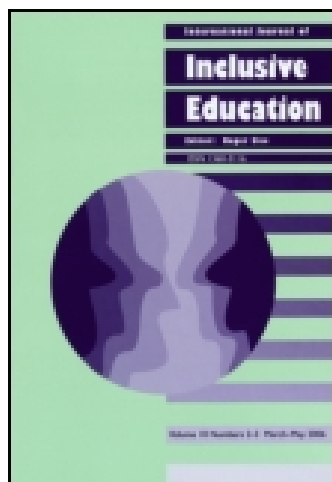


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The deployment of the medico-psychological gaze and disability expertise in relation to children with intellectual disability

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In this study, we adopt the concepts of Michel Foucault on the medical gaze and Nikolas Rose on psychological expertise to differentiate between two forms of expertise evident in the education of intellectually disabled children. We draw on a discourse analytic study carried out in South Africa on intellectual disability in relation to educational practice to examine the operation of a medico-psychological gaze that calls for disability expertise in the management of disability. We conclude our discussion by noting that the dichotomy between impairment and disability that is proposed in the social model of disability does little to destabilise the power of the medico-psychological gaze since impairment is conceded to biomedical knowledge as an object of positive knowledge. This tacit acceptance of the medical authority gives sanction to disability expertise that operates in diffuse ways to regulate the educational experience of learners with intellectual disability. The implications of this conception for inclusive education are briefly explored, and further areas for research are suggested.

Keywords: intellectual disability; inclusive education; special education; Q-method; psychological expertise; medical gaze

The implementation of inclusive education poses a problem in terms of the transfer of specialised skills and expertise, traditionally located within special schools, to regular education systems. Far from being a merely technical issue, specialised skills constitute a contested arena in debates around inclusive education. The positions taken in this respect can be located at some point between two extremes. At the one extreme, there is an argument for the maximum deployment of skilled personnel in general schools, and a shift in personnel from one setting to the other. At the other end of the scale, there is a rejection of the need for special skills, with greater value placed on human rights issues and promoting the teaching skills of the regular teacher.

The former position can be associated with a medical model of disability, in which specialised skills, treatments or pedagogies are addressed at the bodily or mental impairment. In order to focus on this task, a separate and specialised educational provision is preferred. The latter position is in line with a social model of disability that distinguishes between bodily impairment and oppressive disabling social practices. Inclusive education is viewed as a powerful mechanism for challenging the

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oppression of disabled people. In this study, we will argue that this distinction underpins two forms of specialised skill deployed in education in relation to intellectual disability.

Drawing on a larger discourse analytic study undertaken in the Buffalo City district of the Eastern Cape in South Africa (Mckenzie 2010), we discuss the practice of expertise as it relates specifically to intellectual disability in education and we differentiate two forms of specialised skills with differing domains of authority, namely (1) the medico-psychological gaze (focused on impairment) and (2) disability expertise (focused on disability). These two forms interact in multiple ways with each other, with different effects.

In the following, we outline the theoretical tenets of the two forms of specialised skills spoken of in this study. We explicate the methodology followed in the study and analyse the discourses identified in relation to their constructions of expertise. We conclude by examining the implications of these conceptions of expertise for the project of inclusive education. We use the term 'intellectually disabled' rather than 'person with an intellectual disability' for specific reasons in this study, accepting, however, the validity of both terms. While the former is preferred by people who are categorised as intellectually disabled (Central England People First Limited 1996–2000), the latter has the advantage of foregrounding social practices, which disable the individual, rather than placing the emphasis on the person himself or herself and reifying the disability as something that a person 'has'.

Professional expertise in the education of intellectually disabled people

In understanding expertise around intellectual disability in inclusive and special education, we have found the notions of the medical gaze (Foucault 1963/2003) and psychological expertise (Rose 2007) particularly useful. We extend Foucault's notion of the medical gaze to include the psychological gaze and have termed this the medico-psychological gaze. We utilise Rose's (2007) insights regarding psychological expertise in understanding disability expertise. Each of these concepts is briefly discussed below.

