CHAPTER 3

Examining Beliefs and Expanding Notions of Normalcy

Don't Be Afraid of the Water

"What if I don't feel ready to teach those kids?"

Over the last three decades, the field of special education managed to convince a generation of general education teachers that they are not "special" enough (meaning patient, qualified, knowledgeable, and naturally gifted enough) to teach children with disabilities. Even the general public believes that special educators are a breed apart from others. All we have to do is enter a room of strangers, strike up a typical "cocktail party" conversation, and wait to be asked what we do for a living. As soon as "I am a special education teacher" leaves our lips, we are transformed in the eyes of our audience, who lightly gasp and murmur, "Why, you must be a *very* special person yourself." Amid a circle of nodding heads, there is always one who goes on to confess what the others are thinking, "You know, *I* could *never* do what you do. I am glad there are people in the world like you."

Let's unpack the assumptions at work in this exchange. What is unspoken is the belief that disability is a most unfortunate life circumstance—so unfortunate (and far removed from "ordinary" life experience) that this audience cannot imagine life other than one disencumbered from disability. It is further implied that a *very* special person is needed—preferably one with the zeal and sacrificial nature of a missionary—to work with disabled children, who present formidable and presumably undesirable challenges. Perhaps most troubling is the gratitude expressed toward people who *choose* to work with disabled children so that others (meaning themselves) may be spared from having to engage with disability whatsoever.

In the previous chapter, we explored the origins of disability stereotypes within popular culture. Given that public school is a particular culture, where might ideas about disability originate in an educational context? For example, what might account for the willingness of general education teachers to believe that only special educators can and should teach children with disabilities?

Disability Perspectives

Prior to the implementation of P.L. 94–142 within public schools, the medical community (e.g., family doctors, neurologists, psychologists, psychiatrists, neurologists, ophthalmologists, audiologists, physical therapists, speech/language pathologists, occupational therapists) functioned as the primary source of information, treatment, and support for parents of children with disabilities. It is rather unsurprising, then, that the framing of disability within P.L. 94–142 (and all of the subsequent reauthorizations of IDEA, the Individuals with Disabilities Act) reflects this historical relationship between medicine and disability.

The Medical Model of Disability

Anyone who has visited a doctor's office in America is familiar with the medical model. A patient presents with symptoms. The doctor performs a medical examination for the purpose of confirming or ruling out a diagnosis based upon the patient's symptoms. Once a diagnosis is confirmed, the doctor prescribes a curative course of medical treatment to restore the body back to health. The patient is asked to return for a follow-up appointment to evaluate the effectiveness of the treatment.

Now let's look at the assessment, eligibility, and placement procedures delineated under IDEA. The "patient" (student) presents with "symptoms" (educational

problems). The "scientific expert" (school psychologist) performs an "examination" (psycho-educational assessment) in order to confirm or rule out a "diagnosis" (disability). Once a "diagnosis" (disability) is identified, a "prescription" (Individual Education Plan, or IEP) is written with recommendations for a "course of treatment" (special education placement and individualized instruction) intended to "cure" (remediate) the "patient" (student). A "follow-up appointment" (annual IEP review) is scheduled to evaluate the effectiveness of the "treatment plan" (special education services). The medical model's presence within special education practice is unmistakable.

For more than 30 years now, special education has relied upon the medical model as its framework for understanding and responding to disability. Viewed through a medical model lens, disability is conceptualized as a pathological condition intrinsic to the individual. Thus it is a naturalized practice within special education to position the individual student as the unit-of-analysis. For example, under the evaluation procedures set forth by IDEA, a school psychologist administers an *individual* and "scientifically based" assessment battery to determine whether or not a student meets criteria for one or more of 13 disability categories. Special education committee members (school professionals and parents) review results of the psycho-educational evaluation and, in turn, determine student eligibility and placement in regard to special education services. Lastly, an Individual Education Plan (IEP) is developed to target and remediate the student's identified cognitive, academic, and/or behavioral deficits.

Now that you are reading our third chapter, you might anticipate that we are about to invite you to look beyond the existing state of affairs to examine the underbelly of our agreed-upon educational response to children with disabilities. Again, we are not suggesting that non-disabled people are orchestrating some kind of Sinister Plot—à la comic book action flick—to ensure their superior position in the world; however, it is worth reminding ourselves that public schools are highly politicized spaces (see Chapter 1) populated by people who bring along their myriad values, cultures, ethnicities, languages, beliefs, histories, and behaviors. It is also worth remembering that we can legislate policy but we cannot legislate attitude. We need only look at the unintended consequences of special education discussed in Chapter 2 (e.g., social and academic stigma, persisting overrepresentation of students of color in segregated classrooms, inaccessibility to general education curriculum) to recognize the significance of attitude upon student outcomes.

