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# *Relative truths regarding children's learning difficulties in a Queensland regional primary school: Adult stakeholders' positions*

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# ABSTRACT

## *Relative truths regarding children's learning difficulties in a Queensland regional primary school: Adult stakeholders' positions*

This study explored the discursive subject positions that 18 parents, teachers and administrators involved with children identified as experiencing learning difficulties in a Queensland regional primary school between September 2003 and August 2004 drew upon to explain the causes of those children's learning difficulties. The study used a post-structuralist adaptation of positioning theory and social constructionism and a discourse analytic method to analyse relevant policy documents and participants' semi-structured interview transcripts to interrogate what models were being used to explain a student's inability to access the curriculum. Despite the existence of alternative explanatory frameworks that functioned as relatively undeveloped resistant counternarratives, the study demonstrated the medical model's overwhelming dominance in both Education Queensland policy statements and the participants' subject positions. This dominance shapes and informs the adult stakeholders' subjectivities and renders the child docile and potentially irrational.

Key words: discourse/discourse analysis, learning difficulties, positioning theory, post-structuralism, Queensland, primary school, social constructionism.

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# DEDICATION

In loving memory of:

# Charlotte A. Waldrop

## (3 July 1917 - 7 May 2002)

# DECLARATION

I declare that the main text is entirely my own work and that such work has not been previously submitted as a requirement for the award of a degree at Central Queensland University or any other institution of higher learning.

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Wayne Clinton Arizmendi
31 August 2005

# CHAPTER ONE

# PROBLEMATISING LEARNING DIFFICULTIES AND INTERROGATING THEIR CONSTRUCTIONS

*"Say not, "I have found the truth," but rather, "I have found a truth"*
(Gabran, 1997, p. 61)

## Introduction

Just under a decade ago, it was estimated that 10% of the Australian population was experiencing learning difficulties (Prior, 1996). Since that time there have been numerous educational changes regarding learning difficulties in areas including, but not exclusive to, curriculum, pedagogy and assessment. However, the major problem remains that the term 'learning difficulties' is ambiguous and applied inconsistently within Australia, as is demonstrated in Volume One of the three-volume *Mapping the Territory – Primary Students with Learning Difficulties: Literacy and Numeracy*:

> 'Learning difficulties', 'learning disabilities', 'at educational risk' 'special needs' [and] 'needing support.' All these terms and others are used in Australian schools to describe children who have difficulties with literacy and numeracy learning. What the terms mean, which children they are applied to, and what consequences these labels have for children varies from State to State and from school to school. (Louden in Louden, Chan, Elkins, Greaves, House, Milton, Nichols, Rohl, Rivalland & Van Kraayenoord, 2000, vol. 1, p. 3)

This situation regarding the ambiguity of different terms, the application of those terms and the consequences of the labels for children poses a specific problem given that the former Queensland School Curriculum Council (2001) asserted that 20% of the Queensland school population was experiencing learning difficulties. What exactly are learning difficulties? How does one tell the difference between a child experiencing a learning difficulty and a 'lazy' student or a student exhibiting maladaptive behaviour? What is the impact of the label 'learning difficulties' on the child to whom it is assigned? These questions, amongst others, guided my

enquiry for this study regarding adult stakeholder constructions of the term 'learning difficulties'.

Broadly, this thesis is about the phenomenon known as 'learning difficulties' as it is constructed by adult stakeholders involved with children identified as experiencing such difficulties in a Queensland regional primary school. I have focused specifically on adult stakeholders in one school because I view those individuals as the key stakeholders in the academic and social lives of a particular group of children at that school identified as experiencing learning difficulties. Learning difficulties are both a politicised construction and a social practice in any school; the study's focus on a single school enables that construction and that practice to be examined in considerable detail.

Here the Foucauldian notion of a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187) is helpful in understanding the ways in which the adult stakeholders contributed to the domination by medical model discourses of the child identified as experiencing learning difficulties. The "Western medical model" (Freund, McGuire & Podhurst, 2003, p. 6) comprises five "historically created assumptions [about the body and ways of knowing about the body]" (p. 6). These five 'assumptions' are used to guide the data analysis in Chapter Five of this thesis. They are: "The Mind-Body Dualism" (p. 220); "Physical Reductionism" (p. 221); "Specific [A]Etiology" (p. 221); "The Machine Metaphor" (p. 222), and "Regimen and Control" (p. 222).

More specifically, this thesis is about the exercise of power in respect of learning difficulties, particularly through the forces of domination and resistance. The domination of the child by the medical model is explored in Chapter Five in order to understand how that domination operates within adult stakeholder discourses. Equally importantly, the medical model is interrogated in order to discover its potential weaknesses as I investigate moments of resistance voiced by the stakeholders. These moments of resistance are presented in Chapter Six, where I analyse 'other' explanatory frameworks for a child's inability to 'access the curriculum'.

According to Education Queensland:

> Schools must assist students whose access to the curriculum is limited by learning difficulties and learning disabilities, to develop competencies in the areas of literacy, numeracy and/or learning how to learn. (Queensland Department of Education and the Arts, 2002b, n.p.)

Throughout this thesis, I frequently use the phrase 'access the curriculum' to refer back to the quotation above. Although I cover Education Queensland's curriculum in greater detail in the following chapter, I note here that there are a number of strategies, plans and actions required to implement that curriculum and to ensure that the child has 'access' to it. Therefore my use of the phrase 'access the curriculum' is meant to facilitate my discussion of children identified as experiencing learning difficulties by using terminology that aligns this study contextually – although not necessarily philosophically – with the Education Queensland environment in which this study is situated.

In asserting that each stakeholder who participated in the current study contributed to the domination of the child by the medical model, I realise that I may appear to be 'blaming' those individuals. However, I contend that I am unable to 'blame' anyone for the current state of affairs regarding the children identified as experiencing learning difficulties in the school because of the conceptualisation of power to which I subscribe. If power is to be seen as circulatory, rather than isolated (Foucault, 1980), then I cannot view individuals as sites of power. Instead, those stakeholders have constructed the child linguistically in such a way that the medical model discourses have presented themselves and altered the way that the child is viewed and/or treated by those stakeholders. The stakeholders effectively represent the 'strategists' of whom I wrote above.

Therefore identifying individuals as singly responsible for the domination of the child is not possible, given that power can only ever be exercised, not owned. Thus, while these people have the power to construct and re-construct the child, that power is limited by the extent to which its effects are reproduced. Ultimately, the power to create a 'truth' regarding learning difficulties lies with no one and everyone simultaneously. Therefore 'blaming' anyone is neither a possible, nor a useful, endeavour.

As an abstract truth, learning difficulties have been cemented in Education Queensland policy regarding students *with* learning difficulties. By using the term 'abstract truth', I am highlighting the abstract character of learning

difficulties; they are a socio-cultural and political construction that has been formalised within the Queensland educational system. They are intangible, yet represented as 'truth'. This 'truth' has 'concrete' social implications and thus learning difficulties become 'real' for the children identified as experiencing them, as well as for the people involved with those children.

My italicisation of the word "with" in the previous paragraph results from my interpretation of the language used by Education Queensland's CS-13: Educational Provision for Students *with* Learning Difficulties and Learning Disabilities (Queensland Department of Education and the Arts, 2002b; emphasis added). It seems to me that in this context the preposition 'with' implies either 'possession' or 'ownership'. Thus, I concur with Scott (2004) when she discussed the "broad" (p. 5) definitions operating in Queensland: "It is noted that the problem [learning difficulties] is seen to lie with the child" (p. 5).

Far from coincidentally, the medical model has been criticised for its isolation of medical problems or issues as being inherent in the individual (Freund, McGuire & Podhurst, 2003). In this study, I contend that the medical model underlies the Education Queensland policies regarding learning difficulties. In using the preposition "with", Education Queensland presents a learning difficulty and/or a learning disability as coming with – and by association from – the child. Therefore it can be deduced that the institutional system is exonerated from responsibility for the child's inability

to ‘access the curriculum’; instead the school has procedures and systems in place to assist the child “with” learning difficulties/disabilities.

This chapter is organised into four sections. I first discuss the significance of the research and then move on to articulate and justify my research questions. Afterwards I present an outline of the thesis before concluding with a personal note that establishes my personal ‘position’ within this study. I re-visit this note in Chapter Seven.

**Significance of the research**

In this section, I discuss the significance of my research with regard to its contribution to debates about the ‘nature’ or ‘origin’ of learning difficulties. Although there has been considerable disagreement regarding the ‘causes’ of, and ‘treatments’ for, learning difficulties, the fact remains that learning difficulties are an institutionalised component of Education Queensland and viewed as existing within the child:

> [Schools must:] Have a process in place to identify and respond to the needs of students with learning difficulties and learning disabilities. (Queensland Department of Education and the Arts, 2002b, n.p.)

As such, schools are accountable for ensuring that students identified as experiencing learning difficulties have access to the curriculum. However, in an educational context where the child is viewed as ‘having’ a learning difficulty, it would appear that the individuals associated with that context are exonerated from the responsibility for that child’s inability to access the curriculum. It is for this reason that I contend that the construction of the term ‘learning difficulties’ needs to be interrogated in the context of its

enactment in Education Queensland policy and its construction by adult stakeholders in one Education Queensland school.

This study is significant, therefore, in seeking to focus attention upon the power circulating amongst a particular group of adult stakeholders as they construct and re-construct the child identified as experiencing learning difficulties. This power is linked with the positions that the adult stakeholders occupy within specific discourses used to explain 'what' a learning difficulty is/is not. Thus, the subtle implications of using particular discourses can be traced through the voices of the participants as they create and re-create the 'child with learning difficulties' typology in talk. Those voices are presented in Chapters Five and Six in order to show that domination and resistance are both 'real' and possible depending upon the particular subject positions that are occupied when describing the child.

In Chapter Two, I discuss the problems one may encounter when engaging with learning difficulty and learning disability in Australia. Whilst Elkins (2002) and Christensen (2000) noted that the two terms are often used interchangeably, Queensland is the exception with a distinct differentiation being made between them. According to Scott (2004), learning disabilities are viewed in Queensland as a sub-set of learning difficulties:

> The Queensland definition of learning difficulties is so expansive that it must be seen as the umbrella term. Learning disabilities can be seen as a sub-set of this category as it is defined as a subgroup within the group of students with learning difficulties. (p. 4)

Because learning difficulties have been institutionalised, they can be viewed as an abstract truth; they are therefore often 'taken-for-granted'. That is, critically questioning learning difficulties as this thesis does is a difficult task because the policies regarding learning difficulties reinforce the default mode, whereby those difficulties are assumed to be inherent in the individual. This point highlights the study's intended significance as one study questioning both the foundation and the *modus operandi* of learning difficulties policy as it is enacted in Education Queensland schools.

At the same time, the lack of a national consensus regarding the definition, and thus the 'nature', of learning difficulties makes educational progress in the field difficult (Louden *et al*. 2000; Cunningham & Firth, 2005). Moreover, this lack emphasises that learning difficulties are a socio-cultural and political construction that varies from state to state in Australia and reinforces the proposition that the very act of defining them is arbitrary. This arbitrariness underscores the importance of this investigation into the ways in which parents, staff and administrators of children identified as experiencing learning difficulties understand those difficulties.

More specifically, I contend that the ambivalence evident within the adults stakeholders' words presented in this study demonstrates that the confusion regarding learning difficulties and learning disabilities is widespread at the levels of both the institution of the school and the individual who is associated with that institution. The key point about this ambivalence and confusion is that the child on the receiving end of the learning difficulties

'label' is a 'real' person who is continuously being defined and re-defined by a variety of individuals with varied kinds and levels of power. The child is effectively silenced and the 'taken-for-granted' assumptions regarding that child often continue unchallenged. This study is an important step in questioning and contesting the construction of learning difficulties as a social practice and it represents an attempt to look 'outwards' from the child identified as experiencing learning difficulties, rather than continuing to look 'inwards' at, and upon, that child.

**Research questions**

Two research questions framed and guided the conduct of the study. They are:

- In what ways is the medical model's dominance enacted in the adult stakeholders' constructions of children identified as experiencing learning difficulties?
- What 'other' explanatory frameworks are displayed in adult stakeholders' constructions of children identified as experiencing learning difficulties?

The first research question was designed to establish what medical model subject positions (metaphorical 'locations' within a given discourse) the stakeholders occupy as they construct the child identified as experiencing learning difficulties. The second research question derived from the proposition that the medical model is not the only way to account for a child's inability to access the curriculum.

These two questions are related by their purpose of exploring stakeholder constructions of learning difficulties in order to establish what subject positions the stakeholders are occupying. The notion of a 'subject position' is a metaphorical space that an individual occupies within a particular discourse when speaking. Harré and van Langenhove (1999) and Foucault (1972) both discuss this concept. For the former, a 'subject position' provides the foundation for a theoretical approach to the analysis of conversation; for the latter, a subject position is part of a broader theory of power that permeates the speakers' words as they draw upon discourse. By focusing upon subject positions, I can explore the discourses that the stakeholders draw upon as they linguistically construct and re-construct the child identified as experiencing learning difficulties while simultaneously constructing and re-constructing themselves.

The two research questions form a dialogical and interdependent pair. In combination, the questions focus on the medical model and its potential alternatives. In addition, the questions focus respectively on a metanarrative of domination and the counter-narratives of resistance, by engaging with the concept of 'domination' as explicated in Chapter Five and that of 'resistance' as explored in Chapter Six.

Choosing these questions was not accidental; rather, the research questions emerged firstly from the process of designing the study and subsequently as a result of examining the data. My primary objective in respect of the first question was to explore the ways in which the adult stakeholders drew upon

medical model discourses in order to construct the child identified as experiencing learning difficulties. This question acknowledged learning difficulties as a 'part' of the everyday experiences of the study's participating parents, teachers and administrators. Although stakeholders were unlikely to make deliberate statements regarding their use of medical model discourses to dominate the child and render her/him 'docile', it was expected that they would refer to those discourses in such a way that I could glimpse what specific medical model discourses they used to construct that child.

Whilst the first question focused specifically upon the domination by the medical model, the second question emphasised the resistance(s) to that domination, although I was still concerned with how the interviewee constructed the child identified as experiencing learning difficulties. I searched for 'other' explanatory frameworks that appeared to move away from a medical model explanation of a child's inability to access the curriculum. Again I did not expect that the adult stakeholders would mention explicitly concepts such as 'resistance' any more than I expected them to consider their words to be a contribution to a 'counter-narrative'; rather, I thought that the individuals would make statements that would allow me – using a specific theoretical analysis – to gain insight into their social worlds and their realities regarding learning difficulties. I sought to explore their many and varied, or relative, truths.

The two research questions set the stage for a representation of both the adult stakeholder and the child as sites of competing and conflicting discourses. For the parents, teachers and administrators, I sought to illuminate the ambivalence that they showed when discussing the child identified as experiencing learning difficulties. I view this ambivalence as the collision of medical model and 'other' explanatory frameworks. At the same time, viewing the child as a site of competing and conflicting discourses is necessary because the child has been effectively silenced in this study just as the child has been silenced in the policy regime that it interrogates. Although I discuss the notion of 'voice' throughout the thesis, I note here that, in creating and re-creating the child, the participating adult stakeholders use a variety of discourses to do so. Through the deployment of these discourses they position the child, and how the child is positioned carries social consequences. The study's research questions have been developed carefully to render those subject positions explicit and hence amenable to interrogation and contestation.

**Outline of the thesis**

The thesis is arranged in seven chapters. This chapter has established the problem to be explored and highlighted that problem's significance. Moreover, I have presented and justified the research questions to be answered throughout the study.

Chapter Two reviews specific literature in three key areas. Education Queensland policy is discussed, the process of identifying children as experiencing learning difficulties is explained and the 'scientific revolution' that assisted with the formation of a medical model way of thinking and knowing about learning difficulties is outlined.

Chapter Three outlines and justifies the conceptual framework of the study. In that chapter, I present the key concepts of positioning theory, social constructionism and discourse analysis. I draw upon a Foucauldian (Foucault, 1980) notion of power to complement those concepts in order to establish a way of exploring the adult stakeholder constructions of learning difficulties.

Chapter Four explains and justifies the research design of the study. In that chapter, I elaborate a design that is a result of my qualitative, interpretivist, post-structuralist framework. I present my data gathering and analytic techniques. The gathering of the data consisted of semi-structured interviews with 18 adult stakeholders over a period of 11 months between October 2003 and August 2004 and the analysis of those data was guided by a discourse analytical approach (Potter & Wetherell, 1987). In addition, I discuss the ethical and political dimensions of my research.

In Chapters Five and Six, I engage comprehensively with the two research questions. Chapter Five addresses the first question, by examining the enactment of the medical model's dominance in learning difficulty

discourses. Chapter Six addresses the second research question, by focusing upon the 'other' explanatory frameworks that are found within the interviewees' voices.

Chapter Seven concludes the study and sums up my journey. I include some suggestions for further research and complete the chapter by revisiting my note about personal positioning outlined below.