The medico-psychological gaze

In one of his earliest works, *The Birth of the Clinic*, Foucault (1963/2003) traces the development of the practice of clinical medicine. He identifies a series of shifts, starting from the late eighteenth century, in which the health of the body came to be seen as relative to a norm (rather than as the overall vitality of the organism) and was viewed through a normal/pathological prism. The power to make the determination of normality was invested in the authorised professional who was controlled by various regulatory structures. The doctor, through observation of the patient, was seen as being able to penetrate the body's secrets just by looking, and thereby to diagnose and to speak wisely about its treatment. This constituted the medical gaze that assumed the status of knowledge of truth about the health of the individual.

However, Foucault argues that this gaze, far from revealing a truth that is already there, waiting to be revealed, actually serves to construct the human body in certain ways and to regulate its actions through the concern with the norm and the desirable state of health that individuals should achieve. Rose notes the development of lines of visibility, that 'arranged bodies, spaces, gazes, inscriptions within a certain regime of

light that sickness – and with it health – became relocated in a thoroughly empirical domain of observable events and mathematical regularities’ (1998b, 61). It has since been the task of clinical medicine to make the invisible visible through a variety of means, beginning with the bedside observation and including the detection of signs, such as pulse and temperature. The differences between individuals became regulated under the authoritative medical gaze of the physician. As long as the difference could be made visible, it ‘makes the person stable through constructing a perceptual system, a way of rendering the mobile and confusing manifold of the sensible into a cognizable field’ (Rose 1998a, 106).

In a later work, *Madness and civilisation*, Foucault traced the history of the great divide between madness and sanity (Foucault 1967/2006). The division initially aimed at confining those with a range of moral failings (including poverty and promiscuity amongst others) in poor houses and asylums. According to Rose (1985), the undifferentiated nature of the asylum came under the medical gaze as the hospital gained ground as the site of treatment for physical illness. As patients were treated in the institution of the hospital, it became possible to compare and contrast their symptoms, diagnoses and prognoses across large numbers of people.

With the advent of compulsory schooling, the need to classify and differentiate the feeble-minded from the norm and from those more severely affected, a norm-referenced mathematical solution was found in the intelligence test. This tool expanded the authority of psychology and granted to psychologists the authority to pronounce on the truth of intellectual disability (Rose 1985). Doctors and psychologists (and to some extent, therapists) were given the authority to exercise the medico-psychological gaze, that is rooted in positivist, scientific claims to truth of expert knowledge, and makes the body (or the mind) visible so that what was already there, waiting to be revealed, is brought into the light of truth (Foucault 1963/2003). In the case of special education, lesser authorities (teachers, nurses and parents) are bound to accept privileged professional knowledge (Howell 2006) and to comply with the prescriptions made. Their task is to *manage* disability, and for this a certain type of expertise is called upon, viz. disability expertise.

It bears mentioning, however, that the medico-psychological gaze is not taken up uniformly and is situated within other power dynamics. In the South African context, the social construction of intellectual disability in the early twentieth century reflected a specifically racial concern borne out of the colonial enterprise and related to eugenic discourses. The lines of division were set between levels of severity (imbecile, idiot and feeble-minded) within the white race group, whereas the black group remained undifferentiated and was not identified as a problem until much later when educational provision was brought into consideration (Foster 1990).

Disability expertise

We have found the notion of psychological expertise as understood by Rose (2007) a useful concept in exploring the positioning of professional ‘know-how’ within education of intellectually disabled people and the overall management of their disability. We argue that the clinical gaze, which plumbs the interior of the body, making its workings simultaneously visible and audible, constitutes the medico-psychological gaze and makes the impairment visible and quantifiable. Psychological expertise, on the other hand, which we have drawn on to conceptualise disability expertise, is concerned with the *management* of subjects through multiple forms of power relations,

such as hierarchical observation, disciplinary technology and confession in an exercise of what Foucault (1979) terms pastoral power.

Rose (1998a) distinguishes expertise from professionalisation. Whereas professionalisation refers to the ways in which the experts of a particular discipline mark out their territory and establish a monopoly on the services that they provide, expertise operates in more diffuse ways. It coalesces an assemblage of techniques and strategies that are bound together more by pedagogy (in the form of text books, courses, special programmes and the like) than by a unifying theory. Psychological expertise has been particularly successful in attaching itself to forms of practice other than psychology – doctors, nurses, social workers, therapists and special educators draw upon this expertise freely in ‘reformulating their ways of explaining normality and pathology in psychological terms, giving their techniques a psychological coloration’ (Rose 1998a, 87). In this process their practice can ‘refer to a particular kind of social *authority*, characteristically deployed around *problems*, exercising a certain *diagnostic* gaze, grounded in a claim to *truth*, asserting technical *efficacy*, and avowing *humane* ethical virtues’ [emphasis in the original] (Rose 1998a, 86).