Having relied upon the medical model of disability for more than three decades, public school personnel generally regard special education's grounding framework as natural and unproblematic. It is, after all, the way we *do* things. Our professional language is rife with phrases to describe the pathology of students with disabilities—"significant discrepancy between ability and achievement," "visual and auditory processing deficits," "delayed visual-motor development," "immature speech," "low risk-taking behavior," "poor inhibitory control," "inattentive behaviors," "language-impairment," "erratic performance," "atypical gait," "tactile defensiveness," and so on and so forth. Consider for a moment how you might conceptualize a child described in a report with *all* of the aforementioned phrases. Hold that picture in your mind. Are you looking at a child in all of his humanity—or as the sum of his deficits? What were your immediate thoughts about this child's academic potential and your ability to teach him? Did the language of pathology influence your viewpoint in any significant way? When we conceptualize difference as deficit, it engenders a particular way of thinking about

and responding to children with disabilities. The more we focus upon the individual, the more it seems the individual is determined by his or her disability status. Perhaps, as disability studies scholar Simi Linton contends, "We are deficient in language to describe it any other way than as a 'problem.'"[1]

The Social Construction of Disability

Let's return for a moment to the example of Teacher A and Teacher B, described at the end of Chapter 1. To recap, Teacher A evaluates whether or not a new student with disabilities will "fit into" her classroom (as well as her teaching repertoire), while Teacher B considers what a new student with disabilities needs in order to succeed in his classroom and engages knowledgeable others (special education staff and parents) in the transitional process. We can expect a different outcome for the student depending upon which context she enters. The biological fact of the student's disability remains constant. What shifts is the *response* to disability.

We do not dispute the biological differences inherent to disability. Nor is it our intention to diminish the positive contributions of science in the lives of persons with disabilities. We wish to emphasize, however, that the *meaning* that societies attribute to disability shifts across both time and culture. Less than 30 years ago, for example, it was considered "right and natural" in the United States for a person with severe disabilities to spend his lifetime within an institution.[2] In contrast, it is commonplace in today's culture for persons with severe disabilities to reside in group homes within their communities. Have the disabilities once deemed severe enough to warrant institutionalization disappeared? Absolutely not. What *has* disappeared is American society's wholesale *response* to severe disabilities—the practice of institutionalization. And, as we continue to point out, it is society's agreed-upon response to disability that determines particular outcomes for persons with disabilities.

In recent years, people with disabilities, disability studies scholars, and disability advocates have distinguished impairment from disability in the following way. An *impairment* refers to "variations that exist in human behavior, appearance, functioning, sensory acuity, and cognitive processing"[3] in contrast to a *disability,* which is the product of social, political, economic, and cultural practices.[4] In other words, there is more at work than a biological difference inherent to an individual. For example, a wheelchair user may have an impairment that requires moving through the world in a way other than walking; however, should the wheelchair user wish to enter a building that is accessible *only* to people who walk, she is now disabled by the context. In this way, disability can be understood as a social construction.

Constructing Disability in Public Schools

As we explained earlier in this chapter, public education relies upon the medical model as its framework for understanding and responding to disability. So it is unsurprising that special education practice incorporates the language and methods of science. It follows, then, that students with disabilities will be conceptualized within the language of pathology in ways that produce particular consequences.

As disability moved from the purview of medicine into public education, the scientific language used to describe disability entered the school context. The language

drawn upon in psycho-educational evaluations differs significantly from the way teachers talk about children who struggle to learn. Think about the elevated status that American society affords to science and scientists. The language of pathology is *culturally* positioned as a powerful discourse. For example, within special education committee meetings, scientific language routinely carries greater status than the language of both teachers and parents.[5] The educational needs of children, described in scientific and psychological terms, sound alien to general education teachers unfamiliar with such terminology—leading them to believe that they possess neither the knowledge nor the skills to address such seemingly complex issues. Thus special education teachers (and an array of support service providers) become positioned as *the* trained professionals to work with *those* children. And an educational myth begins to take shape—that there are *two* types of children—able and disabled—who require different kinds of instruction delivered by differently trained teachers working in parallel systems of public education. And for the last three decades, this myth has circulated among a generation of teachers who have come to regard it as truth. Certainly there are children whose severity of disability *may* require special instruction outside of the general education classroom. However, it has become more and more naturalized to construct struggling learners as *belonging* in special education—a stance increasingly challenged by proponents of inclusive educational practices who contend that all children are far more alike than not, and that general education teachers, in fact, already possess a rich repertoire upon which to draw in teaching everyone.