**Personal positioning**

In this thesis, I struggle with notions of voice, power, domination, resistance and agency. While there are other issues within the text, these five interdependent concepts are the primary ones that have influenced my particular way of thinking and knowing, or coming to know, about learning difficulties. As a result of engaging with these notions, I have realised that I too am a site of competing and conflicting discourses. This realisation has implications for me as a researcher, as an educator and most importantly as a human being.

As a researcher, I am interested in how individuals 'make sense' of the term 'learning difficulties'. The individual voices within this study have expressed their understanding of learning difficulties through narratives that have reflected personal experiences. One assumption of the study is that each individual presented a subjective view of her/his understanding of learning difficulties. However, discourses shape and inform our subjectivities. Thus, an 'abstract truth' such as learning difficulties can be

viewed as 'real' only after an individual accepts and/or internalises the relevant discourses necessary for doing so. It then becomes 'real' because it has "concrete implications" for all involved (Freund, McGuire & Podhurst, 2003, p. 223). The same rules apply to resistance and rejection of those discourses, although the individual will have to choose a subject position in an alternative discourse. Significantly, the individual's rationality is at stake when s/he 'chooses' to occupy a discourse subject position that is not part of the *status quo*.

In exploring how individuals 'make sense' of the term 'learning difficulties', I too, have sought to 'make sense' of it and of them. Although this process of making sense is far from complete, I contend that, as a result of having completed this research project, I have a deeper understanding not only of the field of learning difficulties within Queensland, but also of the richly variegated lifeworlds of those who believe in and encounter them during their everyday personal and/or professional experiences.

As an educator, I am reminded formally and informally that learning difficulties can be found to 'exist' within any given classroom and that it is an aspect of my 'duty of care' to assist students identified as experiencing learning difficulties in accessing the curriculum. Regardless of whether I believe in learning difficulties or not, they are 'real' because the Department of Education Manual (Queensland Department of Education and the Arts, 2002b) tells me that they are. In addition, throughout this study the parents, teachers and administrators have reminded me – as they have related their

personal interactions with children identified as experiencing learning difficulties – that learning difficulties are 'real'. Although I do not wish to offend those individuals who gave of their time to me, I do wish to present some of their storylines as a way of showing that the medical model way of explaining learning difficulties – while dominant and the explanatory default mode – has numerous alternatives. Storylines are portions of an individual's life that contain her or his thoughts, feelings, opinions and perceptions about specific events (Harré & van Langenhove, 1999). Within an individual's storyline can be found the subject positions on offer to other participants in that 'story' to accept, reject or negotiate those positions.

These potential alternative storylines are important to me as an educator, because they allow me to challenge the domination of the child identified as experiencing learning difficulties at the site of its application. In order for the child to be dominated, s/he must be subjected to the discourses of domination. Because those discourses cannot operate without individuals and groups adopting subject positions within them, their enactment is reliant upon those groups and individuals; the child can be viewed as the point of application of that domination. This effectively means that, as an educator, I can work at the 'grassroots' level to attempt to counter some of the effects of the medical model's domination of that child.

Although this point appears promising, I note that there is a fine line of rationality and self-righteousness to be walked here. The dangers of rationality are a result of challenging a dominant way of thinking and

knowing about learning difficulties while the potential self-righteousness can come in the form of me being positioned as 'martyr' or 'saviour'. Clearly, I do not aspire to either of these positions; rather, I believe that I have *some* capacity to effect positive change for the child in what I consider to be a flawed and dubious system. Instead of establishing my viewpoint as 'better' than that of others, I seek to provide enough evidence and strength of argument that people may be compelled of their own accord to challenge the 'system' or the 'institution' and to resist the 'taken for granted' assumption that the medical model is the most effective, let alone the only rational, explanation of the complex and contradictory phenomenon of learning difficulties.

As a human being, I feel ashamed of the practices of categorising, labelling and compartmentalising individuals in such a way that they can be viewed as 'behind' or 'lacking'. I often hear terms such as these used to describe children identified as experiencing learning difficulties and I am continually amazed at how many people take learning difficulties to be the result of some kind of biological trait of the individual. I have a strong interest in social justice issues and I have argued elsewhere (Arizmendi, 2001) for the notion of an 'interdependent universe', whereby each individual acknowledges her/his location in the intricate 'web' of social relations as a way of combating homogenising and reductionist views of individuals and groups that could potentially lead to stigmatisation and marginalisation.

I feel that these practices of categorising, labelling and compartmentalising are the remarkably resilient remnants of a by-gone era. I argue that those notions are directly linked to modernity's search for a single and unified 'truth' by which we could shape our lives and around which we could mould the lives of others. The current *zeitgeist* compels me to question 'all things modern' as I seek to move beyond a 'cause and effect' type understanding of the world and replace that understanding with a healthy scepticism towards 'taken-for-granted' assumptions. As a result, I view the learning difficulties 'label' as an apparatus of control and domination. The practices of categorising, labelling and compartmentalising individuals render those individuals as objects of control and domination. Thus, one of the major prerequisites for a child becoming a 'docile body' (Foucault, 1977) is for that child to receive the title 'child *with* learning difficulties'.

**Conclusion**

This chapter has set the foundation for the remainder of the thesis. I have established that I consider learning difficulties to be a socio-cultural and political construction that is aligned with the domination of the child identified as experiencing them. In addition, I have presented the significance of the study, the research questions and a note about personal positioning; I re-visit that note in Chapter Seven. The following chapter reviews the literature relevant to this study and provides the context in which children are identified as experiencing learning difficulties.

# CHAPTER TWO

# A REVIEW OF THE CONSTRUCTION OF SOME DISCOURSES OF LEARNING DIFFICULTY AND DISABILITY

*We all know that we can define, organize, and arrange things in all sorts of fashions depending upon our needs. In fact, that is what language is for--to define, organize, and arrange. Learning disabilities theory is a product of language. It is a concept that was invented to help explain underachievement by children who seem bright enough not to be underachievers. The LD label is a device that helps us arrange and view children in a certain fashion. The definer selects the system and uses it for her own purposes, but it is an invention by human minds and does not exist outside of the creation. If the invention were helpful, it should be used. But the label does not help, the programs do not work, and we are harming our most precious natural resources, our children.* (Finlan, 1994, p. 7)

## Introduction

This chapter presents a review of the literature related to the construction of learning difficulties in a Queensland regional primary school. It is divided into three sections: *Education Queensland*; *The 'difficulty' in defining learning difficulties*; and *The evolution of the medical model in constructing learning difficulties*. In combination, these three sections present the backdrop for my exploration of adult stakeholders' construction of children identified as experiencing learning difficulties and provide the impetus for the study's research questions. Within this chapter, I portray the components of one particular education system where learning difficulties are 'real' for both the institution and the individuals associated with that institution and where those learning difficulties have as their foundation the medical model.

Whilst this chapter presents and examines excerpts from policy documents, it also demonstrates that Education Queensland is a massive educational bureaucracy that deploys the medical model to construct learning difficulties. Learning difficulties have been institutionalised and as a result they have social, economic and political implications for the children identified as experiencing them. In the first section of the chapter I discuss the different components of the Education Queensland system in order to show the way in which that system operates. My intention in that section is to provide a broad overview of the system in which the study took place and thereby to present the study's contextual background to the reader. The second section regarding the difficulty one encounters when attempting to

define ‘learning difficulties’ analyses in turn the United States, Australian and Queensland contexts. My intention here is to portray a strategically selective synthesis of the history of contemporary learning difficulties by examining one major context where there is a considerable concentration of literature regarding students’ inability to ‘access the curriculum’. In the final section, I show how several hundred years of thinking and rationalising have led to current ways of thinking and knowing about learning difficulties. I argue that the medical model ‘mode’ of thinking is responsible for the domination of the child and the rendering of that child as a ‘docile body’ (Foucault, 1977). Although I discuss this notion at length in the following chapter, I mention it here in order to prefigure that discussion and to highlight the implicit power relations that are related to, and embedded within, the contemporary educational context in which the study took place.

**Education Queensland**

The Australian State of Queensland has a population of approximately 3.6 million (The State of Queensland, 2005), is located in the northeast corner of the country, is affectionately referred to as “The Sunshine State” and has been projected by the government as aspiring to be(come) “The Smart State”. There are more than 1,300 schools in Queensland aligned with Education Queensland, with approximately 35,000 teachers and 490,000 students working at and attending those schools (Queensland Department of Education and the Arts, 2004a). Education Queensland is the governing body of the Queensland public school system; excluded from its governance

are Queensland Catholic Education Commission (QCEC) schools and schools that are members of the Association of Independent Schools of Queensland (AISQ). The school in which the study took place was a Queensland regional primary school governed by Education Queensland.

The current study is situated within a rapidly changing educational context where educational reform is an ongoing process and where the child, as *learner*, is being continuously created and re-created. This process is evident in the educational discourses that serve to shape and mould the individual child as s/he attempts to negotiate the curriculum that has been developed within the broader schooling framework.

This literature review is contextually situated within the *Queensland State Education – 2010* (hereafter QSE-2010) strategy and the subsequent *Destination 2010* action plan that have served, and that continue to serve, as a 10-year plan for the future of the Queensland educational system. *QSE-2010* was endorsed by the Queensland Government in February 2000 (Queensland Department of Education and the Arts, 2002c) "as a statement of policy and strategic direction for state education for the next 10 years" (n.p.). This 10-year educational plan is considered by Education Queensland to reflect

> …parents' expectations that their children have the best opportunities for success in a knowledge-based society. It also reflects the needs of the community and of business and industry for an educated society and [a] workforce that supports economic development and social cohesion. (2002c, n.p.)

Education Queensland staff recently adopted *Destination 2010* "as the vehicle for implementing this framework [QSE-2010], with all schools establishing local targets in relation to the systemic targets outlined in this action plan" (Queensland Department of Education and the Arts, 2002c, n.p.). Together, these documents represent the conversion of a theory or educational ideal into institutional practice. The success of that practice is contingent upon several factors, the most important of which is the enactment of the policy by the educational stakeholders.

*QSE – 2010* has two major goals. The first goal is to "improve the quality of the education experience in state schools for all students" (2002c, n.p.) while the second goal is to "increase the number of young Queenslanders who complete 12 years of schooling by the age of 24" (2002c, n.p.). Schooling is compulsory in the State of Queensland for children between the ages of six and 15. However, as of 2006, "it will be compulsory for young people to stay at school until they complete Year 10 or turn 16, whichever comes first" (Queensland Department of Education and the Arts, 2002c, n.p.). The schooling framework presented in this literature review is the current framework in which children identified as experiencing learning difficulties are being educated.

Accompanying the two goals of QSE-2010 are the five objectives listed in Table 2.1 following:

| Objective | Broad explanation of objective |
|---|---|
| Learning | Implement a learning framework to prepare students for living in complex, multicultural, networked societies. |
| Schools | Create learning communities that meet diverse student and community needs. |
| Workforce | Ensure the workforce has the capacity and flexibility to deliver the objectives of QSE-2010. |
| School services | Provide services that facilitate the work of schools and learning relationships. |
| Portfolio relationships | Ensure relationships with other government departments and statutory authorities are focused to support the work of teachers and to benefit diverse student pathways. |

Table 2.1. QSE-2010 objectives (Queensland Department of Education and the Arts, 2002c, n.p.)

Underlying the two goals and five objectives listed above are the Department's five values. These values are considered to be what the Department of Education and the Arts "is committed to" (2002c, n.p.):

> Excellence — Setting standards and delivering high quality educational services.
>
> Inclusiveness — Recognising diversity and treating all people with respect and dignity.
>
> Participation — Encouraging community participation and involvement of parents/carers in partnership in schools and supporting young people's access to diverse learning pathways.
>
> Safety — Creating safe and tolerant learning environments for all students, teachers and staff.
>
> Accountability — Upholding the standards community, parents/carers and government set for effective performance of educational and professional services. (Queensland Department of Education and the Arts, 2002c, n.p.)

The two goals, five objectives and five values are the core of the *Queensland State Education – 2010* strategy and *Destination 2010* action plan.

So far in this section on Education Queensland, I have introduced the general backdrop against which the study rests. In the following four sub-sections, I investigate the key areas that have been developed within the strategy and promoted by the action plan named above. Considered to be "an integrated framework for curriculum, pedagogy and assessment" (Queensland Department of Education and the Arts, 2001, n.p.), the addition of "reporting" (2001, n.p.) to these three items establishes the four elements that comprise that "curriculum framework" known as *QSE – 2010* (2001, n.p.):

- Core learnings (n.p.);
- Teaching strategies (n.p.);
- Utilisation and development of a range of assessment devices (n.p.);
- Reporting on student progress and achievement (n.p.).

I have separated these four elements into sub-sections. I consider "core learnings" to fall under the 'curriculum' sub-heading; "teaching strategies" to fall under 'pedagogy'; "utilisation and development of a range of assessment devices" to fall under 'assessment'; and "reporting on student progress and achievement" to fall under 'reporting'. In the following sub-section, I present the curriculum in the form of the core learnings that have

been prescribed for all Education Queensland schools as a result of Queensland State Education–2010 (*QSE–2010*).

*Curriculum*

In this sub-section, I discuss Education Queensland curriculum by means of the concept of 'core learnings'. Core learnings are considered to be "the knowledges, understandings and skills deemed to be essential for all students" (Queensland Department of Education and the Arts, 2001, n.p.). Although schools may include other areas of learning within their curriculum, the core learnings are an essential component of each school's curriculum delivery. Moreover, the school's 'curriculum plan' is required to describe "how the core learnings are to be organised, scheduled and delivered" (n.p.). It is evident from the statement above that the knowledge considered to be 'essential' has been formalised within the system. However, the concept of essential knowledge is problematic because emphasising the 'same' curriculum content for each Queensland student is associated with the risk of implementing a homogeneous approach to educational delivery. Furthermore, if that homogeneous approach does not suit the needs of a particular child and yet that child is on the 'receiving end' of the curriculum, then a logical extension is that the child, rather than the creators, maintainers and deliverers of that curriculum, is responsible for not accessing that curriculum.

Core learnings are outcomes-based and therefore the child's ability is measured and compared using a variety of assessment techniques (which are discussed in a later sub-section): Core learning outcomes (CLOs) or essential learnings are what students should know and be able to do as a result of planned learning experiences (Queensland Department of Education and the Arts, 2001, n.p.).

Arguably an outcomes-based approach focusing on 'product' rather than 'process' can be criticised for its representation of ability as a measurable and identifiable characteristic of the student. If this is the case, then students who do not meet the desired outcomes can be considered to be lacking or deficient in specific learning areas. Thus, if one is to consider that knowledge is a socio-cultural and political construction, then it would appear that the measurement of that knowledge is, of necessity, arbitrary. In consequence, ambiguity and 'grey areas' that appear to lie along the boundaries of supposedly mutually exclusive categories are unlikely to be acknowledged.

The Education Queensland curriculum is compartmentalised into eight Key Learning Areas (KLAs), *viz*. English, Health and Physical Education, Languages Other Than English (LOTE), Mathematics, Science, Studies of Society and Environment (SOSE), Technology and The Arts (Queensland Department of Education and the Arts, 2001, n.p.). This compartmentalisation reflects the belief that these eight KLAs could effectively encapsulate the range of desirable learnings offered in schools

Australia–wide – as had been affirmed in the Adelaide Declaration (Ministerial Council on Education, Employment, Training and Youth Affairs, 1999; cited in Queensland Department of Education and the Arts, 2001, n.p.).

Each KLA has its own outcomes viewed in terms of "knowledges, practices and dispositions that should be developed by students who engage in that KLA. Typically, any one KLA has six to eight such outcomes" (Queensland Department of Education and the Arts, 2001, n.p.). Within each KLA, there are 'strands' or collections of concepts found within it. Table 2.2 following shows the eight KLAs and their respective strands.

Although the KLAs and their respective strands represent a way of organising and presenting, or 'delivering', knowledge to the child, there have been significant criticisms of Education Queensland's approach. Notably, Wilson (2003) highlighted two concerns regarding the KLAs. They were

> [T]he conceptual inadequacy and practical difficulties of some learning areas, which leads to the burial of key content and skill areas within broader categories and
>
> [T]he clear failure of the eight KLA structure in the early years. (n.p.)