We argue that special educators apply this form of expertise in particular ways, and we use the term ‘disability expertise’ in our discussion. As a form of psychological expertise, disability expertise draws on the language and ideas of psychology as a means to ‘render rational the grounds of decision and action’ (Rose 1998a, 87). Safely located within this legitimate psychological frame, disability expertise gathers an ethical and moral force.

The claim to knowledge is based on rendering individuals calculable and comparable through the application of technology as exemplified in the test. Disability expertise seeks to identify, describe and manage behaviour that is assumed to arise from the biological defect identified through the medico-psychological gaze. Special education and its therapeutic allies use tests of language skills, reading ability, problem-solving skills and so forth to identify and quantify physical, social and academic deficits. These defects are then managed through the application of special educational teaching strategies, such as remedial reading programmes amongst others. However, Rose (1998a) argues that these technologies are neither measures of an objective quality of the individual nor are they merely administrative controlling practices. Rather the technologies and organisational practice of expertise *make* knowledge in certain ways and ‘truth becomes effective to the extent that it is embodied in technique’ (Rose 1998a, 89).

Method

Research question

Within the theoretical context outlined above, this study examines conceptions of specialised skills drawn on by participants in a larger study that examined discourses of education for intellectually disabled people in the city of East London in the Buffalo City district of the Eastern Cape, South Africa. The questions posed in the larger study were:

- (1) What discourses are deployed in the representation of those identified as intellectually disabled in East London, South Africa?
- (2) What discourses are deployed concerning the practices of education of those identified as intellectually disabled in East London, South Africa?
- (3) What are the effects of these discourses in constructing the intellectually disabled subject and associated educational practice?

This study speaks specifically to those discourses that draw on the notion of expertise in an understanding of education of people with intellectual disability in posing the question of how specialised skills are deployed in relation to education of intellectually disabled people.

In this study a discourse analytic methodology was used to delineate a range of discourses of intellectual disability and the practices of education deployed in the study area of Buffalo City. This study made use of Q-methodology, adapting the method in line with a discourse analytic school of the method (Stainton Rogers 1998). The methodology enables the participation of intellectually disabled people themselves, taking into account the disability studies framework of this study and the imperative to engage disabled people themselves in research (Goodley 2004; Scior 2003; Walmsley 2001, 2004).

Q-methodology was originally developed by William Stephenson, a researcher in the psychological laboratories of Spearman and Burt in the UK in the 1920s and 1930s (Brown 1997). These researchers made use of factor analytic techniques (in what Stephenson termed R-methodology) that allowed for the identification of groupings of highly inter-correlated tests or variables (termed factors) that were then theorised as underlying latent psychological variables, such as intelligence. Subsequent individuals could then be tested with respect to this variable and ranked relative to statistical norms (Brown 1980).

Stephenson made two innovations to this method in his development of Q-methodology. Firstly, the data gathered differ from R-methodology in that it consists of evaluations, such as 'agree with' or 'disagree with', by the participants of items with which he or she is presented. This requires an active decision-making process by the participant as he or she constructs meaning through interaction with the research instrument (Watts 2002). Secondly, the data are analysed as a whole pattern as opposed to seeking individual differences (Kitzinger 1999). In keeping with the notion of discourse as constructing a field of possibility, it is anticipated that the range of patterns constructed by individuals cluster together in a finite range of diversity. In this study, it was argued that these clustered patterns could be viewed as accounts or as discourses.

