning of ASD is articulated, communicated to those who are diagnosed and their
families, and which shapes the course of medical treatment. Further, practitioners’ talk about ASD, in addition to having direct implications for medicine, permeates broader social discourses and, in turn, can impact the lived experiences of those diagnosed. For instance, Bagatell (2007) demonstrates in her ethnographic work with a boy named Ben how discourse manifests in the experiences of those with autism:

As Ben listened to the voices around him, he found himself persistently cast in a marginalized position. Within the discourse of ‘normalcy’ Ben was a failure. A person with a disability is considered successful when they listen to the voices and conform, or at least make an effort to conform, to act ‘normal’ (Swain & Cameron, 1999). Authoritative voices label and marginalize individuals who look or act in ‘undesirable’ ways. As he got older Ben became aware of the authoritative voices around him that told him that in order to have a meaningful life he would have to ‘act normal’. He would need to act in certain ways and engage in certain practices in order to be accepted (p. 418).

In contrast to dominant discourse, however, “the discourse of the Aspie world […] gave him a way to reinterpret his life, to reframe who he is, to construct a positive identity as a person with autism. Instead of looking for a cure and trying to fit in, Ben began to conceive of a meaningful life as a person with autism” (p. 420). Discourse can thus shape how individuals move through and experience the world and, as was the case of Ben, counter discourses of ASD can facilitate a positive outlook on what it means to be an autistic person.

Against the background of such dominant cultural constructions of ASD and approaches to medical practice, how might clinicians then go about the business of ASD diagnosis? Several studies have demonstrated the ways in which biomedical discourse is deployed by medical practitioners to legitimize their claims in diagnosing ASD. As already noted, Waltz (2005) examined medical case studies published in academic books and journals of ASD patients,
arguing that in these cases, the autistic person is constructed as an uninformed and passive recipient of care, while the practitioner is positioned as the expert and objective observer. Such positionings can thus work to legitimize diagnostic claims, recommended courses of treatment, and the general authority of the practitioners, while simultaneously delegitimizing the voices and agency of those diagnosed (Waltz, 2005). While these practices are not labelled as paternalistic, Waltz’s (2005) conclusions about these case studies – in which the patient is, “strangely abstracted”, objectified, and denied agency in light of expert knowledge (p. 428) – resemble the characteristics of paternalistic practice described by its critics.

Similarly, in a series of conversation analyses of audio and visual recordings of child assessments, personnel interviews, and case conferences, researchers found that practitioners employ various discursive strategies in making and legitimizing their diagnostic claims about ASD. For example, clinicians position themselves and their instruments to be neutral and objective in gathering information (Turowetz, 2015a), emphasize patients’ similarities to and dissimilarities from particular groups and diagnostic categories in a manner that reinforces their diagnostic claims (Turowetz & Maynard, 2015), invoke language that suggests their conclusions about patients’ behaviours to be objectively true and independent of situational context (Maynard & Turowetz, 2017), and recount their interactions with patients in a way that supports other practitioners’ diagnostic conclusions despite alternative possible interpretations of the event (Turowetz, 2015b). As put by Turowetz and Maynard (2019), under such conditions, ASD becomes, “an inherent feature of the child: something she has, rather than something she does in interaction with relevant others” (p. 1036). These studies demonstrate that as practitioners
position their diagnostic claims as clinical fact, they, in turn, reify ASD as a discrete, syndrome-like disorder.

1.7 Research questions

This study builds on this extant body of research, which has predominately analyzed conversations about ASD that occur within the diagnostic encounter, by examining discourses of ASD diagnosis amongst practitioners who make diagnoses in Ontario, Canada. Research on discursive constructions of ASD and diagnosis within such a context are particularly critical for several reasons. First, as discussed, these constructions — and what they imply about the nature and diagnosis of ASD — can inform and shape the course of treatment. Analyses of practitioners’ talk about ASD and diagnosis can thus facilitate insights into the ways in which certain courses of treatment are legitimized while others are disregarded. Second, as medical practitioners are attributed expert status in Western culture (Romelli, Frigerio, & Colombo, 2016), the ways in which they speak of ASD and diagnosis – within and outside of the diagnostic context – have direct implications for medicine and for the lives of those diagnosed, particularly as public discourse around ASD and its treatment has become increasingly salient and steeped in conflict in Ontario. This study thus provides insight into how Ontario-based practitioners who make ASD diagnoses talk about ASD, explain its nature and symptoms, and describe the process of diagnosis, with the goal of addressing two research questions:

1.7.1 Research question one: How do practitioners discursively construct ASD?

This question is concerned with what constitutes ASD in practitioners’ talk about the disorder. Interest here is in the purported nature and symptoms of ASD as it is constructed by participants and how such constructions relate to broader cultural assumptions about disability
and normality. That is, are practitioners reproducing particular discourses around what it means to be normal or abnormal when they speak about ASD? How might practitioners navigate broader discursive tensions in social constructions of ASD? By attending to practitioners’ speech in this way, this thesis can address the dearth of research on the social construction of ASD amongst those who make diagnoses in Ontario.

1.7.2 Research question two: How do practitioners discursively construct an ASD diagnosis?

The second research question that will be explored in this thesis is concerned with the practitioners’ discursive constructions of the diagnostic process itself. Here, I am asking what constitutes diagnosis and how speaking of diagnosis in certain ways might facilitate particular practices and/or claims. Again, I will focus on the broader cultural assumptions that are rejected or reinforced by particular constructions and how practitioners may negotiate the multiple and potentially conflicting discourses of both ASD and its diagnosis.

Constructions of ASD and the process of diagnosis are intertwined and mutually reinforcing, particularly in practitioners’ talk of the diagnostic process (Goldstein Jutel, 2011): that is, the way in which practitioners’ talk of accomplishing diagnoses is sustained by particular assumptions about ASD and vice versa (Goldstein Jutel, 2011). Thus, focusing on not just practitioners’ constructions of ASD but also on the diagnostic process will shed light on how particular discourses of ASD are legitimized and enacted through talk about diagnosis.
2 Method

2.1 Recruitment

To recruit interview participants, I contacted psychologists who had advertised themselves as regulated professionals on websites meant to connect autistic people to service providers (e.g. Ontario Ministry of Children and Youth Services; Psychology Today). Potential participants were sent an initial email, which described the study’s purpose and procedure, mentioned an incentive of a ten-dollar donation to the Canadian Mental Health Association per participant, and invited recipients to respond with any questions they might have about the study (Appendix A). If an individual responded and expressed interest in participating in the study, I sent a copy of the study’s consent form via email (Appendix B) and sought to arrange an interview.

While a consistent interview method between participants would have been ideal, the geographical distance of some practitioners prohibited my conducting in-person interviews with them. Furthermore, I anticipated that some clinicians might have been more willing to participate if given the option to be interviewed via telephone or Skype. Thus, clinicians were asked if they preferred to be interviewed in-person, by telephone, or on Skype, and interviews were arranged according to their preference.

Two months after sending the initial recruitment email, I sent a follow-up email to the individuals who had not yet responded (Appendix C). In all, 43 psychologists were emailed over the course of recruitment. Of those 43 psychologists, three responded that they were not interested in participating in the study, three had automatic email responses indicating that they were on extended leaves or no longer practicing, and eight expressed interest, and eventually
participated, in an interview. Of the eight interviews conducted, two were conducted in person and six were conducted by telephone.

2.2 Participants

This thesis involved interviews with eight psychologists who make ASD diagnoses in Ontario and averaged 16.36 of reported years of experience in the field at the time of their interviews (see Table 1). When this thesis was initially conceptualized, I intended to speak with various types of practitioners who are qualified to make ASD diagnoses in Ontario – such as psychologists, psychiatrists, and physicians – in order to obtain a more diverse and representative sample of discourse about ASD and the diagnostic process. However, it became clear during recruitment that while psychologists make their contact information and areas of specialty publicly available, clinicians, like pediatricians and psychiatrists, do not. Consequently, I sought to recruit other types of practitioners who diagnose ASD through snowball sampling, asking psychologists who participated in an interview if they knew of any psychiatrists or physicians who diagnose ASD and might be interested in an interview. However, I was unable to connect with other practitioners using this method.

The results of this thesis are thus based on my interviews with eight psychologists. Ultimately, the goal of this study is not to provide a generalizable account of all discourses of ASD and ASD diagnosis. Instead, the objective is to exemplify some of the ways in which practitioners reproduce particular cultural understandings of ASD and diagnosis, and the implications of doing so for medical practice, autistic people, and social understandings of the disorder. To achieve this goal, it is not necessary to have a representative sample of individuals who make ASD diagnoses, and the psychologists interviewed in this study did facilitate an
analysis of this sort. Further, by focusing solely on psychologists’ accounts of ASD and the
diagnostic process, this thesis provides an in-depth analysis of psychologists’ talk, which can
afford unique insights into this particular community of clinicians. In future studies, it would be
useful to add to these insights by exploring the accounts of other practitioners as such findings
might differ from those presented in this study and provide further insight into the cultural-
situatedness of ASD and the diagnostic process.

2.3 Data collection

Interviews with the psychologists were individual and semi-structured. In semi-structured
interviews, the interviewer has a set of guiding open-ended questions but can probe points of
interest in participants’ responses (Banister et al., 2002). In this study, I asked psychologists a
series of open-ended questions (see Appendix D) that encouraged them to talk about ASD and
diagnostic/treatment decisions and directed the conversation towards the topics of interest to the
study. By using a semi-structured interview technique, I was able to follow up on unexpected,
ambiguous, or particularly relevant parts of participants’ responses (Banister, Burman, Parker,
Taylor, & Tindall, 2002). Semi-structured interviews thus allowed for the possibility and
exploration of unexpected talk about ASD, normality, and diagnosis, rather than only those that
were predefined or expected prior to the interviews (Banister, Burman, Parker, Taylor, &
Tindall, 2002).

Interviews lasted between approximately 45 and 60 minutes. Before beginning the
interview, I reviewed the consent form with participants and invited them to ask questions about
the study (Appendix B). Participants were then asked to sign and return the form, should they
choose to proceed with the interview. When the interview was conducted in person, participants
signed and returned a physical copy of the consent form. When the interview was conducted over the phone, the consent form was signed and returned via email. All psychologists who began the interview process gave consent to participate and none withdrew from the study during or after the interview.

After obtaining participant consent, I began the interview process. As an introduction, I first asked psychologists about their background in the field (e.g. How long had they been working as a psychologist? What drew them to the field? What is their educational background and how were general and ASD diagnosis covered over the course of their training?). Then, psychologists were asked to recall two instances of ASD diagnosis: one in which they were unsure about making an ASD diagnosis and one in which they were certain almost immediately that an individual would be diagnosed with ASD. The goal in asking participants to recount these experiences was to elicit talk that provided insight into six domains of interest: (1) indicators of ASD, (2) the process of formulating a possible diagnosis or diagnoses, (3) managing diagnostic uncertainty (e.g., distinguishing ASD from other disorders or from normal behaviour/functioning), (4) the practitioner’s treatment of different sources of data/diagnostic tools, (5) making diagnostic claims, and (6) making recommendations for treatment. After these questions, I asked psychologists for their thoughts on the neurodiversity movement as a direct means of getting participants to discursively engage with broader cultural understandings of ASD. I concluded the interview by asking psychologists to share any additional thoughts or comments that they did not feel like they had an opportunity to share but felt were important to the interview/topic.
All interviews were audio-recorded and transcribed (see Table 2 for transcription notation). As the focus of this thesis is on the content and meaning of speech rather than the conversational use of language, transcriptions were denaturalized. Denaturalized transcripts attempt the accurate recording of speech while removing its “idiosyncratic elements… (e.g., stutters, pauses, nonverbal, involuntary vocalizations)” (Oliver, Serovich, & Mason, 2005, p. 1273). In addition to denaturalizing the transcripts, I also redacted any information or statements that could be used to identify participants, such as names or places of work.

This thesis was reviewed and approved by the Research Ethics Board at the University of Guelph (REB #18-12-011) (see Appendix E).

2.4 Analysis

2.4.1 Analytic framework

Once all interviews were transcribed, I began conducting a discourse analysis on the interview transcripts. Discourse analysis, as a social constructionist framework, is concerned with the patterned ways of speaking or writing, known as discourse, that emerge within particular cultural and historical conditions, and thus reflect culturally shared ways of understanding the world (Willig, 2013). Based on this framework, participants’ talk is treated in this thesis as a reification and negotiation of culturally available ways of speaking about particular subjects, specifically ASD and diagnosis, that surfaced in the context of specific interview questions and conditions (Potter and Wetherell, 1988). It is important to emphasize that from such a perspective, the constructions of ASD and diagnosis that I discuss in the analysis are not treated or understood as necessarily reflecting participants’ internal cognitions or attitudes (Potter and Wetherell, 1988). Rather, what participants’ constructions reflect from this
perspective are culturally available ways of speaking about the subjects discussed, which can, in turn, facilitate a discussion about the consequences of such discourse for the treatment and experiences of those with ASD.

There are various approaches to and analytic objects of discourse analysis. However, central to this thesis is the Foucauldian approach that focuses on the discursive construction of particular *subjects* (i.e., doctor, patient, person with ASD) and *objects* (i.e., DSM-V, diagnostic tools) (Willig, 2013). Within such an approach, the research is concerned with the *positioning* of different subjects in relation to one another (Willig, 2013), as particular subject positionings are understood to facilitate and impede an individual’s ability to pursue certain courses of action, as well as the characteristics of the *objects* of discourse (Willig, 2013). For example, in the case studies examined by Waltz (2005), the autistic individual is constructed as an uninformed and passive recipient of care, while the practitioner is positioned as the expert and objective observer: this construction legitimizes the practitioner’s diagnostic claims, recommended courses of treatment, and general authority, while simultaneously delegitimizing the voices and agency of those with ASD (Waltz, 2005). Practitioners’ constructions of ASD and diagnosis are thus here understood to not only reflect and reinforce cultural assumptions about ASD, but also to facilitate and impede certain courses of action for the individuals implicated in these constructions.