Wilson's (2003) criticisms are both timely and relevant considering I am examining the phenomenon of learning difficulties through a post-structuralist lens that emphasises the socially constructed 'nature' of power and knowledge. In the broader picture, we have a policy that incorporates knowledge deemed to be essential for all students. That knowledge has

| | |
|---|---|
| English | • Cultural<br>• Operational<br>• Critical |
| Health and Physical Education [HPE] | • Promoting the health of individuals and communities<br>• Developing concepts and skills for physical activity<br>• Enhancing personal development |
| Languages Other Than English [LOTE] | • Comprehending and composing language |
| Mathematics | • Number<br>• Measurement<br>• Spatial concepts and visualisation<br>• Patterning and algebra<br>• Chance and data |
| Science | • Science and society<br>• Earth and beyond<br>• Energy and change<br>• Life and living<br>• Natural and processed materials |
| Studies of Society and Environment [SOSE] | • Time, continuity and change<br>• Place and space<br>• Culture and identity<br>• Systems, resources and power |
| Technology | • Technology practice<br>• Information<br>• Materials<br>• Systems |
| The Arts | • Dance<br>• Drama<br>• Media<br>• Music<br>• Visual arts |

Table 2.2. The eight KLAs and their respective strands. (Queensland Department of Education and the Arts, 2001, n.p.)

been segmented and compartmentalised in order to present the components of the curriculum known as KLAs. In addition, each particular component

of the 'essential' knowledges appears to be presented as being equal. Yet Wilson (2003) argues that those areas are not equal:

> We offer little general guidance about the relative value of different areas of the curriculum apart from a broad injunction concerning literacy and numeracy. We are, characteristically of this point in cultural history, almost unable to make distinctions of value. (n.p.)

With regard to the 'value' of the KLAs, I am suggesting that some KLAs are 'more equal' than others. Although this point may be viewed as contentious and the teachers who teach the 'less important' subjects would disagree, I am attempting to highlight the social ramifications of an educational system that rests on a fundamental contradiction and that to some extent focuses on quantity rather than quality. The major monitoring of students' ability to access the curriculum comes in the form of the Year Two Net and the Years Three, Five and Seven tests (discussed below); both focus specifically on literacy and numeracy as indicators of a child's achievement.

> But we need to recall that the eight KLAs are not tablets handed down by God, each of an equal size. They are an outcome of a political and intellectual accommodation reached by Ministers and others as a way of moving forward from a position of difference. They have no inherent conceptual rigour, apart from those which are based directly on a single, well-established discipline. We should regard them as a convenience, to be manipulated according to our educational priorities. If they no longer add value, they should be abandoned. (Wilson, 2003, n.p.)

Thus, the point is clear that the KLAs are not the 'be all and end all' with regard to the multitude of ways in which the curriculum can be both developed and delivered. The flaws in the KLAs mean that there is room for improvement, but also that children within a flawed system are at risk of falling victim to the inefficiencies and inconsistencies of that system.

In further refining the curriculum, there are different 'levels' of student learning. Because learning is viewed as being on a continuum, the Queensland School Curriculum Council (2001) syllabi have identified eight different levels from primary to high school: "Levels are points along the developmental continuum of student learning. The QSCC syllabuses identify eight levels: Foundation Level, Levels 1-6, and Beyond Level 6 (listed in order of increasing sophistication and complexity of learning outcomes)" (Queensland Department of Education and the Arts, 2001, n.p.).

Moreover, the levels are often – but not always – notionally tied to particular year levels and/or age bands. Thus the outcomes levels are generally related to the year levels as follows:

- Students demonstrating Level 2 outcomes are at the end of Year 3.
- Students demonstrating Level 3 outcomes are at the end of Year 5.
- Students demonstrating Level 4 outcomes are at the end of Year 7.
- Students demonstrating Level 6 outcomes are at the end of Year 10. (Queensland Department of Education and the Arts, 2001, n.p.)

One apparent problem with levels being generally tied to age is that there may be exceptional cases. One such case can be a child who meets the outcomes for a given year level ahead of the completion of the school year. The child is effectively stagnated for the sake of the homogeneous curriculum that failed to take into account the variability of students' ability to learn. Thus, the systematic production and delivery of the system in a

homogeneous way means that the individuals who are not centred in the middle or 'average' are seen to be 'exceptional' cases, whereby the school has to make necessary accommodations to cater to that particular student's educational needs. This constitutes fertile ground for the potential flourishing of the phenomenon of 'students with learning difficulties'.

In this sub-section I have reviewed the Education Queensland curriculum through the concept of 'core learnings' by way of KLAs, strands and outcomes. I have presented arguments against a homogeneous approach to curriculum delivery and set the context in which children are expected to perform as students. In the following sub-section, I analyse the notion of pedagogy as conceptualised and implemented by Education Queensland.

*Pedagogy*

Education Queensland (Queensland Department of Education and the Arts, 2001) promotes teachers' deployment of an "array of teaching strategies" (n.p.). As a means of delivering the curriculum to students, teachers are urged to use these strategies to facilitate intellectual quality; global and local connectedness; supportive social environments, and recognition of difference (2001, n.p.). These four items are presented in Table 2.3 below in order to facilitate an understanding of their conceptualisation.

| What is being promoted | General outline of what is being promoted |
|---|---|
| Intellectual quality | All students should be involved in intellectually challenging pursuits—those that provide opportunities for deep engagement with a topic or concept. When students of all backgrounds are expected to undertake work of high intellectual quality, overall academic performance improves and equity gaps diminish. The 'dumbing down' of curriculum must be resisted (especially for at-risk students). |
| Global and local connectedness | Classroom practices that engage students in solving a particular problem of significance and relevance to their worlds—be it a community, school-based or regional problem—provide the greatest opportunity for connectedness to the world beyond the classroom. |
| Supportive social environments | Strategies that promote supportive social environments have high expectations for all students, make explicit what is required for success, and foster high levels of student ownership and motivation. Teachers respond positively to all attempts by students to display their knowledges and skills and explicitly acknowledge behavioural and classroom procedures. |
| Recognition of difference | Strategies that recognise difference do so in ways that actively support individuals in participating, having their individual perspectives and experiences given status, and operating within embedded democratic values. |

Table 2.3. Pedagogical focal points (Queensland Department of Education and the Arts, 2001, n.p.)

This "array of teaching strategies" is an initiative underpinning "Productive Pedagogies" (Queensland Department of Education and the Arts, 2001, n.p.). Those pedagogies can be considered to be "…a common framework under which teachers can choose and develop strategies in relation to:

- what they are teaching
- the variable styles, approaches and backgrounds of their students" (n.p.).

The purpose of productive pedagogies is to assist teachers with focusing instruction and improving students' outcomes. Productive pedagogies are considered to be a way of adapting and adjusting to the rapidly changing educational environment in which the curriculum is being delivered. In total, there are 20 productive pedagogies (Queensland Department of Education and the Arts, 2001) and teachers can use them to:

- consider and understand the backgrounds and preferred learning styles of their students
- identify the repertoires of practice and operational fields to be targeted
- evaluate their own array of teaching strategies and select and apply the appropriate ones. (Queensland Department of Education and the Arts, 2001, n.p.)

However, there appears to be a potential imbalance between this rhetoric and the practical realities of an outcomes-based system within a vast educational bureaucracy. Although the official discourse appears robust and to have considerable depth, there are several criticisms of productive pedagogies that need to be taken into account. Firstly, the concept of productive pedagogies is designed to encourage teachers to discuss the

professional practices in which they are engaged. Although this move appears to promote dialogue, it can also be viewed as a subtle way of subjecting the teachers to potential surveillance in order to assess what they are/are not doing in the classroom – that is, to identify what pedagogies (in relation to the 20 official pedagogies) are/are not being used in the classroom.

Secondly, the approach underpinning productive pedagogies appears to have a 'deficit' foundation considering "The SRLS [School Reform Longitudinal Study] research was used to advocate that teachers were not currently using many of the productive pedagogies" (Hill, 2002, n.p.). In addition, Hill (2002) noted that there did not appear to be any justification for the sets and groupings of the pedagogies. Ultimately, the compartmentalisation of teaching styles into 20 distinct areas can be viewed as being problematic because it potentially excludes 'other' creative and/or original pedagogical approaches that may be successful in assisting the child with accessing the curriculum. Hill (2002) related that one major question from teachers was whether or not any pedagogy not listed was considered to be *not* productive:

> …this inference raised problems for them [the teachers] regarding several pedagogies that they could not see clearly articulated in the model, and that their experience had taught them were productive or useful worthwhile pedagogies. They gave as two examples: time management and safety management. (n.p.)

In addition, one further criticism of outcomes-based education is aligned with the notion of institutional accountability and complements the quotation directly above:

> Some are concerned that while the outcome measures serve external accountability purposes, they distort the teaching and learning process. The emphasis upon the measurable, and upon areas such as literacy, numeracy, science and technology means, according to some teachers, that non-quantifiable learning is downgraded. Others argue that the strict adherence to standards-based outcomes restrict[s] the teacher's autonomy and the exercise of professional judgment… (Vinson, 2001, n.p.)

Thus, the prescribed nature of outcomes means that a student's conformity to the system in which s/he is situated becomes an essential tool for survival within that system. Establishing a standard without knowledge of particular students' 'strengths and talents' (see also Chapter Six) appears contradictory to the curriculum rhetoric positing that that curriculum is learner-centred. Thus, the instruments of assessment are focused upon the student and the student appears to take the responsibility for her/his failure to access the curriculum. A further danger implicit in assessing an individual based upon pre-determined outcomes is that the teaching could effectively be 'funnelled' toward the outcomes, thereby limiting the opportunity for 'external' contributions of contextual occurrences that may contribute to the delivery and reception of the curriculum.

I have highlighted in the previous sub-section some of the implicit issues associated with the Queensland curriculum framework in which children as *learners* are situated and in which pedagogy has been constructed by policy. It can be argued that the current general system leaves those children to take responsibility for their own failure to access the curriculum. This situation – combined with definitions of learning difficulty and learning disabilities that utilise the medical model as their foundation – is a dangerous combination

that can potentially prove troublesome for a child who is struggling to access what appears to be a 'one-size-fits-all' curriculum (Murray, Shea & Shea, 2004). That approach is already criticised as being representative of the western educational system (Kincheloe, 1993) and for further complicating the education of students with special educational needs: "The idea that the student must be changed to fit the system, instead of the system being changed to fit the student, is a perfect example of the one-size-fits-all philosophy…" (Detterman & Thompson, 1997, p. 1088).

In this sub-section I have identified some of the issues associated with Education Queensland's implementation of the 'Productive Pedagogies' plan. In the following sub-section, I address the notion of assessment in order to show some of the ways in which a student's (in)ability to access the curriculum is measured.

*Assessment*

In this sub-section, I present the modalities of assessment used by Education Queensland as well as its justification for using those forms of assessment. Within Education Queensland, assessment is considered to be "the purposeful, systematic and ongoing collection of information as evidence for use in making judgments about student learning" (Queensland Department of Education and the Arts, 2001, n.p.). Education Queensland (Queensland Department of Education and the Arts, 2001) posits that the purposes of assessment are to "…promote, assist and improve student learning; inform programs of teaching and learning; and provide data that can be communicated to a range of people about the progress and

achievements of individual students or groups of students" (n.p.). Thus, assessment becomes an institutional tool for monitoring the progress of the students within the system who are attempting to access the curriculum.

When examined against the backdrop of an outcomes-based educational approach, the assessment process involves giving students opportunities to demonstrate their attainment of the established core learning outcomes (Queensland Department of Education and the Arts, 2001, n.p.); provides the school with the necessary 'evidence' regarding the student's attainment of those core learning outcomes (n.p.); and allows "overall judgements about students' demonstrations of core learning outcomes" (n.p.) to be made using the above-mentioned evidence as a basis for those decisions. Techniques for gathering evidence for assessment come in a variety of forms, including "observation, consultation and focused analysis of student demonstrations of learning outcomes" (n.p.). In addition, "Assessment instruments include, but are not restricted to, assignments, oral work, demonstrations, practical work and tests" (n.p.).

Education Queensland (2001) describes three forms of assessment: formative, diagnostic and summative. Formative assessment can be either formal (e.g., testing) or informal (e.g., classroom questioning) and is "primarily intended for, and instrumental in, helping a student attain a higher level of performance" (Queensland Department of Education and the Arts, 2001, n.p.). Diagnostic assessment is one type of formative assessment and it is used "…for determining the nature of a student's

learning problems and then providing the appropriate feedback or intervention (or, alternatively, determining the nature of a student's success and then providing the appropriate extension activities)" (n.p.).

Although diagnostic assessment is meant to identify "the nature of a student's learning problems", it should be noted that the results from a diagnostic assessment are not accounted for in summative assessment. In other words, a student who has performed poorly on a diagnostic assessment will not have her/his report grades affected or impacted upon. Summative assessment is designed "to indicate the achievement status or level of performance attained by a student at the end of a course of study. It is geared towards reporting or certificate" (Queensland Department of Education and the Arts, 2001, n.p.).

Assessment is therefore the crucial element in determining whether or not students are accessing the curriculum. The curriculum is delivered through a variety of teaching methods or pedagogies and the fact that that curriculum is outcomes-based means that there will be a measurable demonstration of the student's attainment of those outcomes. However, since that measurement process is designed to gauge attainment of the curriculum, the assumption is that all students are attaining the same information at the same rate. This is one crucial corollary of a standardised curriculum that establishes what knowledge is most important within a particular educational system. The implication of this assumption is that all students are being taught in the same way, or that all teachers are delivering the

curriculum in the most efficient and 'productive' manner possible. Therefore learning difficulties are going to be viewed as an inherent individual deficit because the very nature of the curriculum functions in a top–down mode that assesses the child before – if ever – assessing the system.

Although assessment plays a variety of roles within the Education Queensland system (for example, accountability and measurement of progress in relation to *QSE – 2010*), caution should be taken when establishing pre-determined measurements of an individual and apparently neglecting to acknowledge that individual's capabilities as well as failing to account for the individual as a dynamic person. In addition, this caution should be applied particularly when identifying students as experiencing learning difficulties.

Bourdieu and Passerson (1977) argued that assessment is a mechanism of intellectual and socio-cultural segmentation and stratification. That is, although educational assessment can be used to create possibilities for positive change within a specific context, it can also be an agent of educational power and domination. A system that assesses in/ability effectively promotes educational stratification in that it creates classifications of learners that can be subjected to stigmatisation. One such 'group' of learners who are disadvantaged by the assessment process are students identified as experiencing learning difficulties; their label

highlights their inability to access the curriculum and systematically renders them a 'docile body' that is subject to marginalisation.

Within the Education Queensland schooling system, upon completion of assessment, the fourth and final element is 'reporting'. In the following sub-section, I outline the nature of reporting and analyse its contribution to that system's bureaucratisation and standardisation of the identification of students experiencing learning difficulties.

*Reporting*

Reporting is the communication of the assessment results of a child; it "…is the communication of information on the results of assessment of student achievement to a variety of audiences in a variety of styles for a variety of purposes" (Queensland Department of Education and the Arts, 2001, n.p.).

The act of reporting is meant to record and disseminate information about a particular student's achievements. As noted above, there is a wide "variety" of uses for reporting. However, I do not intend to pursue these possible uses here. Suffice to say that I consider learning difficulties to be a socio-cultural and historical construction and therefore reporting on the success or failure of a particular child plays a crucial part in perpetuating the belief that learning difficulties are an inherent deficit. Because the curriculum is outcomes-based and because each child needs to be assessed for her/his particular educational strengths and weaknesses, the 'recording' of information plays an important part in the delivery and maintenance of that

curriculum. The Educational Queensland rhetorical discourse calls for a recording system that "…is adaptable, easily managed, efficient in terms of school data collection, and capable of providing easy access to individual or group data on student demonstration of core learning outcomes in any KLA in any period" (Queensland Department of Education and the Arts, 2001, n.p.). In addition, Education Queensland notes that potential uses for the records collected and kept could be for "school-parent reporting, reporting on mobile students, systemic reporting, and research" (2001, n.p.).

Thus, each particular school is responsible for developing and implementing this centralised reporting system. This means that a school-based management system is not only responsible for the enactment of the curriculum, but also for identifying children who are experiencing difficulties in accessing that curriculum. One potential risk of this approach is that it is assumed that the curriculum is being delivered efficiently and effectively by the particular school.

With regard to the specific kinds of information that reporting conveys, it should be noted that there are policy requirements for formalised reporting to parents and/or caregivers. As a result, reporting has five criteria that schools must follow:

- Reporting must occur at least once per semester;
- Reporting must communicate information on the student's achievements against the set of outcomes planned for that reporting period;

- Reporting must, for students with disabilities working on Individual Education Plans, communicate information on the student's achievement of goals planned for that reporting period;
- Reporting must also provide qualitative data on the academic and social skills acquired by the student during that reporting period;
- Reporting must indicate if there is insufficient evidence for an assessment to be made. (Queensland Department of Education and the Arts, 2001, n.p.)

The process of reporting has several functions. Notably, it encourages accountability from the school and informs particular stakeholders of how well a child is accessing the curriculum. However, reporting can also serve as an apparatus of surveillance in that it can check to see that the institution and the individuals within it are engaging with their given tasks. In addition to the requirements of schools with regard to the reporting listed above, there are other types of assessment from which stakeholders will receive results and/or information. These are named "additional reports" (Queensland Department of Education and the Arts, 2001, n.p.) and are considered to be items including, but not restricted to, "reports for students in Years 2, 3, 5 and 7 who receive separate reports on their basic skills in aspects of literacy and numeracy" (n.p.).

