

AJOB Neuroscience

ISSN: 2150-7740 (Print) 2150-7759 (Online) Journal homepage: www.tandfonline.com/journals/uabn20

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To cite this article: Dean Evan Hart (2025) Is "Neurodiversity" the Proper Nomenclature for Mental Health Gradation?, AJOB Neuroscience, 16:1, 46-48, DOI: 10.1080/21507740.2024.2437996

To link to this article: https://doi.org/10.1080/21507740.2024.2437996

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Published online: 13 Jan 2025.

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AJOB NEUROSCIENCE
2025, VOL. 16, NO. 1, 46–48
https://doi.org/10.1080/21507740.2024.2437996

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Is "Neurodiversity" the Proper Nomenclature for Mental Health Gradation?

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INTRODUCTION

Julia Knopes's study (2025) provides a constructive contribution to neuroethics, demonstrating that individuals in peer support networks understand their mental health conditions in terms that draw from both the neurodiversity framework and the medical model of disability.

She recommends that future research and clinical practice take a significant improvement to approaching people with mental health conditions, incorporating this complexity and ambiguity. This commentary seeks to develop Knopes's findings by considering the limits of the neurodiversity framework and creating a more explicit understanding of its normative judgments.

The neurodiversity framework claims that mental health conditions should not necessarily be understood as pathological. Some proponents further argue that this neurodivergence can be a positive good. The framework then hinges on precisely what is considered a "mental health condition."

The term "neurodivergent" originated in the autistic community but now encompasses those with neurodevelopmental disorders or atypical neurocognitive functioning (Walker 2021). Knopes clarifies that by "people with mental health conditions," she refers to "all individuals who experience a psychological disability and difference" (21). Participants studied included individuals with neurodevelopmental

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disorders, such as autism and ADHD, as well as people with mood and personality disorders.

However, the expansive definition of neurodiversity raises questions about its extension. Although Knopes purports to include anyone with a psychological disability or difference, her study and discussion only extend to those with particular neurodevelopmental, mood, and personality disorders. She, therefore, fails to consider the position of those with intellectual disabilities and other comparable neurological conditions.

Individuals with congenital intellectual disabilities, such as Down's Syndrome, are increasingly understood as neurodivergent (Armstrong 2015). However, this framework runs into problems when considering those born with versus whose intellectual disabilities result from injury or disease.

To understand why this terminology needs to be revised, we must present a more critical understanding of the neurodiversity framework and the nature of its claims.

The descriptive claim can be understood as a response to the pathological approach of the medical model of disability. The claim states that neurocognitive diversity exists and does not constitute harm, pathology, or a barrier to living a happy, meaningful life. It is descriptive because it describes neurodiversity in value-neutral terms, unlike the medical model, which understands neurodivergence pathologically. The force of descriptive claims lies in recognizing that difference is not necessarily wrong, destructive, or harmful.

This encompasses normative judgments favoring neurodiversity, asserting good or valuable perspectives. In this way, it inverts the medical model. As Knopes puts it, some participants identified to varying extents, that "mental health conditions [are] valuable forms of difference that could be highly adaptive, albeit not without personal cost" (26). Unpacking how and why these differences are valuable affords us a more granular appreciation of the needs of individuals with mental health conditions and the limits of neurodiversity frameworks.

THE VALUE OF NEURODIVERSITY

Although both Knopes and the participants studied affirmed the value of neurodiversity, the nature and extent of this value remain largely unarticulated: I wish to explore three different dynamics within neurodivergence.

First, "value," as used in this context, can be direct or indirect usefulness. This distinction depends on whether what is being valued is a symptom or aspect of the condition or something resulting from it. A value of being neurodivergent is direct if it is unmediated and relates to what neurodivergence does or is. For example, it could be a capacity to accomplish engagements or endeavors that a mental health condition provides. Consider the creativity in people with mood disorders that Daniel identifies or the information processing "superpower" Tim attributes to his bipolar disorder.

An indirect value of being neurodivergent will come about due to the condition but does not relate to it. This can be seen in Sam's sensitivity to stigma and Daniel's empathy. In both cases, these are not symptoms of their mental health conditions but rather consequences of dealing with them. Sam becomes sensitive to stigma through being stigmatized as a result of being neurodivergent. In contrast, Daniel attributes his empathy to the pain he has experienced as a consequence of his mood disorder.