### 2.4.2 Coding and analysis

When analyzing the interview transcripts, I first read each of the interview transcripts multiple times to ensure my familiarity with their content and to gain a general impression about
the salient features within and across interviews. Next, I analyzed each transcript independently with the goal of addressing the first research question of this study: How do practitioners discursively construct ASD? To address this question, I read and coded transcripts for the ways in which practitioners construct particular traits and behaviours as being associated with or indicative of ASD. I focused on the ways in which these traits and behaviours distinguish those with ASD from those without (i.e., Do autistic people exhibit too much or too little of an otherwise desired trait or behaviour? Do they lack certain socially valued skills altogether?). Taking into account the first research question in coding the transcripts, I also attended to the described nature of these symptoms (i.e., What causes them? How do they manifest? How are they identified or measured for diagnosis? In what ways can or should they be treated?). Overall, I was interested in the characteristics and nature of ASD as it was established by clinicians and how the construction of this “disorder” reproduces and reinforces broader cultural notions of normality and functioning.

After coding transcripts in light of the first research questions, I analyzed transcripts with a consideration of the second research question of this study: How do practitioners discursively construct the diagnostic process? It was in addressing this second question that the analytic tool of subject positionings became particularly relevant. Specifically, I addressed this question by attending to the particular subjects that are constructed in practitioners’ accounts of ASD and diagnosis: Who is involved in making an ASD diagnosis? What are the characteristics of these subjects? Are they biased or neutral? Which subjects have the power to make authoritative claims? Which subjects’ voices are subordinate? In what way do these subject positionings
support the practitioners’ claims about the diagnostic process and ASD? How might these subject positionings inform the suggestions for, and course of, treatment?

After analyzing each transcript independently with consideration given to these research questions, I compared the findings from each interview to one another. The goal of this comparison was to identify constructions of ASD and diagnosis that were prominent because they occurred in multiple interviews or were anomalous from other constructions of ASD or diagnosis in some significant or meaningful way (Jorgensen & Phillips, 2002).
3 Analysis

3.1 Introduction

In this analysis, I will demonstrate how psychologists’ talk about ASD diagnosis shifts around the notion of clinical impairment. On the one hand, psychologists construct ASD diagnosis as a hypothetico-deductive process that is concerned with the accurate determination of the presence of ASD while, on the other hand, it is constructed as an act of care concerned not with accurate identification of pathology but with assessing and addressing suffering in practical ways. I argue that despite this shift in how psychologists speak about ASD diagnosis, in both cases, ASD is implied to be a sort of deficit.

To make this argument, I will first detail how psychologists construct ASD diagnosis as a hypothetico-deductive process. I show how such talk frames the diagnostic process as concerned with the accurate determination of ASD pathology and, in doing so, constructs ASD as an innate and discrete disorder and positions psychologists as impartial scientists trying to discern the presence or absence of a true ASD pathology. Then, I will show how psychologists’ talk shifts when psychologists invoke the notion of clinical impairment, wherein ASD is only regarded as such when an individual is experiencing a reduced quality of life as a result of their symptoms. When psychologists draw on the notion of clinical impairment, diagnosis is constructed as an act of care and psychologists are positioned as pragmatic caregivers who will do what is necessary to care for a suffering patient in the context of current social and institutional realities. Unlike psychologists’ talk of ASD diagnosis as a process concerned with making accurate deductions of pathology, here, diagnosis is constructed as agnostic about discerning the precise nature of impairment and is, instead, meant to connect individuals to supports and services. ASD is,
consequently, constructed as a diffuse and pragmatic label. I conclude by demonstrating how, implicit in each construction, is the notion of ASD as a deficit.

Throughout this section, I will use interview excerpts to illustrate my arguments. Excerpts are each assigned a specific number (e.g. excerpt 1), which is used to indicate the excerpts that correspond with related analysis. In addition, each excerpt denotes a specific speaker: the letter I, indicates an excerpt spoken by the interviewer; while psychologists are indicated by the letter P and a specific number that refers to that psychologist throughout the analysis (e.g. P1).

It is important to emphasize that the constructions and discourses I discuss in the sections that follow are not exhaustive or mutually exclusive. These ways of speaking often overlap and could be sectioned off in other ways. Their organization as it appears in this thesis simply provides a useful way of making sense of psychologists’ talk in order to describe its features as it relates to the goals of this study.

3.2 ASD diagnosis as a hypothetico-deductive process

I will begin by detailing what I refer to as the hypothetico-deductive construction of ASD diagnosis, given its resemblance to the eponymous scientific method (Willig, 2013). In the hypothetico-deductive scientific method, which dominates Western experimental psychology’s approach to knowledge and clinical reasoning in broader diagnostic practice, a scientist acquires “knowledge” through the systematic collection of evidence and observations that are used to disconfirm or corroborate a particular hypothesis (Willig, 2013; Elstein, Shulman, & Sprafka, 1987; Elstein, 2009; Ju & Choi, 2018). In much the same way, psychologists here construct diagnosis as a process that involves the formulation of impartial diagnostic “hypotheses” which are then tested through deduction and diagnostic “evidence.” However, while these features
resonate with the hypothetico-deductive scientific method, psychologists also paradoxically
describe using intuition, rather than just impartiality and “evidence,” to disconfirm or
corroborate their diagnostic hypothesis. I will explicate each of these features in this section and
argue that threading this paradoxical construction together is the psychologist’s pursuit of
accurate determinations of ASD pathology through diagnosis. I conclude by demonstrating how,
within this construction, ASD is constructed as an innate and discrete syndrome.

3.2.1 The objective “diagnostic hypotheses” and detached psychologist

In the hypothetico-deductive scientific method, a scientist first identifies a problem area
then derives one or several testable hypotheses from a particular theory (O’Donohue, 2013).
Research on clinical reasoning has documented a comparable diagnostic approach wherein
clinicians collect health-related information and concerns in a medical interview and formulate a
series of diagnostic hypotheses that are then tested through the assessment process (Elstein,
Shulman, & Sprafka, 1987; Elstein, 2009; Ju & Choi, 2018). As mentioned, this approach
informs and predominates diagnostic medical training (White & Stancombe, 2003; Marcum,
2008). It is thus not surprising that psychologists in this study similarly spoke of their diagnostic
“hypotheses,” which are developed in the early stages of the assessment process, often after
consulting with the individual and/or their family about their area(s) of concern. However, as I
will emphasize in this section, when speaking of ASD diagnosis as a hypothetico-deductive
process, psychologists’ employ language that discursively bolsters the impression of ASD
diagnosis as a technical and objective procedure. Consider, for example, the following excerpts
in which psychologists describe formulating diagnostic hypotheses through the diagnostic
interview:
Excerpt 1 [P2]: So the intake interview takes an hour and it’s a comprehensive development history, starting with pregnancy and going all the way through, and at the end of that I will usually jot down some working hypotheses that help me pick which tools I’m going to use.

Excerpt 2 [P2]: I have a working hypothesis, yes. But I adjust that based on the steps […] I automatically add the specialized tools for what pings during the intake interview, but if anything else comes up from the broad assessment tools then I follow that as well.

Excerpt 3 [P4]: So, the interview is pretty thorough, it lasts an hour and a half, two hours. And so, through that I’m formulating almost like a schematic. If you answer yes to this, we go down that path.

Excerpt 4 [P6]: So, I have parents come in for one- to one-and-a-half hour interviews to gather some information. Usually if the children are old enough, usually around age 12 or above I’ll ask them to join as well. And I will gather some information from all of them about background, history, and where things are at now. And of course, if specific information comes up about things like attention or things like autism or autism types of traits then I will certainly start to dig further into those areas.

Mishler (1984) documents the pervading conceptualization in medicine of the medical interview as a “technical procedure” which is “analogue to an experiment in physiology or biochemistry” (p. 10). Such a conceptualization of the interview as a technical and scientific procedure resonates with the above excerpts. For instance, in these excerpts, the clinical interview takes on an image of a well-defined and comprehensive process. Psychologists describe the specific amount of time involved in each interview, “an hour” in excerpt 1, “an hour and a half, two hours” in excerpt 3, and “one- to one-and-a-half hour[s]” in excerpt 4. In denoting the precise time involved in each interview, psychologists discursively establish clear boundaries around the clinical interview and, as such, signal that it is a demarcated rather than fluid process. This image is further reinforced by the implication of it having a predetermined structure concerned with particular subjects. For example, one psychologist explicitly describes the interview as involving certain “steps” (excerpt 2) and another implies these steps as she states, “if you answer yes to
this, we go down that path” (excerpt 3). These “steps” (excerpt 2) or this “path” (excerpt 3) “comprehensive[ly]” (excerpt 1) and “thorough[ly]” (excerpt 3) cover topics related to an individual’s “developmental history” (excerpt 1), “background,… and where things are now” (excerpt 4). The implication is that this well-defined and comprehensive interview provides “specific information” (excerpt 4) that can then be used to “formulat[e] (excerpt 3) what the psychologist in excerpt 1 refers to as “working hypotheses,” psychologist in excerpt 3 calls a “schematic,”” and psychologist in excerpt 4 describes more indirectly through examples like “attention” or “autism types of traits.”

Moving from the interview to specific diagnostic possibilities is, however, framed in psychologists’ talk as a mechanical process – one in which the clinician’s subjectivity is largely absent. For instance, the psychologist in excerpt 3 refers to “formulating almost like a schematic.” Words “formulating” and “schematic” evoke an image of a detached computer-like process devoid of humanness. Take also excerpt 2 in which P2 uses the term “ping” to describe her insights over the course of the intake interview. The term “ping” likens the psychologist to a radar, possessing the ability to “detect” indicators of pathology which, in turn, implies her observations to be a detached and objective assessment of the information collected during the intake interview. Further, in excerpt 2, she suggests that she “automatically adds the specialized tools” for what “pings.” The term “automatic” implies that this process is unconscious and mechanized. This sort of talk around the assessment process and, specifically, around developing diagnostic hypotheses, creates an image not of a human, but rather of a mechanical “detector” of ASD: this effectively positions the psychologist as a detached and impartial collector and
interpreter of diagnostic information. The diagnostic hypothesis, in turn, appears automated and objective.

This mechanical language might well reflect broader scientific ideals that began to predominate Western medicine in the twentieth century, in which “objectivity” is conceived as a route to diagnostic “accuracy” (Halpern, 2001, p. 17). This “objectivity” takes on a striking quality in these excerpts – clinicians are positioned as objective to such a degree that they are conceived almost entirely as mechanical objects without a subjective interview experience. The clinical interview – as the site of impartial data collection that lends itself to the generation of accurate diagnostic hypotheses – thus takes on and reinforce the “ideal” features of a scientific experiment and is implied, within the context of broader values in medical practice, to facilitate accurate diagnostic hypotheses (Mishler, 1984; Halpern, 2001, p. 17).

3.2.2 “Differential diagnoses” and deduction as the path to diagnostic knowledge

A central element of the hypothetico-deductive scientific method is the falsification of alternate hypotheses as a means of testing and establishing the validity of a scientist’s working hypothesis (Willig, 2013). In my conversations with psychologists, this falsification of alternative hypotheses took the form of the “differential diagnosis” in which psychologists proposed and sought to rule out possible explanations for an individual’s symptoms. The process of differential diagnosis is deductive in that it centers on testing various possible explanations for a set of symptoms in order to obtain a closer approximation of their “true” cause. Take, for instance, the following excerpts:

Excerpt 5 [P7]: […] during the interview I’m thinking of potential diagnoses depending on what the parents are reporting or what the clients are reporting. So, with adults, and in adult females, I find that one of the differentials is borderline personality disorder as well. Because in both conditions, they tend to be very
sensitive, kind of fragile […], they come across as very emotionally dysregulated and have a lot of trouble in interpersonal relationships, but the source of those difficulties is different.

Excerpt 6 [P5]: I’m also looking at the cognitive piece in most cases. Either that they already had a cognitive assessment and I’ll be looking at the results of some previous assessment or that I would be doing a cognitive assessment. Especially if we’re looking at autism and trying to differentiate it from a global developmental disability. So I’d be figuring out, you know, where are they developmentally and can the things that we’re seeing be attributed to a cognitive delay not specific to autism?

In each excerpt, the psychologists present a possible diagnosis in addition to ASD: P7 “find[s] that one of the differentials is borderline personality disorder [BPD]” (excerpt 5), while P5 is “trying to differentiate [ASD] from a global developmental disability” (excerpt 6). However, both suggest that ASD and its differential are of a different cause. For instance, P7 states that in ASD and BPD, “the source of those difficulties is different.” In excerpt 6, P5 describes using cognitive assessments to determine whether, “the things that [they are] seeing [can] be attributed to a cognitive delay not specific to autism.” Words like “source” and “attributed” imply a fundamental difference between ASD and its differentials and, in turn, suggest that the process of differential diagnosis is concerned with objectively capturing the correct disorder. Like in the hypothetico-deductive scientific process – wherein a scientist pursues truth by disconfirming possible explanations of a dataset (Willig, 2013) – differential diagnosis here becomes the path to diagnostic accuracy, a process of correctly identifying the source of an individual’s symptoms through ruling out various possible diagnoses. Psychologists’ talk about ASD diagnosis and, specifically, differential diagnosis therefore resonates with the hypothetico-deductive method and scientific discourse that treats deduction as a path to impartial diagnostic knowledge (Willig, 2013).
In psychologists’ talk, this path to diagnostic knowledge through differential diagnosis is a straightforward one. Turowetz and Maynard (2018) observe that although differential diagnosis of ASD is a narrative achievement wherein, “clinicians deploy their findings to support a given diagnosis” (p. 376), diagnostic guides obscure diagnostic clinicians’ narrative work: instead, diagnosis suggest is presented as a straightforward process wherein the, “clinician only needs to examine the patient and map her symptoms onto diagnostic criteria, or score the patient’s test performance and convert it into a population-normed clinical category” (p. 376). In the excerpts presented in this section, differential diagnosis takes on a quality similar to that of the diagnostic manuals and test protocols discussed by Turowetz and Maynard (2018). For instance, in order to “figure[e] out” if “the things that we’re seeing [can] be attributed to a cognitive delay not specific to autism,” P5 simply conducts a “cognitive assessment” (except 6). Such talk reduces differential diagnosis to a straightforward process wherein psychologists are able to test a hypothesis and make an accurate “attribution” claim about an individual’s symptoms. Deduction, which in the case of ASD takes the form of differential diagnosis, is thus framed as a direct and straightforward path to knowledge about the “source” (excerpt 5) of an individual’s behaviour.

