

Crossroads: The Intersection of Affirming Cultural and Neurological Diversity

Mina Chun and Marni E. Fisher*
Chapman University

As a result of societal and dominant cultural definitions of “normal,” individuals have to fight for space and voice for each quality outside this hegemonic definition. (Dis)ability has largely been defined within the medical model, which increases alienation and dismisses (dis)ability from discussions of diversity. The intersection of cultural diversity for multilingual learners and neurodiversity in terms of autism offers a space where the affirmation of all forms of diversity promotes change. Beginning with the role of diversity, as previously defined in multicultural and multilingual settings, the defining of autism is then scrutinized through three lenses: cultural and linguistic diversity, within the medical model, and finally as a form of neurodiversity, which encourages an alternative understanding of autism. Using these lenses, teachers who teach in English language learner programs or otherwise have the power to embrace forms of diversity and ability as a point of enrichment within the classroom setting and align services and instruction with home language, beliefs, and culture.

Keywords: autism, diversity, medical model, multicultural, multilingual, neurodiversity

People are measured based on society’s standard of “normal” (Goodley, 2011). The dominant culture determines what is “normal” while relegating minority and multicultural voices as less significant (Darder, Baltodano, & Torres, 2003; Walker, 2012). Individuals have to fight for space and voice for each quality outside the norm (Sanders-Lawson, Smith-Campbell, & Benham, 2006). Not only do cultural mores affect how disability is considered (Matson et al., 2012), but also how the combination of multilingualism and cultural difference with disability relegates the individual to at least two levels of silence and Othering (see SooHoo, 2006, for multiple examinations of “Other”). The professional tendency to identify the needs of individuals with disabilities and provide appropriate interventions to become “normal” (Brownlow, 2010), or “indistinguishable” from “normal” people (without disabilities) (Winter, 2012), contributes to alienation. “Hegemony is a cultural encasement of meanings, a prison-house of language and ideas, that is ‘freely’ entered into by both dominators and the dominated” (McLaren, 2003, p. 77). However, looking, acting, and thinking differently from society’s norm should not be considered wrong, disabled, abnormal, or unfit. Diversity should be seen as a precious resource and the affirmation of diversity as social justice (Nieto, 2002). In examining the intersection of cultural for multilingual learners and neurodiversity in terms of autism, the hope is to proffer the affirmation of diversity to promote “personal, collective, and institutional change” (p. 277).

The purpose of this literature review is to examine the crossroads of diversity and neurodiversity. Beginning with the role of diversity, as has been previously defined in multicultural and multilingual settings, the definition of autism is then scrutinized through three lenses: cultural and linguistic diversity, within the medical model, and finally as a form of neurodiversity. Parents with different culture and language backgrounds raising autistic individuals view disability through a cultural lens. The medical model is often utilized to eliminate or improve autistic traits in individuals. The neurodiversity model includes voices of autistic individuals and encourages autism as a human diversity.

Many autistic individuals who are supportive of neurodiversity believe autism is part of their identity, and therefore they prefer an identity-first language of “autistic individuals” (Kapp, Gillespie-Lynch, Sherman, & Hutman, 2013). For example, in her book *Grandin* (2006) states, “If I could snap my fingers and be nonautistic, I would not—because then I wouldn’t be me. Autism is part of who I am” (p. xviii). Honoring this preference, in this paper the identity-first language of “autistic individuals” to identify individuals diagnosed with autism is used rather than “individuals with autism,” a person-first language. Disability will be framed as “(dis)ability” when referred to as a form of diversity, and as “disability” when referred to as a format for alienation. Finally, the word “autism” will represent the autism spectrum disorder.

Affirming Diversity

Studies of diversity tend to focus on definitions of race, ethnicity, gender, culture, sexual orientation, and personality differences (Smith, S. D., Ng, Brinson, & Mityagin, 2008). Not only is it important to recognize the value of diversity (Nieto, 2002), but also that “affirming diversity is above all about social justice” (p. 278). Conversely, the inclusion of (dis)ability in discussions of diversity becomes conspicuous by its absence throughout the literature (Gordon & Rosenblum, 2001; Pearson, 2010), further shifting the role of the Other toward an extreme for those with disabilities. Like diversity, (dis)ability falls within a socially constructed frame by being “(1) named, (2) aggregated and disaggregated, (3) dichotomized and stigmatized, and (4) denied the attributes valued in the culture” (Gordon & Rosenblum, 2001, p. 6), but (dis)ability is chronically labeled as a medical condition rather than a form of diversity. When examining the importance of embedded multicultural education (Nieto, 2002) combined with intermingled cultures and heritages (Dewey, 1916), the addition of (dis)ability, particularly through the medium of neurodiversity, can further expand the advantages of affirming diversity.