This section of the literature review discussed the four elements of Education Queensland's *Curriculum Framework for Education Queensland School Years 1-10* (Queensland Department of Education and the Arts, 2001). Those four elements – curriculum, pedagogy, assessment and reporting – have served as the sub-sections within this section as I located

that ‘framework’ within the broader backdrop of *Queensland–2010*. The curriculum framework provides a step-by-step process for an outcomes-based curriculum and its pedagogical delivery as well as a way to assess and report the success of that delivery by the teachers and its receipt by the students.

In addition, this section presented the context in which the participants in this study were situated. In relation to that context, the four elements analysed above function together to create an apparatus of power that can effectively shape and mould any individual who enters the system. A unified curriculum framework is similar to a lens through which children are assessed, analysed, manipulated and remedied. Thus, a bureaucratic apparatus such as the schooling framework outlined in this section can readily be enlisted by the medical model to dominate the child identified as experiencing learning difficulties and render her/him docile. In the following section, I present the history and foundation of contemporary Queensland understandings of learning difficulties.

**The ‘difficulty’ in defining ‘learning difficulties’**

One of the most challenging aspects of reviewing literature regarding children who are identified as experiencing difficulty with learning is navigating through the plethora of terminology that is used to describe those children and the multiplicity of ways in which individuals use that terminology internationally, nationally and in Queensland. In addition, the terms ‘learning difficulties’ and ‘learning disabilities’ have been, as

Christensen (2000) noted, used interchangeably by a majority of researchers within the field in Australia; this makes discussing my research topic problematic from the outset and further justifies the need to explore how adult stakeholders construct the term 'learning difficulties'.

In order to examine and discuss the literature relevant to this particular study of adult stakeholders' constructions of learning difficulties, I have separated this section into three sub-sections. The first sub-section presents a historical overview of learning disabilities; the second deals with the Australian 'learning difficulty'; context and the third interrogates the 'learning difficulty' and the 'learning disability' context in Queensland.

Scott (2004) noted that "[m]uch of the research on learning disabilities has been completed in the United States, so it is necessary to understand the American context" (p. 2). In addition, Elkins (2002) highlighted that the learning disabilities movement in the United States was quite influential in Australia: 'learning disabilities' is the common term internationally for what is often referred to in the Australian national context as 'learning difficulties' (n.p.). Therefore my intention is to provide a broad overview of the field, including constructions of learning disabilities in the United States, and gradually narrow the literature down to the specific Queensland context in which the study took place. In the following sub-section, I present the 'learning disabilities' historical context in order to establish part of the foundation of contemporary learning difficulties research.

*A historical overview of learning disabilities*

In order to establish a general history of learning difficulties, I traced the concept's ancestral footprints – by way of learning disabilities – from the literature beginning in the 1800s until, by narrowing my search to address the Education Queensland context specifically, I concluded with literature from the year 2005. My justification for beginning with the learning disabilities literature derives from Hallahan and Mercer's (2001) contention that the roots of learning disabilities extend back to at least the 1800s – in other words, long before the term 'learning difficulties' with which 'learning disabilities' is often associated and/or contrasted entered academic discourse. In addition, prominent researchers in the field of learning difficulties in Australia (Christensen, 2000; Elkins, 2002; Scott, 2004) often engage with the United States context when discussing the concept of learning difficulties in Australia. I have chosen to follow in their footsteps.

As a method for structuring the presentation of the information in this sub-section, I have adopted Hallahan and Mock's (2003, pp. 17-27) chronological summary of the history of learning disabilities into five time periods: European Foundation Period (*circa* 1800 to 1920); United States Foundation Period (*circa* 1920 to 1960); Emergent Period (*circa* 1960 to 1975); Solidification Period (*circa* 1975 to 1985), and Turbulent Period (*circa* 1985 to present). Each of these 'periods' produced a vast amount of research that has contributed to contemporary understandings of the phenomenon known as learning difficulties. I introduce these periods below and discuss relevant research from each specific time period.

European Foundation Period *(circa 1800-1920)*

This period relied little upon 19th century technology, yet it is responsible for some of the most important seminal works in the field of learning disabilities (Hallahan & Mock, 2003, p. 17):

> During this period, some European physicians and researchers explored the relationship between brain injury and behaviors, primarily disorders of spoken language. Later, in the second half of this period, this research gave way to investigations concerning presumed brain abnormalities and disorders of reading. (p. 17)

There were several prominent advances during this time regarding the localisation of brain function and the link between brain injuries and mental impairment (Gall & Spurzheim, 1809). Broca (1861) identified specific areas of the brain responsible for particular speech functions, while Wernicke (1874) coined the term "sensory aphasia"; Kussmal (1877) described an inability to read in terms of "word blindness" and Berlin (1884) coined the term "dyslexia" to focus upon the neurological basis of "word blindness" (Hallahan & Mock, 2003, p. 18). However, Hinshelwood's (1917) publication of *Congenital Word-Blindness* re-ignited the debate regarding terminology and identified a specific area of the brain as being responsible for a reading disability (p. 18).

United States Foundation Period *(circa* 1920-1960)

Focus during this period was upon literacy, given that schooling was compulsory for all children (Hallahan & Mock, 2003), and that literacy was flagged as being an essential component of schooling. Although there are notable researchers (Fernald & Keller, 1921; Goldstein, 1936, 1939; Kirk, 1935, 1936; Monroe, 1932; Orton, 1937; Werner & Strauss, 1940, 1941) in this period who influenced greatly the development and understanding of learning disabilities, many "…moved beyond observing and explaining abnormal behavior. Instead, many found themselves working with children in educational settings where remediation, not etiology, became the focus" (p. 18).

The researchers noted above not only expanded upon the work done by "their European predecessors" (Hallahan & Mock, 2003, p. 18), but also "developed diagnostic categories, assessment tools, and remedial interventions that would influence future practice" (p. 18). A majority of this work focused specifically upon reading disabilities and it was during this period that the International Dyslexia Society was founded.

Emergent Period *(circa* 1960-1975)

The development of categories, assessment tools and interventions indicated above provided the necessary framework with which to work towards "identifying and educating students with learning disabilities" (Hallahan & Mock, 2003, p. 21). However, the term 'learning disabilities' did not exist yet, even though "[t]hey [the researchers] had sufficient knowledge to claim

existence of a specific construct….[T]he time was ripe for the emergence of LD into the public domain" (p. 21).

The 'emergent period' represents the transformation of a general belief system about the causes of an individual's inability to perform tasks (e.g., reading) into an abstract truth. It was during this time that parents and teachers

> …became acquainted with the notion of LD and founded organizations to advocate for children with this disability, federal officials began to take notice of the rising tide of public concern for students with this disability, and researchers created interventions that would later set standards for practice….[T]his period is characterized by the efforts of numerous individuals and groups to put forward comprehensive definitions and educational programming. (Hallahan & Mock, 2003, p. 21)

It was during the 'emergent period' that Kirk (1962) developed the term "learning disability" (p. 263). An individual's inability to learn now had a name and the term 'learning disabilities' had significant implications in social, cultural and political arenas; the culmination of hundreds of years of research united to form a way of thinking and knowing about children's inabilities to learn that remains potent in contemporary society. Moreover, significant effort was put into developing a working definition of learning disabilities. As a result, *The First Annual Report of the National Advisory Committee of Handicapped Children* was published in 1968 (Hallahan & Mock, 2003, p. 23) using a definition of learning disabilities similar to that of Kirk (1962):

> Children with special (specific) LD exhibit a disorder in one or more of the basic psychological processes involved in understanding or in using spoken and written language.

> These may be manifested in disorders of listening, thinking, talking, reading, writing, spelling, or arithmetic. They include conditions which have been referred to as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, developmental aphasia, etc. They do not include learning problems that are due primarily to visual, hearing or motor handicaps, to mental retardation, emotional disturbance, or to environmental disadvantage. (United States Office of Education, 1968, p. 34)

It should be noted that the committee named above was chaired by Kirk and that the intention of the definition was to "set policy and secure funding" (Hallahan & Mock, 2003, p. 23).

Solidification Period *(circa* 1975-1985)

Solidifying "both the definition and federal regulations for identifying students with LDs" was the characteristic of this period (Hallahan & Mock, 2003, p. 24). As well, 1975 witnessed the introduction into United States law of the provision of "free and appropriate education to all of their students, including students with LD" (p. 24).

It was during this period that definitions of learning disability were re-visited and revised in lieu of progress in the field. Two bodies that articulated their respective definitions were the United States Office of Education (1977) and the National Joint Committee on Learning Disability (Hammill, Leigh, McNutt & Larsen, 1981, p. 336; cited in Hallahan & Mock, 2003, p. 25). The major difference between their definitions was that the latter excluded intentionally a psychological clause (p. 25). Thus, disability discourses were being created and re-created in different arenas. That made agreement on the term's meaning problematic.

Turbulent Period *(circa* 1985-present)

Although numerous definitions of learning disability were put forth by different agencies during this period, there is an implicit irony in the fact that the most commonly quoted definition in United States research (Scott, 2004) was predicated upon that proposed by Kirk in 1962 (Hallahan & Mock, 2003).

The inability to decide upon a common definition of learning disabilities, the exponential growth of learning disabilities 'cases' and confusion between attempting to gauge either ability or achievement as a means of identifying students as experiencing learning disabilities (Hallahan & Mock, 2003) created 'turbulence' during this period. In addition, there was a "disproportionate representation of some ethnic groups in the LD category" (p. 26). The formation of both modernist and postmodernist debates regarding the social construction of disability as "incorrect [and] immoral assumptions regarding difference" (p. 26) *vis-à-vis* a "medical model that places the locus of disability within the individual" (p. 27) ensured that the 'turbulence' is far from over.

The foregoing historical overview is by no means comprehensive. Further investigation is necessary, especially considering Read's (1997) reminder that "History shows that the concept of learning disability is not rigid, fixed or immutable, but is an evolving process, an interaction and an amalgam of numerous influences" (p. 60). This point not only highlights the elusive

nature of specific definitions of learning disabilities/difficulties, but also coalesces with the underlying theme of this thesis: there are random contextual factors colliding within a particular social arena to produce a typology known as the 'student with learning difficulties'. Thus, this historical overview of the development of disability discourses effectively leads us towards understanding the origin of contemporary Australian conceptualisations of learning difficulties.

*Australia: learning disabilities*

In the following sub-section, I focus upon the Commonwealth Disability Discrimination Act (CDDA) (Commonwealth of Australia, 1992) in order to operationalise the term 'disability'. I note that Education Queensland (Queensland Department of Education and the Arts, 2002b) considers itself to comply with the standards set forth in the CDDA. Thus, it is considered that a disability

> …in relation to a person, means: (a) total or partial loss of the person's bodily or mental functions; or (b) total or partial loss of a part of the body; or (c) the presence in the body of organisms causing disease or illness; or (d) the presence in the body of organisms capable of causing disease or illness; or (e) the malfunction, malformation or disfigurement of a part of the person's body; or (f) *a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction*; or (g) a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour; and includes a disability that: (h) presently exists; or (i) previously existed but no longer exists; or (j) may exist in the future; or (k) is imputed to a person. (Commonwealth of Australia, 1992, n.p.; emphasis added)

I draw particular attention to '(f)' above because it is the part of the Act with which Education Queensland complies. Thus, the official government rhetoric has classified an individual who learns 'differently' as having a disability. The implication of this assertion is that the person who is experiencing the disability is seen to have a "disorder or malfunction" (Commonwealth of Australia, 1992, n.p.) that is causing her/him to learn differently. The disability has effectively been located within the individual who learns differently.

The CDDA (Commonwealth of Australia, 1992) further identifies the regulations that apply to an individual who is considered to have a (learning) disability.

> (1) It is unlawful for an educational authority to discriminate against a person on the ground of the person's disability or a disability of any of the other person's associates: (a) by refusing or failing to accept the person's application for admission as a student; or (b) in the terms or conditions on which it is prepared to admit the person as a student.
>
> (2) It is unlawful for an educational authority to discriminate against a student on the ground of the student's disability or a disability of any of the student's associates: (a) by denying the student access, or limiting the student's access, to any benefit provided by the educational authority; or (b) by expelling the student; or (c) by subjecting the student to any other detriment.
>
> (2A) It is unlawful for an education provider to discriminate against a person on the ground of the person's disability or a disability of any of the person's associates: (a) by developing curricula or training courses having a content that will either exclude the person from participation, or subject the person to any other detriment; or (b) by accrediting curricula or training courses having such a content. (Commonwealth of Australia, 1992, n.p.)

Thus, discrimination against a person with a disability is unlawful in Australia and must be avoided as such. Although 'disability' has been defined, 'difficulty' has not. In 2004, Scott noted that "…there is no operational definition of learning difficulty nationally in Australia" (p. 2). Therefore students with learning disabilities are accounted for by the school, but it would appear to be not so for children identified as experiencing learning difficulties.

*Queensland: learning difficulties and learning disabilities*

As a result of the inconsistencies in learning difficulty definition in Australia, Cunningham and Firth (2005) recommended: "That there be a nationally agreed definition of learning difficulties so that the phenomenon of learning difficulties can be effectively included in Australian discourse on educational policy and practice" (p. 2).

Whilst this suggestion appears to be logical and, if adopted, might simplify the current differentiated national system and perhaps in the process increase the opportunities for states to revisit their respective policies, Louden *et al.* (2000) described the difficulty associated with establishing formal definitions of learning disabilities and presented a timely reminder that changing the current system is problematic:

> Issues of definition and treatment approaches have been the most contentious topics in the field of learning disabilities (LD) for several decades. Further, a variety of terms have been used in the literature to refer to a similar group of children who experience problems in academic learning and achieve poorly in school. The confusion can be attributed to the lack of consensus in the concept itself and in the explanations of the causes of the problems in learning. The confusion is exacerbated by the fact that professionals from a

> variety of disciplines—general educators, special educators, physical educators, neurologists, ophthalmologists, optometrists, paediatricians, physical therapists, psychologists, sociologists, and a host of others—have all taken an interest in the area. Each has brought with them a different background and hence a different theoretical perspective to the topic. (p. 179)

This "different background" and different "theoretical perspective" have proved to be challenging because of the lack of consensus among designated professionals. Representatives of each of those professions can be seen to be creating and re-creating the child as they draw upon specific, conflicting and competing discourses in order to establish their respective viewpoints. As those viewpoints meet at that child as a site of power and a pliable body, the child's identity is effectively created and re-created as well. Thus, whenever an individual identifies what learning difficulties – keeping in mind that learning disabilities are assumed in Queensland to be a subgroup of learning difficulties – *are*, they are effectively creating the child as well as positioning the child and themselves.

Moreover, the reference to the different 'professionals' signifies the western education characteristic of compartmentalising knowledge. The segregation of knowledge into 'specialised units' represents a reductionist view of the world. Thus, the very 'roles' that those professionals fulfil in relation to exploring learning difficulties are simultaneously maintaining the 'learning difficulty as child deficit' typology. However, that typology is arbitrary and it is worth questioning how such a phenomenon can continue to exist without a unified notion of what exactly a learning difficulty or learning

disability is. This leads to the institutionalisation of learning difficulties and learning disabilities as 'abstract truths' being questionable.

Furthermore, the implication of a lack of a common definition of learning difficulties and learning disabilities nationally is that individual states and territories are isolated from one another in the broader national context. This could have serious implications for research regarding the learning difficulties and learning disabilities phenomena as well as for the education systems that work to define, identify and remediate them.

In his review of the history of learning difficulties in the Australian context, Elkins (2002) noted the following:

> Australian state and territory education systems do not generally distinguish between learning difficulty and learning disability, using the former term to concern all students with high incidence educational problems. However, in Queensland the distinction is recognised, with a process known as appraisement being used to establish that a student meets the criteria set down. Increasingly, the term learning disabilities is reserved for those who have not responded to remedial intervention. (n.p.)

This introduces the ways in which Education Queensland is able to address matters of learning difficulties through assessment processes.

The "Frequently Asked Questions" (FAQ) section regarding learning difficulties (Queensland Department of Education and the Arts, 2004b) discusses how the techniques used to assess students with learning difficulties require specific information about how those students develop academically as well as about any obstructions preventing them from

accessing the curriculum. The FAQ section specifically highlights the fact that assessment techniques are required to:

> …reveal relevant and useful information about students' needs and competencies in relation to the learning of literacy, numeracy and learning how to learn; provide sufficient relevant information to inform the planning of support, that is, to enable the class teacher and support teacher: learning difficulties [ST:LD] to collaboratively develop effective support plans based on class programs. (Queensland Department of Education and the Arts, 2002a, n.p.)

When gathering 'evidence' regarding a student's perceived learning difficulty, the class teachers may also consult data collected from systemic assessments including the Year 2 Diagnostic Net Validation Tasks in Literacy and Numeracy, literacy and numeracy developmental continua and Years 3, 5 and 7 literacy and numeracy tests (Queensland Department of Education and the Arts, 2002a, n.p.).