3.2.3 Diagnostic assessments and observations as “evidence” or “science”

While I have detailed thus far how psychologists construct diagnosis as a detached and objective process involving the formulation of hypotheses and differential diagnoses, I have yet to explore in detail the objects that are involved in moving from a diagnostic hypothesis to a diagnostic decision. In psychologists’ talk, diagnostic hypotheses are “tested” and constructed as fact through formalized assessment tools and observation. Such tools and observations take on the quality of “evidence” or “science,” and, as such, acquire the ability confirm/disconfirm their
hypotheses and legitimize their diagnostic conclusions for others. Take, for example, the following exchange that follows from a conversation about the signs of ASD in unclear cases:

Excerpt 7 [P1]: I think the biggest signs were the things I think that aren’t common with other disorders. Right? So the things you would probably only see with ASD. So I would say it would be more the unusual behaviours – the clearly repetitive behaviours – or the complete lack of interaction.

I: And how did you identify those signs with those kids? Did you observe them yourself? Did you interview people who knew them?

Excerpt 8 [P1]: […] So I did the ADOS [Autism Diagnostic Observation Schedule]. I always… you know. Yeah. Then I also tried to do some cognitive testing. Sometimes more successfully than others. Then some formal and informal play. Spend a lot of time talking to the parents. And then if I could get information from the school or daycare I did that too.

I: And what helped you decide eventually that this person actually did or didn’t have ASD?

Excerpt 9 [P1]: Hm. That’s a very good question. Was there one thing? Hm. I think it was the consistency of the evidence. […]

In excerpt 7, the psychologist states that in unclear cases, “the biggest signs were the things I think that aren’t common with other disorders” and “that you would probably only see with ASD.” This claim echoes the sentiments of differential diagnosis and deduction in which the psychologist establish the validity of diagnostic knowledge through the process of distinguishing ASD from other possible diagnoses. Here, the psychologist is able to determine that an individual is autistic on the basis of behaviours that “you would only see with ASD.” Interestingly, the psychologist uses polarizing descriptors to qualify the behaviours that “you would only see with ASD.” She adjusts her statement about “unusual” behaviours to instead say “clearly repetitive behaviours” and describes “the complete lack of interaction” that are characteristic of ASD and “aren’t common with other disorders.” Descriptors like “clearly,” “complete,” and “unusual” create the impression that these ASD-specific behaviours are obvious
in their manifestation and render autistic people as markedly distinct from those with or without other syndromes. Such a construction makes plausible the differential diagnosis of ASD on the basis that autistic people are distinct from non-autistic people in overt ways.

Nevertheless, when asked how she identifies these signs in her assessment, this psychologist discusses various sources of information – like the ADOS, “cognitive testing,” “formal and informal play,” “the parents,” and sometimes, “information from the school or daycare” (excerpt 8) – and then describes this information as “evidence” that helped her come to a diagnostic conclusion. She therefore constructs assessment tools and diagnostic observations as “evidence” and “evidence” as a pathway to knowledge. This construction of “evidence,” as a route to diagnostic knowledge, implies the objects that constitute it to be impartial reflections of “truth.” Such a construction is evocative of dominant scientific discourses in which truth claims are made on the basis of impartial “evidence” (Goldenberg, 2006). Further, through the notion of evidence and its construction as a route to truth, P1 positions herself within these discourses – she makes diagnostic decisions based on “evidence” and, as such, assumes the role of a scientist or judge who determines the factualness of a diagnostic claim. From such a position, she is a rational arbiter who is able make an accurate determination that an individual is or is not autistic, even in uncertain cases, on the basis of diagnostic assessment tools and observation.

This exchange highlights the construction of assessment tools and observations as a path to objective diagnostic knowledge. In the following excerpt, which was produced in response to a question about whether the psychologist follows, “the same assessment process with all the same tools” if she is fairly certain about an ASD diagnosis immediately after meeting an
individual, we can see how equating these tools with “science” similarly establishes the legitimacy of diagnostic knowledge:

Excerpt 10 [P4]: Yeah because if you don’t then you risk the chance of not being taken seriously and you really and truly, just because I have a hypothesis, I need science to back that up.

In this excerpt, the psychologist equates “assessment tools” with “science;” she follows the same process with the same assessment tools because she “needs science to back [her hypothesis] up.” She claims that her diagnostic hypothesis alone is insufficient to be “taken seriously” and “really and truly” requires “science to back [it] up.” Through this statement, she contrasts diagnostic hypotheses that are supposedly not “serious” when considered alone, with the seriousness of a hypothesis that has been “back[ed]…up” by “science.” She reifies “science” as a knowledge-generating process that can effectively confirm what were once “just” hypotheses (Willig, 2013) and ascribes assessment tools this same status. Interestingly, however, the psychologist seems to imply that assessment tools are necessary to legitimize diagnostic conclusions for an unspecified other: the phrase “taken seriously” suggests that the “serious[ness]” of her diagnosis is being judged by someone and must be legitimized by “science,” in the form of assessment tools, in order to be accepted.

Diagnostic tools and observations are thus constructed as detached fact-finding and -corroborating tools for both the psychologists themselves and others. This construction of “evidence” mirrors its treatment within broader Western medicine and science as a path to truth (Goldenberg, 2006): psychologists, here, frame diagnostic assessments as evidence for themselves and others of the truth of their diagnostic claim.
3.2.4 “Gut feeling” and the embodied scientist

While the features of this construction that I have outlined thus far are consistent with the values of hypothetico-deductive scientific process, embedded in psychologists’ constructions of ASD as a hypothetico-deductive process is the paradoxical notion that psychologists often just “know” when an individual is autistic. In contrast to the aforementioned features of the hypothetico-deductive procedure wherein psychologists are able to know because they have followed a rigorous method informed by objectivity, evidence, and deduction, psychologists here imply that knowing is not dependent on such an approach alone; it can, at times, also be guided by instinct or intuition. Such talk – wherein diagnostic knowledge is informed by intuition – contradicts the features of this construction that frame diagnosis as a detached approach to knowledge, while still constructing diagnosis as concerned with accurate diagnostic deductions. See, for example, the following interaction, which is a continuation of the conversation in excerpt 5, on differentiating ASD and borderline personality disorder in women:

Excerpt 11 [P7]: [...] so, one of the things I’ve noticed is just the desire for social interactions. Where in ASD there’s less of an interest in developing those relationships and the person can be quite happy with just one close relationship. And there’s less of – especially in the older adults – there’s less of that up and down in the relationships, that kind of “I hate you… I love you and I hate you” that kind of dynamic. The level of negative affect I find is much stronger in individuals that struggle with borderline. Then, in ASD I find that there’s a lot more of that sensory sensitivity, where I’ve been noticing things like misophonia, so really sensitivity to sound, to textures, is much more pronounced and there’s that history of that. And borderline, I find there’s more of that tendency towards self-harm and suicidal ideation and previous suicide attempts, as well as just a comorbidity with a number of other disorders. So, on things like the PAI [Personality Assessment Inventory], I find that the individuals that I see that are more borderline or Axis II spectrum, they tend to endorse many many symptoms associated with emotional distress and emotion dysfunction. And, just qualitatively, I feel there’s a difference in the presentation, like just in the interview the person.

I: You can feel a difference between them?
Excerpt 12 [P7]: Yeah, it’s almost like your own response to the person, there’s a bit of a difference.

In excerpt 11, P7 discursively distinguishes the characteristics of BPD from those of ASD and references the use of diagnostic tools to corroborate this distinction: she states that individuals with BPD “endorse many many symptoms associated with emotional distress and emotion dysfunction on the Personality Assessment Inventory.” Such talk, wherein the psychologist speaks of corroborating her diagnostic hypothesis through differential diagnosis and assessment tools, bears the features of the construction of diagnosis as a hypothetico-deductive method outlined thus far.

However, she then states that in addition to the characteristic differences between the syndromes that can be measured using tests like the PAI she, “qualitatively… feel[s] there’s a difference in the presentation, like just in the interview the person.” She thus introduces the notion that diagnosis is not simply a matter of methodical and evidence-based deduction but can also be “qualitative” and guided by a “feel[ing].” When I looked for some clarity on this statement by asking, “you can feel a difference between them?,” she described a “bit of a difference” in her “own response to the person.” She modifies the hypothetico-deductive approach to diagnosis by introducing her “feeling” as the diagnostician to the diagnostic process: she is, in addition to using assessment tools, drawing on her own “response” to individuals to differentiate between borderline personality disorder and ASD and, ultimately, frames this response as aiding her ability to make an accurate diagnosis in possible cases of ASD.

The use of instinct and/or feeling in the diagnostic process resonates with diagnostic concepts like clinical judgment, wherein intuition is regarded as a cultivated skills of a medical
expert that can aid diagnostic decisions (White & Stancombe, 2003), and countertransference, wherein psychologists use their feelings within clinical encounters as a source of insight to guide practice (Abend, 2018). As such, it is not altogether surprising that psychologists might speak about the role of their own instincts or feelings within diagnosis. Interestingly, when “instinct” or “feeling” is introduced into psychologists’ talk about their diagnostic decisions, psychologists reintroduce themselves as embodied beings. Consider, for example, how the following psychologist describes the process of identifying and differentially diagnosing ASD:

Excerpt 13 [P8]: I’d say more typically, there’s a gut feeling that is pretty sure. That something’s odd and doesn’t seem like your normal ADHD or LD. Sometimes it can be confusing between – this is one other thing – between a non-verbal learning disability. Because severe non-verbal learning disabilities have that social awkward, lack of eye contact too. So, sometimes I’m thinking I need to do that and so, yeah, when I’m looking at ASD and I’m wondering if it can be a non-verbal learning disability, there’s certain tests from the old WISC [Wechsler Intelligence Scale for Children] version, like object assembly, that are much more telling and that are no longer on it. And so, I go back and give some extra tests to see is this an NVLD [non-verbal learning disability]?

This excerpt, again, bears many of the features of the hypothetico-deductive construction outlined thus far. She describes developing a diagnostic hypothesis of ASD and then making a differential diagnosis between autism and a non-verbal learning disability using “certain tests” that are “telling” and allow her “to see [if] this [is] an NVLD.” Describing “certain tests” of the WISC as “telling” again suggests that the tests establish an authoritative and detached report of a child’s intelligence: “telling” implies an ability to reveal and convey truth. This “telling” quality is particularly important given the “confusing” nature of distinguishing ASD from a NVLD because, “severe non-verbal learning disabilities have that social awkward, lack of eye contact too.” These tests are therefore implied to effectively provide the evidence necessary to make a
conclusive and accurate differential diagnosis. Diagnosis is, again, constructed as a deductive and evidence-based process that facilitates clear and substantiated diagnostic conclusions.

However, in addition to these features, she describes, like P7, being guided by a “feeling” – in this case a “gut feeling” – that an individual is autistic. Qualifying this feeling as a “gut feeling” stands in clear contrast to psychologists’ earlier positioning as detached computer-like “detectors” of ASD, in which they are devoid of human quality. Here, P8 speaks of her “gut” and is introduced in this excerpt as an embodied person. Further, she describes being guided by her “gut feeling” which is “pretty sure” in diagnosis and, as such, suggests that her humanness informs her diagnostic hypotheses at least somewhat accurately. This statement implies that the objective of diagnosis is an accurate diagnostic determination: an objective that is here realized through the combined insights afforded by the psychologist’s “pretty sure” feeling and the subsequent confirmation of that feeling by the use of diagnostic tools. She thus blends her human instinct with the typical detached features of the hypothetico-deductive method to achieve an accurate diagnostic conclusion.

Instinct is, however, supplemental to, rather than instrumental in, the assessment process in these excerpts: in excerpt 11, intuition appears as an afterthought to the psychologist’s description of the different symptom profile in ASD and BPD that she observes and tests; while in excerpt 13, the psychologist describes corroborating her “gut feeling” with the WISC and “some extra tests.” Traynor, Boland, and Buus (2010) found a similar pattern in nurses’ accounts of their clinical decisions wherein, “instinct and intuition” were “subordinated … to their experience and/or more formalized assessments” (p. 1588). Thus, while psychologists introduce intuition and themselves as embodied beings within the diagnostic context, intuition and
embodiment are secondary to detached diagnostic evidence. Diagnosis is, here, still governed by psychologists’ pursuit of accurate diagnostic deductions.

3.2.5 ASD as an innate and discrete syndrome

I have demonstrated in this section that psychologists construct ASD diagnosis as a hypothetico-deductive process that centers on the pursuit of accurate diagnostic claims. I will now outline how such talk constructs ASD as an innate and discrete syndrome.

To make this point, I would first like to return to the discussion of differential diagnosis and focus further attention on excerpts 5 and 6. In excerpt 5, a psychologist speaks about differentiating ASD from BPD and states that autistic individuals and those with BPD are both “sensitive,” “fragile, “emotionally dysregulated,” and “have trouble in interpersonal relationships.” In doing so, the psychologist draws our attention to the similarities between the two syndromes. However, she proclaims that despite these apparent similarities, “the source of [these common] difficulties is different.” Through this claim, and particularly the use of the term “source,” the psychologist effectively suggests innate, though distinct, causes of ASD and BPD: “source” implies that the origin of these two disorders is different. This excerpt therefore simultaneously implies ASD to be an innate and discrete syndrome, one with an innate and distinct “source.” Similarly, the psychologist speaking in excerpt 6 describes “differentiat[ing]” autism from a global developmental disability using cognitive assessment. She states that using cognitive tools helps her “figure out” “whether the thing [they are] seeing can be attributed to a cognitive delay not specific to autism.” This language, again, suggests that symptoms can be “attributed” to a pathology and thus constructs cognitive delay and autism as innate and discrete syndromes. As such, ASD is constructed as both innate – its cause being located within the
individual – and discrete – as a distinct and differentiable syndrome – in the construction of ASD diagnosis as a hypothetico-deductive method.