We realize that you may be asking yourself—why *not* teach children with disabilities in smaller classes using specialized instructional materials and strategies? That has to be a good thing, especially in this Age of Accountability, right? Why *should* general education teachers include children with disabilities in their classrooms when special classrooms and teachers are available? Well, the answer to that question has to do with "all that *other* stuff" we talked about in Chapter 1, which has everything to do with the unintended consequences of special education discussed in Chapter 2. In other words, we must consider how the medical model of disability functions within both public education and American culture.

As established earlier in this chapter, the medical model centers the individual as the unit-of-analysis. Working within the conceptualization of disability as inherent to the individual, an "objective expert" (school psychologist) administers a one-on-one standardized assessment battery that typically includes an IQ test (e.g., Wechsler Intelligence Scale for Children or WISC-IV, Stanford-Binet Intelligence Scales; Woodcock-Johnson III NU Tests of Cognitive Abilities); achievement tests (e.g., Wechsler Individual Achievement Test or WIAT II, Woodcock-Johnson III Tests of Achievement, Peabody Individual Achievement Test or PIAT-R/NU); and behavioral measures (e.g., Vineland Adaptive Behavior Scales or VABS, Child Behavior Checklist, Conners Comprehensive Behavior Rating Scales or Conners CBRS). Results of the evaluation form the basis of a treatment plan intended to remediate the individual's deficits. This appears to be a reasonable approach. What could be the problem?

For starters, let's consider some assumptions embedded within our naturalized practices. Special education spins around the notion of normal/abnormal. In order for "abnormal" to exist, there necessarily must be a concept of "normal." In other words, the parameters of "normal" must be defined in order to determine what is "abnormal" by comparison. And here is where "all that *other* stuff" comes into play again. *Who*

decides what constitutes "normal" and "abnormal" across the range of human behavior? Is it right and natural to conceptualize human ability as distributed along a "normal curve"? Does strict adherence to scientific and objective standardization (in regard to test environments, procedures, and measurement tools) yield the most accurate representation of human ability? What might be the consequences of our agreed-upon methods for determining and responding to disability within American public schools?

The Reign of Normal

When, where, and how did the concept of *normal* originate in the first place? Have you ever wondered, or is the concept so natural that you have never even thought about it?

The Origins of Normal

We can trace the word *normal* to the mid-1840s, when it first appeared within the English lexicon as part of the vocabulary generated by the emerging discipline of statistics. The new field had been conceived in Europe as a way to amass data about industrial production and public health; however, Adolphe Quetelet, a French statistician, thought to apply statistical usage to physical attributes (e.g., height and weight), thereby constructing an abstraction of "the ideal man"—the first framework within which to compare human beings as either "normal" or "not normal."[6]

In the second half of the nineteenth century, Sir Francis Galton, scientist, explorer, statistician, and half-cousin of Charles Darwin, extended Quetelet's work to include a "normal curve of distribution" and quartile divisions for ranking human traits as average, inferior, or superior.[7] (It is worth noting that Galton's notion of the "normal curve of distribution" is used in *current-day* assessment and eligibility criteria for special education services.) Galton, along with other European statisticians, promoted the statistical study of human traits as part of a popular ideology of the day known as eugenics. Eugenicists sought to enhance positive traits of a population by keeping its weakest members from mixing with more desirable members;[8] in other words, the human race could be improved through the practice of controlled breeding. Galton advanced the idea that intelligence is an inheritable trait distributed *unequally* among human beings according to *class* and *race* (i.e., cultured whites possessed innate superior intelligence as compared to less cultured nonwhites) and urged intelligent people to marry one another to offset the increasing birthrate of the undesirable lower classes.[9] We begin to see how science—a particular Discourse of Truth that gained momentum well beyond the late nineteenth century—began to function in a way to support the dominant culture's socially constructed ideas about race, class, and intelligence.

It appears, then, that science enabled the rationalization for assigning value to human beings along a hierarchy of inherited traits. Let's consider a few examples. Early in the twentieth century, eugenicists contributed to the passage of the Immigration Act of 1924 by testifying that *inherent* undesirable traits of southern and eastern Europeans posed a significant health threat to the American population. Around the same time, American legislators, drawing upon the eugenics literature, passed state laws to prohibit marriages among the mentally ill and mentally disabled, forcing sterilization as a preventive measure against transmission to subsequent generations. And most sobering of all, the eugenics movement figured heavily into Adolf Hitler's construction of the Final

Solution—providing him with scientific justification for eradicating so-called genetic defects in order to create the Master Race. (It is worth noting that Hitler first targeted the mentally and physically disabled, whom he referred to as "useless eaters," before turning his attention to the persecution and extermination of Gypsies, homosexuals, and Jews.)[10] Who could have anticipated that the development of statistical data analysis would contribute to the unimaginable horrors of the Holocaust?