In the Queensland regional primary school in which this study was located, if the students are not identified either by the classroom teacher or by any of the aforementioned assessment items, then no action is taken. One exception to this process is if a parent or guardian brings a child to an external facility for assessment and a certified professional – such as a doctor or a psychiatrist – validates the child's condition.

Education Queensland's specific policy regarding learning difficulties acknowledges not only the Commonwealth Disability Discrimination Act (Commonwealth of Australia, 1992), but also four State-mandated legislative procedures: the Education (General Provisions) Act of 1989; the

Anti-Discrimination Act of 1991; the Freedom of Information Act of 1992; and the Judicial Review Act of 1991 (Queensland Department of Education and the Arts, 2002b, n.p.).

The importance of highlighting such legislative 'weight' of the concept of learning difficulties in the edu-political arena is that that weight exemplifies the strong, rhetorical presence of the term in the Queensland educational context and shows how that particular context impacts upon the construction of learning difficulties as a label within the broader educational system. Furthermore, an awareness of the numerous governing policies associated with learning difficulties in Queensland is just as crucial to this study as is the actual history of the terminology.

The governing policies are relevant because the perpetuation of learning difficulties as an individual deficit is a direct result of the institutional discourses driving the identification and treatment, by schools and parents, of students identified as experiencing such difficulties. Thus, if the notion of learning difficulties exists as 'truth' within the structure of the educational institution, then the actors within that institution are in a position where they – as a result of following required protocols regarding learning difficulty identification – contribute to the dominant discourses of the medical model responsible for establishing the child as possessing an intrinsic deficit.

At the time of writing this thesis, Education Queensland was instituting major changes to the assessment and management of learning disabilities and difficulties. While the appraisement process used to identify students experiencing learning difficulties remains intact, the ascertainment process to identify students experiencing learning disabilities is being replaced with the Educational Adjustment Program (EAP). This is a result of a recommendation of the Ministerial Taskforce on Inclusive Education: Students with Disabilities (2004). The EAP has a three-year implementation timeline beginning in 2005 (Queensland Department of Education and the Arts, 2005). This policy confirms a difference between children identified as experiencing learning difficulties and children identified as experiencing learning disabilities as follows:

> 1.1 Learning difficulties and learning disabilities refer to barriers which limit some students' access to, participation in and outcomes from the curriculum.
>
> 1.2 Students with learning difficulties are those whose access to the curriculum is limited because of short-term or persistent problems in one or more of the areas of literacy, numeracy and learning how to learn.
>
> 1.3 Students with learning disabilities are one small group of students with learning difficulties who because of the neurological basis of their difficulties, have persistent long-term problems and high support needs in one or more of the areas of literacy, numeracy and learning how to learn. These students do not have generalised intellectual impairments but rather demonstrate idiosyncratic learning styles which are determined by the nature of their specific disorders and inhibit their learning at school. (Queensland Department of Education and the Arts, 2002b, n.p.)

Scott (2004) has criticised the definition of learning difficulty as being a term "so broad it is virtually rendered meaningless as a label for a category of children" (p. 4). Similarly, there is an immense amount of artificiality

and irrationality in a definition where learning disability is positioned as a subset of learning difficulty at one end of the continuum, whereas other jurisdictions use the terms interchangeably.

As the system currently operates in Queensland, it is the responsibility of the classroom teacher to refer a child to the learning support unit for appraisement in the event that s/he suspects that that child might be experiencing learning difficulties:

> When a class teacher suspects a student in their class has learning difficulties they gather sufficient information to refer the student to the principal and to the structure within the school which is responsible for the management of support for students with special needs. (Queensland Department of Education and the Arts, 2002a, n.p.)

In this way, the onus is upon the teacher to be aware of, and to engage with, the 'formal' procedure (for example, filling out the required paperwork in the form of a 'referral form') for identifying a student as experiencing difficulty in accessing the curriculum. However, therein lies the problem. Reschly (cited in Fuchs, Fuchs & Speece, 2002) described learning disabilities as a 'soft' disability with no distinguishable physical markers. Therefore the identification of children who may be experiencing difficulties in accessing the curriculum is a subjective process (Fuchs, Fuchs & Speece, 2002). Considering that learning disabilities are often flagged by an unanticipated failure to learn, "the discrepancy between intelligence and achievement is the central organizing theme of most definitions of learning disabilities" (2002, n.p.). If the subjectivity of the teacher is combined with potential unfamiliarity with the formal identification and referral

procedures, then it is likely that there will be discrepancies from teacher to teacher as to what exactly constitutes a learning difficulty.

This point will be demonstrated in Chapter Five: two first-year teachers who participated in this research study presented varying degrees of knowledge about, and understanding of, the concept of learning difficulties, as well as the process for identifying students as experiencing them. Furthermore, the teachers' personal narratives presented elements of the medical model, thereby demonstrating that their professional positions and the institutional rhetoric with which they were familiar coalesced to make learning difficulties 'real'.

Situations such as those above have led researchers such as McDermott (1993) to contend that "there is no such thing as LD [learning disability], only a social practice of displaying, noticing, documenting, remediating and explaining it" (p. 272). Thus, the institutional 'safeguards' actually provide a "formal mechanism" (Christensen, 2000, p. 239) for 'creating' a learning difficulty: "They establish procedures by which school failure is seen to reflect the qualities of the child rather than political processes where children are sorted, classified, and placed according to culturally determined, institutionalized procedures" (p. 239).

Education Queensland notes specifically that "[l]earning difficulties and learning disabilities refer to barriers which limit some students' access to, participation in and outcomes from the curriculum" (Queensland

Department of Education, 2002b, n.p.). In this thesis, I frequently use the phrase 'access the curriculum' in order to allude to this quotation, rather than using the entire phrase each time.

To reiterate, Queensland has established a formal definition of learning difficulties which distinguish them from learning disabilities. With the distinction being recognised and written into official policy (CS-13: Educational Provision for Students with Learning Difficulties and Learning Disabilities), one can begin to view one avenue through which an abstract notion (learning difficulties) becomes a 'truth' (that is, 'real'). This occurs through the agency of research and policy. For example, policy would not have a method of travel if the individuals working in Education Queensland did not enact it. Moreover, the lines between an objective and equitable policy become blurred when we realise that the vehicle through which the policy travels is the individual – the only organic aspect of the puzzle and consequently a vehicle that is driven by the forces of a social network set against a political backdrop. For a student to be identified as having a learning difficulty in Queensland, that student's classroom teacher must initiate a formal process known as appraisement.

Appraisement is "…school-based and provides a process for schools to use to identify the educational needs of students defined by the Education Queensland policy, Educational Provisions for Students with Learning Difficulties and Learning Disabilities – (CS-13)" (Queensland Department of Education and the Arts, 2002a, n.p.). Upon the initiation of the

appraisement process, a Support Teacher: Learning Difficulty (ST:LD) proceeds to use a variety of assessment techniques in order to determine the nature of the problem and what, if any, further action is necessary. Such action may include "the recommendation of a Program Type which determines the level of modifications required to the strategies, resources and classroom environment", and the collaborative development by the ST:LD and the classroom teacher of a Support Plan" (Queensland Department of Education and the Arts, 2002a, n.p.).

Because "learning difficulties" is the "umbrella term" (Scott, 2004, p. 4) which includes learning disabilities as a "…subgroup within the group of students with learning difficulties" (p. 4), this means theoretically that "…all students are eligible for appraisement and subsequent educational funding" (p. 5). In terms of institutional attempts to remediate learning difficulties, this is a positive step. However, Scott (2004) highlights the economic *impasse* facing schools regarding funding to support remediation when she writes: "Appraisement…is not directly linked to funding of individual students and so whilst school personnel acknowledge that/ a child requires additional support, this must be provided within the general staffing structure of schools" (p. 5). The appraisement process includes the gathering of information regarding the "student's literacy knowledge, processes, skills and attitudes" through:

- Observation of their attempts at reading, writing and learning in relation to spoken, written and visual texts; observation of their attempts at completing numeracy tasks in relation to e.g. number, space measurement;

- Consultation with them as they read, write, engage in numeracy tasks and learn, analysis of their responses and/or recording of related comments;
- Focused analysis of work samples such as records of oral reading, writing samples, spelling samples, numeracy samples, etc;
- Peer and self-assessment where students keep learning logs, complete personal checklists, comment critically on their own learning, etc. (Queensland Department of Education and the Arts, 2002a, n.p.)

As long as there are methods and programs in place (such as Appraisement) for the treatment of children 'with' learning difficulties, then there will always be a professional obligation for the schools to utilise those methods and programs. Thus, the label 'learning difficulties' can be considered to herald a 'self-fulfilling prophecy' in that they are perpetuated within an institutional setting and re-enforced continually by academic discourses contributing to their realization as a truth.

In this section, I have presented a historical overview of the development of notions of learning difficulties and learning disabilities, as well as how those notions are constructed in Australia. In addition, I have established the nature of the constructions of learning difficulties in the Education Queensland context in which this study took place. In doing so, I have set the platform for the following section where I discuss the development of a way of thinking and knowing about the world – and the individual within it – that I consider to be reductionist in nature.

**The evolution of the medical model in constructing learning difficulties**

Thus far in this chapter, I have presented the historical and educational context in which this study took place. I established the development of learning difficulties as an institutionalised abstract truth and demonstrated how learning difficulties discourses have saturated the rhetoric of the Queensland educational system, thus maintaining that typology institutionally. In this third and final section of the chapter, I identify what exactly the medical model is, as well as present a historical overview of specific ways of thinking and knowing that have impacted greatly upon our understanding of the world through the lens of that model. In addition, I present some specific criticisms of the medical model from 20th and early 21st centuries perspectives.

The inclusion of reference to the medical model of learning difficulties in this literature is essential because that model represents a dominant way of thinking and knowing about learning difficulties that often suffocates 'other' explanatory models such as those described below and in Chapter Six. Fundamentally, the medical model is the 'default' explanatory mode for an individual's inability to access the curriculum; it is embedded in the Education Queensland schooling system as demonstrated above. The power and prevalence of the medical model, and its contrast with 'other' explanatory models for a child's inability to access the curriculum, are important in this research because they establish parameters within which to discuss and analyse the study's interviewees' positions whilst simultaneously allowing me to address my two research questions.

The "Western biomedical model" (Freund, McGuire & Podhurst, 2003, p. 6), also known in the literature as the 'biomedical model' (Kirby, 2004; Miley, 1999) and the 'medical model' (Kauffman & Hallahan, 1974; Pfeiffer, 2000; Strauss, 2003), refers to a particular way of thinking and knowing about the individual that effectively renders that individual docile. In this study, I use the term 'the medical model' and present it in this section as contributing to the explanation of a child's inability to learn in the area(s) of literacy, numeracy and learning how to learn (Queensland Department of Education and the Arts, 2002b, n.p.) and also as a deficit inherent in the individual.

At the same time, although the medical model is established in this chapter and Chapter Five as the dominant way of viewing students with learning difficulties, there are also 'other' explanatory models providing subject positions that were occupied by participants in the current study. They are presented in this chapter, as well as in Chapter Six. However, I note here that the alternatives to the medical model below, and gleaned from the current literature, generally differ from the 'other' explanatory frameworks that I outline in Chapter Six. The latter were derived directly, as resistance discourses, from the words of the adult stakeholders as they constructed the concept of learning difficulties.

*An overview of the medical model as applied to learning difficulties*

According to Miley (1999), a foundation of the medical model is the belief that there are biomechanical and neuro-physiological reasons for a particular disorder. That is, a disease or illness is seen as a fault within the physical body that requires medical treatment in order to return that body to 'normal' biological or physiological functioning. Early medical model discourses were reportedly perpetuated by the Catholic Church, which consigned the mind of an individual to a spiritual area that was inexplicable by physical means (Miley, 1999). This being the case, the psychosocial factors influencing the individual were disregarded whilst the physical symptoms were focused upon, thereby creating a 'dualism' that separated the mind and the body.

The contemporary concept of the medical model is considered to be

> …the culmination of philosophical developments in Europe over the past 500 years that have transformed metaphysical medicine into scientific medicine. The philosophical changes were a materialisation of life (empiricism), the marginalisation of spiritual and other considerations in health (secularism) and physical reductionism (i.e., understanding by breaking up into components). (Kasule, 2002, n.p.)

As such, this concept provides an effective metaphor for describing a dominant and reductionist way of thinking and knowing about the world. As a mechanism of power, the medical model contributes to the systematic domination of individuals through the use of five key components. This is done by the reduction of the individual into isolated 'parts' that can be studied, analysed and objectified. Below I draw on Freund, McGuire and Podhurst (2003) to outline those five key components associated with the

medical model in order to elaborate what exactly the term 'medical model' represents in this thesis.

Freund, McGuire and Podhurst (2003) note that "…the present system of medical knowledge is based upon a number of assumptions about the body, disease, and ways of knowing" (p. 220). Those assumptions are outlined in Table 2.4 following.

The five components of the assumed medical model outlined in Table 2.4 isolate 'illness' as being within the individual. Despite this, the individual's experiences with illness are diverse and contextualised. Therefore focusing specifically upon the individual as the sole site of illness excludes other explanatory factors that may contribute fundamentally to understanding the ill person's situation.

In attempting to link the medical model and learning difficulties, Christensen (2000) established that conventional models of learning disability (from which contemporary learning difficulty discourses emerged) were based upon the medical model. She asserted that in the medical model the symptoms of a disease signal an underlying pathology. The pathology needs to be identified by an accurate diagnosis and that diagnosis will indicate appropriate treatment. The treatment, in turn, will destroy the pathology and effect a cure (p. 229). Thus, when examining the concept of learning disabilities through the lens of the medical model, it becomes apparent that:

| | |
|---|---|
| **Mind-Body Dualism** (also referred to as the 'Cartesian dualism' [Mohr, 2003], which was named after René Descartes) | "The medical model assumes a clear dichotomy between the mind and the body…" (Freund, McGuire & Podhurst, 2003, p. 220). The result of this assumption is what Foucault (1977) considered to be the objectification of the body, thus rendering it 'docile': "A body that is docile may be subjected, used, transformed and improved" (p. 136). |
| **Physical Reductionism** | "The medical model not only dichotomizes body and mind, but also assumes that illness can be reduced to disordered bodily (biochemical or neurophysiological) functions" (Freund, McGuire & Podhurst, 2003, p. 221). As Engel (1977) noted, this way of viewing the *individual* body – in contrast to the *social* body – excluded other potential explanatory factors in illness. |
| **Specific (A)etiology** | Dubos (1959) described "…the belief that each disease is caused by a specific, potentially identifiable agent" as the "Doctrine of Specific Etiology" (pp. 130-135; cited in Freund, McGuire & Podhurst, 2003, p. 221). |
| **The Machine Metaphor** | "One of the oldest Western images for understanding the body is a comparison with the functioning of a machine. Accordingly, disease is a malfunctioning of some constituent mechanism (such as a 'break-down' of the heart)" (Freund, McGuire & Podhurst, 2003, p. 222). |
| **Regimen and Control** | "Partly as a product of the machine metaphor and the quest for mastery, the Western medical model also conceptualizes the body as the proper object of regimen and control, again emphasizing the responsibility of the individual to exercise this |

control in order to maintain or restore health" (Freund, McGuire & Podhurst, 2003, p. 222).

Table 2.4. Assumptions of the medical model (adapted from Freund, McGuire & Podhurst, 2003, pp. 6-7, 220-223)

> [S]chool failure (the symptom) is due to an underlying neurological deficit (the pathology). Accurate diagnosis (psychological assessment) will indicate appropriate treatment (provision of an individualized educational program and placement in a remedial program). Remediation should result in a cure (normal achievement). (Christensen, 2000, p. 230)

Here one can see how the contemporary typology of 'student with learning difficulties' is created through a reductionist lens that often neglects to interrogate other explanatory factors for a student's inability to 'access the curriculum'. Moreover, if learning difficulties is truly 'something in the brain', then the school, the parents and the child are exempt from responsibility for that child's inability to access the curriculum. Christensen (2000) posits that: "This view of learning disability is intuitively appealing to the naïve observer who sees that despite teachers' and parents' best efforts, some children fail to learn to read, write, or do mathematics" (p. 229). Thus, viewing an inability to learn as being intrinsic to the individual creates a "no-fault, no-blame clause" (p. 238), effectively letting everyone "off the hook" (p. 238).

With regard to the five assumptions of the medical model and its capacity for domination of the child identified as experiencing learning difficulties, I emphasise that, in order for one to be aligned with its way of thinking and knowing, one does not have to subscribe to each component of it. This is

part of the reason for the medical model having such a strong capacity for domination: it subsumes many of the dominant thinking and speaking positions to such an extent that one can easily 'slip into' its discourses and subject positions without realising it. Language, using discourse to create and maintain a specific reality, has implicit power relations – especially when that language is entrenched within Education Queensland (Department of Education and the Arts, 2002a. 2002b).