A large set of statements about intellectual disability and educational practice was derived from a careful and informed review of the literature, media and textbooks, and interviews with a range of stakeholders. These statements were then reduced to a manageable number through a thematic analysis that sought to include a diversity of understandings of the research topic (Mckenzie 2010; Watts and Stenner 2005) to develop two Q-sets, namely (1) Q-set A, a set of statements concerning representation of intellectually disabled people (see Table 1), and (2) Q-set B, a set of statements concerning educational practices for intellectually disabled people (see Table 2). Participants were then asked to sort these statements along the dimension of relative dis/agreement, ensuring that every statement was allocated a slot on the scale (-3 to +3 in Q-set A and -6 to +6 in Q-set B). For intellectually disabled people, the instructions and the statements were presented in an easy read format, including pictures, custom made for the project by Inspired Services, an agency that specialises in this field (<http://www.inspiredservices.org.uk/>).

The data for analysis consisted of a sorting pattern for each individual, termed a Q-sort, and the participants' explanatory comments. Three sets of participants, namely (1) 22 intellectually disabled adults, (2) 30 parents of intellectually disabled people, and (3) 33 professionals working with intellectually disabled people completed Q-sorts for Q-set A. The definition of an intellectually disabled person for the purpose of

Table 1. Selected statements from Q-set A.

Statement
8. They often find it hard to behave or act in the right way.
10. They do not know how to stand up for their rights – things that all human beings should be allowed to do or have.
12. They need speech therapy, physiotherapy and other kinds of help to be able to live a normal life.
16. They are scared of failing in learning.
19. When parents and teachers plan for their future, they do not include the disabled persons' dreams or wishes.
22. They should be brought up within their families no matter what special needs they might have.
23. They will always need a lot of help from their families.

Table 2. Selected statements from Q-set B.

13. The success of education of children and youth with intellectual disability (CYWID) depends more on the approach of the particular school and the teachers than on the nature of the disability.
18. CYWID in regular schools should be promoted with their peer group.
21. It takes a very special and compassionate person with the right attitude to be an effective teacher of CYWID.
31. Over time, all CYWID will be accommodated in what are currently considered to be 'ordinary schools'.
53. Human rights to equality for CYWID can only be achieved through education in IE settings.

participant selection was simply a person who has been an ongoing recipient of services addressed toward intellectual disability. Q-set B was completed by 30 parents and 32 professionals and analysed as a whole, forming Q-study B. Of the 85 participants in the study, 44 identified as white and 41 as black. Participants were not selected to represent demographic variables but rather to reflect, based on the experience of the researchers and relevant literature, a range of perspectives on the topic under discussion (Stainton Rogers 1995). Accordingly, it is very difficult to generalise discourses as belonging to one demographic group or another as the sample is not representative in this sense. Thus, discourses do not 'belong' to one or other group of participants and any claim made in this respect is tentative. Rather discourses should be viewed as available ways of viewing the education of intellectually disabled people in the context of Buffalo City, South Africa (Curt 1994).

Through the application of the statistical analysis of Q-methodology, factor analytic patterns were derived.¹ Factor solutions for each Q-study were adopted on the basis of (1) providing clear factors, and (2) allowing the greatest number of participants to load onto any one of the factors (for further discussion see Mckenzie 2010).

Four discourses of representation of intellectual disability were identified in Q-study A. Six discourses of educational practice were derived from participant interaction with Q-set B. These discourses were drawn from an interpretation of the patterns of responses evident in the statistically identified factors, related to each other and analysed in the light of a theoretical framework and the literature. In the analysis that follows, we outline how the various discourses identified drew off and perpetuated various conceptions of expertise.

Results

The discourses in which different conceptions of professional expertise were in evidence in Q-study A can be summarised as follows:

A1: Interactive discourse

The intellectually disabled person is in the process of becoming competent through interaction. The judicious provision of support in this process supersedes considerations of autonomy and independent decision-making. Social inclusion and interaction are crucial to the development of competence.

A2: Social model/human rights discourse

The intellectually disabled person has a right to education in a socially inclusive context regardless of their level of severity or competence. Since autonomy is critical, education should be aimed at supporting its development.

A3: Medical model discourse

The competence of an intellectually disabled person is limited by organic impairment. Education requires the application of specialised techniques to make the most of the impaired intellect.

A4: Community discourse

Everyone in the community has some kind of problem, and for an intellectually disabled person this problem is limited competence due to intellectual impairment. The intellectually disabled person belongs within the caring community and must learn 'community competence'.

The conceptions of expertise within these discourses are highlighted in Table 3.