In addressing issues of diversity, there is an inherent tension and conflict between social classes, which “provokes and shapes cultural ways of being, and therefore, generates contradictory expressions of culture” (Freire & Macedo, 2003, p. 357). Caught within this tension, teachers may hesitate to include or address diversity issues out of “fear that classrooms will be uncontrollable, [and] that emotions and passions will not be contained” (hooks, 1994, p. 39). Coupled with this fear is the potential for conflict and contention, while a lack of knowledge about race and ethnicity further encourages teachers to allow issues of difference to lie untouched (Nieto, 2003), promoting hegemony (McLaren, 2003). Thus,

in a multi-racial, ethnically variegated society, the American experience (certainly in its schools) has been an experience of cultural assault, discriminatory rejection of educational opportunity for many children, and that continuation of social and economic advantage for a white Anglo-Saxon, Protestant, middle-class patrician elite. (Cordasco, 1973, p. 63)

This, in turn, results in the Othering of individuals outside the dominant culture (Giroux, 2003; SooHoo, 2006). For individuals with disabilities, exclusion is a societal issue (Slee, 2011), and individuals wearing multiple non-dominant factors find themselves needing to fight for a voice and rights for each combination of race, ethnicity, gender, language, disability, and other factors (Sanders-Lawson et al., 2006).

Affirming diversity needs to include multiple forms of difference, centering children's learning around the experiences they bring with them to the classroom: language and culture (Dewey, 1916; Peterson, 2003), historical background (Giroux, 2003), family structure (Reichman, 2012), and (dis)ability (Armstrong, 2012). Multicultural learning needs to be embedded within the curriculum (Nieto, 2002, 2003, 2005; Nieto & Bode, 2012), as does the integration of a variety of learning modalities meeting the students' individual learning strengths and weaknesses (Gardner, 2006, 2011). By the same token, the integration of (dis)ability and neurodiversity offers a space to enrich the educational classroom through accepting forms of neurodiversity; teaching children flexibility that is useful in developing broader viewpoints, vision, and experience (Dewey, 1916); and offering alternate perspectives for problem solving (Carpenter et al., 1999). In addition, the integration of literature representing a multiplicity of cultural, linguistic, and (dis)ability-related diversity breaks away from literacy programs that offer only "predetermined and pre-established discourse while silencing their own voices" (Freire & Macedo, 2003, p. 360), thus creating a space for students to both learn about what is different and also see characters and cultures where the children recognize themselves (Lynch-Brown, Short, & Tomlinson, 2013; Nieto, 2002).

Of course, the integration of any form of diversity into education is not without challenges. As Nieto correctly points out, "Presenting new knowledge and perspectives may upset students' taken-for-granted assumptions about reality, including their biases and stereotypes about certain groups of people, an uncritical acceptance of what they read and hear, and a limited understanding of history, both national and international" (2005, pp. 209–210). Still, despite the difficulties, the potential advantages of including culture and neurodiversity can outweigh disadvantages, because students who feel connected and valued both personally and in terms of their diversity are more likely to be successful in school (Bishop & Berryman, 2006; Nieto, 2003).

Implementing successful changes requires application at the personal, collective, institutional, and leadership levels (Evans, 2009; Gill, 2011; Lindsey, Roberts, & Campbell-Jones, 2005; Nieto, 2002); in addition, there needs to be an acknowledgment and consideration of the fears teachers have when asked to shift their paradigms (hooks, 1994). Embracing the diversity of students, instituting an embedded multicultural curriculum that also embraces (dis)ability as a form of diversity, and teaching elements of equity and equality are the beginnings of creating a foundation that includes social justice and equality while developing empowerment (McLaren, 2003; Nieto, 2002).