These 'implicit power relations' were highlighted by Freund, McGuire and Podhurst (2003) when they noted that "Medical knowledge sometimes serves ideological purposes, legitimating the interests of certain persons or groups" (pp. 222-223). This point is one of the most important in this study because it touches upon the core of my argument that learning difficulties are a construction and that there is an immense amount of power implicit in the linguistic foundation of that construction. Learning difficulties as an institutionalised abstract truth have concrete social consequences for the child identified as experiencing them. Some of those consequences can include the restriction – if not the loss – of agency and voice and the expansion of docility.

In this sub-section I have presented a brief overview of the medical model in order to elaborate a term that appears frequently within this thesis and that represents an increasingly authoritative presence in contemporary society. In the following sub-section, I present a historical overview of the reductionist way of thinking that serves as the foundation of the medical

model, in order to demonstrate the centuries-old antecedents of that authoritative presence.

*A historical overview of a reductionist way of thinking*

Above I emphasised that the medical model has five components, each of which contributes to the domination of the child identified as experiencing learning difficulties. In order to understand better how the medical model came to be, I present here an outline of key periods in time as well as prominent thinkers who – presumably unintentionally and unknowingly – contributed to the emergence and dissemination of a way of thinking and knowing that is closely aligned with that domination. The concept of a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187) is applicable here because it assists me in identifying a series of practices that were individually random and spontaneous, and yet contributed collectively to domination. No one intended to create a method for dominating individuals; rather, a large number of individuals contributed to a mechanism of power over a long period of time through their individual efforts in a variety of fields.

Korten (2000) traced how the "…mechanistic worldview that became the underpinning of modern science, and ultimately of modernism and its values, grew out of the work of the sixteenth- and seventeenth-century scientists and philosophers who gave birth to the age of science and reason" (p. 24). Furthermore, he established how a variety of individuals, and their work, unknowingly provided the impetus for, and the foundation of, a

scientific view of 'reality' that both objectifies the individual and reduces her/him to the smallest possible part, thereby neglecting to investigate other explanatory factors influencing that individual. I contend that it is this 'mechanistic view' of the universe that gave birth to the medical model.

Key individuals linked to the development of scientific rationality are presented in the following summary of Korten's (2000) historical overview. Although this list is not exhaustive, it does include significant contributors to a way of thinking and knowing that constitutes a very effective tool of domination or apparatus of power that remains active in contemporary society – including in the Education Queensland schooling system and in its policy régime pertaining to 'students with learning difficulties'.

*Nicholas Copernicus* (1473-1543) was a Polish astronomer and mathematician whose work *On the Revolution of the Heavenly Spheres*, published in 1543, challenged the dominant view of the world (literally) when he purported that the earth made one rotation on its axis each day and one rotation around the sun each year (Korten, 2000, p. 24). Copernicus's work was validated by the astronomical observations of Italian *Galileo Galilei* (1546-1642), who assisted in the rendering of the heliocentric theory as a 'truth' and was successful in convincing a majority of scientists of that time to change their views (p. 24).

*René Descartes* (1596-1650) was a French philosopher and prominent supporter of rationalism. He built upon the Copernican and Galilean findings by teaching that the various bodies constructing the universe moved in a "predictable mechanical relationship to one another" (Korten, 2000, p. 24). Descartes emphasised that God was responsible for setting the forces behind the relationships in motion (p. 24). Because what would be considered today to be an 'existential' debate was occurring regarding the existence and role of God and religion, the strength of science as an explanatory framework for understanding life began to increase dramatically.

*John Locke* (1632-1704) was an English philosopher who presented the notion that "the human mind is a 'blank slate' at birth with nothing written upon it – not even God or right or wrong" (Korten, 2000, p. 25). Locke's thinking was extremely influential in the quest for truth because he effectively argued that knowledge was a result of "sense perception" (p. 25). Therefore the only legitimate sources of truth were "observation and reason" (p. 25).

*Sir Isaac Newton* (1642-1727) was an English mathematician who developed the "mathematical description of the law of gravity" (Korten, 2000, p. 25). He extended this law of gravity by applying it to the bodies within the solar system, thereby providing confirmation of Descartes's teachings (p. 25). In addition, Newton's support of Descartes's teaching led

to "broad acceptance of the view that every event in nature is governed by universal laws that can be described in mathematical notation" (p. 25).

The combination and accumulation of theories and philosophies outlined above represented an entirely new way of thinking and knowing about the world. The individuals named here were collectively responsible for a shift from revelation to rationality. One implication of these 'discoveries' was that the mysticism relegated to an 'almighty' who was in charge of the heavens and the earth was replaced by a materialist and realist focus upon structured and predictable patterns of movement and universal 'laws' or 'truths'.

As contributions to the medical model's conceptualisation, the ideas listed above meant that humankind had the capacity to 'play God' if it were able to discover those particular universal laws and truths. It was believed that truth could be discovered by using logical enquiry and rational thinking. The work of the individuals above set the foundation for the era in Europe known as 'the enlightenment'. This logic and rationality contributed to the medical model's power by making it the only 'common sense' possible. In addition, the dominant way of thinking and knowing of that time presented the foundation for contemporary 'taken-for-granted' explanations of phenomena such as 'students *with* learning difficulties'.

I now present a brief outline of the 18th-20th centuries in order to bring the medical model and its underlying foundation of reductionism, objectivity and control into a contemporary setting. Rather than mentioning specific individuals, I have chosen to provide brief accounts of the occurrences during this timeframe that were partially a result of the activity of which Korten (2000) wrote and that are currently responsible for upholding the 'traditional' ways of thinking and knowing. When examined historically, the development of a reductionist way of thinking and knowing was not an intentional approach to the objectification of human existence; it was more a result of humankind's seemingly insatiable curiosity and desire to control as many variables in one's life as possible. In this way, the combination of numerous scientific discourses established the medical model as a dominant discourse and a metanarrative, thereby providing the perception that we can manipulate and control an 'objective' reality if we can identify and compartmentalise it.

In briefly covering the developments of the 18th-20th centuries, I present the enlightenment, the industrial revolution and the 20th century. The enlightenment and the industrial revolution led into the 20th century and therefore I present a brief overview of each, yet am wary of stating that there are definitive delineations between the time period classifications. Thus, some overlap among these accounts can be expected as there are certain aspects of each period that are still relevant and applicable today.

Within that context, the enlightenment in Europe (*circa* 1650-1800) was marked by discourses of rationality and progress in the areas of ethics, aesthetics and knowledge. As Robertson (1997) noted, the enlightenment consisted of "…a common set of values, prominent among which were reason, humanity, liberty and tolerance" (n.p.). Thus life and the way in which individuals experienced it were being effectively re-defined by discourses of "humanity, liberty and tolerance" (n.p.). With specific regard to this study, the enlightenment was responsible for the compartmentalisation of knowledge into measurable and thus controllable units. From that period, we receive the notion that knowledge can be segmented into disciplines.

The implication of the enlightenment for the medical model's dominance was that its move towards empiricism meant that individuals were also subjected to the same rules of enquiry guiding rational thought. That is, the body became a proper object of enquiry to be examined and meticulously dissected in order to discover the inner workings of 'rational man' (Foucault, 1977).

The industrial revolution (*circa* 1700-1850) began in England and quickly spread through the west. It is relevant in this sub-section because it represents the realisation of the mechanised view of the universe (Korten, 2000) in which humankind became increasingly obsessed with industry and manufacturing while further sacrificing the individual for the sake of progress. Productivity was crucial. Notions of early capitalism and

competition can be found during this time and there was an increase in the number of individuals needed to enter the workforce and support the booming economy (Stearns, 1998). The individual was treated inhumanely, the work conditions were far below what is considered acceptable today and there were very few, if any, laws protecting the worker. Thus, objectification and domination of the individual were apparent and became all but systematic during this time as that individual was subjected to dangerous working conditions, extremely long working hours and minimal pay (1998).

As a result of industrialisation and urbanisation, the idea of mass schooling evolved and the school became a site that could effectively produce a cheap and semi-skilled workforce (Bynom, 2003). Thus the scientific and industrial revolutions – when set against the backdrop of the enlightenment and modernity – can be viewed as having contributed to the domination of the individual. Dickens began his novel *Hard Times* (1854), which was set in England during the industrial revolution, in a classroom and presented it as a microcosm of the outside world. The school operated to expunge childhood innocence and prepare the child for a future as a factory worker engaging in the "mindless drudgery of factory work" (Bynom, n.p.).

In many respects, the 20$^{th}$ century can be seen as the culmination of the events discussed in this sub-section. Rapid progress and development in areas such as technology and science have continuously reinforced the ideals of modernity. A plethora of inventions (e. g., cars, planes, television,

space travel, atomic energy and atomic weapons) have furthered the discoveries of those individuals named previously. The advent of Fordism (Womack, Jones & Roos, 1990) and increased production and consumption meant that there was a greater need to compartmentalise knowledge as a way of categorising and controlling the reality and the worldview that were being created and re-created. The individual gradually held less and less importance as s/he was viewed as being a 'part' of an ideological 'whole'. That is, the search for 'the truth' saw the sacrifice of individuality and a reduction of the individual to such an extent that she/he was, and still is, de-centred.

In this sub-section I have discussed some of the historical developments that have contributed to the current medical model way of thinking and knowing about the world and the individual. The emphasis here is upon the collision of a variety of scientific and industrial developments that further encouraged the reduction of the individual into the smallest possible 'part'. Students identified as experiencing learning difficulties in contemporary society can be viewed as being on the receiving end of those developments considering the medical model underlies explanations for those difficulties. In the following sub-section, I present some contemporary criticisms of that model.

*Contemporary criticisms of the medical model*

When investigating the individual positions in this study relative to the medical model, it became apparent that that model was operating within the

discourses of the administrators, teachers and parents associated with the school where the study took place. Not only was the concept of a learning difficulty a relative 'truth' for all of the participants, but it also constituted a way of viewing the child that relegated her/his inability to access the curriculum to a bio-neurological deficit. Therefore the problem was constructed as being intrinsic and as excluding social, emotional and psychological factors impacting upon the child.

This view of learning difficulties fails to account for the possible failure of the school and/or the parent in the child's inability to learn – nor does it account for a lack of effort on behalf of the child. In this sub-section I present some criticisms of the medical model in order to demonstrate that there are alternative ways of thinking and knowing about learning difficulties. As I noted above, these criticisms have been gleaned from the literature, and they help to frame the alternatives to the medical model that emerged from the interviews conducted with the administrators, teachers and parents and that are explored in Chapter Six.

Engel (1960, 1977a, 1977b, 1978) criticised the medical model as being reductionist and dualist: 'reductionist' in that the medical model reduced the individual to the smallest parts in order to treat the symptoms; and 'dualist' in that the medical model asserted a distinction between mind and body. As I noted when I outlined the five components of the medical model above, the exclusion of 'other' explanatory frameworks for a child's inability to access the curriculum effectively locates a deficit within the child. Bloom

(1995) points out that the medical model, or the reductionist paradigm, took a very simplistic view of complex and chronic social problems and ignored many individual and environmental factors that influence underlying conditions and prevention outcomes.

Cassidy (1994) later supported Engel's characterisation of the medical model as reductionist, yet also attested to its dominance in the western world, when she wrote: "At present, the reductionistic paradigm is dominant in the Western world and in scientific research" (n.p.). Cassidy (1994) established a binary between a reductionist approach and a holistic approach, locating the medical model in the former. In the former, the individual is objectified into quantifiable 'parts' whereby the 'treatment' of the illness or disease is the goal. In the latter, the individual is seen as a whole and the treatment process incorporates the subjective experiences of the individual in order to place the person's healing in context. In the former, the metaphor of the body as a 'machine' is used; in the latter, the metaphor of a body as a 'garden' may be used. Cassidy (1994) argued against the medical model and criticised it for failing to account for the individual's social experiences that impacted upon that individual's well-being.

With regard to education, Forness and Kavale (2001) discussed the marriage of education and the medical model. They described how the medical model's:

> …origin in modern-era special education for children with learning or behavioral disorders came about early in the second half of the 20th century when underlying psychodynamic conflicts or, subsequently, minimal brain dysfunction were seen as etiologies of disordered school behavior or learning. It was assumed that these factors had to be diagnosed before any meaningful intervention could proceed. Worse yet, the medical model often implied that underlying psychodynamic conflicts, perceptual-motor deficits, or the like had to be resolved before any meaningful instruction could take place. (n.p.)

Thus, the medical model can be viewed as being problematic because of its unilateral focus upon finding and isolating the problem, rather than examining contextual factors that have contributed to, or even caused, the problem. The medical model has been evolving rapidly for centuries and the coinciding focus on a reductionist way of thinking and knowing about the world provided fertile ground for the growth of a view of learning difficulties that were located within the child. The formal adoption of policies that solidified learning difficulties as an abstract truth meant that that medical model and the reductionist way of thinking and knowing were afforded longstanding security within the confines of policy that eventually led to practice.

The three components of this section were developed explicitly to provide a general view of one foundation of contemporary conceptualisations of learning difficulties. The evolution of the medical model and a 'mechanised view of the universe' gradually and effectively served to provide a way of thinking and knowing that facilitated the domination of the individual. Although current criticisms of the medical model and its foundation are

acknowledged, the medical model's dominance continues. Thus, the three sub-sections presented here have been developed in order to present a powerful, if not overwhelming, view of a mechanism of domination that has been effectively institutionalised and practiced in contemporary society as well as in the school in which the study took place.

**Conclusion**

This review has introduced the three areas of literature that frame this study and to which it seeks to contribute: Education Queensland; learning difficulties, and the medical model. In each section I have established a key context that contributes to the domination of the child identified as experiencing learning difficulties. Moreover, I have presented arguments against a reductionist way of thinking and knowing as well as providing criticisms of the medical model.

The 'Education Queensland' section presented selections from policy in order to establish the contextual background in which learning difficulties have been created and are maintained through that policy combined with practice. Education Queensland is viewed as a powerful institution where children are systematically rendered docile through a variety of practices.

The second section regarding learning disabilities/difficulties showed the difficulties faced when attempting to establish a working definition and traced significant historical developments regarding learning difficulties/disabilities from the 1800s. The intention of that section was to

demonstrate that the continuous focus 'inwards' to discover the causes of learning disabilities/difficulties was aligned directly with the medical model and a mechanistic way of thinking and knowing and could be criticised for its exclusion of 'other' explanatory factors for an individual's inability to perform specific tasks.

The third and final section regarding the medical model worked to establish the evolution of a specific way of thinking and knowing that continues to grow and expand in contemporary society. The child and her/his particular agency and voice are considered to be in danger as the school utilises a view of learning difficulties that has as its foundation the medical model. The broad sweep of history in this section showed numerous individual occurrences that contributed collectively to a way of thinking and knowing that is responsible for the domination of the child identified as experiencing learning difficulties. Thus, the child is on the receiving end of centuries of 'tradition' that are currently serving to dominate her/him; resistance appears futile, but I contend that it is both possible and apparent in this study. The following chapter introduces the conceptual framework that was constructed in order to guide and frame this study of adult stakeholder constructions of learning difficulties.

# CHAPTER THREE

# CONCEPTUALISING POSITIONS AND CONSTRUCTIONS ABOUT LEARNING DIFFICULTIES

*A person is not a natural object, but a cultural artefact*. (Harré, 1983, p. 20)

*Positioning*...[is] *the dynamic construction of personal identities relative to those of others*. (Parrott, 2003, p. 29)

*We shall argue that the constitutive force of each discursive practice lies in its provision of subject positions. A subject position incorporates both a conceptual repertoire and a location for persons within the structure of rights and duties for those who use that repertoire*. (Davies & Harré, 1990, p. 46)

## Introduction

In the previous chapter, I presented a historical overview of learning difficulties discourses and established the concept of learning difficulties as it is conceived and regulated by Education Queensland, the governing body of the regional primary school in which this study took place. As a governing body and "established régim[e] of thought" (Foucault, 1980, p. 81), Education Queensland is responsible for operationalising the term 'learning difficulty' and for producing policies addressing access to the curriculum by students identified as having a learning difficulty, or multiple learning difficulties.

Within this thesis, I see positioning theory – "The study of local moral orders as ever-shifting patterns of mutual and contestable rights and obligations of speaking and acting" (Harré & van Langenhove, 1999, p. 1) – and social constructionism as effective conceptual tools for illustrating the subjective ways in which learning difficulty as a term is made manifest in the school noted above. Therefore my objective is not to disclose the 'truth' about learning difficulty, but rather to examine how the relative 'truths' of the stakeholders, in the production of students with learning difficulties, are constructed within a particular context. Accordingly the purpose of the thesis is to demonstrate that Education Queensland's definition of a learning difficulty is in fact not an objective truth, but rather a subjective experience that is continuously defined and redefined by the stakeholders within the communal context of that school.

This chapter describes and justifies positioning theory as the central element of the conceptual framework used for my study of adult stakeholder constructions of learning difficulties in the school mentioned above. Positioning theory deals with the metaphorical spaces that people occupy and with the negotiated rules governing those spaces when engaged in social interaction. Also included are specific key concepts that contribute to the study's capacity to engage with the research questions outlined in Chapter One. Those questions are:

- In what ways is the medical model's dominance enacted in the adult stakeholders' constructions of children identified as experiencing learning difficulties?