Consider, in addition, the following exchange in which I discuss with a psychologist the process of distinguishing symptoms of seizures from those of ASD in one particular case:

Excerpt 14 [P4]: Well I think I’d say what this child needs is a neuropsychological assessment […] it would be much fuller and parse some of the things apart.

I: And I know it’s your area but not what you’re practicing, but do you have a sense of what they are actually looking for to parse that apart?

Excerpt 15 [P4]: […] they would be doing probably some more focal assessments that would be looking at which part of the brain is doing what […]

In these excerpts, P4 has two working diagnostic hypotheses – symptoms as being caused by ASD or symptoms as being caused by seizures – and claims that a “neuropsychological assessment […] would be much fuller and parse some of the things apart.” The psychologist’s use of the phrase “parse apart” brings to mind an image of the diagnostic clinician pulling apart two separate entities. This image presents seizures and ASD to be two distinct “things” that can be physically distinguished through diagnosis. Such talk, again, effectively constructs ASD as a discrete syndrome.

In addition to constructing ASD as an inherent feature of the individual, P4 also explicitly locates the site of this physical separation in an individual’s brain: for this psychologist, a “neuropsychological assessment” (excerpt 14) in which a practitioner would be “looking at which part of the brain is doing what” (excerpt 15) would aid the diagnostic process. Through this statement, which locates ASD within an individual’s brain, P4 reproduces dominant biomedical discourse that posits a biological cause of ASD (O’Dell et al., 2016). Such talk also
bears a common feature of biomedical discourse – biological reductionism and determinism – wherein an individual’s behaviours are described as produced in isolation by their biology (Nadesan, 2013): it is, here, the girl’s “brain” that is “doing” and is, as such, the cause of the her symptoms.

Overall, the excerpts discussed in this section “attribute” (excerpt 6) “difficulties” or observed behaviours to an inherent feature of the individual that is being assessed: in each excerpt, the psychologist is asking whether an individual’s symptoms are a sign of ASD or a different syndrome and looks to distinguish the true “source” of these symptoms through “cognitive” and “neurological” tests. This talk simultaneously implies ASD to be discrete – in that it is known to be separate from other syndromes – and innate – being caused by something within the “affected” individual – and, in doing so, reifies dominant biomedical discourse in which ASD is constructed as a biological disorder (O’Dell et al., 2016). This dominant discourse has, as is documented here, the capacity to reduce ASD to a biological syndrome.

3.3 A shift in psychologists’ talk about ASD diagnosis

Thus far, I have demonstrated how psychologists speak of ASD diagnosis as a hypothetico-deductive method. Finding credence in Western culture’s widespread regard for the hypothetico-deductive scientific method as a path to objective knowledge (Willig, 2013), this construction of diagnosis effectively suggests that through the systematic collection of evidence, psychologists can corroborate and disconfirm diagnostic hypotheses and instincts and, in turn, establish a reasonable degree of certainty about whether an individual is inherently autistic. In this construction, ASD diagnosis is therefore the pursuit of impartial truth about the presence or absence of an innate and discrete ASD pathology. However, as mentioned, psychologists’ talk
about ASD diagnosis shifts around the notion of clinical impairment. In this section, I will explicate the concept of clinical impairment as it appears in the interviews and detail how this concept functions to necessitate diagnosis when dominant discourses of ASD render diagnosis precarious rather than valid.

### 3.3.1 The notion of “clinical impairment”

The notion of clinical impairment centres on the claim that ASD diagnoses are only appropriate for individuals who are experiencing a reduced quality of life due to their symptoms. This concept is reflected in current diagnostic criteria for ASD. For example, the DSM-V (2013) specifies about the symptoms of ASD that:

> the social and communication impairments and restricted repetitive behaviors that define autism spectrum disorder are clear in the developmental period. In later life, intervention or compensation, as well as current supports, may mask these difficulties in at least some contexts. However, symptoms remain sufficient to cause current impairment in social, occupational, or other important areas of functioning” (299.0, F84.0).

The DSM-V (2013) thus denotes that for an individual to be diagnosed with ASD, their symptoms must be “sufficient to cause current impairment in social, occupational, or other important areas of functioning” (299.0, F84.0), particularly when being assessed in later life.

Psychologists reproduce this notion of clinical impairment in their talk about ASD diagnosis. Take the following excerpts:

Excerpt 16 [P2]: […] it’s only a diagnosis of a disability if it is impairing someone’s ability to function, to thrive, and to succeed.

Excerpt 17 [P7]: I think for some adults I could make the argument that, “you know, I don’t think you necessarily meet the full criteria. I see there’s definitely features but seems more on the normative spectrum of things. It’s not interfering on your life significantly.”
Excerpt 18 [P2]: I think we need to keep in mind that if it’s not clinically impairing someone’s life then it’s simply just for grouping personality traits which can be very positive.

In these excerpts, ASD is only a “diagnosis of disability” when it is “interfering” (excerpt 17) with an individual’s “ability to function, to thrive, and to succeed” (excerpt 16). The psychologist speaking in excerpt 17 explicitly describes features that are, “on the normative spectrum of things” as those which are, “not interfering on your life significantly,” while the psychologist speaking in excerpt 18 distinguishes between personality traits, “which can be very positive” from those traits which are, “clinically impairing someone’s life.” This sort of talk establishes a boundary between the “normative spectrum” of behaviour or “positive” “personality traits” (excerpt 17) and ASD on the basis of clinical impairment: the traits associated with ASD are not inherently abnormal or negative, but rather become so when they interfere with an individual’s ability to function in daily life. “Normal” is thus the ability to “thrive” and “succeed” (excerpt 16) without experiencing impairment: an ability which is then lacking in individuals who receive an ASD diagnosis.

Notably, clinical impairment appears as a categorical experience within each of these excerpts. Determinations of clinical impairment are, in each case, absolute: either “it is impairing someone’s ability to function” (excerpt 16) or “it’s not interfering” (excerpt 17) or “clinically impairing” (excerpt 18). Such a construction suggests that clinical impairment exists not on a spectrum but as a matter of fact and definitive experience. Here, an individual is or is not clinically impaired, with no in between.

In an attempt to elicit further talk on the process of distinguishing between “impairment” and “success,” I asked P2 if she could speak more on how she determines “when there is a
clinical impairment.” In response, she spoke, first, about high functioning individuals who experience anxiety and depression as a result of social challenges:

Excerpt 19 [P2]: So, for the high functioning kids, anxiety and depression is often a huge piece of it, typically because they’re having challenges in their interpersonal relationships with peers, with teachers.

Next, she spoke about individuals who experience difficulties at university due to problems in executive functioning:

Excerpt 20 [P2]: It’s maybe they’re having severe challenges with executive functioning, like with keeping themselves organized and coordinated. So, I see a fair number of college kids and in high school, where everything was very organized, you had tons of little assignments, mom and dad monitored your homework, they were fine. And then they go off to college and the lack in executive functioning, in being able to coordinate themselves and organize themselves, all of a sudden just makes life completely unmanageable for them.

Then, she spoke about adults who experience problems in their marriages and/or workplace due to challenges with interpersonal communication, perspective taking, and rigidity:

Excerpt 21 [P2]: Sometimes I diagnose adults, it’s not as common. And quite often what brings them to me is acute issues in their marriage or in their employment. And with employment it often has to do with the interpersonal communication challenges with coworkers and with their boss, and rigidity […] Or in their marriage, their marriage has gotten to a point of divorce because their ability to navigate that interpersonal relationship or have any kind of perspective taken and it’s in a crisis mode.

This psychologist through these excerpts describes clinical impairment in terms of an individual’s ability to maintain relationships and/or succeed in school or work and the secondary symptoms – such as depression or anxiety – that result from a lack of “success” in these areas. She uses extreme language to qualify each case of impairment. Terms like “huge” (excerpt 19), “severe”, (excerpt 21), “completely unmanageable” (excerpt 20), “acute” (excerpt 21), and “crisis” (excerpt 21) evoke a sense that these are substantial challenges in the individuals’ lives. Further, she attributes these “challenges” to individual themselves: anxiety and depression are
explained as a product of “their interpersonal challenges,” their problems at school as due to “severe challenges with executive functioning,” and their problems at work or in marriage as a result of, “interpersonal communication challenges” or their “ability to have any kind of perspective taking.” This attribution is evocative of dominant Western discourse around illness and success, specifically biomedical and neoliberal discourse. While biomedical discourse locates the cause of illness within the “affected” individual (O’Dell et al., 2016), neoliberal discourse places responsibility for well-being on individual members of society (Gruson-Wood, 2016). Discourse which reifies notions of individual-driven success and places the responsibility for impairment solely on the individual – as P2 does – further obscures the social conditions that foster the expectation of such skills and naturalizes the idea that the absence of these skills denotes pathology. Such talk is conducive to medical intervention that focuses on the individual alone, rather than on the social system that contribute to this view of pathology (Gruson-Wood, 2016; Waltz, 2005) and, as such, curbs the possibility that we might realize a society in which a more diverse skillset is recognized as valid instead of in need of modification (Yergeau, 2018).

The naturalization of unfulfilled social expectations as pathology in these excerpts is particularly critical given that clinical impairment is here, again, constructed as a matter of fact. While individuals are said to have “challenges in their interpersonal relationships with peers, with teachers” (excerpt 19), “severe challenges with executive functioning, like with keeping themselves organized and coordinated” (excerpt 20), and/or “acute issues in their marriage or in their employment” (excerpt 21), these experiences appear in these excerpts as detached reports of experience and interactions that seem to come from nowhere or no one in particular. From such a detached perspective, specific experiences of clinical impairment are, like clinical impairment
more generally, constructed as a matter of fact: the autistic individual is, as a result of the
detached accounts of experiences or behaviours, framed as objectively experiencing these
difficulties. Such talk ultimately obscures the information and sources that might inform
determinations of clinical impairment in ASD diagnosis.

3.3.2 “Clinical impairment” at the limits of biomedicine

Psychologists drew on the notion of clinical impairment at the moments in our discussion
wherein dominant biomedical discourse rendered ASD diagnosis precarious, rather than valid
and/or legitimate. This precariousness manifested in two ways in my conversations with
psychologists. First, at the intersection of dominant biomedical discourse and talk about ASD
diagnosis is the fact that although ASD is constructed as an innate and discrete biological
syndrome within dominant biomedical discourse, research has yet to identify one or multiple
biological correlates that can be used to diagnose ASD (Nadesan, 2013). Within the context of
biomedical discourse, ASD diagnoses might thus appear spurious. At this intersection,
psychologists invoke the notion of clinical impairment. Consider, for instance, the following
claim that precedes excerpt 16, in which P2 states of ASD that, “it’s only a diagnosis of a
disability if it is impairing someone’s ability to function, to thrive, and to succeed”:

Excerpt 22 [P2]: […] it’s not a blood test or a genetics test. It’s a similar grouping
of symptoms. And at a certain point, it’s just a group of personality traits. Right?

Prior to drawing on the notion of clinical impairment in excerpt 16, P2 states without prompt that
ASD diagnosis is not “a blood test or a genetics test” but rather “a similar grouping of
symptoms” or “personality traits.” In drawing a contrast between diagnoses that are based on
biological tests and ASD, which is instead based on “a similar grouping of symptoms,” she thus
finds the limits of biomedical discourses of ASD in talk about diagnosis: current methods of diagnosis do not rely on biology but rather on behavioural observations and reports. Diagnostic claims can therefore not be legitimized on the basis of biomedical discourse. At the discursive limit of biomedical discourse, she draws on the notion of clinical impairment and states that, “it’s only a diagnosis of a disability if it is impairing someone’s ability to function, to thrive, and to succeed” (excerpt 16). The notion of clinical impairment thus functions where biomedicine cannot and legitimizes ASD diagnosis on the basis that in the absence of “a blood” or “genetics test,” a diagnosis of disability is contingent on functional impairment.

Second, the notion of clinical impairment surfaced when psychologist spoke about neurodiversity. Neurodiversity discourse was, unsurprisingly, particularly salient during the point of the interview in which I asked psychologists’ their thoughts on the movement. Several psychologists agreed with the tenet that ASD is part of a normal neurological continuum and is not necessarily a disorder. For example:

Excerpt 23 [P4]: Well first of all I don’t think it should be labelled as a disorder or a – I mean we’re all on a spectrum and we all are neurodiverse in our own ways. And yet, this is one part of normal.

Excerpt 24 [P8]: As thinking about it, it is neurodiversity, I mean always feel this way about any diagnosis, right? Like we’re all on this continuum, we’re all whatever, and what is the value of labelling?

In these excerpts, psychologists employ the language of the neurodiversity movement and suggest that they agree with the movement’s tenets. In excerpt 23, the psychologist maintains that “we’re all on a spectrum” and ASD “is one part of normal,” while the psychologist in excerpt 24 states that, “it is neurodiversity” and “we’re all on this continuum.” Such language echoes the sentiments of the neurodiversity movement, in which ASD is understood to reflect
one manifestation of the diverse neurological functioning that can exist between people (Runswick-Cole, 2014).

Interestingly, when psychologists in these excerpts align themselves with the neurodiversity movement, they refrain from using diagnostic labels. Both psychologists refer to ASD as “it”: in excerpt 23, the psychologist does not think “it” – presumably meaning ASD – “should be labelled as a disorder” and in excerpt 24, the psychologist states that, “it” – again, presumably referring to ASD – is an expression of neurodiversity. This discursive strategy, in which psychologists invoke language of the neurodiversity movement and forgo the language associated with biomedicine, may reflect psychologists’ attempts to distance themselves from the medical community and instead position themselves within the neurodiversity community.

