whether discussions about these variations in constructions of autism mentioned above would be helpful to facilitate moving away from "deficit" or stereotypical thinking and more importantly in reducing the anxiety about meeting autistic people? Q2 It might be the case that discussing the basis of alternative constructions and images is a very abstract exercise in comparison to talking with individuals with autism.

« 5 » The constructions identified in the research in the target article clearly emphasize the deficits associated with ASD. Further, while there was a question about whether respondents knew a person with ASD (§19), the responses to this question were not used in the analysis. In the discussion of reactions to people with ASD (§31), for example, no mention is made of variations in the respondents' experience of ASD depending on their experience of this group of people. The comments about "pity" in §31 are not necessarily related to personal experience but rather to how people in general might react to an autistic person (Table 6). In our studies on attitudes to children with learning difficulties and special needs, we found that personal experience of children with learning difficulties or special needs influenced pupils' thinking about children with such difficulties (Gash 1993, 1996; Gash et al. 2000). For example, children who reported that they had experience of a child with learning difficulties were more positive about them than children who had no such experience. There was also a gender difference, with girls being more positive than boys. Children who were educated in integrated classrooms with children who had learning difficulties were more aware of the educational needs of this group of children. As experience and gender influenced children's thinking about both learning difficulties and Down's Syndrome, one can expect that this would also be the case for people's thinking about ASD. I worked with student teachers and arranged for them to have weekly work experience in special schools over a semester during their initial teacher education. The students found this experience significantly helped them to overcome misperceptions and the type of fear, uncertainty and negativity observed in the target article (§§31–35). The data in the target article were neither analysed to allow insight into the effects of variations in respondents' experience of people with autism, nor to see if men and women differed in some of their responses to the questionnaire. I wonder whether further research into the interface of the basis of the different types of constructions that people have about ASD would lead to new valuable insights. Q3

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From Deficit to Difference in the Discourse on Autism and Mental Health

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> Abstract • I emphasize the relevance of Wodziński and Gołaska-Ciesielska's target article for the enrichment of the medical/psychiatric model and care of people with so-called "autism" and other "mental disorders." They point to what a medicalized approach to "autism" needs most: the deconstruction of the usual objectivistic and reified understanding of the category of "autism" and the construction of the epistemologically more inclusive, contextualized and integrated descriptions of "autism" and other mental health phenomena.

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« 1 » As a psychiatrist and psychotherapist, I find the socially sensible, content-rich and clearly written target article by Maciej Wodziński and Paulina Gołaska-Ciesielska very important for the deconstruction of the objectivistic, medicalized understanding of "autism" or "autism spectrum disorder (ASD)." They contribute to the depathologization and destigmatization not only of people who are labelled "autistic," but also people who are labelled with other categorial diagnoses deriving from manuals such as the DSM-V and ICD-10.

« 2 » One of the main messages of their research is that the shift from the "perspective of deficit" to the "perspective of difference" is crucial if "neurotypical" people want to develop an understanding of "non-neurotypical" people as different and not pathological. This shift can raise epistemological awareness, because it emphasizes the claim that the most basic act of epistemology is the creation of difference or distinction. The good news connected to this claim is that there is no end to the variety of distinctions one can draw. Francisco Varela (1979: 107) pointed out that drawing distinctions enables us to create "physical boundaries, functional groupings, conceptual categori-

zation, and so on, in an infinitely variegated museum of possible distinctions." However, the bad news is that we constantly tend to forget that we, as observers, are constructing our realities with our "epistemological knife of discrimination" (Keeney 1983) and we even tend to forget that we are forgetting this fundamental insight (Barnes & Možina 2020).

« 3 » I remember very vividly the period of my intense confusion, from 1985 till 1987, when I, as a resident of psychiatry, started training in psychotherapy, during which I was introduced to second-order cybernetics, constructivism and social constructionism (Možina 1998; Barnes & Možina 2020; Možina 2020). After seven years of studying medicine (1976–1983), in which I was systematically encouraged to forget that the world of medical diagnoses is constructed and not "real" in an objectivist sense and even encouraged to forget that I had forgotten this, our psychotherapy teacher, Graham Barnes (1994), unveiled this oblivion. It was as though the world had been pulled out from under my feet. I felt very confused and unsure about everything I had learned, because during my study of medicine I had been trained to aim for certainty. I dreamed of becoming an excellent diagnostician who knows what is "wrong" with a patient the moment she walks in (or, at least, after some minutes of talking to her). After precise physical examination and some laboratorial checking, I would become certain about the diagnosis. And with the "right" diagnosis, I would prescribe the "right" therapy. My teachers radiated a certainty that I admired (or perhaps I simply projected it into them).