Table 3. Summary of conceptions of expertise in discourses of Q-study A.

Discourse	Conception of expertise
A1: Interactive discourse	Support, not necessarily specialised expertise, is required from others for the intellectually disabled person to become competent through interaction.
A2: Social model/human rights discourse	Special skills are required in order to understand and treat impairment. However, human rights and autonomy should be prioritised to challenge disabling social practices.
A3: Medical model/religious discourse	Specialised skills are required to determine the nature of the impairment and to prescribe and implement an appropriate course of action. Care and protection are needed as communities and parents are often ignorant of the real needs of the intellectually disabled person.
A4: Community/religious discourse	The community must know and understand disability. The impairment is not going change so the community must learn to accept the limitations that impairment poses and adapt accordingly.

The discourses about the nature of expertise in the education of intellectually disabled people as derived from Q-study B are summarised below.

B1: Inclusion as a human right

Inclusion does not benefit only people with disabilities and their families but also the community as a whole insofar as it promotes human rights of all citizens. The focus of education should be on the development of a curriculum that is flexible and supportive. The ‘specialness’ of intellectual disability and its concomitant teaching practices is rejected in favour of an account wherein it is one aspect of diversity within a classroom.

B2: Special needs require special provision

Inclusion is impossible because regular school classrooms are too big and their teachers are not trained. Special schools, on the other hand, offer teachers who are caring and compassionate and an educational programme that is suited to the needs of intellectually disabled children, which are very different to ‘normal’ children. Different educational placements apply to different categories of learners according to severity of disability or competence levels.

B3: Inclusive education is a dream of the future

Inclusive education is desirable but difficult to achieve. This is because children with very severe disabilities need specialised skills and technologies that are only available in the special school system.

B4: Excellent special education as a right

Education for intellectually disabled children should focus on the development of skills that will make them employable, rather than life skills that can be taught in the home. This is best done through well-resourced special schools that are separate but equal to ordinary schools. Here, they will receive the additional technical skills and equipment that they need to learn on account of their disability.

B5: Effective education must be tailored to the child’s needs

Differing degrees of severity of impairment require the provision of a range of placements, from a care environment for the most severely disabled to the mainstream for the more competent. Change needs to occur within regular schools to increase inclusion for those with less severe impairment. Each disabled child has unique needs that can only be met through careful identification and the application of targeted programmes.

B6: Special education keeps children safe

This account presents a strong rejection of inclusive education because the classes are too large in regular schools, the teachers are untrained and know little about disability. Intellectually disabled children will not be safe in these schools. In contrast, special schools provide therapy, expertise and a compassionate understanding of disability.

A summary of the views on expertise evidenced in the discourses of Q-study B is presented in Table 4.

Table 4. Summary of views on professional expertise in discourses of Q-study A.

Discourse	View on expertise
B1: Inclusion as a human right	Specialised skills and expertise are rejected in favour of good classroom practice.
B2: Special needs require special provision	Teachers located in special schools provide love and knowledge about the needs of disabled children but therapists provide specialised skills.
B3: IE is a dream of the future	Special schools have expertise with severe disability but 'softer' skills exist in the mainstream for mild disability.
B4: Excellent special education as a right	With sufficient expertise and resources, the impairment can be overcome to a large extent.
B5: Effective education must be tailored to the child's needs	Expertise is necessary to identify the impairment in the individual and to ameliorate this deficit as well as to prescribe appropriate educational measures.
B6: Special education keeps children safe	Professional expertise is required to understand disability and to educate others about its nature so as to protect with kindness and compassion.

Discussion

The relationships between discourses of representation, education and models of disability with respect to intellectual disability are presented in Table 5 and are further discussed below.

Medical model

The discourse of *A3: Medical model discourse* can be seen to relate to the educational practices of *B2: Special needs require special provision*, *B4: Excellent special*

Table 5. Relationship of discourses of representation and educational practice to models of disability.