- What 'other' explanatory frameworks are displayed in adult stakeholders' constructions of children identified as experiencing learning difficulties?

In particular, I address nine crucial and interrelated sets of ideas in this chapter:

1) Role theory
2) The de-centred subject
3) Power/Knowledge
    a) Established régimes of thought
    b) Docile bodies
    c) Rationality
4) Episodes
5) Positions
6) Speech-acts
7) Storylines
8) Social constructionism
    a) Exogenic and endogenic viewpoints
    b) Constructionism *vis-à-vis* constructivism
9) The concept of discourse
    a) The dynamics of discourse
    b) Discourse and community
    c) Discourse analytic technique.

Each of these ideas is essential for understanding positioning theory as a whole and contributes to that understanding in a particular way. Primarily, positioning theory can be seen as a way of overcoming the static and therefore problematic nature of role in social analyses owing to positioning theory's focus upon multiple and ever-changing subjects. Thus, the individual – while not necessarily 'centred' – does retain some aspect of agency in positioning theory. The notion of the 'de-centred subject' is located in this chapter as a way of recognising and moving beyond the constant tension that I have experienced in this study. This tension is located between the concept of an individual with complete autonomy and the ability to make fully informed decisions (a rational and enlightened being) and the concept of an individual who is wholly subjected to discourses as those discourses shape and inform her/his subjectivity, thereby leading the individual to believe that s/he has a 'choice' (ideology) when s/he is really serving as a 'medium'. Located somewhere in the middle of these two extremes is the notion of positioning, where the individual retains agency in that s/he is considered a 'choosing subject' who has the ability to resist subordination and domination, but exists within an interdependent universe where other individuals are striving to do the same; therefore not everyone has the same capacity for resistance and some will accordingly be dominated.

Thus, the use of positioning theory in this thesis can be seen as a way of attempting to grapple with notions of individual agency and autonomy in an increasingly hostile atmosphere where administrators, teachers and parents

are frequently subjected to subordination and domination by dominant discourses such as the medical model as presented and discussed in Chapter Two of this thesis. That is, as Davies and Harré (1999) note, positioning theory allows us "…to think of ourselves as choosing subjects" (p. 41) and a 'choosing subject' has the opportunity at least to contest and reject domination.

Following discussions of the role theory that positioning theory seeks to contest and extend and of the de-centred subject that is crucial to understanding positioning theory, I move into the area of power/knowledge (Foucault, 1980) in order to highlight the importance of the intersection of power and knowledge as they have played a part in developing this thesis. For Foucault, sciences such as medicine, psychology, linguistics and sociology defined humans while simultaneously describing them. When paired with institutions such as asylums, prisons and schools, those sciences have significant effects on individuals. A principal outcome of this study is the identification of those effects, inspired by Foucault's ideas and facilitated by positioning theory, as they are made manifest in constructions of students with learning difficulties.

In order to identify positions that have been occupied, rejected and so forth, it is necessary to be aware of the speech-acts and storylines that create those positions. Thus, as this thesis is an analysis of the medical model, and other, discourse subject 'positions' occupied by a speaker describing what s/he believes learning difficulties to be, it is important to establish that

episode, position, speech-act and storyline are inter-related and comprise positioning theory – a lens for viewing the discursive production of the subject.

Afterwards I move on to social constructionism and the concept of discourse. These two notions contribute significantly to positioning in a variety of ways that will be discussed below. The implication of a social constructionist approach is that individuals work actively to co-produce meaning. People act with intent and attach meaning to their actions. However, that meaning must be negotiated and re-negotiated between the parties involved in order to arrive at an agreement about the meaning of the action. If the term 'construct' can be viewed as implying the wilful or deliberate creation of something (e.g., of knowledge or reality), then the presence of 'social' in front of 'constructionism' implies that the item is a product of social interaction, thereby becoming a social practice. Of course, social practices change just as people change and therefore an examination of a particular social practice can be only temporary because it is bound by the socio-cultural context in which it occurs.

As a concept, discourse is inextricably linked to social constructionism. Often approaches to discourse analysis derive from structuralist and post-structuralist linguistic philosophy which states that our access to reality occurs through language. However, in using language to create a representation of reality, we are constructing it rather than merely reporting on a pre-existing reality (Phillips & Jørgensen, 2002). The implication of

this idea of language and discourse is that the meaning and representations that we build can be seen to be 'real'. Moreover, the physical objects in our world can be viewed as real; however, they gain meaning only through discourse. Thus, discourses shape and inform our subjectivity as we work to create meaning in our world(s).

Overall, the nine concepts introduced in this section have provided me with an effective and powerful conceptual framework. This framework has been indispensable in engaging with my research questions, in exploring the social constructions of children identified as experiencing learning difficulties in a Queensland regional primary school and – as I elaborate in Chapter Seven – in making a significant contribution to conceptual as well as to methodological and empirical knowledge.

**Role theory**

Given that positioning theory introduced the concept of 'positioning' as a "dynamic alternative to the more static concept of role" (van Langenhove & Harré, 1999a, p. 14), it is worth investigating the notion of role theory here in order to establish what the term 'role' signifies and why it is important to transcend its static nature. The notion of a 'role' in social analysis has been characterised as being prescriptive in nature and thereby as dictating the acting and speaking opportunities of the individual. Thus, a role defines a person, defines her/his self-concept and regulates her/his behaviour; the self is therefore considered singular and unified and it is only through occupation of a role that one achieves a sense of identity. If this is the case,

then role theory can produce generalisability and predictability because the self is considered to equate with the individual performing the role and roles are normatively defined, performed and enacted in every aspect of one's daily life.

Therein lies the problem. The emphasis upon a single individual's occupation of multiple roles fails to acknowledge the multiple selves of that individual. Aaronson (1998) not only identified the advantageous nature of the term 'positioning' over 'role', but also identified authors who used concepts similar to position and positioning in studies of context-bound discursive practices:

> In traditional sociology, "role" is a problematic given. If social identity is analyzed in terms of identity-in-interaction, the local positioning of someone is foregrounded. In what ways do speakers position themselves or others in specific speaker roles? In mapping identity-in-interaction in a social space, *position* and *positioning* are therefore key concepts. Various such notions have been employed in social and cultural studies of situated discursive practices (Goffman, 1959; Bourdieu, 1971; Gumperz, 1982; Goodwin & Goodwin, 1992; Ochs, 1992). In these quite distinct analyses, the notion of context is partly deconstructed in that it is not entirely given. (p. 79; emphasis in original)

Thus, role theory does not answer for either individual variability or flexibility within a specified role where the individual may not act 'according to plan'. Here the notion of 'deviance' (discussed below in the subsection entitled 'Rationality') warrants a brief mention, considering that one of the main criticisms of role theory is its inability to account for deviant behaviour, or behaviour that is in opposition to established socio-cultural norms.

A contemporary re-interpretation of 'role' is the notion of 'position'. Whilst 'position' is discussed below in greater detail, I present it briefly here as it represents an attempt to overcome role theory's fixed conceptualisation of the individual as an actor in a social drama and to replace that conceptualisation with the notion of a fluid and dynamic individual who is representative of an infinite multiplicity of selves in social interaction. Thus, positioning, as a move away from the classical dramaturgical model (Goffman, 1959, 1963, 1967) focusing on 'role', allows us:

> …to think of ourselves as choosing subjects, locating ourselves in conversations according to those narrative forms with which we are familiar and bringing to those narratives our own subjective lived histories through which we have learnt metaphors, characters and plot. (Davies & Harré, 1999, p. 41)

Here the implication for positioning theory as opposed to role theory is that there exists a discursively produced individual within each particular 'role' and therefore the notion of role is ill-equipped to present a portrait of that individual that carries significant depth and breadth or agency. In its focus upon the finely nuanced patterns of social action against the backdrop of broader patterns of discourse, a position transcends a role even though the two concepts can be considered to be related.

I have chosen to use positioning theory because it emphasises the idea that the role does not determine the individual's action(s); rather, the individual has some control in framing and shaping her/his actions. Here the implication is that the individual has a certain amount of agency and

therefore choice, rather than merely 'playing the part' in society as an automaton. Moreover, in the social constructionist sense that is outlined in a section later in this chapter, this agency is retained as the individual's use of language and discourse is considered to be goal-oriented. This point assists in further removing the individual from the restrictive nature of prescribed thinking and acting associated with role theory, as the individual is cognisant of purpose and intent, yet highlights the potential danger of an over-emphasis on the self, which could result in a charge of solipsism. For this reason the notion of the 'de-centred subject' is presented in the next section in order to reinforce the notion of multiple subjectivities and to emphasise that a singular subject is not possible. In this thesis, the subject is continuously changing as it constitutes, and is constituted by, discourse.

This section has established what the term 'role' represents and how the notion of a 'position' overcomes that term's restrictive nature in social enquiry. Central to this section is the assertion that positioning theory exceeds the static notion of role. Thus, positioning theory and a focus on positions rather than on roles are suitable tools for investigating adult stakeholders' constructions of learning difficulties in ways that role theory would never be able to attain. In particular, positioning theory provides a way of investigating the texts of the participants at a deeper level than role theory would permit.

**The de-centred subject**

Positioning theory is a form of social psychology that moves from the static concept of 'role' to the dynamic concept of 'position' when investigating the establishment of the self in social interaction (Harré & van Langenhove, 1999). The primary discontent with role theory lies in van Langenhove and Harré's (1999a) assertion that "fluid positionings, not fixed roles, are used by people to cope with the situation they usually find themselves in" (p. 17). However, the concept of 'self' as it was defined in modern times has been debated by post-structuralist thinkers such as Lacan (1975), Derrida (1981) and Foucault (1972), and it continues to be problematic for individuals in contemporary society who contend that a centred subject is not possible. For Lacan (1975), the self does not exist in isolation and therefore is unable to be identified separately from its significant others; for Derrida (1981), the concept of self continuously undergoes a process of deconstruction (Sampson, 1989), to such an extent that a 'centred' self is not possible.

Although Foucault is traditionally referred to as a post-structuralist along with Derrida (1981) and Lacan (1975), Usher and Edwards (1994) explain that he differs from Derrida and Lacan as a result of his concern with transcending "the role of language and textuality into an explicit consideration of the nature and role of power" (p. 83). It is for this reason that Foucault's (1980) concept of power/knowledge is discussed below as contributing conceptually to this thesis by way of examining the medical model subject positions that the participants occupied and that constituted a

subordinating apparatus of power that rendered the child identified as experiencing learning difficulties a docile body.

As the concept of self is often problematised by individuals aligned with post-structuralist ways of thinking, those individuals argue for the term 'de-centred subject' rather than 'self' because, as Lye (1996) explains:

> Post-structuralism contests the concept of 'man' as developed by enlightenment thought and idealist philosophy. Rather than holding…the enlightenment view that 'individuals' are sacred, separate and intact, their minds the only true realm of meaning and value, their rights individual and inalienable, their value and nature rooted in a universal and transhistorical essence…the post-structural view holds that persons are culturally and discursively structured, created in interaction as situated, symbolic beings. The common term for a person so conceived is a 'subject'. (n.p.)

Thus, in an era that seeks to move beyond the ideals of structuralism and modernity, the consideration of the individual as a 'subject' necessitates the deconstruction of notions of selfhood, society and the social practices of the self in society. This deconstruction is necessary in order to view the elements of individuals that are grounded in culture, context and experience, thereby making the individual un-centrable.

Thus, as Guignon (2004) explains, the act of de-centring the subject means "…rethinking humans as polycentric, fluid contextual subjectivities, selves with limited powers of autonomous choice and multiple centers with diverse perspectives" (p. 109). Here the flagging of a post-structuralist view of the subject is central to positioning theory because it shares the notion that the

human subject is neither fixed nor centred but instead is polycentric. In positioning theory, the subject is discursively produced and reproduced as individuals engage in a series of goal-oriented speech-acts.

However, viewing the individual as a 'de-centred subject' may have implications for the participant such as the perceived loss of agency (and therefore voice), thereby resulting in the individual becoming "a medium for the culture and its language" (Kvale, 1992, p. 36) – something that does not sit well with the Western conceptualisation of the self as an "autonomous and sovereign entity" (Phillips & Jørgensen, 2002, p. 15). This is perhaps why Davies and Harré (1999) noted that positioning theory allows us "…to think of ourselves as choosing subjects" (p. 41).

On the one hand, this quotation can be seen merely as two individual Western scholars situated within their respective ideological stances and opposed to the notion of being subjectified by discourse and therefore completely de-centred as a pawn in a chess game. On the other hand, Davies and Harré (1999) have rejected views of the "monological self" (Guignon, 2004, p. 120) that emerged from modernity in favour of a self consisting of multiplicity and having some capacity for choice. Notably, to borrow a term from the Russian literary theorist Mikhail Bakhtin (1981), positioning theory presents a *dialogical* self, an individual who is created and recreated by her/himself and by others in conversation. Here the intention is not to draw upon Bakhtin's (1981) theory; rather, I use the term 'dialogical self' as a reference point to locate what a position is. Wetherell

(2003) concurs when she mentions specifically that "Bakhtin's concepts of *voice* and *dialogical* are also becoming standard reference points" (p. 100; emphasis in original) when used by individuals to explain positioning theory and the act of positioning.

A recognition of multiple individual 'selves', rather than conceiving of the self as fixed or centred, can offset the unequal power relations residing in the production of truth. That is, if one is to consider the multiplicity of factors preventing the parent, teacher or administrator from becoming a centred self in the construction of a child identified as experiencing learning difficulties, then one may be able to view the areas of tension where the subject positions that they occupy are problematic for the social existence of that child.

This section discussed the concept of the de-centred subject and established positioning theory as an approach that aligns with this concept, I now examine the contributions to this thesis of Foucault's (1980) notion of 'power/knowledge' as it assists me in illustrating some of the ways in which dominant discourses are implicated in power and knowledge and are reproduced through social practice. Thus, issues of domination and resistance are discussed below as well before moving onto a discussion of 'episodes', or the social interactions/exchanges in which positioning takes place.

**Power/Knowledge**

In this section, I engage with Foucault's (1980) concept of "power/knowledge" and detail its relevance to this study as it is an important contribution to understanding how medical model discourses can dominate the child identified as experiencing learning difficulties in the subject positions that its associated discourses construct. Within this section, I operationalise three key terms that are used throughout this thesis. These terms are *established régimes of thought* (Foucault, 1980), *docile bodies* (Foucault, 1977) and *rationality*. The first term refers to the 'ways' of thinking and knowing that contribute to establishing what particular knowledge or truths are valid, while the second term relates to the idea that an individual can be analysed, manipulated and regulated through discourse. Rationality signifies an individual's level of acceptance within a particular socio-cultural context. In each instance, power is the underlying foundation because it either enables or prevents the effectiveness of such ways of thinking in dominating the individual.

*Established régimes of thought*

For Foucault, power and knowledge are a 'couplet'; they are not one-and-the-same, but separate entities with a reciprocal relationship. Foucault's influence can be traced throughout positioning theory (Harré & van Langenhove, 1999) and positioning theorists' writings (Boxer, 2003; May, 2003) as the notion of 'subject positions' (discussed below and used in this thesis) emerged from his early work in *The Archaeology of Knowledge* (Foucault, 1972). Moreover, Foucault's work (1972, 1977, 1980)

complements that of Lacan (1975) and Derrida (1981) as it contributed significantly to the post-structuralist notion that the subject is de-centred and focused on how discourses shape and shift the linguistic landscape of the individual (knowledge), thereby rendering, shaping and informing her/his subjectivity. As a result, individuals are subjected to discourses as they draw upon those discourses and this notion is a result of implicit power relations which establish which discourses are privileged and which discourses are not.

Ultimately, I draw upon a Foucauldian notion of power (Foucault, 1980) in which power is not centralised but is everywhere and nowhere at once. That is, there is not one specific structure or agent working intentionally to dominate the child identified as experiencing learning difficulties; rather, the domination of that child is a result of a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187). By this term, I mean that there is a variety of socio-cultural, historical and contextual factors all impacting upon the subordination of that child in some way. However, there is no grand 'plan' in place and the individuals involved have not united to create the child deficit typology; that typology is the result of centuries of a combination of knowledge, power and discourse. Thus, the intention of this thesis is not to bestow blame on one specific individual or institution. Rather, learning difficulties are a result of a violent collision of social, political, economical, historical and contextual factors that have all rendered the child as student a 'docile body'.

The way in which I consider – based upon my engagement with a Foucauldian notion of power – such power to *operate* is that it is something that is exercised rather than owned. Therefore an "*ascending* analysis of power" (Foucault, 1980, p. 99; emphasis in original) is needed. The starting point for this "*ascending* analysis of power" is "[i]ts infinitesimal mechanisms, [in] which each have [*sic*] their own history, their own trajectory, their own techniques and tactics" in order to establish how "…these mechanisms of power have been – and continue to be – invested, colonised, utilised, involuted, transformed, displaced, extended, etc., by ever more general mechanisms and by forms of global domination" (p. 99).