Autism

When considering the presence of (dis)ability within affirming diversity, the movement of understanding autism as a form of neurodiversity offers a starting place. Autism is one of the (dis)abilities that people encounter on TV, radio, newspapers, blogs, and websites (Bagatell, 2010; Murray, 2008). Given the pervasive reference to “autism” in modern media, providing a concise definition of just what is meant by it is in order. Autism revolves around patterns of neurological difference (Dalton, 2013; Robertson, 2010), which align easily with the understanding of individuality, differentiation (Kliebard, 1967; Whitaker, 2004), and multiple intelligences (Gardner, 2006, 2011) that is already a part of quality education. It is considered a neurodevelopmental and lifelong disorder (Hebert & Koulouglioti, 2010; Wing, 2007).

Recent years have witnessed a growing trend in the number of autistic children worldwide. The prevalence rate of autism in 2008 was 13 per 10,000 children in Japan and 9.8 per 10,000 children in China (Sun & Allison, 2010). In South Korea, 94 per 10,000 children are diagnosed with autism (Elsabbagh et al., 2012; Kim et al., 2011). The Centers for Disease Control and Prevention (2012, 2014) in the United States also estimated autism prevalence rates at one in 88 children, or 113.6 per 10,000, in 2008, and one in 68 children, or 147 per 10,000, in 2010. As the statistics above show, autism is no longer a rare condition.

The foundational research of the characteristics of autism was done by Kanner (1943) who studied eight boys and three girls with language abnormalities. In this study, the children were not able to relate to themselves or to others in the usual manner, and therefore were described as “acting as if people weren’t there, perfectly oblivious to everything about him, giving the impression of silent wisdom, failing to develop the usual amount of social awareness” by their parents (p. 242). Children also presented “an extreme autistic aloneness that . . . shuts out anything that comes to the child from the outside” (p. 242). The children exhibited fears of “loud noises and moving objects” and an “anxiously obsessive desire for the maintenance of sameness” (p. 245).

The diagnostic category for autism was not originally included in the *DSM-I* and *DSM-II*; therefore, characteristics of autism were analyzed as Schizophrenia-Childhood Type (American Psychiatric Association, 1952, 1968). In the *DSM-II* (1968), however, characteristics of “autistic, atypical and withdrawn behavior” were included as conditions of Schizophrenia-Childhood Type (p. 35). In 1980, autism was recognized as a separate diagnostic category in the *DSM-III*, which was called infantile autism. The characteristics of autism in *DSM-IV-TR* included a triad of impairments such as social interaction, communication, and repetitive behaviors before the age of three years (American Psychiatric Association, 2000).

The *DSM IV* (American Psychiatric Association, 2000) included five subcategories of pervasive developmental disorders (PDDs): autistic disorder, Asperger’s disorder, childhood disintegrative disorder, Rett’s disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS). However, the *DSM-V* (American Psychiatric Association, 2013) removed the subcategories (Bowler, 2011; Tsai & Ghaziuddin, 2014), and renamed the PDDs as autism spectrum disorder (ASD) (Tsai & Ghaziuddin, 2014). In addition, ASD was identified in three severity levels (i.e., requiring support, substantial

support, and very substantial support) in two categories, such as social communication impairments and restricted, repetitive patterns of behavior (American Psychiatric Association, 2013).

This has sparked controversy and objections, particularly from people diagnosed with Asperger's syndrome, which is often identified as a higher functioning form of autism (Ghaziuddin, 2010), over "the possible loss of their label, which they much prefer to that of autism spectrum disorder or just 'autism' " (Wing, Gould, & Gilberg, 2011, p. 771). Further concerns include the fear that "individuals might be excluded due to good specificity but poor sensitivity of the new DSM-V criteria" (Kent et al., 2013, p. 1242), and that the potential exclusion of Asperger's syndrome could result in a loss of medical and/or social services for those who are diagnosed with Asperger's syndrome (Wing et al., 2011). In testing the validity of the new criteria, some researchers have found it effective in most areas (see, for example, Guthrie, Swineford, Wetherby, & Lord, 2013; Kent et al., 2013), whereas others have been concerned about continued inaccuracy in diagnosis, particularly in young girls and women (Wing et al., 2011). Regardless of the criteria structure, one point that has remained consistent is the use of behavioral markers for the diagnosis of "a neurodevelopmental disorder with genetic causes and biological consequences" (Guthrie et al., 2013, p. 797).