And so our point is this. We must be vigilant about both intended *and* unintended consequences of scientific practices. In the case of eugenics, its proponents meant to lessen human suffering through selective breeding, a scientific means for eradicating disease and disability in order to create stronger and healthier families. Yet, as history was to reveal, things are not so simple. *Who* decides what inheritable traits are more or less desirable (which ultimately defines *which* people are more or less valued), for what purpose, and for whose benefit? These questions sustain relevance as we consider the "rise of normal" within American public schools.

The Rise of Normal Within Public Schools

The intelligence test is a ubiquitous feature within public schools. Sitting center stage in the process for determining eligibility for special education services, the IQ test is the standard against which other measurements are compared (e.g., discrepancies between IQ and achievement scores are thought to hold significance in regard to identifying certain disabilities). The intelligence test requires that we believe in its efficacy in order for the institution of special education—as we have chosen to conceive it—to operate smoothly. Although IQ testing has always had its critics, there has been little actual resistance to our reliance upon IQ scores as part of the assessment required for determining eligibility and placement in special education.

So how did intelligence testing become a naturalized practice within public education? Let's return again to the early twentieth century. With eugenicists steadily advancing the notion of inheritable intelligence, it is unsurprising that the field of psychometrics emerges to provide a means by which to measure intellectual capacity. By 1905, Alfred Binet, a French psychologist, constructs the first intelligence test at the behest of the French ministry of education to identify students in need of educational assistance. (It is noteworthy that French law extended public education to *all* students, including those considered "mentally handicapped.") Foreseeing the potential for over-reliance on a single IQ score, Binet publicly expresses caveats about its use.[11] Despite Binet's concerns about widespread use of his intelligence test, demand for the test immediately grows, particularly in the United States. By 1916, Lewis Terman, a psychologist at Stanford University, modifies, expands, and renames the test (Stanford-Binet), thereby popularizing its use in the United States.[12]

Science reigns sovereign as Discourse of Truth in the early twentieth century. Remember those social efficiency proponents (see Chapter 1) who drew upon "scientific rationality and technology" to increase the efficiency of public schooling? The emerging field of psychometrics supplies just the "scientific tools" needed to differentiate education according to students' *predicted* vocational potential. Thus IQ testing becomes the means by which to sort individuals into performance levels (e.g., below normal, normal, above normal), thereby maximizing efficiency by offering students *only* the education needed for their predetermined places in society. Given that IQ tests

emerge out of the tradition of science, their legitimacy is not called into question, nor is the practice of separating students according to IQ scores. What naturalizes such practices is their association with the methods of natural science.[13]

If we think about the historical relationship between science and disability as well as the long-established tradition of IQ testing within public schools, it is rather predictable that the IQ test is chosen as a primary assessment tool for special education's eligibility and placement procedures. It is worth noting again that our reliance upon IQ testing for the last 30 years has contributed to a well-documented and persisting overrepresentation of children of color in segregated special education settings (see Chapter 2). In the name of meeting the educational needs of children with disabilities, might we have inadvertently reinscribed notions advanced by the eugenicists—that is, that culturally dominant students of middle to upper social class *belong* in mainstream public education and represent the ideal ("normality") to which others are compared and sorted? And we pose our question again for your consideration—Who benefits from this particular conceptualization and practice?

Disability in Context

Imagine the following scenario. You are teaching in your classroom as you do each day. There is a knock at the door. A stranger enters and asks you to come with her. When you ask what this is about, she smiles and explains that she needs to find out how to best help you to teach. Although you are not aware that you need any help in the classroom, you intuit that this encounter has been prearranged by someone and is not up for negotiation. Your students stare as you are led from the classroom. On your way down the hallway, you note that all other teachers remain in their classrooms as usual. The stranger takes you to a small windowless room. She explains that you will be answering questions and that you should do your best. She cautions that there will be some questions that she cannot repeat and some questions that you must answer under a time limit. She takes out a stopwatch. Lastly, you are reminded not to ask whether or not your answers are correct. The questioning begins. You wonder why the questions do not seem to have much to do with teaching. At the end of two hours, the stranger thanks you for your hard work and accompanies you back to your classroom.

Weeks pass. You are too embarrassed to ask if any other teacher has met with the stranger. You finally put the encounter out of your mind. Then one day the principal calls you into his office. He opens a file that contains paperwork regarding your teaching performance, including a report written by the stranger, in which she explains how well you answered questions compared to same-age teachers working in other parts of the United States. A single numeric score sums up her discussion. In addition to this report, the file contains observations of your teaching (conducted unbeknownst to you) and teacher performance checklists filled out by your principal and your supervisor. The principal explains that your assessment results indicate that you would benefit from teaching fewer students in a smaller classroom with closer supervision. You are moved to the new classroom the following day. You hear the unspoken message. You are less competent than the teachers who remain in their classrooms.