Discourses of representation	Educational discourses	Model of disability
A2: Social model/ human rights discourse	B1: Inclusion as a human right	Social model – concerns of autonomy human rights and inclusion as more important than expertise.
A3: Medical model/ religious discourse	B2: Special needs require special provision B4: IE is a dream of the future B5: Effective education must be tailored to the child's needs	Medical model – an organic deficit comes to be known through medical understanding, which differentiates between the different grades and provisions for different levels of disability.
A4: Community/ religious discourse	B3: IE is a dream of the future B6: Special education keeps children safe	Community model – expertise is not only for professionals but for communities as well.
A1: Interactive discourse		Interactive model of disability – support is required to reach competence in a situational understanding of competence.

education as a right and *B5: Effective education must be tailored to the child's needs*. Here, the major problem of intellectual disability is an organic deficit that comes to be known through a medical understanding. It is only the medico-psychological authority that knows the truth about intellectual disability and that can differentiate between the different grades and provisions for different levels of disability. The better the knowledge and the closer the supervision of parents and teachers by the authorities, the better the outcomes envisioned for intellectually disabled people. The distinction made between disability expertise and the medico-psychological gaze is made differently across these discourses. In *B2: Special needs require special provision*, teachers have a general disability expertise but therapists have skills that can directly impact on the impairment itself and are therefore possessors of a certain medical authority. The true needs of the child, made visible by the competent authorities, must determine educational provision. In *B4: Excellent special education as a right*, such is the power of the medico-psychological authority that it can, if applied with sufficient intensity, ameliorate the organic deficit itself. Professional knowledge is invoked, at whatever expense, to address and change organic deficit to the point where the disabled child can do what the 'normal' child can. For *B5: Effective education must be tailored to the child's needs*, the medico-psychological authority is required to classify intellectual disability into different grades and to prescribe the appropriate course of action that will then be implemented by those agents with a lesser form of power disability expertise. These discourses (B2, B4 and B5) prize technical skill and diagnostic mastery that can address the very real impairment, the organic deficit of the individual body. This is in contrast to (but sometimes in combination with) the concept of disability expertise as a more malleable and diffuse concept that is directed toward the *effects* of impairment, that is, the disability and its appropriate management.

Social model

Neither *A2: Social model/human rights discourse* nor *B1: Inclusion as a human right* directly challenges the nature of organic impairment and the specialised skills that might be required to diagnose and treat this deficit. The impairment remains hidden to all but the medico-psychological authorities, but a challenge is made to the excessive power of the gaze. The deployment of disability expertise under such an authority is also challenged. General educational expertise is seen to stand in for this specialised skill.

Community model

For *B3: Inclusive education is a dream of the future*, expertise can be found in regular schools. However, where the disability is very severe, the medico-psychological authority of the special schools is invoked. Disability expertise will help to ensure that their organic impairment does not make intellectually disabled children a target for abuse within the discourse of *B6: Special education keeps children safe*. The power of the medico-psychological authority is not dissipated but it is somewhat distant in B3 and B6. This distance is not viewed as a desirable state of affairs but a reality that must be dealt with through the development of disability expertise in communities and schools, especially in cases where the disability is viewed as being severe.

Interactive model

The discourse of *AI: Interactive discourse* is not reflected in educational discourses and is unique in this study. The notion of support to achieve competence was adopted largely by intellectually disabled adults and is the only discourse that eschews the notion of fixed impairment in favour of a situational understanding of developing competence. In so doing, it completely undermines the authority of the medico-psychological gaze as there is no one truth to be known, but rather a contextual understanding of support requirements is called for.

In concluding this discussion, we examine the configuration of the medico-psychological gaze and disability expertise in education and the implications of these relationships within the models of disability.

Medico-psychological gaze

The medico-psychological gaze has long been a target for disability rights activists advocating for a social model of disability (Oliver 1996). The excessive power of professionals to pronounce upon the correct management of the disabled body has been vigorously resisted. However, we believe that such an outright rejection is based on an understanding of power as repressive and neglects the productive nature of exercise of power. The gaze does not operate successfully through prohibiting forms of thought and behaviour but rather it constructs and produces behaviour by structuring what it is possible to say or do (Foucault 1976/1998). While increasingly medical professionals move away from seeing disability as purely a medical issue, as for example in the case of community-based rehabilitation (World Health Organisation 2004), this does not in any way diminish their ability to exert the gaze when required nor the expectation of lay persons that they will do so through processes of assessment, diagnosis and prescription of the course of action required.