While there is no specific known cause of autism, researchers have found a strong link between genetics and environmental factors (Krcsek, 2013). In addition, autistic individuals have different brain structures (Jaarsma & Welin, 2012) compared to individuals without autism, as a result of their "social brain which includes the medial prefrontal cortex and the amygdala is frequently underactive" (Murray, 2012, pp. 4–5). Autistic individuals often have difficulties with understanding nonverbal behaviors, developing relationships with others, sharing interests and pleasures with others, and social or emotional reciprocity (American Psychiatric Association, 2000). Autism produces impairments that delay language, which also affects the ability to initiate or sustain a conversation with others. Individuals present restricted and repetitive behavior, interests, and activities; autistic individuals may have difficulty with changes in environment or daily routine, and "in managing several simultaneous tasks, understanding social nuances, filtering competing sensory stimuli, and planning tasks of daily living" (Robertson, 2010, para. 6).

As a consequence of these traits exhibited by autistic individuals, it is often implied that their deficits affect their ability to have high-quality and successful lives in society (Robertson, 2010). Often, autistic individuals' weaknesses are heavily emphasized when their strengths deserve to be emphasized as well (Armstrong, 2012). Autistic individuals have strengths in "detailed thinking, expansive long-term memories, a comfort with rules and guidelines, and an affinity for analyzing complex patterns in the social and physical worlds" (Robertson, 2010, para. 6). Autistic individuals' strengths align with musical pitch, attention to detail, and visual-spatial skills (Dalton, 2013). It is important to consider their strengths and talents and provide individualized support strategies based on their learning style; this promotes educational and career success as well as better quality of life (Armstrong, 2012).

Autism in a Culturally and Linguistically Diverse Context

The connection of culture and (dis)ability plays a key role in both parental expectations (Matson et al., 2012) and choices for support and services (Ku & Bryce, 2011). Since there is no definitive explanation for the cause of autism, parents define autism based on “their cultural values, personal experiences, upbringing, family attitudes, friends, and community” (Hebert & Koulouglioti, 2010, pp. 150-151). This difference in the perception based on culture and parental expectations (Matson et al., 2012) can result in a lack of “effective and inclusive social support” for autistic children arising from culturally based parental choices (Ku & Bryce, 2011, p. 497).

Based on the background, even the identification of “impairment” may be influenced by culture (Matson et al., 2012). Among participants from the United Kingdom (UK), the United States, South Korea, and Israel, those from the UK identified the highest significant impairments in all four domains—nonverbal communication/socialization, verbal communication, social relationships, and insistence of sameness/restricted interests. Participants from the United States identified impairments as second highest in all domains except verbal communication. South Korea identified verbal communication as the second highest impairment after the UK. Compared to the UK, the United States, and South Korea, participants from Israel identified significantly fewer impairments in all four domains.

Parental perceptions of the causes of autism also vary from country to country. Dale, Jahoda, and Knott (2006) conducted a study of parental beliefs about autism with 16 Caucasian mothers of autistic children residing in the UK. The mothers considered birth; pregnancy; the measles, mumps, and rubella (MMR) vaccine; genetics; and biological and maternal behaviors as possible causes of their children’s autism, but most “focused on the future and helping their children to progress” (p. 472). In France, a study with 78 parents showed they believed the causes of autism were brain abnormalities, genetic factors, complications during pregnancy, food allergy, trauma experiences very early in life, and a chemical imbalance (Dardennes et al., 2011). In Saudi Arabia, most parents believed vaccines were the cause of autism (Alqahtani, 2012). Some parents believed pregnancy difficulties were the cause, and therefore had frequent medical investigations during the pregnancy. Many parents believed the cause of autism could be “the evil eye and black magic” (p. 15). Mothers commonly felt guilty, often blaming themselves for their child’s autism. Chinese parents noted the difficulty in sharing their child’s autism with others because of the socially constructed “low awareness and acceptance of disability and difference” (McCabe, 2007, p. 43). Some Chinese parents feared discrimination, unworthiness, or exclusion from those without disabilities; other Chinese parents blamed themselves for their child’s diagnosis. Their children experienced rejection from schools based on their condition or skills in China, leaving parents anxious about their children’s educational opportunities (McCabe, 2007).