« 4 » However, as soon as I started to work as a resident in psychiatry, I was overwhelmed every day by the complexity of patients. Labeling them with diagnoses did not turn out be helpful for me, because each of them was so different and unique. I had more and more questions about how to understand and help them, and I was surprised that colleagues at professional meetings were interested in making a diagnosis and prescribing medication according to some of the usual schemes. They gave the impression that everything was clear to them and that they were the ones who knew. My psychotherapy training, on the contrary, encouraged me to learn the opposite approach: to accept the uncertainty of "not knowing" and to learn from the patients.

« 5 » Based on this experience, I know how demanding the shift proposed by Wodziński and Gołaska-Ciesielska is, which does not only include some superficial learning on the conscious intellectual level but, above all, a change of one's unconscious attitude and premises. While I agree with them that such a change would lead "to an improved quality of psychiatric practice" (§54), it is especially hard for medically educated professionals, because they have to give up and leave behind the solidity and certainty of the objectivist medical world and embrace the uncertainty and "fluid nature of phenomena such as autism, or even mental health more generally" (§54). This fluid, relativistic world offers only one kind of certainty, the "certainty of uncertainty" (Možina 2010). An aggravating circumstance is that the deficit approach is reinforced by the pharma industry (Gøtzsche 2013, 2015; Whitaker 2010), which makes it even more important that "further efforts are needed to educate and raise awareness within society" (§55), including, in particular, groups and organizations of service users and their relatives: The key impetus for the enrichment of the medical model will not come from medical circles and institutions, but from society at large. In Možina (2019), I described similar problems and challenges in connection with the medical understanding of hallucinations, where the Hearing Voices Movement promotes an alternative way of understanding the experience of people who "hear voices." Although, in institutions and society, the medical model is still dominant and the constructivist one still marginal, I also proposed that, on the scientific level, the constructivist model could embrace and integrate the medical model.

« 6 » On the scientific conceptual level, such a shift from "deficit" to "difference" can be understood as a shift from the medical objectivist model, which informs the mainstream discourse also in the field of autism, to the constructivist (social constructionist) model (Table 1). This shift does not imply an either–or dichotomy, but that the medical model can be integrated, on a new level of abstraction, into the constructivist model, very much like the shift Heinz von Foerster proposed from *analytical clarity* to *trust* and from *objectivity* to *responsibility* (Kordeš 2005), and Bradford Keeney's "cybernetic complementarities" (Keeney 1983), as well as Varela's nondualistic sense of "trinity":

> "By trinity I mean the contemplation of the ways in which pairs (poles, extremes, modes, sides) are related and yet remain distinct […] For every hegelian pair of the form, A/not A, there exists a more inclusive [form], where the apparent opposites are components of the right hand side." (Varela 1976: 62, 64)

« 7 » In the case of a medical objectivist–constructivist pair where a symmetry of opposites is proposed, one can always reframe this pair as part of a more encompassing cybernetic complementarity. Such a complementarity involves different orders of recursion (which we can imagine as nesting Russian dolls). The pure medical objectivist perspective remains at the level of recursion that does not include the awareness that it is only one kind of construction, i.e., the construction under objectivist rules and premises. By contrast, the constructivist perspective can include both the awareness of objectivism as one possible way of construction and the awareness of constructivism as another possible way. So, the constructivist perspective can be understood not only as the Hegelian opposite to the medical pole, but as a more encompassing level of recursion, as a larger Russian doll that contains the smaller, medical doll. This recursive leap from medical to constructivist understanding avoids being stuck in medical technical and control approaches to the treatment of people with so-called "mental disorders."

« 8 » With this shift, medicine and psychiatry turn into a discursive, dialogical (and polylogical) activity, which accepts its epistemological responsibility (Miškulin 2017). This responsibility includes taking into account context dependency, historical variability, circular, multicausal explanations with the inclusion of the observer (participatory position, Kordeš 2005), and dialogical pluralism (Gelo & Pritz 2020).

« 9 » It is important that Wodziński and Gołaska-Ciesielska, on the one hand, praise the neurodiversity and critical autism studies, which are critical of medical attempts to "ontologize autism" and "to discover

one 'true' nature of this extremely diverse and complex phenomenon" (§9). Yet it is equally important that, on the other hand, they advocate a conceptual integration that is similar to the one proposed in Table 1, by pointing out that –

> "[…] in order to capture and analyze the multifaceted nature of the autism phenomenon and the numerous – clashing – discourses, narratives, and conceptualizations of the notion, as well as to identify potential models of identity formation of persons on the spectrum under the influence of these factors, a whole range of both first- and third-person perspectives would need to be considered." (§44)

Their view is in accordance with Varela's neurophenomenological approach, where research on autism also combines first- and third-person methods (Glezerman 2013). This kind of research offers new perspectives on how autistic persons understand words, feel, perceive the world, faces, space and spatial relations, etc.