Disability expertise

The relationship between disability expertise and the medico-psychological gaze is not an equal one in terms of the network of power that constructs inclusive education practice. It appears that the medico-psychological gaze is the more authoritative source of power. It is based on the 'truth' of disability as revealed through medical knowledge that has aligned itself with tools, such as the intelligence test. The power to exert the medico-psychological gaze is carefully regulated through professional associations and only bestowed at the end of arduous and scarce professional training (doctors, psychologists and therapists).

Disability expertise is more diffuse than the gaze and can be acquired 'on the job' with the important caveat that it should be under the supervision of (and may be exercised by) the medico-psychological authority. Only those who have had special training or the experience of working in a special school can lay claim to this expertise. The professional practice of the regular teacher does not include disability expertise and these teachers are disqualified from educating disabled learners unless they receive the required training.

Within a *medical model*, disability and impairment are conflated, and the distinction between the medico-psychological gaze and disability expertise is largely a matter of degree of authority. The former denotes an in-depth understanding and authority, whereas the latter is concerned with incomplete knowledge that must be

guided by professionals. The authorities of the medico-psychological gaze possess scientific knowledge and special diagnostic instruments to pronounce upon biological defect. In so doing, they set the limits of possibility and fix impairment as a static entity (sometimes with a number, such as IQ attached), a property of the individual, and on this basis they prescribe valid disciplinary responses to impairment. Significantly, this is not only a rational authority but also an ethical one as the caring professions act in the 'best interests of the child' within a loving relationship that carries the weight of expertise, in such a way as to obscure the operation of power (Rose 2007).

The medico-psychological authorities' presence is most required where the level of impairment is severe and their skills are most likely to be deployed in specialised or pivotal decision-making settings. An important component of disability expertise in this perspective is that it encompasses the ability to be compassionate and to 'understand disability'.

A *social model* targets the medico-psychological gaze that privileges impairment as a source of oppression and exclusion of disabled people (Oliver 1990). However, it has little to say about diffuse forms of disability expertise that encompass forms of caring and the exercise of pastoral power. However, in this approach the impairment is made invisible and conceded to bio-medical authorities as the object of disability expertise. Yet, as we have seen above, the medico-psychological gaze is not neutral with respect to disability expertise but rather it *supervises* and *controls* disability expertise. A recognition of this power relation is evident in an attempt to reverse it as in the discourse of *B1: Inclusion as a human right*, where any intervention directed at the impairment is considered less important than the pursuit of human rights.

Within a *community model*, the distance from the technique increases and a more diffuse form of disability expertise becomes apparent. The medico-psychological gaze is absent in areas that are poorly resourced in terms of professional services, and its authorities are then enlisted into the project of training others about disability who will then be agents of disability expertise in the wider community (see for example Department of Education 2001; World Health Organisation 2004).

The *interactive model* is subversive in that it does not operate within the category of disability as an object of specialised medico-psychological skills. This discourse resists power that: 'operates through the production and deployment of discursive categories whereby individuals must recognise themselves and through which they must be recognised by others' (Durrheim 1997, 33–4). A more every day notion of support is drawn on such as that which applies to any human being, rather than a specialised form of skill. We note with Yates, Dyson, and Hiles that 'the ways that people understand and form relationships with themselves and their own conduct' (2008, 256) are often neglected in research into intellectual disability. It is possibly in this investigation that one would begin to detect the forms of resistance identified by feminist scholars as being embedded in relations rather than of a revolutionary nature (McLaren 1997).

Conclusion: implications for inclusive education

The operation of disability expertise can undermine an inclusive intent for regular educators as they are not authorised to draw on this expertise. The early exclusion of problematic children from the mainstream and the subsequent development of the discipline of special education have rendered the teaching of such children as an extraordinary skill that is not encompassed within the general tenets of sound pedagogy

as it applies to the ‘normal’ child (Schoeman and Schoeman 2002). The regular educator is lacking in the special skills that are required to teach a certain class of children – those that are classified as disabled in some respect. Should they be required to teach such children they will require training and support from professionals with the requisite expertise (Department of Education 1997, 2001). In the absence of such training, the requirement that they teach the full range of learning needs can, in some views, be seen as an abuse of their rights (Alston 2006). The lack of expertise in the regular school introduces the element of conditionality on the participation of disabled learners in the mainstream dependent on capacity building aimed at ensuring the requisite levels of expertise (Slee 2001).