Within the United States, some Navajo parents believed “the cause of autism was the fault of the parents or a result of witchcraft” (Dyches, Wilder, Sudweeks, Obiakor, & Algozzine, 2004, p. 219). Young Latino mothers, however, who had emigrated from Puerto Rico and Mexico believed their autistic child was a blessing from God, and therefore they were “dedicated, sacrificing, and suffering” (p. 219) to be good mothers.

Parents from South Asia who had immigrated to the United States believed Allah gave their autistic children to them (Jegatheesan, Miller, & Fowler, 2010). They also thought that, before Allah gave the child disabilities, Allah considered “the parents’ moral character, loving nature, and resilience; their ability to protect the child; and their fate or Karmic connection to the child” (p. 101). Therefore, parents felt blessed and “chosen” to raise a child with disabilities. Parents relied on their religion to maintain a positive attitude because complaining about their child’s disabilities equated with complaining about Allah. The child’s disabilities were part of human diversity, because, “in the words of Allah, it is written that not every human being is the same. These differences were not to be perceived as ‘something less’ or ‘something more’ ” (p. 102), and parents often emphasized children’s strengths rather than their deficits, refusing to participate in interventions focused on normalization.

The positive connection of multilingualism with disability is especially clear within the Jegatheesan et al. (2010) study on Muslim parents from South Asia who had immigrated to a Midwestern city in the United States; participants’ home languages included Bangla, Hindi, Arabic, Urdu, Kachhi, Gujarati, and English. The parents’ inclusion of their autistic child(ren) in “religious activities at home, in the mosque, and in the community” (p. 103) determined inclusion within a multilingual world. This required speaking and understanding: (a) their native language, which differed based on the South Asian country of origin, to interact with the family or community; (b) Arabic, to directly ask for blessings and forgiveness from Allah; and (c) English, to succeed in school, therapy, and other social interactions in the United States.

Conversely, some Chinese immigrant mothers were encouraged by professionals to use only English with their children because “bilingualism was viewed as a potential risk that could hinder their children’s access to intervention or even undo progress that had been achieved” (Yu, 2013, p. 10), creating a greater capacity for alienation within the crossing of multilingualism and (dis)ability. The mothers believed learning more than one language could be confusing and challenging, so they focused on their children’s gain in fluency in English before their native language; this was emphasized by the provision of education and interventions in English. Even though mothers wanted to support their children, using English was difficult for some multilingual immigrant mothers and caused additional stress. However, when education, recommendations, and interventions were aligned with their beliefs and language, then families could more easily access and maintain practices and services (Jegatheesan et al., 2010; Yu, 2013).

Autism in the Medical Model

Many families and professionals believe eliminating or improving the identified deficits of individuals with autism can allow those individuals to eventually experience “normal” life that “normal” people (people without disabilities) experience in society (Chamak, 2008; Dale et al., 2006; Goin-Kochel & Myers, 2005; Winter, 2012) and therefore have a better future (M. G. Wong & Heriot, 2007). Consequently, resources, such as “training programs, books, special diet requirements, different behavioral methods, genetic tests and various biological dosages, as well as unorthodox therapies” (Chamak, 2008, pp. 79-80), have been established to help autistic individuals manage identified deficits.

Currently, the medical model, which focuses on the disability as a deficit of the individual, and therefore a problem to be “normalized” (Goodley, 2011), is used for the defining and intervention of various disabilities. Individuals with disabilities are viewed as clinical objects, and the medical model approaches concentrate on eliminating or improving individuals (Kras, 2010). In 2005, Autism Speaks, one of the largest autism organizations in the United States, funded “between \$22 and 32 million in autism research annually” to support researchers (Pellicano & Stears, 2011, p. 272) because Autism Speaks aims to “change the future for all who struggle with autism” by supporting with the identification of treatments, cures, and causes of autism (Autism Speaks, 2012, p. 2).