However, there exists an inherent tension in psychologists’ reproduction of counter discourses of ASD. Neurodiversity discourse, by framing ASD as “normal” and not a “disorder” (excerpt 23), challenges the biomedical notion of ASD as an inherent disability. Biomedical discourse in which ASD is inherently abnormal can thus not function within this talk to legitimize ASD diagnosis. Like before, psychologists here justify diagnosis on the basis of clinical impairment. Consider the following excerpts:

Excerpt 25 [P1]: I think that it is also talking about it as sort of a difference rather than necessarily a disability. There’s certainly things that can be disabling about the condition. The more severe you get the less you can say it’s only just a different way of being, ‘cause if your quality of life is really affected. But on the milder end of it, that seems to make a lot more sense. That it’s really just sort of a different way of seeing things and if its accommodated and people are recognizing that’s the difference then that’s a pretty valid way of seeing who you are.

Excerpt 26 [P3]: Again for me at the end of the day it’s not about whether I make a diagnosis or not. It really is, if there is this much diversity that’s great but if it’s
actually negatively impacting a kid’s daily functioning in any specific areas then I feel that some sort of supports or interventions are necessary.

In these excerpts, psychologists begin by aligning themselves with the neurodiversity movement: P1 states that, “it” is “a different rather than necessarily a disability” (excerpt 25), while P3 claims that “it’s not about whether [he] makes a diagnosis” and that “if there is this much diversity that’s great” (excerpt 26). However, as demonstrated above, this discourse calls into question the act of diagnosis. We can see, in the above excerpts, how psychologists draw on the notion of clinical impairment to resolve this tension: P1 says that, “the more severe you get the less you can say it’s only just a different way of being” and P3 states that, “if it’s actually negatively impacting a kid’s daily functioning in any specific areas then I feel that some sort of supports or interventions are necessary.” As biomedical discourse is challenged as psychologists speak about neurodiversity, psychologists invoke the notion of clinical impairment, which takes the form of “quality of life” in excerpt 25 and “daily functioning” in excerpt 26, to legitimate diagnosis.

The notion of clinical impairment thus lives at the margins of dominant discourses of ASD. However, as demonstrated, the first construction of diagnosis as a hypothetico-deductive method implicitly hinges on and reproduces dominant biomedical constructions of ASD as an innate and discrete syndrome (O’Dell et al., 2016). How, then, is diagnosis and ASD constructed when psychologists reach the limits of this discourse and invoke the notion of clinical impairment?
3.4 Constructing ASD diagnosis as an act of care

When psychologists invoke the notion of clinical impairment at the margins of biomedical discourse, ASD diagnosis is constructed as an act of care. I refer to this construction of diagnosis as an act of care given its resemblance to the logic or ethic of care described in medical literature (Mol, 2008). As described in the introduction of this thesis, care, in this literature, is not governed by an external morality but is itself the moral act, one in which the caregiver and receiver engage in an ongoing, collaborative, and contextually sensitive practice (Mol, 2008). In this section, I will demonstrate how, in speaking of ASD diagnosis as a pragmatic pathway to “support” within our current institutional and social systems, psychologists similarly construct diagnosis as an act of care. Throughout this section, I will highlight how this construction differs from ASD diagnosis as a hypothetico-deductive process. I conclude by demonstrating how, within this construction of ASD diagnosis, ASD is constructed as a diffuse and pragmatic label with practical use rather than as an innate and discrete syndrome as was the case in its first construction.

3.4.1 Diagnosis as a pragmatic path to “support”

When ASD diagnosis is constructed as an act of care, diagnosis centres on assessing whether an individual is experiencing a reduced quality of life due to symptoms that are typically associated with ASD and is deemed to be in need of support for those symptoms. As such, when diagnosis is constructed as an act of care it is not a matter of accurately deducing pathology as in the hypothetico-deductive construction, but rather of pragmatically addressing suffering.

Consider, for instance, the following excerpt:

Excerpt 27 [P7]: I’ve had conversations with parents where I’ve said, “it’s really on the border and I don’t know if I would necessarily diagnose your child with autism,
autism spectrum disorder” but then they’re at a loss because they feel like they can’t get any support for their child, who is clearly struggling in daily functioning without that diagnosis. So, if I’m veering on whether or not to provide that diagnosis, I will often go with the diagnosis because otherwise they will get no supports and they’re really struggling.

The psychologist describes cases that are “really on the border” and which she does not “know if [she] would necessarily diagnose [a] child with autism” but “who [are] clearly struggling in daily function without that diagnosis.” She draws a distinction between “struggling in daily functioning” and “autism:” although a child is “struggling” she does not “know if [she] would […] diagnose.” Nevertheless, despite establishing this distinction she states that she “will often go with the diagnosis because otherwise they will get no supports and they’re really struggling.”

In this excerpt, diagnosis is not an objective pursuit meant to determine whether an individual is inherently autistic, as is the case when diagnosis is constructed as a hypothetico-deductive process – for if that were the case she would not “necessarily diagnose…autism.” Instead, she constructs diagnosis as a pragmatic decision – one that is context-specific (Mol, 2008) – and is meant to help address the suffering of an individual in need by connecting them with helpful supports.

The contextual nature of diagnosis in this construction becomes particularly evident in the following exchange, wherein a psychologist describes withholding diagnoses in cases where she feels it would be more harmful than beneficial:

Excerpt 28 [P6]: I think the one big takeaway I have diagnosing autism is it’s not always about diagnosis. Yes, it’s important, absolutely, for receiving services and maybe for better understanding a child, but I think it’s more important for a clinician to be sensitive to a family’s needs and supporting them to understand the child and how they are going to manage support this child throughout their life. And that’s more my goal.

I: So, in some cases diagnosis doesn’t necessarily help the family?
Excerpt 29 [P6]: Sometimes it doesn’t. No. Sometimes it can just make things harder. Especially when I’m working with kids who have… Or families who have high functioning kids as well. I mean maybe for families who are really struggling, like when I just worked with families who [inaudible]. They need that diagnosis for funding and different things like that. Absolutely, it makes tons of sense. But sometimes, families have a really hard time hearing it and sometimes you have to ease their way into it, or you have to work with what resources they have, ‘cause otherwise if it falls on deaf ears what are you going to do with it?

In contrast to excerpt 27, the psychologist in this exchange constructs diagnosis as an act of care through an inverse case, wherein diagnosis “falls on deaf ears” and is thus implied to be of no use. This psychologist effectively draws a distinction between cases wherein diagnosis is helpful – supposedly those in which “families are really struggling and […] need diagnosis for funding and different things like that” – and those in which diagnosis is said “to make things harder” – those in which “families have a really hard time hearing it” and especially those “with high functioning kids.” Through this distinction, this psychologist implies that diagnosis is not a matter of making accurate determinations of pathology but, rather, a matter of determining what will be most helpful within each particular case: as she puts it, “you have to work with what resources [the families] have” (excerpt 30). While a diagnosis is deemed helpful to some, it is, for others, not beneficial and is therefore futile: Diagnosis is here not a matter of truth, but of addressing needs in ways that are deemed context appropriate and allow for an ongoing and supportive relationship with the family or individual. This construction of ASD diagnosis as a context-sensitive and collaborate practice echoes descriptions of care found in the medical literature, which emphasize a case-sensitive and collaborative approach to healthcare (Mol, 2008).
3.4.2 Social and institutional realities and our immutable “systems”

Based on the notion of clinical impairment and the construction of diagnosis as a pragmatic path to support alone, however, it would be reasonable to question why ASD diagnosis is necessary to provide support for those experiencing clinical impairment. After all, could psychologists not provide care without deploying diagnostic categories? In constructions of diagnosis as an act of care, diagnosis is constructed as necessary for two reasons. First, because of institutional structures that require labels for access to resources:

Excerpt 30 [P5]: A diagnosis is a way to categorize people so that we can have funding available to help them with whatever they’re challenged with.

Excerpt 31 [P7]: I rely on that a lot too, like the level of interference in somebody’s life, but I absolutely agree that looking around, all of us have strengths and weaknesses in different areas, whether they’re social communication or other areas, and doesn’t all mean that we should all be diagnosed with something. But I think that for the purposes of getting accommodations at school, or getting some resources, it’s hard to do that because of the way the current systems are set up. That there’s a need for a diagnosis.

And second, because diagnosis fosters self and social acceptance in the face of cultural norms that ostracize those who are different:

Excerpt 32 [P5]: […] it’s really to help you understand how you might be functioning differently than some other people, what we call typical people.

Excerpt 33 [P6]: […] there are some times where you do have to be a little bit flexible and change a little bit and you have to be okay with trying to do that as well, because unfortunately, our world is not one where we just accept everybody. I wish we could.

Psychologists in excerpts 30 and 31 locate the “need for diagnosis” (excerpt 31) within current institutional systems, which require labels for access to funding and services; while psychologists in excerpts 32 and 33 intimate that, in the context of current social and behavioural norms, diagnosis can foster personal and social acceptance for nonconforming individuals that
can mitigate ostracism and its effects. Interestingly, psychologists in excerpts 31 and 33 position themselves as outside of, and powerless within, the system that establishes or perpetuates these norms. Phrases like “current systems” (excerpt 31) and “our world” (excerpt 33) evoke an image of a vast order that operates outside of human intervention. Psychologists’ lack of control within this structure is implicit at several points in these excerpts. For instance, P7 claims that she, “absolutely agree[s] that looking around, all of us have strengths and weaknesses in different areas, whether they’re social communication or other areas, and doesn’t all mean that we should all be diagnosed with something” (excerpt 32). She establishes a likeness between people with diagnoses and those without based on the claim that “all of us have strengths and weaknesses.” Nevertheless, she maintains that, diagnosis is “need[ed],” despite the fact that we all have strengths and weaknesses, “because of “the way the current systems are set up.” This excerpt establishes a divide between the psychologist and the “system” in which she operates. She exists separately from and holds opinions that differ from this “system,” however, the “system” is positioned in this excerpt as more powerful: in the end, she must provide diagnoses because of this system, regardless of her own views. Similarly, in excerpt 33, P6 states that, “unfortunately, our world is not one where we just accept everybody” though she, “wishes we could.” This statement again suggests that although the psychologist holds views that might challenge the need for diagnosis, our “world” is immutable and necessitates that we provide diagnoses so people can find acceptance. Psychologists are thus positioned as constrained, having limited means of providing services and acceptance within our current context. It is from this position that psychologists establish the moral underpinning of this construction, wherein ASD diagnosis is necessary within our current political and social system in order to help someone who is
suffering. Diagnosis is thus constructed as a moral act in and of itself and, as such, becomes an act of care (Mol, 2008).

Ironically, however, psychologists’ positioning as powerless within this construction could further cement the social and institutional systems that are said to constrain their available courses of action in the first place. Psychologists construct “our systems” (excerpt 31) and “world” (excerpt 33) as inflexible – P7 states that it’s “hard” to refrain from diagnosis given, “the way the current systems are set up” (excerpt 31) and P6 states that while she, “wishes we could” “our world is not one where we just accept everybody” (excerpt 33). This talk implies a degree of immutability within our systems: we cannot change them so we must work within them. However, at the same time, the suggestion that our systems are immutable curbs our imagination of a world in which support and acceptance might not be contingent on medical diagnoses: after all, what would be the purpose of trying to change something that is fixed? Thus, by reproducing the notion that our systems and world cannot be changed, psychologists ironically reinforce these systems and their own restricted capacity to resist them.

3.4.3 Psychologists as caregivers and collaborators

Within constructions of diagnosis as an act of care, psychologists assume the role of the empathetic and collaborative caregiver. Notice how, in excerpt 28, the clinician is required to be “sensitive” and “support[ive]” of the “family’s needs.” This talk positions the psychologist as a sensitive collaborator who is attending to and working with the family and, as such, evokes an image resembling that of the collaborate process of care (Mol, 2008).

Psychologists’ positioning, here, differs markedly from that within constructions of ASD diagnosis as a hypothetico-deductive method. Psychologists in hypothetico-deduction
constructions often lacked human quality and could, at most, “feel” or have “intuition.” However, these feelings were a guidepost in the pursuit of accurate diagnostic deductions, rather than a means of context-specific and collaborative engagement with the family. This contrast between these positions is, perhaps, most evident in my later interaction with P6:

I: So it sounds like the ultimate goal is supporting the family and sometimes that involves the diagnosis and sometimes that doesn’t.

Excerpt 34 [P6]: Yeah. Yeah. For sure. And that may not be the best approach as a psychologist. I know we’re trained to assess, diagnose, and treat, but I don’t know. I think maintaining the relationship and trying to work with them is, for me, more important.

In this excerpt, P6 again takes up the position of the empathetic and collaborative caregiver who is concerned with establishing an ongoing and supportive care relationship (Mol, 2008). However, here, she also juxtaposes this position with her training as a psychologist. As a psychologist, she was “trained to assess, diagnose, and treat,” but states that, for her, “maintaining the relationship and trying to work with them is […] more important.” This juxtaposition implies that in her training to “assess, diagnose, and treat,” she was not taught to maintain a collaborative relationship with the family, but to perform a mechanical process much like that described in constructions of ASD diagnosis as a hypothetico-deductive method. In constructing these two approaches as in opposition to one another, P6 implies that in approaching diagnosis as an act of care and assuming the role of the empathetic and collaborative caregiver, she vacates her position as the mechanical psychologist. Psychologists are thus positioned in contrary ways between these two constructions of diagnosis: on the one hand, they are impartial detectors of an ASD pathology and, on the other, they are empathetic caregivers who are trying to support those in need.
3.4.4 ASD as a diffuse and pragmatic label

When ASD diagnosis is constructed as an act of care, a diagnosis of ASD does not signify an innate or discrete pathology as in the first construction of ASD diagnosis. Instead, ASD is a pragmatic label – one about which psychologists can remain ambivalent about the precise nature and that can be liberally applied in order to connect an individual with supports. Within this construction, ASD becomes much more diffuse than in its construction as an innate and discrete disorder. Consider again, for instance, excerpt 27, wherein P7 states that if she is, “veering on whether or not to provide that diagnosis, [she] will often go with the diagnosis because otherwise they will get no supports and they’re really struggling.” In this excerpt, ASD does not necessarily suggest something inherent in an individual’s makeup – the individual’s behaviour may or may not be indicative of an “actual” underlying pathology. Instead, ASD diagnosis connects an individual who is “struggling” to “supports”. ASD here takes on a much more diffuse meaning: it is a flexible and pragmatic label that can be applied even if the exact nature of an individual’s “struggle” is indeterminate.