We acknowledge a bit of hyperbole in making our point. However, given that school personnel typically regard special education practices as natural and largely

unproblematic, we hope to challenge you to reflect more deeply upon what is considered business as usual. For example, the scenario just described sounds absurd when applied to assessing teacher performance. Yet we expect students (and their parents) to accept this process—without question—as legitimate and beneficial.

Special education assessment is grounded in methods of science. Standardized tests compare an individual's performance to a normative sample; thus examiners must follow a strict procedure (e.g., using exact words when prompting an examinee and *only* under prescribed circumstances, presenting tasks in a particular order, placing blocks and puzzle pieces in front of the examinee in a specified way). Environmental conditions are likewise standardized. Testing must take place in a de-contextualized setting free from visual and auditory distraction. Moreover, examiners are required to maintain an objective stance to minimize unintended influences upon the testing conditions. Any violation of these procedures invalidates results.

The assessment procedures outlined under IDEA require us to regard such methods of science as "right and good" and beyond reproach. We are asked to believe that (1) standardized methods yield accurate measures of behavior and cognition; (2) objectivity, de-contextualization, and standardization control for undue influences upon test performance; and (3) deviation from these procedures invalidates truth as conceived by the test author. It is assumed that the "practice of science" *itself* is bias-free and a non-contributory factor within the assessment context. Yet how might the very *practice of standardization* influence test performance as well as the construction of disability?

Context Matters

Not unlike our hyperbolic teacher performance illustration, we might consider what an unnatural social situation it is for a child (who typically is caught unawares) to accompany an unfamiliar adult (who offers minimal explanation) to a small room where timed and untimed questions (of the adult's choosing) are presented for the duration of at least two hours. What is a matter of routine practice to the adult may be experienced by a child as something akin to being "taken in" for police interrogation. In both cases, "the authority" possesses knowledge to which "the subject" is not privy; thus heightened anxiety on the part of "the subject" might be anticipated and acknowledged as an undue influence upon performance. Yet it is not. Other than the occasional case of a child's extreme resistance to testing, assessments are typically considered to be valid measures of performance. Special education's reliance upon methods of natural science neglects an essential truth—that "human beings are not, like the objects of natural science, things which do not understand themselves."[14] What might children have to tell us about themselves? What aspects of children do we *not* consider, and does that matter? Is it possible that our agreed-upon assessment procedures construct ability/disability in particular ways and not others? To engage you in thinking about these questions with us, we introduce two persons with disabilities, Paul and Madelyn, for you to consider within the *context* of their respective real-life stories.

Genius of Invention

Jan's husband, Paul, has a congenital sensioneural hearing impairment. He easily moves through the world with two hearing aids and a lifetime's worth of acquired compensatory strategies. What began as a mild hearing loss during childhood is now a moderate

to severe hearing loss at midlife. Although there are a few tones within the speaking range that he cannot hear at all, Paul's hearing loss is not readily discernible to others, nor does he claim a disabled identity. He considers his hearing loss as one of many traits that make him who he is—a contributing trait no different in scale, for example, than his Italian-American heritage.

Having attended elementary school during the 1960s (before the advent of P.L. 94–142), Paul's hearing loss drew attention only during the routine vision and hearing screenings administered by school nurses. Each year, he took a letter home indicating a failed hearing screening. And each year, his parents disregarded the letter. Within the context of a large and lively Italian-American household, Paul's hearing loss was simply a matter of accommodation. Rather than "fix" Paul's ears, everyone watched TV with the volume turned up a little louder. Instead of asking Paul to approximate normal hearing behavior, family members adjusted *their* manner of interaction (e.g., using touch to get his attention, facing him when speaking, repeating speech as needed). No more or less attention was given to these accommodations than those made for any other family member's particular needs. And, in turn, he figured out how to compensate for his hearing difference in ways that worked for him and others.

Paul earned a college degree without the benefit of academic accommodations or sound amplification. By young adulthood, however, his hearing worsened. At the time of our marriage in 1980, Paul was fitted with a single hearing aid for the first time. In light of the shifting nature of his hearing loss over time, each new stage brought another opportunity for problem solving—not unlike any other life challenge we face together. Increasing technological advances offer a range of solutions at every phase—most of which we could not have imagined years earlier.

We keep a thickening file of annual audiograms that traces the degenerative path of Paul's hearing. At his yearly examination, Paul sits in a soundproof booth and repeats single words spoken to him through a headset. He takes the same test each year so that comparisons can be drawn. Based upon the results, the audiologist calibrates Paul's hearing aids.

I always accompany Paul to these audiology appointments. And each year, the extent of hearing loss revealed by the examination stuns me. I had begun to wonder if I might be in denial about the progression of his hearing loss because he never *seems* to me as impaired as results indicate. Moreover, Paul dreads these sessions because of his own inability to reconcile the audiogram results with the way he sees himself. For years, it never occurred to us to question the *nature* of these examinations.