The medical model, however, ignores the crossroads of (dis)ability with any form of multilingualism, multiculturalism, or diversity, creating a situation where disability in combination with other forms of diversity increases alienation and supports cultural beliefs. If parents believe their children’s autism was influenced by genetics, then they seek educative interventions (Dardennesa et al., 2011). Special diets and vitamins are implemented with children when parents believe autism was caused by chemical imbalance. Parents in Hong Kong use acupuncture, treatments to detoxify mercury, and other types of complementary and alternative medicine to improve the quality of life of their autistic children (V. C. Wong, 2009) through yoga, homeopathy, and herbal medicines (Ravindran & Myers, 2012) to “restore the harmony in one’s body, as well as the balance in one’s brain and nervous system” (Ghosh, Koch, Suresh Kumar, & Rao, 2009, p. 3). Most families are dedicated to providing any treatments and interventions to help their children, regardless of expense—and are even “willing to spend all of their money, and even borrow from others, to attend the intervention programs” (McCabe, 2007, p. 47).

The most popular and effective interventions recommended for individuals with autism are interventions based on Applied Behavioral Analysis (ABA) principles (Chamak, 2008; Matson et al., 2012); “ABA is the applied branch of the science of behavior analysis that can be valuable regardless of the developmental level or ability” (Dillenburger, Keenan, Doherty, Byrne, & Gallagher, 2012, p. 113). ABA gained its popularity through the study that Lovaas (1987) published at the University of California at Los Angeles in 1987 (Smith, T., & Eikeseth, 2011), which was conducted with 40 children in which 19 children received 40 hours of one-to-one training per week in a highly structured teaching format (Rosenwasser & Axelrod, 2001). Lovaas’ goal was to make those children “indistinguishable” from “normal” (majority) children and increase the comfort for the majority children (Silberman, 2010, para. 55). His study found that 47% of the children who received 40 hours of one-to-one training per week “achieved IQ’s exceeding 100” (Rosenwasser & Axelrod, 2001, p. 3). The study was considered successful because children with autism became “indistinguishable” from “normal” children by discouraging “their stereotypes and sometimes aggressive behaviours, and by [helping them] reach school integration” (Chamak, 2008, p. 80).

Parents of autistic individuals focused on eliminating and “curing” the identified deficits in communication, social interaction, and repetitive behaviors (Brownlow, 2010), so their autistic children could become “normal.” To do this, some interventions

taught eye contact and praise for making improvements in making eye contact (Winter, 2012). People without disabilities considered particular interests or behaviors of autistic individuals as obsessions; to counter this, interventions were applied to restrict those interests to decrease particular interests or behaviors of autistic individuals (Winter, 2012). Parents often tried many different types of treatments and interventions because their children were not making the desired progress (Mandell & Novak, 2005). Parents believed these methods gave “hope to modify the gloomy fate of their children” (Chamak, 2008, p. 80).

Autism in the Neurodiversity Model

Despite the “parents’ movement dedicated to awakening public awareness and marshaling more support for research and treatment” (Antze, 2010, p. 314), some autistic individuals felt their families and professionals saw autism as a disease to be cured not as a need to acknowledge the individuals’ “cognitive strengths, their diverse way of being, and their gifts and talents” (Robertson, 2010, para. 2). Those individuals felt their opinions were ignored or not welcome (Ortega, 2009), so they started the neurodiversity movement to share their perspectives and experiences. The neurodiversity model views autism and other neurological conditions, along with “attention deficit-hyperactivity disorder, bipolar disorder, developmental dyspraxia, dyslexia, epilepsy, and Tourette’s syndrome” (Fenton & Krahn, 2007, p. 1), as natural human variation and diversity similar to other forms of diversity, such as race, religion, gender, culture, and sexual orientation (Jaarsma & Welin, 2012; Krcek, 2013; Ortega, 2009; Walker, 2012).

Neurodiversity disagrees with rhetoric describing autism as a deficit that needs to be eliminated or cured (Brownlow, 2010; Bumiller, 2008; Ortega, 2009; Walker, 2012), viewing autism instead as a positive identity (Bumiller, 2008; Kapp et al., 2013). “Neurological diversity is the norm in the natural world” (Fenton & Krahn, 2007, p. 3) and “there is no ‘normal’ style of human brain or human mind, any more than there is ‘normal’ race, ethnicity, gender, or culture” (Walker, 2012, p. 154). Educators, parents, service providers, and other adults should have “a deep respect for each child’s unique brain and seek to create the best differentiated learning environment” (Armstrong, 2012, p. 13). When society understands neurological differences, neurodiversity can then be accepted as a human diversity (Baker, 2006; Ortega, 2009).