The consequence of constructing ASD as a functional label rather than a foundational syndrome is that if the label no longer serves its function, an individual may no longer have an ASD diagnosis. Take the following excerpt:

Excerpt 35 [P2]: I’ll talk to the parents about how maybe it is causing a significant impairment right now, but if we can get the support, the resources, the coaching, the therapy, you know, if they can teach them the coping skills that these kids need, and by the time they go off to college technically it won’t be a clinical diagnosis because they will have these coping skills.

This excerpt stands in striking contrast to dominant biomedical discourse wherein ASD is typically regarded as a lifelong disorder (Broderick & Ne’eman, 2008). In excerpt 35, ASD is
constructed as a functional label meant to provide support: if an individual no longer needs these supports, P2 states, “technically it won’t be a clinical diagnosis.” This excerpt highlights that, within such talk, ASD is not an inherent feature of a person – it is a pragmatic label that need not be applied when no longer helpful. The contradiction between biomedical discourse and constructions of ASD as a functional label evidently do not pose a discursive problem for P2. In this excerpt, she constructs ASD as pragmatic without engaging or addressing biomedical discourse. However, looking to address this contradiction more directly in a conversation about clinical impairment in one interview (see excerpt 17), I asked a psychologist:

I: So, you mentioned before the idea of clinically impairing someone’s life being important criteria for you in terms of diagnosis. Do you believe that someone can move in and out of a diagnosis then if they get the supports that they need?

This was her response:

Excerpt 36 [P7]: I definitely, uh, I feel like that’s more of that thought that we’re diverse and that things are on a spectrum, and if you get the tools that you need, and you’re taught the skills that it might no longer impair you. So, I think it’s, yeah, I think I have mixed feelings about labelling people with all sorts of things. When I think that a lot of the times the people I see will come in with a number of different psychiatric diagnoses, whether or not one of them is a neurodevelopmental diagnosis as well is questionable, but a lot of the time there’s difficulties that underlie things that are common in these individuals. So, they’re very sensitive to things around them, just neurologically they seem to be more sensitive to things, and they tend to be more introverted, they tend to have trouble with emotional awareness or become very overwhelmed by emotions. So, I feel like they may come in with five diagnoses, but then at the centre of it all those things are related to them being a very highly sensitive emotionally fragile individual, who doesn’t have the coping skills necessary to deal with that yet. And it’s coming out in all sorts of symptoms, that have received labels from all sorts of people. Yeah, so I think it’s, yeah, I think it’s possible for someone to move in and out of diagnoses, depending on the level of impairment it’s causing at that time. But it’s a bit more challenging with the neurodevelopmental ones rather than the psychiatric ones, but I can see somebody, where they’re questioning a possible diagnosis to begin with, but then when you do the early intervention, the child may no longer meet.
When directly asked for her thoughts on an individual moving in and out of an ASD diagnosis – an idea that is counter to dominant constructions of ASD – P7 vacillates between discourses and refrains from making precise claims about the nature of ASD. She begins within reference to neurodiversity, stating that the idea of moving out of a diagnosis is, “more of that thought that we’re diverse and that things are on a spectrum, and if you get the tools that you need, and you’re taught the skills that it might no longer impair you,” but then states that, “a lot of the time there’s difficulties that underlie things that are common in these individuals,” and thereby suggests an innate cause of ASD. Through these statements, P7 exemplifies the tension between constructions of ASD as diffuse and pragmatic and dominant biomedical discourse: for P7 the idea of moving in and out of diagnosis is more consistent with the “thought” of neurodiversity and is incompatible biomedical discourse.

Interestingly, despite constructing ASD as a diffuse and pragmatic label in reference to clinical impairment (excerpt 17) and as innate and discrete (excerpt 5) at different points in our conversation, P7’s talk around ASD is markedly ambiguous in excerpt 36. She abstains here from making an explicit comment on the nature of ASD at all. Notice how she at no point in this excerpt mentions ASD: she uses phrases like “all sorts of things,” “neurodevelopmental ones,” “psychiatric ones,” and simply “diagnosis,” but never makes clear to which “ones” she is referencing. Ultimately, when asked to reconcile dominant discourse with constructions of ASD as a diffuse and pragmatic label, P7 vacillates between various discourses and, in the end, makes no comment about the nature of ASD. This lack of resolution contrasts the P2’s response to the tension between neurodiversity and biomedicine: where P7 shows a lack of resolution (excerpt 36), P2 eschews biomedical discourses of ASD (excerpt 35). These two extremes – in which P2
constructs ASD as diffuse and pragmatic with no reference to biomedicine and P7 refrains from making any claims about ASD at all when confronted with this tension – demonstrates the discordance between the two constructions of ASD that I have outlined in this analysis. In one case, ASD is innate and discrete and, in the other, it is a functional label that is intended to help an individual address clinical impairment.

### 3.5 ASD as a deficit

Despite the differences between the two constructions of ASD I have detailed in this analysis, implicit in each construction is the notion that ASD is a kind of deficit. In this section, I will first demonstrate how, when ASD is constructed as an innate and discrete disorder, autistic individuals are implied to be deficient in agency. Then, I will show how when ASD is constructed as a diffuse and pragmatic label, autistic individuals are implied to be deficient in necessary skills.

#### 3.5.1 ASD as a deficit in agency

When psychologists construct ASD as an innate and discrete disorder, autistic individuals are implied to be deficient in agency. To demonstrate this point, I would like to return to excerpts discussed earlier in this analysis. Consider, again, the following exchange:

Excerpt 14 [P4]: Well I think I’d say what this child needs is a neuropsychological assessment […] it would be much fuller and parse some of the things apart.

I: And I know it’s your area but not what you’re practicing, but do you have a sense of what they are actually looking for to parse that apart?

Excerpt 15 [P4]: […] they would be doing probably some more focal assessments that would be looking at which part of the brain is doing what […]

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In reference to excerpt 15, I have argued that in locating the cause of the girl’s symptoms within the brain, P4 reifies biomedical discourse. This excerpt, however, not only constructs ASD as an inherent feature of the individual – being located in her neurology – but also objectifies the girl as a “brain” rather than an entire person. P4 speaks of the individual’s “brain” and its “doing” and, in doing so, suggests that the girl is, herself, not agentic in her own behaviour. Rather, she is here subject to the “doing” of her brain. Such talk, wherein behaviour is a product of one’s physiological makeup, confines the target of intervention to the individuals themselves (Gruson-Wood, 2016; Waltz, 2005) and denies autistic individuals’ agency in suggesting them to be passive and unintentional in their conduct (Yergeau, 2018).

This attribution of an individual’s behaviour to something other than intention appears not only when psychologists locate the “brain” as the site of an individual’s symptoms, but also when psychologists construct ASD as an innate and discrete disorder more generally. Take, again, excerpts 5 and 6:

Excerpt 5 [P7]: […] during the interview I’m thinking of potential diagnoses depending on what the parents are reporting or what the clients are reporting. So, with adults, and in adult females, I find that one of the differentials is borderline personality disorder as well. Because in both conditions, they tend to be very sensitive, kind of fragile […], they come across as very emotionally dysregulated and have a lot of trouble in interpersonal relationships, but the source of those difficulties is different.

Excerpt 6 [P5]: I’m also looking at the cognitive piece in most cases. Either that they already had a cognitive assessment and I’ll be looking at the results of some previous assessment or that I would be doing a cognitive assessment. Especially if we’re looking at autism and trying to differentiate it from a global developmental disability. So I’d be figuring out, you know, where are they developmentally and can the things that we’re seeing be attributed to a cognitive delay not specific to autism?
As already discussed, when P7 and P5 describe the process of trying to “differentiate” (excerpt 6) the “source” of an individual’s “difficulties” (excerpt 5), ASD is constructed as an innate and discrete disorder. However, implicit in these excerpts is also the notion that an individual’s behaviour can itself be “source[d]” or “attributed” to autism. The implication of this language is that an individual’s behaviours are a product of disorder, rather than of individual intention. As such, the autistic individual, within such a construction, is subject to their disorder: in excerpt 5, autism becomes the “source” of an individual’s sensitivity, emotions, and relationship troubles; in excerpt 6, a cognitive assessment helps to determine whether “the things we’re seeing” can be “attributed” to autism. Within such an account of autism, autistic individuals are implied to be without agency. Behaviours are, here, a product of disorder rather than intention (Yergeau, 2018).

3.5.2 ASD as a deficit in necessary skills

In contrast to the deficit in agency implied in constructions of ASD as a discrete and innate disorder, when ASD is constructed as a diffuse and pragmatic label, ASD is implied to be a deficit in necessary skills. Consider, again, excerpts 20 and 35:

Excerpt 20 [P2]: It’s maybe they’re having severe challenges with executive functioning, like with keeping themselves organized and coordinated. So, I see a fair number of college kids and in high school, where everything was very organized, you had tons of little assignments, mom and dad monitored your homework, they were fine. And then they go off to college and the lack in executive functioning, in being able to coordinate themselves and organize themselves, all of a sudden just makes life completely unmanageable for them.

Excerpt 35 [P2]: I’ll talk to the parents about how maybe it is causing a significant impairment right now, but if we can get the support, the resources, the coaching, the therapy, you know, if they can teach them the coping skills that these kids need, and by the time they go off to college technically it won’t be a clinical diagnosis because they will have these coping skills.
In excerpt 20, P2 describes an example of clinical impairment in which she suggests a diagnosis of ASD to be appropriate. Here, a diagnosis of ASD is appropriate because an individual is unable to “coordinate themselves and organize themselves” in a college setting due to “the lack in executive functioning.” The use of the word “lack” to describe the individual’s executive function, coordination, and organization explicitly denotes a deficit in skill. Furthermore, attendance of and success in college comes to signify expected levels of functioning within this excerpt, wherein an individual’s purported “lack” is framed as an impediment to this ultimate goal. Thus, when ASD diagnosis is constructed as a determination of clinical impairment, those diagnosed are framed as experiencing a deficit in some necessary or expected skill.

This implied deficit becomes even clearer when one considers excerpt 35, in which P2 states that if the individual can learn “coping skills” then “technically it won’t be a clinical diagnosis.” Within this construction, a “clinical diagnosis” of ASD is that in which an individual is without certain skill: as an individual acquires these skills, there is no longer a “clinical diagnosis.” Autistic individuals, given their diagnosis, are therefore implied to lack in some necessary skill. This construction of ASD centres, again, on deficiency – though this time, not in agency, but the individual’s skills. Thus, although in their accounts of ASD diagnosis psychologists produce two different construction of ASD, these constructions find commonality in discourse that frames ASD as a deficit.

3.6 Reflexive account

Like all research, this thesis is the product of a particular social and historical circumstance. While this understanding is central to the social constructionist framework that informed this study, its social and historical location contributed to the findings and should thus
be made transparent. For example, this analysis is based on my interviews with psychologists who were aware of my status as a younger woman, who is a graduate student in Psychology. My identity, when met with the identity of the psychologists, could – and seemingly did – play out in various ways over the course of the interviews.

I was, at times, positioned as a member of the same community as the interviewees. For instance, one psychologist stated, “I’m preaching to the choir here, right?,” about the difficulties of diagnosing ASD, and, in doing so, suggested that we shared common understanding of ASD diagnosis because of our shared belonging to a particular community. In moments like this, where I was treated as a fellow member of the psychological community, psychologists may have been more inclined to speak of ASD and diagnosis in ways that are meaningful to and dominant within this particular community today – as perhaps, being biological in nature or as a scientific-like method.

At other times, however, my identity felt as though it contributed to a power imbalance between myself and the interviewees. In these moments, I felt as if the psychologists were positioned as more educated and experienced and were, as such, teaching me about a subject with which I was less familiar. For example, when I asked one psychologist about the key indicators of ASD, they responded:

[…] the ones that are most well-known I guess are this thing called eye contact.

That the psychologists said, “this thing called eye contact” rather than just simply, “eye contact” felt like a suggestion of the obviousness of the claim. However, I was, and still am, unsure of the speaker’s reasoning for suggesting this obviousness: were they suggesting that this statement was
obvious and assumed this was obvious to me, too, as a Psychology student; were they suggesting that this was something I should know and assumed that I did not know, given my question; or, was this just a passing comment that made me feel as if I was being positioned as uninformed, because of my own sensitivities to my identity? Further, if this psychologist was condescending to me, it is unclear whether this was because of my age – as I was younger than the participants, because of my gender as a woman, or because of my status as a student in a field in which the psychologist is more experienced. Nevertheless, whether due to my own sensitivities or the positioning of myself in relation to the interviewee, it was, at these times, evident that my identity and the identity of the participants would shape the conversation in perceptible yet ambiguous ways.

Additionally, the psychologists with whom I spoke are working in a particular historical and geographical location. Specifically, the psychologists are practicing diagnosis in present-day Ontario – with one psychologist also working in another Canadian province. Historical accounts of ASD have demonstrated its shifting meaning across time and space (for example, Nadesan, 2013). As mentioned, dominant discourse in general and those of ASD specifically reflect persisting worldviews and, because of this persistence, individuals may unintentionally position themselves within and produce the outcomes associated with cultural discourses. At the same time, however, worldviews vary between locations and shift over time and, as such, the particular discursive constructions demonstrated in this study should not be assumed to reflect the constructions that may be found across cultures or at different points in time (Willig, 2013).
Overall, these examples demonstrate that the interviews upon which my analysis is based were produced in a particular social and historical circumstance. It is likely that, had the interviews been conducted by a different person in another location or at another point in time, the conversations would have been different and could have led to different research conclusions. As such, the findings of this study cannot be generalized beyond its specific context: both because of the micro-context of my interactions with the psychologists and the broader cultural and historical context that framed the conversations. This thesis is thus simultaneously facilitated by a recognition of the situatedness of knowledge claims and limited in the claims it can make based on this recognition.