Certainly, the technology of sound amplification has had a positive impact upon Paul's daily life. In fact, I initially attributed Paul's successful negotiation of the "hearing world" solely to the technology in his ears—until we took our first trip abroad. Having convinced my dubious husband that we could rely upon my high school French, I eagerly took up the task of translation as soon as we touched European soil. In the time it took for me to translate the first sign, Paul figured out where to go and what to do. I stared at him. He grinned back. "You know what? I can't hear in English. And I can't hear in French. It really doesn't matter where I am, now does it?" And so I trailed behind my tour guide, who moved competently and confidently through the world as he does every day—relying upon ingenious ways of his own invention to cull meaning from visual context.

As a result of that trip, I came to understand the discrepancy between my perceptions of Paul "in the world" and the audiogram results. The enclosed environment of the

audiology booth strips Paul of all sensory input other than auditory stimuli presented through a headset. It is a pure measure of auditory acuity. What the examination does not measure is Paul's "hearing behavior" within the context of daily life. His *actual* level of functioning in the world, even without hearing aids, is stronger than would be expected given the level of pathology documented on the audiogram. In other words, Paul's disability can be constructed differently depending upon whether we focus upon his auditory acuity as measured within a clinical context for the purpose of calibrating his hearing aids or upon his "hearing behavior" as performed within the context of everyday life.

If we return to our discussion of special education assessment practices, we can see how a focus upon uncovering pathology (disability) as a condition within-the-individual might yield a different construction than an evaluation that acknowledges the individual-in-context. If context matters—which we believe it does—what might we be missing by evaluating children using de-contextualized, standardized, and objective methods of science? Is it possible that children appear less able when asked to perform under conditions that remove everyday contextual cues? Could reliance upon methods of science account for discrepancies parents report between depictions of their child within psycho-educational reports and their perceptions of their child-in-context? How might educational ideas and practices about what constitutes normal/abnormal (and the accompanying values assigned to children on either side of this imposed dichotomy) extend into our communities and larger culture? We invite you to consider these questions as you read on to Madelyn's story.

Madelyn's Village

Madelyn is a newly-turned-nine-year-old (an important distinction in Kid World) with deep brown eyes and an impish grin. She wears her light brown hair in a jaunty ponytail that swishes from side to side as she walks. I spent a recent warm and breezy Saturday with Madelyn. We shared a lazy afternoon playing cards on the back porch, munching on chips and dip, pouring endless refills of soda, and shaking pinky fingers to swear secrecy about Madelyn's whispered opinions about the cutest boys in the fourth grade.

But all is not as it seems. Madelyn is the daughter of a friend of mine who participated in a pilot study I conducted a few years ago on mothers and special education. Currently, Madelyn's mother is challenging the school district's change in her daughter's disability status from "language-impaired" to "mentally impaired" and asked for my consultative assistance.

In order to make sense of my afternoon with Madelyn, it is necessary to locate Madelyn within the swirling discourses of school in America. Madelyn's particular biography belongs to the discourse of school in America that has naturalized ways of talking about the characteristics of *individual* children. In its adoption of the necessary dichotomy of success/failure put forth by school in America, Madelyn's community school has enveloped her within its discourse of child development, norms, tests, grade levels, and achievement and labeled her deficient on all counts. Her immediate world is a white middle-class family with college-educated parents and four academically gifted older siblings. The family lives in a wealthy bedroom community of New York City whose mostly white and Asian American inhabitants are successful (in American terms), as are their offspring. As a whole, this is a community comprising persons at the

top of the competition game in America. Madelyn does not fit neatly within any of these worlds. Given that her cultural, socioeconomic, and ethnic background is a good match for success in school, there can be only one explanation for the unexpected failure in her young life. She *is* "mentally impaired," and what a tragedy it is for her and her family. Madelyn is Failure as defined for nine-year-old children in America.

Although I know Madelyn's parents fairly well, I had not seen Madelyn in a few years. Madelyn is, however, quite close to a mutual friend, Kate, who frequently spends time in the family's home. I arranged to visit Kate on a day that she had agreed to baby-sit Madelyn. I anticipated that my presence in this scenario would be more natural than an artificially arranged time with Madelyn. To my surprise, this was not to be. Let us enter the scene. As soon as I arrive, Kate makes quick introductions between Madelyn and myself and breezes out to attend a wedding—abruptly leaving Madelyn and me to ourselves. We barely turn to one another when a neighbor comes onto the porch. Out of nowhere, Kate's cousin materializes to urgently shoo him away. I hear her whisper to him, "She's here to work with Madelyn." And so it seems that Madelyn and I are unable to escape the Discourse of School. Others behave around us in accordance with the labels School has given us. Madelyn is the Defective Child and I am the Benevolent Special Educator Who Knows How to Look at Defective Children. This discourse has followed us from school and into the community.

