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## Special Theme for this Issue: “Neurodiversity”

Psychiatric and neurological disorders affect roughly 400 million people globally. In June 2004, the Journal of the American Medical Association published the results from the world’s largest survey on mental health. From one to five percent of the populations of most countries surveyed have some form of mental illness. More recently, results from a US study on mental illness published in June 2005 showed that about half of all Americans will have conditions that meet criteria of the Diagnostic and Statistical Manual of Mental Disorders over the course of their lifetime. Yet many neurological and psychiatric conditions are not well understood by the general public. Indeed, some of these conditions are not well understood by many mental health professionals.

‘Neurodiversity’ usually appears in discussions of autism spectrum disorders and the view that individuals with these disorders have at least as much mental ability as disability. Their neurological and psychological traits form a unique and valued identity, which forces us to reconsider accepted models of “normal” and “abnormal” states of mind. Construed more broadly, however, neurodiversity can describe a wider range of conditions consisting of complex sets of traits and symptoms influenced by biological and environmental factors. These conditions may pose a challenge for clinicians in explaining their etiology and establishing a diagnosis. They often also involve questions about whether or how they should be treated. The authors of the four papers in this thematic issue of the Journal of Ethics in Mental Health recognize the scope of neurodiversity and explore its clinical, ethical, personal, and social implications.

I point out that many people have a constellation of both normal and pathological mental traits in “Neurodiversity.” I describe cases of individuals with mental traits associated with exceptional intellectual or artistic ability, despite being diagnosed with a neurological or psychiatric

disorder. These cases raise the question of whether mental traits that deviate from accepted standards of normal neurological and mental function should be characterized as differences or disabilities. They also raise the question of whether it is always in an individual’s best interests to be treated for a disordered mind.

In “Autism, Neurodiversity, and Equality Beyond the ‘Normal,’” Andrew Fenton and Tim Krahn present neurodiversity as a part of the struggle for the civil rights of people with neurological or neurodevelopmental disorders. They argue that the goal of “neuro-equality” requires a critical examination of current nosology that pathologizes the phenotypes associated with these disorders. It also requires a critique of the social institutions that set standards for what counts as properly functioning cognitive capacities. In their discussion of certain forms of autism spectrum disorders, Fenton and Krahn show that an appeal to functional and neurological diversity can help to achieve neuro-equality.

In “Neglecting the Social System: Clinical Neuroimaging and the Biological Reductionism of Addiction,” Daniel Buchman explains how addictions arise from the interaction of genetic, environmental, and social influences. Heavy reliance on neuroimaging to display brain activity underlying addiction is a form of biological reductionism that ignores the effect of these influences on the brain’s response to addictive substances. Buchman emphasizes that brain plasticity does not occur in a biological vacuum. Biological reductionism will only further marginalize and harm people with addictions. In particular, recognition of the influence of social factors on brain function could lead to more effective pharmacological and psychosocial interventions that could help to prevent or control drug abuse.

“Locked in Syndrome, PVS and Ethics at the End of Life” is a poignant account of Nick Chisholm’s experience with locked-in syndrome (LIS) by Chisholm and neurosurgeon and bioethicist Grant Gillett. Fully conscious and aware of his surroundings but trapped inside his body as a result of a brain injury, Chisholm describes how his condition altered his phenomenological experience as a being in the world with others. This case also shows how subtle indicators critical to diagnosing the condition may be missed by medical professionals. Unlike patients in a persistent or permanent vegetative state (PVS), a patient in an LIS can be reconnected to the world. Because of this and other differences in the neurological status of LIS and PVS patients, clinicians have different duties of care to these two groups.

Gillett emphasizes two related duties of care that should be discharged to all individuals with neurological and psychiatric disorders: “Attention to and recognition of the patient as the creator of and living being at the centre of the story of his or her own life.” This can promote better understanding and more effective treatment of these disorders. It can also help to reduce the marginalization and stigma associated with mental illness.

**Walter Glannon PhD**

Canada Research Chair in Medical Bioethics and Ethical Theory, Departments of Philosophy and Community Health Sciences, University of Calgary, Alberta, Canada

e-mail: [wglannon@ucalgary.ca](mailto:wglannon@ucalgary.ca)