« 10 » While I find myself in agreement with Wodziński and Gołaska-Ciesielska's epistemological orientation, some methodological issues in their target article left me curious and raised some questions. To start with, why did the authors formulate Question 5 in the rather generalizing sense of "how do people…" and not "how do you react…"? Q1 This is an interesting detail, because other questions are mostly of the second, personal sense and because the authors point out that the aim of the questionnaire was to find out "more subjective issues such as experiences of the respondents in their contacts with people with ASD" (§20). One can assume that Question 5, formulated as "How do *you* react to contact with an autistic person?" might have resulted in fewer negative answers.

« 11 » The authors also seem to have refrained from analyzing the possible differences in reflective knowledge and, in particular, background knowledge between, on the one hand, respondents who have a person with ASD in their close family or have such a friend (25% of respondents) and three other groups (distant family or friend, no contact, other response), as well as those with some, more or less intense, contact (25% and 33%) and, on the other hand, those with no contact. Since one could expect that those with closer contacts with a person with ASD would have a more positive attitude in comparison to those having no contact, further details on this issue would be greatly appreciated. Q2

Medical "deficit" model	Constructivist "difference" model
Decontextualization	Context dependency, historical variability
Successful alleviation of acute symptoms	More suitable for solving chronic problems and for understanding acute symptomatology as part of a longer, context-dependent process of evolution
Biological determinism	Social constructionism
Linear, causal explanations	Circular, multicausal explanations with the inclusion of the observer (participatory position)
Dualism illness (disorder)/health, so that health is understood as the absence of illness	Overcoming the illness (disorder)/health dualism, so that health is understood as the ability to coexist with an illness (disorder); it is this coexistence that increases the chances of survival and evolution
Objectivism; positivism; scientific monism	Constructivism; relativism; dialogical pluralism; systemic, hermeneutical and transformative epistemology
Tendency toward trivialization of complex systems	Consideration of nontriviality of complex systems (science of complexity and self-organization)
Emphasis on pathology and pathogenesis	Emphasis on salutology and salutogenesis – resources, resilience, empowerment
Symptom as text without context	Symptom as punctuation and metaphor of broader context
The goal of medical treatment is reduction of symptoms and eradication of pathogenetic factors	In addition to reducing acute symptoms, contextual approach aims to increase quality of life and coevolution with so called "pathogenic" factors
Nomothetics, third-person perspective, quantitative methodology	Idiography, integration of first- and third-person perspectives, mixed-methods (qualitative-quantitative) design
Somatic interventions are prevailing	Dialogical interventions are prevailing
Bag of tricks, emphasis on techniques	Wisdom, emphasis on holistic treatment
Certainty, knowing and analytical clarity as virtues	Uncertainty, curiosity and trust as virtues

Table 1 • Comparison of the medical ("deficit") model and the constructivist ("difference") model.

« 12 » My experience is that close clinical and personal contacts with people diagnosed with ASD are crucial for starting to appreciate their diversity and to learn from them. I was again and again pleasantly surprised how many family members, who live with people with ASD, have become much broader and deeper in their understanding of the human condition and growth than others. As experts by experience, they have taught me invaluable lessons and helped me to step out of many of my stereotypical convictions about autism.

« 13 » I would like to close with a short vignette about Robert, to whom, and to whose family, I am especially grateful. I met Robert, whom psychiatrists diagnosed as having Asperger syndrome, for the first time, in 1985, in the milieu therapy project (Možina & Stritih 1998). I was a member of

a team of 20 volunteers. Every summer we organized camps for around 40 children and adolescents with different psychosocial problems. Robert was nine years old and his behavior was so atypical that he soon became the "super star" of our group. One of his specialties was that, all of a sudden, he would approach another person from behind, so that this person was not expecting him at all, and jump on the person's back. Then, looking directly into the person's eyes from just a centimeter away, he would ask with his eyes wide open: "Are you angry?" Soon we found out that we could not stop his behavior, which posed quite a challenge. It turned out to be crucial that, in the team, we helped one another to stay empathic despite his quite annoying behavior. So, we changed our attitude rather than trying to change him. As a result, after a few days, his jumps became more predictable and less frequent. Nobody could explain the mechanism of this change, but we were quite relieved. He started to approach others from the front but he kept his different perception of personal space for years and kept coming very close when he wanted something. He attended our camps for 18 years and became a member of our volunteer team and he was able to help other troubled children. Of course, he never became "normal" or "typical," for his range of unusual behavior was too broad (including constant questioning, tics, unexpected bursts of laughter, bouncing, muttering, escaping, and falling because of different spatial orientation) but helped us to learn how to become more flexible and empathic in our responses to his diversity. He taught us to be more open for surprises and to accept certainty of uncertainty. With our support, he finished school and found a job in a library, where he has been doing fine for many years.

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