On a beautiful Saturday afternoon, a nine-year-old (supposedly "mentally impaired") girl confronts an unusual social situation. An unfamiliar overgrown playmate is dumped inexplicably into her world. Through some sense of intuition, Madelyn recognizes and accepts the responsibility that has been thrust upon her and dutifully interacts with me. She is engaging and embracing. I wonder how many other nine-year-old children would have done the same.

In the midst of a card game, Kate's cousin reappears, watches for a moment, and asks aloud, "Is this to test her cognitive skills?" I grimace and state the obvious—we are playing a game. Immediately I recognize my lie. I am complicit in constructing Madelyn in terms of Success and Failure. Like those who search for evidence of What Madelyn Cannot Do, I, under the guise of play, search for evidence of What Madelyn *Can* Do. I am guilty of participating in the endless gazing upon and documenting of Madelyn.

Kate returns and asks, "How did she do?" I flatly reply that Madelyn and I had a fun time together. She goes on to describe her concerns about Madelyn's conversational skills, recounting a series of questions she asked Madelyn earlier in the day to which she received little elaboration—the boring kinds of questions that adults ask children when they are not really interested in hearing what they have to say. Any nine-year-old might have responded in monosyllables. Yet this behavior is registered and documented as deficient because that is what Madelyn now is *expected* to be—and the behavior is catalogued as additional evidence of Madelyn's Failure. This exchange supports Varenne and McDermott's critique of American public schools in which they point out that "the child is made to occupy the foreground for extended comparison to other children. It may take a whole village to raise a child, but in America, at the most sacred of times when lives are in balance, the child stands alone for the village to judge."[15] And Madelyn's village, in particular, sets comparisons at the highest competitive point.

Later, we all gather on the front porch. The neighbor fumbles for a lighter. Madelyn watches him. She asks me discreetly to remind her of his name. She politely steps up to

him, addresses him by name, and asks that he please not smoke around us. This massive young man, a bouncer by profession, smiles around the cigarette poised in his mouth for lighting and continues his smoker's ritual. Madelyn stands firm and politely repeats her request. He stares at her momentarily, then moves off the porch. Satisfied, Madelyn resettles herself back into her chair.

It is worth noting that Madelyn scored below her age level on the Vineland Adaptive Behavior Scales—one of the social behavior measures that contributed to her newly acquired label of "mentally impaired." Had the previous scenario been a test of social competence, how many nine-year-olds could have negotiated it as successfully as Madelyn? Is this but one example of the "fleeting moments of success that no one notices . . . the things kids can do that nonetheless disappear in the normal tellings of their lives"[16]?

Now let's return to the questions we asked you to consider while reading Madelyn's story. How well do you think a typical special education assessment might reflect the *essence* of Madelyn? Is it possible that Madelyn could appear less able when asked to perform in a de-contextualized and standardized environment? How might reliance upon methods of science account for a discrepancy between the way Madelyn's mother understands her child-in-context and the scientific test results that point to an *acquired* "mental impairment" since her last assessment? In what ways could you see ideas and values regarding "normal" and "abnormal" circulating beyond school and into Madelyn's community? And what does all of this mean for Madelyn's young life?

Expanding Notions of Diversity

We recognize that it is unsettling to trouble what appears natural and right. Here you are, a first-year teacher, focused upon *getting* it right, and we ask you to think about *if* it is right. We imagine that survival takes up most of your energy at this point. And now we remind you that teaching is also a *social* responsibility requiring careful thought and action. Young lives are at stake. The responsibility of it all can—and should—seem overwhelming. It is tempting to believe that "all that *other* stuff" will take care of itself somehow. Besides, it feels good to receive praise for carrying out your prescribed duties well and without question. Why complicate an inherently complicated job with concerns about ethics?

From our vantage point as veteran special educators, we regard the passage of P.L. 94–142 as a *major* advancement for persons with disabilities in this country. The spirit of the law reflects the hopes and dreams of persons with disabilities and their advocates. Special education law guarantees the right to a free and appropriate public education for *all* children. Thus it is not our intention to dismiss the many positive contributions of this law. We do not doubt the "right and good" intentions of those who work hard to uphold the procedures and practices that support our agreed-upon response to disability in public schools. What does concern us, however, is that a far greater amount of time, energy, and money is devoted to maintaining the current system than is spent on recognizing, reflecting upon, and responding to the *consequences* of those procedures and practices in the lives of children with disabilities and their families.