Within this frame, the pressure for exclusion remains potent even where supposedly progressive practices of inclusive education are implemented (Slee 2001). The practices of expertise are grounded in a medical, positivist understanding of disability that sets it as a thing apart, a property of an individual that requires special knowledge (Reid and Knight 2006). Only the expert has the deep, penetrating knowledge of this form of difference from which they are able to exercise authority over educational decision-making.

The operation of the medico-psychological gaze and disability expertise also militates against the involvement of parents in their children’s education. Within the context of education in South Africa, parents are encouraged to become involved in the education of their children, and inclusive education policy specifically promotes a collaborative approach between parents and teachers in addressing their children’s needs (McKenzie and Loebenstein 2006). This is expressed as the desire for partnership between parents and professionals. However, the intuitive, subjective knowledge of the parent is no match for the disciplinary powers of the professional, especially when it is couched in the language of the child’s best interest (McKenzie and Muller 2006).

While the social model of disability explicitly rejects the power of the medico-psychological authority, it remains powerless against notions of disability expertise. This is because the social model espouses a binary relation between disability as social and impairment as organic thereby conceding impairment to biomedical intervention (Hughes and Paterson 1997). Biomedical intervention falls under the authority of the medico-psychological authority and extends into education as a disability expertise. A social model perspective of inclusive education is therefore constrained by the need to provide disability expertise and a conflict between expertise and human rights is not readily resolved. This conception of expertise also provides a tool for opponents of inclusion to appeal to the truth about what is really needed to address disability. In this regard, a further exploration of the use of professionalism as a form of resistance to the democratisation of education as elucidated by Fulcher (1986) would be enlightening. The insertion of the notion of disability expertise into her analysis of ‘the struggle over who controls special educational practices’ (Fulcher 1986, 46) can contribute to ‘provid(ing) and account beyond the normative understanding of the discrepancy between the rhetoric, or ‘policy’, and implementation’ (1986, 46).

We have argued that intellectual disability in education falls within the realm of a medico-psychological gaze that employs multiple agents with varying levels of authority in addressing either the organic impairment or the effects of disability. The medical and psychological professions diagnose the inherent lack within the individual (intellectual impairment), relative to the norm of the average intelligence and behaviour that is deemed necessary for participation in regular classrooms. This class

of professionals pronounces on the limit of possibility through techniques of assessment, diagnosis and prognosis.

The diagnosis of intellectual impairment mobilises the need for disability expertise in the management of disability. This expertise is a scarce resource requiring delivery mechanisms and special placement. Disability expertise defines members of a category of troubling (and often troublesome) individuals who mark the limit of success that ordinary teaching can be expected to achieve. The impairment, outside of normal diversity and within the domain of the abnormal, can be addressed through the application of professional knowledge applied in the spirit of the caring and compassion.

The notion of disability expertise needs to be further explored. The role of therapists in the exercise of this form of expertise is somewhat ambiguous as they have a certain medical authority but do not have access to the definitive diagnostic techniques of the medical examination and the intelligence tests. A further question relates to the nature of medico-psychological skills in under-resourced settings such as the one in which this study was conducted. In these situations, the authorities are physically absent but exert authority in an almost mythical manner. Finally, further research on the operation of disability expertise in the practice of inclusive education could yield interesting insights into some of the barriers that continue to bedevil its implementation. Such research would have implications for teacher education in support of attempts to undo the rigid separation between 'special' and 'ordinary' education and promote inclusive teaching.

In conclusion, we would like to suggest that the project of inclusive education cannot accept a social model of disability in an uncritical manner. The dichotomy between disability and impairment needs to be explored with respect to the inherent power relations of the medico-psychological gaze with respect to disability expertise. A possible form of resistance to this power can be detected in the interactive discourse that emphasises the fluidity and situational nature of disability and this could be explored as a way forward.

Note

1. The statistical analysis is performed by dedicated software, PCQ for Windows (Stricklin and Almeida 2004). Each Q-sort is correlated with every other Q-sort, and the statistical method of factor analysis is used to detect and expose common or shared points of view among these Q-sorts.

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