3.7 Conclusion of analysis

In this analysis, I have demonstrated that psychologists’ talk about ASD diagnosis shifts around the notion of clinical impairment which functions at the margins of dominant discourses of ASD. On the one hand, ASD diagnosis is constructed as an objective hypothetico-deductive process that is concerned with accurate deductions about an innate and discrete ASD pathology. On the other hand, diagnosis is constructed as an act of care wherein ASD is a diffuse and pragmatic label that is used to support suffering individuals within our current institutional and social realities. By invoking the notion of clinical impairment, psychologists can thus legitimize ASD diagnosis within the context of both dominant and counter discourses of ASD. However, embedded in and across constructions is the notion of autism as a deficit: in the construction of ASD as innate and discrete, autistic individuals are implied to lack agency in their behaviours; while in constructions of ASD as a diffuse and pragmatic label, autistic individuals are implied to
lack necessary skills. In the next section, I will discuss the implications of these findings, their limitations, and future directions for research.
4 Discussion and Conclusions

I embarked on this discourse analysis with the goal of addressing two research questions: How do practitioners discursively construct ASD? And how do practitioners discursively construct the diagnostic process? In this study, I have illustrated two ways in which psychologists construct ASD and its diagnosis. Psychologists, on the one hand, constructed diagnosis as a hypothetico-deductive process and ASD as an innate and discrete disorder. However, at the limits of this biomedical discourse, psychologists invoked the notion of clinical impairment, thereby constructing diagnosis as an act of care and ASD as a diffuse and pragmatic label. I argued that in both constructions, ASD was implied to be a kind of deficit. In this section, I will outline some of the study’s theoretical contributions, practical implications, limitations, and suggest possible directions for future research.

4.1 Theoretical contribution

This thesis takes a new perspective on persistent concerns in the medical community around ASD diagnosis (Lenne & Waldby, 2011). ASD diagnosis has, in recent years, been largely explored through a reductionist biomedical lens which obscures the social situatedness of ASD and its diagnosis (Nadesan, 2013). In order to improve the diagnostic process, we must establish greater awareness and transparency about the taken-for-granted assumptions that are embedded within clinicians’ claims. Existing literature on the social construction of ASD has explicated the reification of dominant (O’Dell et al., 2016; Waltz, 2005) and counter discourses of ASD within various communities (Brownlow & O’Dell, 2006; Molloy & Vasil, 2002), and has discussed the ways in which clinicians discursively legitimize their diagnostic claims within
diagnostic encounters (Waltz, 2005; Turowetz, 2015a; Turowetz, 2015b; Turowetz & Maynard, 2019; Turowetz & Maynard, 2015; Maynard & Turowetz, 2017). However, a dearth of social constructionist research existed on the specific ways in which clinicians who diagnose ASD – who are central to articulating and reinforcing particular understandings of the disorder and practice – speak about ASD diagnosis itself. This study thus challenges predominant research on ASD diagnosis and contributes to the burgeoning social constructionist literature on the subject by demonstrating the ways in which these phenomena are constituted through the talk of Ontario-based psychologists.

The findings of this thesis suggest that while psychologists who diagnose ASD construct the “disorder” and diagnosis in ways that reify dominant and well-documented discourses – like those related to biomedicine, science, and neoliberalism – there are also important nuances in their talk. First, while psychologists drew on dominant discourses – specifically scientific discourse and biomedical discourse – when constructing diagnosis as a hypothetico-deductive method, embedded in this construction was the notion that diagnosis is also guided by psychologists’ intuition and feelings that bear resonance with well-documented diagnostic concepts like clinical judgement and countertransference (White & Stancombe, 2003; Abend, 2018). Ultimately, however, psychologists subordinated intuition to objectivity in their construction of diagnosis as a hypothetico-deductive process and, in the end, reinforced the dominant notion of impartiality and deduction as a path to knowledge (Willig, 2013; Halpern, 2001). This nuance in clinicians’ talk about medical decision making has been found elsewhere in the literature (Traynor, Boland, and Buus, 2010).
Furthermore, the findings of this study suggest that as psychologists encountered the limits of biomedical discourse in their talk about ASD diagnosis, they invoked the notion of clinical impairment, wherein an individual is only diagnosed with ASD if their quality of life is reduced by their symptoms. In considering how one psychologist described clinical impairment as challenges in one’s relationships and/or in work and academic settings, this study demonstrated that clinical impairment could be situated within normative expectations of sociability and productivity that are rooted in neoliberal ideology and notions of competence. While research has documented the pathologization of the absence of these traits in other domains (e.g. Crowe, 2000; Scott, 2006), they have not been explicated in relation to clinical impairment in ASD diagnosis. Additionally, while notions of clinical impairment can be found elsewhere in academic literature – for instance, in the DSM-V (APA, 2013), which requires that an individual experience clinical impairment as a result of their symptoms in order to be diagnosed with ASD – the argument presented in the thesis, that this concept can function to legitimize diagnosis, appears to be a new contribution to the literature.

When psychologists invoked the notion of clinical impairment, diagnosis was constructed as an act of care and ASD was constructed as a diffuse and pragmatic label. In these constructions, diagnosis was not a matter of truth about an innate ASD pathology, but of addressing needs in ways that are deemed context appropriate and allow for an ongoing and supportive relationship with the family or individual. While this construction echoes descriptions of care found in the medical literature (e.g. Mol, 2008), the literature on care and ASD appears limited. The arguments put forth around care, its function in talk about ASD diagnosis, and its implications for constructions of ASD are thus a novel contribution of this study.
Ultimately, however, I argued that within both construction of ASD and diagnosis, ASD is constructed as a deficit: in the construction of ASD as innate and discrete, autistic individuals are implied to lack agency in their behaviours; while in constructions of ASD as a diffuse and pragmatic label, autistic individuals are implied to lack necessary skills. The construction of ASD as a deficit is documented elsewhere in the literature (e.g. Gruson-Wood 2016; Yergeau, 2018); however, this construction is predominantly spoken of in reference to biomedical discourse. While this thesis supports this claim – as ASD is argued to be framed as a deficit in personhood when psychologists reproduce biomedical discourse – it also suggests that this construction of ASD as a deficit can permeate various ways of speaking about ASD and diagnosis.

4.2 Practical implications

This study has direct implications for medicine, Ontario’s political climate, and autistic individuals themselves. First, the findings of this study are particularly relevant to the current concerns that surround ASD diagnosis within the broader medical community and within Ontario’s current political climate. While the medical community has become increasingly concerned with the accurate diagnosis of ASD, Ontario’s provincial government has been the subject of public scrutiny with regards to funding changes within the Ontario Autism Program that maintains autistic children’s pressing need for supports and services. Within this context, psychologists act as the gatekeepers of these government resources – facilitating access to funding and services through diagnosis – and, consequently, we must consider the implications of this study for the delegation of these resources.
For instance, when psychologists construct diagnosis as a hypothetico-deductive process, ASD diagnoses are framed as impartial and objective. However, as I have demonstrated within this thesis, this construction is rooted in scientific ideals that began to predominate Western medicine in the twentieth century, in which “objectivity” is conceived as a route to diagnostic “accuracy” (Halpern, 2001, p. 17) and is predicated on dominant discourse that constructs ASD as an innate and discrete pathology (O’Dell et al., 2016). While such a construction might suggest that the psychologist is making detached diagnostic decisions, these are, upon closer look, value-laden judgements that are rooted in dominant discourses related to medicine. Such talk ultimately obscures the reproduction and material consequences of such discourse in suggesting it to be an objective fact. This construction might effectively suggest that those who do not receive a diagnosis are not in need of resources on the basis that an objective process determined them to not be autistic: a suggestion that would only be amplified by biological approaches to diagnosis, which, within the Decades of the Brain, are viewed as more valid (Lenne & Waldby, 2011).

In contrast, when psychologists construct the diagnostic process as an act of care, diagnostic decisions are made on the basis of clinical impairment. Within this construction, psychologists explicitly suggest diagnostic decisions to be pragmatic rather than impartial: when someone is in need of services, a diagnosis is appropriate. However, as also demonstrated by this study, psychologists’ talk around clinical impairment – wherein it is constructed as a matter of fact – can obscure the process of identifying impairment and, specifically, the information and sources that inform determinations of clinical impairment during the diagnostic process. By rendering this obscurity visible, this analysis raises questions about who and what should inform
such decisions. For example, should the diagnostician be afforded the authority to determine when an individual is or is not experiencing clinical impairment and upon what criteria should clinical impairment be judged? Or, should an individual themselves and/or their families be able to assert their own clinical impairment? These questions, when answered, could have significant implications for how autism funds might be accessed through diagnosis in Ontario.

This study also suggests that psychologists employ the notion of clinical impairment to render diagnosis essential at the limits of biomedical discourse. Practically speaking, the notion of clinical impairment can further normalize ASD as a diagnostic category and diagnosis as a practice within broader society, particularly when such talk comes from clinicians who are regarded as having expert status in Western culture (Romelli, Frigerio, & Colombo, 2016).

Finally, this study could have significant implications for the experiences of autistic individuals themselves. In the construction of ASD as an innate and discrete syndrome, we saw the biological reductionism and determinism – wherein an individual’s behaviours are described as produced in isolation by their biology – that is a common feature of biomedical discourse (Nadesan, 2013). Such talk confines the target of intervention to the individuals themselves (Gruson-Wood, 2016; Waltz, 2005). For instance, Gruson-Wood (2016) demonstrated through an ethnographic approach that applied behavioural therapy for autistic people in Ontario “reproduces psychocentrism” (p. 53) in which “all human problems are individually rooted rather than socially constituted” (p. 39). In these psychocentric-based interventions, “the autistic subject is subjected to normalizing disciplinary techniques and practices” which are framed as, “necessarily intense” in order to, “compel conduct toward collective norms” (Gruson-Wood, 2016, p. 54). In other words, deficit-based models of ASD – like those identified across
psychologists’ constructions of diagnosis – reinforce and are reinforced by individual-focused interventions, which problematically attempt to modify autistic people’s behaviours to conform to social expectations and place the responsibility for change on the autistic individuals themselves. Furthermore, this talk, in denying autistic individuals’ full personhood and suggesting them to be passive and unintentional in their conduct (Yergeau, 2018), can dramatically impact how autistic people are able to move through the world. If autistic people are treated as passive and unintentional in their actions, it could effectively obstruct their personal agency.

In the construction of ASD as a diffuse and pragmatic label, ASD was characterized as a deficit in skill. This too could have significant implications for autistic individuals’ subjectivities and experiences. For instance, Bagatell’s (2010), in her ethnography with Ben, detailed how Ben “found himself persistently cast in a marginalized position” wherein a “person with a disability is considered successful when they listen to the voices and conform, or at least make an effort to conform, to act ‘normal’” (p. 418). Autistic individuals who are constructed as lacking necessary skills might similarly feel the need to conform as a means of achieving success. Such talk might thus reinforce the predominance of individual-focused medical intervention and limit the changes that might, also, be focused on the social system that contribute to this view of pathology (Gruson-Wood, 2016; Waltz, 2005). This, in turn, would curb the possibility that we might realize a society in which a more diverse skillset is recognized as valid instead of in need of modification (Yergeau, 2018).
4.3 Limitations

The findings of this study must be considered in light of its limitations. This study is limited to the claims of only the eight psychologists whom I interviewed for several reasons. First, while I intended to speak with various types of practitioners who diagnose ASD, in the end I recruited only psychologists. The way in which psychologists speak about ASD and diagnosis may differ from how other clinicians who diagnose ASD, like pediatricians or psychiatrists, speak about the disorder and the diagnostic process. For instance, psychologists are trained as researchers when obtaining their PhD. Given that what I refer to in this thesis as the hypothetico-deductive method currently predominates psychological research, it is possible that psychologists’ research training may inform how they speak about diagnosis – for instance, making them more inclined to speak in dominant scientific discourse. Second, it is possible that this study’s findings were influenced by self-selection: the psychologists who responded to my recruitment email and eventually agreed to an interview could differ in some way from those psychologists who did not respond. These findings are thus limited to the comments of the eight psychologists with whom I spoke and should not be generalized or assumed to be indicative of how other psychologists or practitioners talk about the disorder and practice. As stated, the objective of this study was to demonstrate the cultural discourses that underlie some of the ways in which psychologists talk about ASD and diagnosis and their various implications, not to make generalizable claims about discourses of ASD and diagnosis. Although I have demonstrated that these discourses are rooted in culturally meaningful ways of making sense of the world, we cannot assume that other practitioners or even all psychologists will speak of ASD and diagnosis in these same ways.
In addition, this thesis cannot comment on psychologists’ cognitions or intentions during our interviews. As already mentioned, based on a social constructionist framework, participants’ talk was treated in this thesis as a reification and negotiation of culturally available ways of speaking about particular subjects, specifically ASD and diagnosis, that surfaced in the context of specific interview questions and conditions (Potter and Wetherell, 1988). From such a perspective, I can only offer insight into culturally available ways of speaking about ASD and diagnosis and the implications of this discourse for those with ASD and cannot deduce a speaker’s intentions or thoughts on the basis of their talk (Potter and Wetherell, 1988).