Under the neurodiversity model, autism is seen “as much a social as a medical phenomenon . . . [contending] that the ‘cure’ approach is not the best way forward for securing people’s quality of life” (Ne’eman, 2010, para. 5). In addition, society’s lack of accommodation (Brownlow, 2010) creates daily living challenges for disabled individuals (Robertson, 2010). Instead of seeing autism as suffering from a deficit, problem, or disease, society needs to acknowledge autism “as different ‘ways of being’ from what is commonly represented or understood as normal or neuro-typical” (Fenton & Krahn, 2007, p. 2)—a difference that “should be tolerated and respected in the same way as other human differences” (Griffin & Pollak, 2009, p. 25). Autistic individuals should have equal access, rights, and opportunities as people without disabilities (Owren & Stenhammer, 2013; Robertson, 2010). It is important to pay attention to the

experiences, concerns, and goals of autistic individuals in order to understand their needs and provide practical and valuable supports that are needed and desired (Owren & Stenhammer, 2013).

Conclusion

The intersection of multiculturalism and multilingualism with (dis)ability involves interwoven spheres of influence, whether recognized or not. Acknowledging the absence of (dis)ability within the discussions of diversity, and embracing (dis)ability as a form of diversity, are essential pieces of this attempt toward inclusion. In the same way, the juncture of diversity and neurodiversity within any classroom, whether the students are multicultural, bilingual, or Standard English learners, offers a space for changing people's perception and removing barriers, thus creating an intersection for affirming cultural and neurological diversity.

On a practical level, every time a teacher steps into a new class, regardless of level, the goal is to create change for each student. That change often involves connecting with students, appreciating what is important to them, understanding their culture and diversity, building an understanding of students' strengths and weaknesses, and then identifying ways to meet individual needs and learning goals. Success may look different and require different measures for each student, and connecting students with tools and services quickly is important. Quality teaching, as defined by the National Board (2014), requires teachers to regularly explore new strategies to build success for all students (Fisher, 2012). This includes differentiation and methodology that takes multiple forms to meet students' individual needs (Fisher, 2008; Gauthier, 2008; Kliebard, 1967; Tomlinson et al., 2003; Whitaker, 2004).

The typical medical model, when applied to (dis)ability, makes an assumption of what is "normal," and then applies hegemonic and dominant cultural overtones to name anything outside of that norm as deficient. The beauty of neurodiversity is that its recognition that each person has his or her own definition of what is "normal" and that there is nothing wrong with that difference, which can then become a recognized and embraced point of diversity. It is important to remember that autistic individuals have their own unique strengths and talents; therefore, individualized interventions and strategies are required based on their learning styles (Armstrong, 2012) to help them increase their quality of life.

Stepping forward into change, teachers can use the points of diversity in culture, language, and (dis)ability to enhance learning throughout the classroom and build tolerance and understanding. At the same time, teachers must also keep in mind that each culture views (dis)ability differently. Taking the time to understand the needs of the community and families enables teachers and resource specialists to align education, recommendations, and interventions with the home culture and language to promote successful implementation (Jegatheesan et al., 2010; Lo, 2012; Yu, 2013). In addition, communication that includes the parents as participants rather than merely recipients before starting the individualized education program (IEP) process, then checks for clarity of communication both during and after meetings, increases student success (Lo, 2012). Furthermore, taking steps to educate parents and families without

denigrating the home culture can aid in shifting perspectives and promoting success. When interacting with parents, teachers should keep in mind that the cultural and linguistic background of a particular child affects parental perceptions of the disability itself, the child, and the teachers.

Creating change may be easier if it takes place on multiple levels (McLaren, 2003; Nieto, 2002), embedding the value for all forms of diversity—whether that diversity revolves around culture, language, learning patterns, family structure, or ability—into the curriculum and culture of the community, school, and classroom. Ideally, school leaders and officials should institutionally promote change and embrace diversity while keeping in mind that these efforts take more preparation and time than traditional methods. Similarly, smaller class sizes promote student success while reducing teacher burnout (Mulnar, 2003). However, even though change is easier if implemented from within by leadership and then modeled for transformational change at the institutional level (Evans, 2009; Lindsey et al., 2005), the teacher also has the power to embrace and then create change within his or her own sphere of power: the classroom (Ayers, 2012).

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*Corresponding authors: chun124@mail.chapman.edu and fisher@chapman.edu