Secondly, something can be prized either as a means to acquire something or as a desirable end. Consider Tim's bipolar disorder, which he alleges "special cognitive abilities that he later said contributed to his professional and personal success" (16). Although Tim might also believe his cognitive abilities are valuable in themselves, he expressed their value as instrumental to achieving success.

If something is intrinsically valuable in and of itself, it is valued in itself, irrespective of other factors. Daniel identified creativity and empathy with mood disorders, two character traits that people generally understand as intrinsically valuable, such as being good in themselves. This distinction does not mean that something intrinsically valuable cannot have instrumental extrinsic value: being empathetic can make you a better friend or partner, but to value empathy merely as a means for better relationships may strike us as wrong because it treats something we value in itself as a mere means to something else.

Furthermore, something can be valuable, either qualified or unqualified. This distinction shows that the value of being neurodivergent is qualified for individuals in Knope's study. It is valuable to the extent that it makes one creative, empathetic, or successful, but not absolutely.

Neurodivergent reality reflects the nuanced and complex relation to neurodiversity frameworks that Knopes identifies in the studies' participants and may be ineffable by nature. Of course, if the value of something is qualified, there is also the further judgment of whether it is valuable. This was not addressed explicitly by Knopes, but Tim claims that the positives of his condition outweigh the negatives, overall, he considers being neurodivergent to be valuable. While

no one identified their mental health condition as unqualifiedly valuable, someone who subscribed to "mad pride" and a social model of disability might do so. That is to say; one might value one's autism unqualifiedly and claim that any negative associations result from societal stigma and prejudice.

LIMITS TO THE VALUE OF NEURODIVERSITY

Given how most participants qualified the value of being neurodivergent to particular features—direct symptoms or indirect consequences of their mental health conditions—one might ask whether different mental health conditions from those surveyed by Knopes would be valued differently. For example, if neurodivergence encompasses anyone with a psychological disability or difference, to what extent would someone with neurological impairment as a result of Alzheimer's disease find the neurodiversity framework constructive?

The experience of age-related mental health dementia conditions, for example Alzheimer's, affords those subjects nothing akin to the creativity or special cognitive abilities the participants of the study spoke of. Whereas those with ADHD or autism can claim to be differently abled, the experience of dementia is primarily one of cognitive functions gradually becoming degraded. In these cases, neurocognitive differences occur solely through impairment and privation, which presents the difficulty in valuing these differences. Therefore, these cases could be better understood through the medical model than the neurodiversity framework.

Neurodivergence in dementia consists not of differences in abilities but loss of ability. Vitally, as Alzheimer's dementia is untreatable and terminal, the loss accrues gradually until one has lost even the self that has developed across one's life experiences. This process leads to the loss or occlusion of the "person of a lifetime"—the person one becomes across time through our beliefs, values, choices, tastes, preferences, and memories—and their replacement by a "person of the moment" who is physically the same but has lost the ability to communicate or recall and is thereby bound to the morphing present moment (Hart 2024).

This process marks a clear separation between dementia and the mental health conditions that neurodiversity usually champions. One can value loss if what is lost is harmful or wrong; however, since Alzheimer's causes us to lose the very capacities that we usually take to constitute our personhood (Hart 2024), the idea of there being value in age-related dementias such as Alzheimer's is hard to swallow. Because of this, Alzheimer's dementia represents a mental health condition where the medical model of disability is unambiguously the only plausible approach, thereby demonstrating the limits of the neurodiversity framework. Instead, palliative comfort care is described by precedent autonomy via advanced directives to navigate the pathologically terminal neurodivergent experience moments of time.

While the neurodiversity framework aspires to incorporate all neurocognitive differences, the brute fact is that some differences are inherently pathological. This would suggest that the nuanced approach that Knopes recommends, combining both the neurodiversity framework and the medical model of disability, is valid for certain treatable mental health conditions. Others are likely to be accounted for only by the medical model of disability.

The neurodiversity framework's descriptive claim—the recognition that difference is not harmful—ought to be retained, but skepticism should exist about the scope of its normative claims. This aligns with Chapman's (2020) recommendation of a value-neutral approach to neurocognitive conditions. This does not contradict Knopes's conclusions, only limiting applicability to public health.

FUNDING

The author(s) reported there is no funding associated with the work featured in this article.

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