Finally, and most notably, this thesis does not include the voices of autistic people. I respect the autistic community’s proclamation, “nothing about us without us,” which asserts that research should not be conducted about autistic people without their involvement (Bagatell, 2010, p. 42). Psychologists’ constructions of ASD and diagnosis are certainly about ASD and, as such, have implications for autistic people, which have already been discussed. However, because autistic people were not involved in the conceptualization or execution of this thesis, I choose to limit my claims about the implications of my findings. I choose only to delineate what follows from the various ways in which psychologists spoke of ASD and diagnosis, and not make claims about what should or should not be in regard to such talk and related practices: such claims should be made in consult with autistic people, so as not to speak on behalf of the autistic community without their input.
4.4 Future directions

These findings suggest several future directions for research. First, future studies should explore the ways in which other practitioners who diagnose ASD speak about the disorder. As mentioned, I initially intended to speak with various types of practitioners who diagnose ASD in Ontario in an attempt to collect a more diverse sample of discourses of ASD diagnosis. It is possible that other clinicians speak of ASD and diagnosis in ways that are different from the psychologists with whom I spoke and, as a result, bear different consequences for diagnostic practice and autistic people. Future research should explore this possibility in order to establish further transparency around the cultural situatedness of clinicians’ talk about ASD diagnosis and its implications.

Second, future research should further explore the meaning of clinical impairment and practices of care in relation to ASD and diagnosis. While this thesis begins to demonstrate some of the ways in which notions of clinical impairment are culturally situated, specifically in Western expectations of sociability and productivity, future research should take a more in-depth look at these concepts as they might be employed in talk or applied in practice by clinicians who work with autistic people. Future research on the notion of clinical impairment could facilitate a deeper understanding of its construction, social embeddedness, enaction, and effects.

Lastly, in future work, it would be fruitful to bring the results of this study – and future studies like it – to members of the autistic community. While based on this study’s analysis, I am able to describe the implications of different ways that psychologists speak of ASD and diagnosis for those involved in the process, I am not autistic. I therefore choose not to express
my opinions about how these findings might be applied and suggest that in future research, this endeavor be undertaken in collaboration with members of the autistic community.

4.5 Conclusion

As rates of ASD diagnosis have continued to rise in the past half-century, the medical community has become increasingly concerned about the validity of diagnosis. The research that has followed from this concern has, to a large extent, focused on the identification of biological or genetic causes of ASD, which are not well understood (Nadesan, 2013), and the validity of current diagnostic criteria and procedures (see for example Schaefer & Mendelsohn, 2008; Wing, Gould, & Gillberg, 2011; Nassar et al., 2009). However, in this thesis, I argued that medical research and practice, which are predicated on the assumption that ASD is solely biological or innate, are misguided. This thesis instead focused on practitioners’ talk about ASD diagnosis, with the goal of establishing transparency about its cultural situatedness. By taking a social constructionist approach to the issue, I have demonstrated ASD diagnosis as a culturally situated practice: psychologists who diagnose ASD in Ontario spoke of the disorder and its diagnosis in multiple ways and with different effects over the course of our conversations. While psychologists constructed diagnosis as a hypothetico-deductive method and implied ASD to be an innate and discrete syndrome, this talk shifted at the discursive limits of biomedical discourse. Here, psychologists invoked the notion of clinical impairment and, in turn, constructed diagnosis as an act of care and implied ASD to be a diffuse and pragmatic label. Overall, however, ASD was, across psychologists’ constructions, implied to be a deficit in agency and skill. While concerns about ASD diagnosis may be valid, research that reduces ASD to a biomedical disorder
further naturalizes these cultural constructions and assumptions upon which ASD and diagnosis hinge. This thesis represents a first step in establishing transparency about the cultural situatedness of ASD diagnosis.
### Table 1

Participants’ Experience in the Field

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<td>Pause in speech</td>
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<td>Self-interruption</td>
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REFERENCES


**APPENDICES**

**Appendix A: Recruitment email**

Dear [Insert Name],

My name is Olivia Mann and as part of my master’s thesis at the University of Guelph, I am conducting a study that looks at the process of diagnosing autism spectrum disorder. I am contacting you because of your experience in assessing, diagnosing, and/or working with patients with ASD. If you are interested in sharing your thoughts on this subject, I would like to interview you to explore how you understand and make clinical decisions about ASD.

The interview will take approximately one hour, and I would be happy to meet at a time and place that is convenient for you. It is also completely voluntary, and your identity will remain confidential. You can withdraw at any time or not answer questions with which you are not comfortable.

If you choose to participate in this study, as a thank you for your contribution, we will donate $10 to the Canadian Mental Health Association.

If you are interested in taking part and/or have any questions, please contact me by responding to this email or by calling the following number: 647-554-9951.

Thank you,
Olivia Mann
Appendix B: Consent form

Consent Form: The process of ASD diagnosis in Ontario

Information and informed consent
You are invited to take part in a research project to study how health practitioners understand and make clinical decisions about ASD. The goal of this study is to examine how medical practitioners talk about ASD and explain its nature and symptoms in order to better understand the diagnostic process.

Procedure
As a participant in this study, you will be asked to take part in a semi-structured individual interview that will be approximately one-hour long. Interviews can be conducted in person at an agreed upon location, over the telephone, or by Skype.

Potential risks
There are no known risks associated with participating in this study.

Potential benefits
Participating in this study will not benefit you directly, however, the results of this study will contribute to a more thorough understanding of ASD as a diagnostic category and the process of diagnosis itself, which will potentially help to inform daily clinical practice.

Eligibility, participation and withdrawal
You are eligible to participate in this study if you are a licensed psychologist, psychiatrist, general practitioner, or pediatrician who provides clinical care for people with ASD in Ontario.

Your participation in this study is voluntary. You may withdraw from the study for any reason and skip any interview questions you would prefer not to answer. If you would like to withdraw from this study during your interview, please inform the interviewer. We will stop the interview and delete all of your data. If you would like to withdraw after your interview has been conducted, please contact the primary researcher at the contact details provided below. Your data can be deleted up to one month after your interview. After one month, the findings of the study will likely have been disseminated and can thus no longer be deleted.
Data storage
Participants’ names, contact information, ID numbers, and interest in receiving a copy of the research findings will be stored in a password-protected master list on an encrypted hard drive in a research lab at the University of Guelph. Interviews will be audio recorded and transcribed. Once audio recordings have been transcribed, the audio data files will be securely deleted. Interview transcriptions will be linked to the information in the master list via your participants ID number for one month following your interview to ensure that your data can be deleted should you choose to withdraw from the study during this time. Transcripts will be password protected and stored on an encrypted laptop computer separately from the master list. After one month, participant ID numbers will be removed from the transcripts. De-identified transcripts will be retained indefinitely. This data will be stored on an encrypted hard drive as password-protected files in a research lab at the University of Guelph. Only the research team will have access to this data.

Confidentiality and anonymity
Your participation in this study will be kept confidential. Any identifiable information that is disclosed during your interview will be redacted from your transcript. Your privacy will be respected.

Dissemination of findings
This study is being undertaken as part of a master’s thesis. Findings will thus be published and presented as part of the student’s thesis defence at the University of Guelph. This research may also be presented at national and international conferences and/or be published in peer-reviewed journals. You may request to receive copies of the thesis, presentations, or journal articles by indicating below.

Compensation for participation
As a thank you for your contribution to this study, we will donate $10 to the Canadian Mental Health Association. You may refuse to answer any questions or discontinue the interview for any reason at any time and the donation will still be made.

Consent and signature
I, __________________________, hereby give my free and informed consent to participate in this study.

I would/would not like to receive a copy of any manuscripts or presentations to be published on the findings of this study.

Signature: ___________________________ Date: ___________________________

Questions, contact details and research team
Principal Investigator:
Dr. Jeffery Yen
Associate Professor, Department of Psychology
University of Guelph
jyen@uoguelph.ca

Olivia Mann
MA Candidate, Applied Social Psychology
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University of Guelph
ommann@uoguelph.ca

- You do not waive any legal rights by agreeing to take part in this study.
- This project has been reviewed by the Research Ethics Board for compliance with federal guidelines for research involving human participants.
- If you have questions regarding your rights and welfare as a research participant in this study (REB# 18-12-011), please contact:
  Director, Research Ethics; University of Guelph
  reb@uoguelph.ca
  (519) 824-4120 (ext. 56606.)

This study is funded by the Canadian Institutes of Health Research and the Ontario Graduate Scholarship Program.
Appendix C: Follow-up email

Dear [Insert Name],

I am writing to follow-up on the email below regarding a study that I am conducting on the process of diagnosing autism spectrum disorder as part of my master’s thesis at the University of Guelph.

If you have some time, I would very much appreciate the opportunity to speak with you about your experience in ASD diagnosis.

As I mentioned, the interview would take approximately one hour, and I would be happy to speak in person, by telephone, or by Skype at a time that is convenient for you. As a thank you for your participation, we will donate $10 to the Canadian Mental Health Association.

If you are interested in taking part and/or have any questions, please contact me by responding to this email or by calling the following number: 647-554-9951.

Thank you,
Olivia Mann
Appendix D: Interview schedule

Opening blurb:
Thank you for speaking with me today. Through this interview, I am hoping to get a sense of how you make clinical decisions, and specifically diagnostic decisions, about ASD. So, to start, I would like to ask you a bit about your background as a health practitioner.

1. Practitioner’s professional background
   a. How long have you been working in the field?
   b. How did you decide that this was what you wanted to do?
   c. Can you tell me about your training?
      i. How was diagnosis covered in your training?

2. Context of their practice
   a. Can you tell me a bit your practice?
   Probing questions:
      b. Who is coming to your practice?
      c. How many patients do you see?
      d. Can you walk me through the process of how individuals come to make an appointment with you?
         i. Do they find your practice themselves and call? Are they referred by their general practitioner or pediatrician?
         ii. What are some of the reasons individuals or families contact you?
         iii. Do they have specific concerns? Did someone else (a practitioner, a teacher?) suggest that they make an appointment?
         iv. What steps do you take with these individuals or families once they contact you?

3. The process of formulating a possible diagnosis or diagnoses
   a. Is there a set procedure you typically follow with patients?
   Probing questions:
      i. Does everyone who has an appointment receive an assessment?
      ii. Do you have an idea of possible diagnoses before conducting an assessment? Do you assess for ASD specifically or is it a general assessment?
      iii. Do you have a set procedure when making a diagnosis?

4. Past experiences of diagnosis
   a. Now, I am wondering if there has been a time in your practice when you were unsure about making an ASD diagnosis and if you could tell me about it.
Probing questions:

i. When was this?
ii. Why were you unsure if this person had ASD?
iii. What suggested to you that they might have ASD (Certain traits/behaviours)?
   1. How did you identify those signs? (i.e. Did you observe them in the appointment? Did you interview people who know the individual? Did you speak with the individual themselves?)
iv. What helped you decide that this person did or did not have ASD?
   1. Specific diagnostic tool(s)?
   2. Assessments and/or discussions with other practitioners? (Who? Why?)
v. Are there certain behaviours or traits that are necessary for you to make a diagnosis?
vi. Did you make any recommendations after you came to that decision?
   1. How did you decide to make this recommendation?

b. And, conversely, can you tell me about an instance in which you knew almost immediately that a person would be diagnosed with ASD?

Probing questions:

i. When was this?
ii. How did you know?
   1. Certain traits/behaviours?
   2. Did you observe them in the appointment? Did you interview people who know the individual? Did you speak with the individual themselves?
iii. What did the process of diagnosis look like then?
   1. Specific diagnostic tool(s)?
   2. Assessments and/or discussions with other practitioners? (Who? Why?)
iv. Did you make any recommendations after you made a diagnosis?
   1. How did you decide to make this recommendation?

c. How are these cases different from a typical case? Are these cases typical?

5. Attitudes towards alternative understandings of ASD

a. In recent decades, the neurodiversity movement has advocated recognizing ASD as an expression of normal variation in human functioning rather than as a disability. I am wondering if you have you encountered these other ways of thinking about ASD in your personal or professional experiences? What do you make of these alternative ways of thinking about ASD?
Concluding question:

a. Is there something else you want to share?

Thank you so much for your time.
# Appendix E: REB certifications

**RESEARCH ETHICS BOARDS**

**Certification of Ethical Acceptability of Research Involving Human Participants**

<table>
<thead>
<tr>
<th>APPROVAL PERIOD:</th>
<th>February 8, 2019</th>
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<tr>
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<td>February 7, 2020</td>
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<tr>
<td>TYPE OF REVIEW:</td>
<td>Delegated</td>
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<tr>
<td>PRINCIPAL INVESTIGATOR:</td>
<td>Yen, Jeffery (<a href="mailto:jyen@uoguelph.ca">jyen@uoguelph.ca</a>)</td>
</tr>
<tr>
<td>DEPARTMENT:</td>
<td>Psychology</td>
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<tr>
<td>SPONSOR(S):</td>
<td>CIHR: Ontario Graduate Scholarship - Master's</td>
</tr>
<tr>
<td>TITLE OF PROJECT:</td>
<td>Discourses of autism spectrum disorder among psychiatrists and psychologists in Ontario</td>
</tr>
</tbody>
</table>

The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University’s ethical standards and the Tri-Council Policy Statement, 2nd Edition.

The REB requires that researchers:

- Adhere to the protocol as last reviewed and approved by the REB.
- Receive approval from the REB for any modifications before they can be implemented.
- Report any change in the source of funding.
- Report unexpected events or incidental findings to the REB as soon as possible with an indication of how these events affect, in the view of the Principal Investigator, the safety of the participants, and the continuation of the protocol.
- Are responsible for ascertaining and complying with all applicable legal and regulatory requirements with respect to consent and the protection of privacy of participants in the jurisdiction of the research project.

The Principal Investigator must:

- Ensure that the ethical guidelines and approvals of facilities or institutions involved in the research are obtained and filed with the REB prior to the initiation of any research protocols.
- Submit an Annual Renewal to the REB upon completion of the project. If the research is a multi-year project, a status report must be submitted annually prior to the expiry date. Failure to submit an annual status report will lead to your study being suspended and potentially terminated.

The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: [Signature]  
Date: February 8, 2019

Stephen P. Lewis  
Chair, Research Ethics Board-General
The members of the University of Guelph Research Ethics Board have examined the protocol which describes the participation of the human participants in the above-named research project and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement, 2nd Edition.

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The approval for this protocol terminates on the EXPIRY DATE, or the term of your appointment or employment at the University of Guelph whichever comes first.

Signature: Stephen P. Lewis
Date: June 7, 2019
Chair, Research Ethics Board General