It is easier to believe that the current system is unproblematic than to name and respond to challenges. The former does not require action, while the latter does. Reflecting

upon ourselves is, quite frankly, hard work. For example, let's consider the question posed in our chapter title: *"What if I don't feel ready to teach those children?"* We might understand the question as concern about not having proper training to teach children with disabilities. In fact, a teacher who poses such a question may truly believe that lack of training is her biggest concern. However, "I don't feel ready" may also reflect a variety of *unexamined* attitudes, fears, and beliefs, such as these:

- I don't want to teach those kids.
- I am afraid to teach those kids.
- It is not my job to teach those kids.
- I don't believe those kids belong in my classroom.
- I don't know how to work with those kids.
- I think those kids differ significantly from kids without disabilities.
- I believe that those kids need special teachers because they learn differently.
- I don't think that I can handle those kids *and* do my job.
- I have way too many responsibilities to take on teaching those kids.
- I don't think I have the patience to work with those kids.
- I don't know why I am expected to teach those kids.
- I am afraid that I *can't* teach those kids.
- I don't understand special education paperwork and I don't want to.
- I think that only experienced teachers should teach those kids.
- I believe that those kids unfairly take time from other kids.
- I am afraid those kids will make me look like I don't know what I'm doing.

Do any of these statements ring true to you? If you are able to acknowledge having had any of these thoughts, pat yourself on the back. You are on your way to reflection. It is not our intention to pass judgment on teachers (new or experienced) who agree with any of the above statements. In fact, we hope that our first three chapters help clarify *why* such ideas circulate among teachers. To honestly examine and reflect upon our beliefs, values, attitudes, and fears is to make the first step toward creating inclusive communities. So far, we have focused a great deal upon explaining both how "we got here from there" and how the medical model constructs disability in particular ways. It is our hope that such discussions provide new space within which to (re)consider naturalized ideas about children with *and* without disabilities.

As teacher educators, we ask our graduate students to rethink the "myth of homogeneity" that drives the unending pursuit of new methods for sorting children according to their sameness. We routinely hear teachers lament about the number of students who fall outside of defined "grade level" performance. Year after year, teachers express disappointment that a "grade level" class has yet to materialize in their teaching career. And it never will. We have *constructed* notions about "grade level" in the same way that we have constructed notions about normal and abnormal. In fact, it appears that the institution of special education has reinforced the notion of "grade level" by providing a *place* to send the children *not* on "grade level." If we properly sort out those children who qualify for special education (i.e., those children deemed outside the range of "normal"), surely then we will have "grade level" classrooms. And yet it does not happen—despite all the ways we devise to determine who belongs and who does not belong. So perhaps the problem lies within our expectations. To believe that homogeneity exists (presumably out there somewhere, in someone else's classroom) is to forever be

disappointed—and to miss the point of teaching. Somehow it seems that special education's conceptualization of normal/abnormal has influenced teachers to see students as either "belonging" or "not belonging." Woe be to the child deemed as "not belonging" in special education (i.e., test results indicate ineligibility for services) whose teacher sees him as "not belonging" in general education either. We must step back and ask ourselves what a free and appropriate public education for *all* children really means.

We might begin by reframing our expectations. Why is it that we continue to be surprised by the diversity inherent among students in any given classroom? Why not anticipate *diversity* rather than homogeneity? Every class community is a unique mosaic of variation. Children come to us with all kinds of multiple and intersecting forms of diversity (e.g., ethnicity, socioeconomic class, family configuration, religion, culture, race, linguistic tradition, background knowledge, gender, life experience, and ability). In other words, children come to school bearing all of what makes them human.

Inclusive communities acknowledge and draw upon all manner of human variation. Unlike traditional special education services that target only students deemed "eligible" on the basis of disability, inclusive practices address academic and social needs of *all* students. Diversity *is* the heart of inclusion. So let's move on to the next chapter for a discussion about the nature of inclusive practices.

Questions to Consider

1. What do you see as the consequences of the medical model of disability within public schools?
2. How is disability constructed within public schools?
3. Should we include students with disabilities in the general education classes? Why or why not?
4. Can you see vestiges of eugenics within special education today? Explain.
5. Who benefits from a medical model of disability within public schools and why?
6. How might standardized testing methods influence test performance as well as the construction of disability?
7. How much influence do you think that *context* has upon the way we perceive disability? Give examples to support your position.
8. What unexamined attitudes, fears, or beliefs might you have about students with disabilities? What do you think is the origin of those ideas?
9. In what ways has special education reinforced expectations for homogeneous classrooms?

Endnotes

1. S. Linton, *Claiming Disability* (New York: New York University Press, 1998), p. 141.
2. B. Blatt and F. Kaplan, *Christmas in Purgatory: A Photographic Essay on Mental Retardation* (Syracuse, NY: Human Policy Press, 1966).
3. Linton, *Claiming Disability,* p. 2.
4. M. Corker and T. Shakespeare, *Disability/Postmodernity: Embodying Disability Theory* (New York: Continuum, 2002).