In this study, the emphasis is upon a de-centralised view of power that considers the stakeholders to be inextricably linked to the web of power relations responsible for the development and maintenance of the child deficit typology. Although there is not consensus and resistance does occur, the presence of a way of thinking congruent with subordination and objectification is dominant.

The key to understanding power is to examine the multiplicity of forces that are working within the context to permit that subordination or objectification to occur. Thus, although I am unable to establish every possible cause of the maintenance of the individual deficit typology, I am able to interrogate the individual stakeholders engaged in the power relations of the Queensland educational institution in which this study took place in order to yield some insight into some of the ways in which learning

difficulties are created and maintained as a social practice. A Foucauldian notion of power is used to establish some of the multiplicity of coincidences that function simultaneously in, and that are partially responsible for, the continuation of the individual deficit view with regard to children identified as experiencing learning difficulties.

According to Foucault, there are five "methodological precautions" (1980, p. 96) regarding the intricacies of power. The following is an outline of those 'precautions', as well as a summary of their meaning and their contribution to providing a framework in which I can establish some of the ways in which power functioned at the research site.

The first precaution urges one to avoid seeking to isolate the existence of power to one specific area within a specified structure:

> • …accept that the analysis in question should not concern itself with the regulated and legitimate forms of power in their central locations, with the general mechanisms through which they operate, and the continual effects of these. (p. 96)

If one were to examine power in terms of a 'traditional hierarchy' with disregard for the multiplicity of covert and overt resistance(s) of that power that occur, then the potential exists to contribute to the legitimation of the knowledge that the institution utilises as a foundation for truth. This potential stems from analysing the power of the institution as a truth and ascribing to the Western compartmentalisation of knowledge. This compartmentalisation of knowledge (Ramadier, 2004) results in the production of 'specialists' in certain areas and those specialists engage with

and enact selected discourses necessary to maintain their position and may/may not be aware of the consequences.

Thus, if my analysis of the occupation of subject positions in medical model discourses – and 'other' explanatory model discourses – were to focus specifically upon the school, as an institution of simultaneous socialisation/normalisation (Adler, 1998), then I would be guilty of merely 'shifting blame' rather than 'accepting responsibility' for the potential causes and effects of the subordination of the student identified as experiencing learning difficulties. To put it simply, I cannot place all of the responsibility upon the school, or the individuals within it, for the students' failure to access the curriculum; although the school may have its own deficit(s), it is not the sole site of power.

Foucault (1980) advocates focusing upon power "at its extremities, in its ultimate destinations, with those points where it becomes capillary, that is, in its more regional and local forms and institutions" (p. 96). In order to examine power effectively, one should not be concerned with identifying one particular starting point; rather, one should focus upon the effects of power as they are displayed in social practice. In this study, the effects of power can be seen as the stakeholders and I speak *about*, rather than *with*, the children. Thus, the various rules and regulations regarding a child's voice have been enacted by the participants and me and this thesis can also be seen as contributing to the subordination of the child identified as experiencing learning difficulties because of its exclusion of those

children's voices. I elaborate upon this concern when discussing the ethics and politics of the study in Chapter Four.

The second 'precaution' is in relation to concerning oneself with the reasons *for* action:

- …the analysis itself should not concern itself with power at the level of conscious intention, or decision;…it should not attempt to consider power from its internal point of view and…it should refrain from posing the labyrinthine and unanswerable question: 'Who then has the power and what has he in mind? What is the aim of someone who possesses power?' (p. 97)

In seeking to establish 'who' has power, one is limiting to a single being the vast apparatus of power that exists as an amalgamation of an infinite number of circumstances. Rather than attempting to determine 'who' has power and thus seeking to discover a sovereign entity responsible for subordination and objectification, one should focus upon the multiplicity of events that occurred simultaneously and that allowed the individual to be on the receiving end of the effects of power. Foucault (1980) asserts that

> …what is needed is a study of power in its external visage, at the point where it is in direct and immediate relationships with that which we can call its object, its target, its field of application, there – that is to say – where it installs itself and produces real effects. (p. 97)

Thus, the implication of viewing power in a Foucauldian sense in this study is that it encourages one to explore the multiplicity of effects of power, rather than to attempt to determine single cause-and-effect relationships.

Because power lies within neither structure nor agency, power is not centralised. Ultimately one is encouraged to question "how things work at the level of on-going subjugation, at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, dictate behaviours[,] etc" (Foucault, 1980, p. 97). This prompts me to question the 'taken-for-granted' assumptions that serve to dominate the children identified as experiencing learning difficulties. Thus, the stakeholders are not seen to be intentionally dominating the child; rather, they are seen as reproducing the dominant discourses in their social actions. Moreover, those social actions have social consequences.

The third precaution is summed up eloquently by Foucault (1980) when he states that "individuals are the vehicles of power, not its points of application" (p. 98). This distinction alludes to the idea, introduced above, that power is not owned, but exercised. Power is not to be considered to be isolated within one exclusive individual or group and exercised over a different and specific individual or group. Rather, power is characterised as being circulatory and operating like a link in a chain. As individuals exercise power, they are also subjected to it. This means that the effects of power are unavoidable and therefore must be considered when examining issues relating to labelling and identification in order to ascertain the effects of power upon the individual or group who is labelled or identified. Thus:

- power is not to be taken to be a phenomenon of one individual's consolidated and homogeneous domination over others, or that of one group or class over others. (p. 98)

Establishing a single point of articulation of power is not possible because power is elusive and it is "employed and exercised through a net-like organization" (p. 98). As a result of this 'precaution', one needs to pay close attention to the multiple and seemingly 'random' contextual factors in any particular situation because power is ultimately present and evident within each of those factors and the individuals contributing to them.

The fourth precaution discusses the 'how' of an analysis of power. I have already established a de-centralised view of power (Foucault, 1980) in this thesis, but it is his fourth precaution that assists one with the question of where to look for power:

- …the important thing is not to attempt some kind of deduction of power starting from its centre and aimed at the discovery of the extent to which it permeates into the base, of the degree to which it reproduces itself down to and including the most molecular elements of society. (p. 99)

In this precaution, it becomes evident that an analysis of power must begin with the most minute of elements and mechanisms and work towards investigating general forms of subordination and domination. Foucault (1980) labelled this approach an "*ascending* analysis of power" (p. 99; emphasis in original) and stressed that, as a starting point, one begins with:

> Its infinitesimal mechanisms, [in] which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been – and continue to be – invested, colonized, utilized, involuted, transformed, displaced, extended, etc. by ever more general mechanisms and by forms of global domination. (p. 99)

In the invocation of an "*ascending* analysis of power" (Foucault, 1980, p. 99; emphasis in original), a Foucauldian approach to power contributes to this study because it avoids the isolation of power in one specific area. Thus, each of the relative truths of each parent, teacher and administrator is one small part in the intricate web of power relations that contribute to the domination and subordination as well as the liberation and empowerment of the child identified as experiencing learning difficulties.

This fourth precaution highlighted two key points that demonstrate the direct relevance of an "*ascending* analysis of power" (Foucault, 1980, p. 99; emphasis in original) to this research. Firstly, I eschew a view of power that is isolated to any one particular individual, group or place at any particular time. The implication of this study of a view of power that is 'net-like' means that it is accessible. That is, we are not so far removed from power that we are unable to effect change; it is attainable, although unequally, to each of us. Although this interpretation of power may seem optimistic, this view of power promotes the possibility of agency. By contrast, a view of power as restricted to those elite individuals 'at the top' implies that individuals at the grassroots level are powerless to effect change and are limited by the ideological illusion of choice. Moreover, viewing power as 'accessible' also provides a foundation for resistance against the effects of power. Although resistance is relevant and worth mentioning here, I do so hesitantly, as I explain below.

Secondly, I reject a view of power as being found in a 'top-down' structure. If that were the case, then the responsibility for change would be 'at the top' simply because that is where the power was. However, through the act of viewing power as dynamic and viewing the individual as an intricate part of the web of power relations, the urgency of a social, or collective, responsibility for change becomes evident. The implication of this view of power for this study is that if one were to locate power within a hierarchical framework then one would be powerless to effect change within that framework; the obvious exception is if one were aligned with the 'top' in that hierarchical view of power.

In this study, the view of administrators, teachers and parents as inextricable 'links' in the chain of non-sovereign power operating in the contemporary setting in which the study took place means that each individual shares the responsibility for the subordination of children identified as experiencing learning difficulties. Likewise, each individual shares the responsibility for the liberation of that child from the reductive, deficit discourses operating in and around the school. That is, each individual has played a part in the creation of the child deficit typology, yet the view of power as de-centralised means that the possibility for change is also and always present. Thus, the notion of resistance presents itself and is discussed below after the fifth and final 'methodological precaution' has been presented because individuals have both the opportunity and the 'responsibility' to contest medical model subject positions.

Foucault's (1980) fifth and final 'methodological precaution' is apparently directed at avoiding viewing mechanisms of power in ideological terms as he considers power to be:

> • …both much more and much less than ideology. It is the production of effective instruments for the formation and accumulation of knowledge – methods of observation, techniques of registration, procedures for investigation and research, apparatuses of control. (p. 102)

Above one is discouraged from viewing those mechanisms involved in the formation of knowledge as ideological. Instead, those subtle mechanisms are powerful instruments that constitute, and are constituted by, the subjects involved. The move away from ideological notions of power is yet another attempt to move away from a centralised view of power: "We must escape from the limited field of juridical sovereignty and State institutions, and instead base our analysis of power on the study of the techniques and tactics of domination" (Foucault, 1980, p. 102).

By locating the effects of power within its specific socio-cultural and historical context, one is able to view those effects as social consequences. This overcomes a view of 'centralised' power that effects change upon and through individuals. Because the effects of power are called into question and considered observable (such as in the act of positioning), the opportunities to view how specific power/knowledge relationships are present in contemporary society are possible.

The relevance of resistance in this section on power/knowledge is that Foucault (1980) asserts that "there are no relations of power without resistances" (p. 142). In mentioning resistance specifically here, I am highlighting a view of power, knowledge and resistance that underpins my positioning theory approach to stakeholder constructions of the term 'learning difficulties'. Because the establishment of learning difficulties is a result of scientific knowledge that is privileged, dominant and institutionalised, power is implied in the relationships that served to create learning difficulties as an abstract truth. In this thesis the medical model – presented and discussed in Chapter Two – is considered to be the established régime of thought (Foucault, 1980) that represents a deficit view of the individual identified as experiencing learning difficulties. A deficit view of the individual is discussed in Chapter Five, while the particular moments of individual resistance of that view are presented in Chapter Six. Furthermore, the part that resistance plays in the school is addressed below.

Resistance plays a significant part in this thesis considering that the phenomenon known as learning difficulties represents various truths 'exercising' power and serving to dominate, liberate or implicate the children identified as experiencing learning difficulties. A dominant deficit view of the child implies that the power to shape that child lies externally because of the inherent 'problem' learning that exists within the individual. It is for this reason that I view the child's knowledge as "directly disqualified" (Foucault, 1980, p. 82) because that knowledge has been judged against the backdrop of an "established régim[e] of thought" (p. 81)

and found to be lacking. Here I emphasise the notion of rationality because I contend that, once the child is labelled as irrational on account of her/his learning difficulty, s/he is denied the necessary voice to contribute to the educational forum regarding her/his own education.

In this study I provide Chapter Six as a focus on resistance and view it as in certain respects the antithesis of Chapter Five, where the medical model dominates individual 'ways' of thinking and knowing. Thus, resistance shows itself in a variety of forms. These forms are presented in Chapter Six and establish that a scientific approach to learning difficulties that implicates a child deficit is not always readily accepted and internalised by the parents, teachers or administrators. This contestation of the dominant 'ways' of thinking and knowing by the stakeholders shows that the "established régimes of thought" (Foucault, 1981, p. 81) are not as secure in their foundation as they might be assumed to be. There are minute capillaries of power that are working to resist the notion of a learning difficulty as a child deficit.

I have addressed the notion of "established régimes of thought" (Foucault, 1980, p. 81) in order to establish the medical model as a dominant way of thinking that has prevailed for the past several centuries, as was discussed in Chapter Two of this thesis. The "established regimes" (p. 81) are considered in this thesis to be the ways of thinking that are aligned with the medical model, which is a reductionist view of the individual, and that have rooted themselves in contemporary society. Thus, those ways of thinking

have been ‘established’ through a history of privilege and their knowledge conjoined with power to result in certain ways of thinking that gained superiority over other ways of thinking. When examined in the context of this thesis, the dominant way of thinking is the medical model, whereby the child is believed to have a problem that is inherent and thus the child, administrators, teachers and parents are exonerated from responsibility for that child’s inability to access the curriculum.

The foundation of learning difficulties can be found within these ways of thinking and the ruling notion of a child deficit is embedded in the institution in which this study took place. The reductionist way of thinking serves to dominate the child identified as experiencing learning difficulties because the insinuation is that the child can be positioned as ‘helpless’ and therefore deprived of agency for the sake of her/his ‘own good’. Thus, the medical model, as an “established régim[e] of thought” (Foucault, 1980, p. 81), teaches individuals to look for inherent individual deficits.

*Docile bodies*

In this sub-section, I discuss the notion of the ‘docile body’ (Foucault, 1977). For the sake of this thesis, I consider the child identified as experiencing learning difficulties to be a ‘docile body’ in that, once identified, s/he is subjected to the forces of change operating within and around the school in order to assist that child in accessing the curriculum. These ‘forces of change’ take the forms of assessment, identification and remedialisation, which carry with them constraints, prohibitions and

obligations that are represented in Figure 3.1 below. Thus "A body is docile that may be subjected, used, transformed and improved" (Foucault, 1977, p. 136).

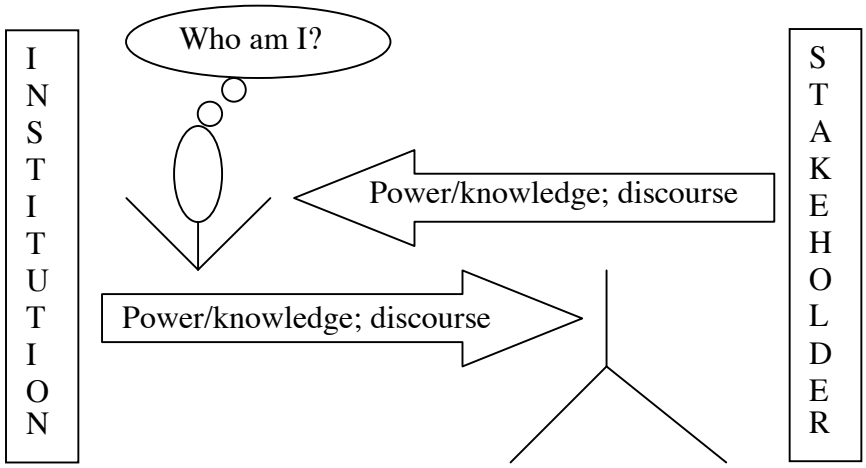
| |
|---|
| Step One: Institution adopts medical model as explanatory model of learning difficulties |
| Step Two: Stakeholder either accepts or internalises medical model as explanatory model of learning difficulties |
| Step Three: Child is not 'accessing the curriculum' |
| Step Four: School stakeholders and/or external specialists analyse child's (in)ability, decide on course of remedial action (if necessary) |
| Child either accepts or internalises medical model as explanatory model of learning difficulties; little opportunity for either agency or voice and thus for resistance. |
|  |



Figure 3.1. The de-centred child as a 'docile body'

In Figure 3.1 above, I illustrate the child as a 'docile body' in order to represent her/his body as a site of power, knowledge and discourse, considering that each of these forces works collaboratively to shape and shift her/his body. I consider the transformation and hence the domination of the child to be a four-step process, each using the medical model as its foundation owing to the fact that that model is an institutionalised abstract truth as discussed in Chapter Two. Although there appear to be five steps in

the process of domination of the child, I emphasise that the child's acceptance and/or internalisation of the medical model discourses is/are optional; the child can be dominated without either accepting or internalising the medical model discourses.

The first step in subordinating the child is for the institution to adopt formally a reductionist view of learning difficulties that locates them within the individual. This step is crucial because, without the institutionally encouraged acceptance of and internalisation of the notion of student deficit, the particular social system would be quite different. Rather than speculate as to how it would be different, I note simply that learning difficulties were 'real' in the school where the study took place and the interview texts demonstrate that the stakeholders did often accept and internalise the medical model as an explanatory model for students identified as experiencing learning difficulties. The first step represents the transformation of an abstract truth into a truth. Thus, learning difficulties are made 'real' by the institutional processes that define them.

In relation to the second step where the stakeholders either accept or internalise the deficit view of the child, I note that the stakeholder can be positioned to do this, do it intentionally or do it unintentionally. Thus, there is a multitude of ways in which the medical model can maintain its foothold in the school by being a part of policy and by having employees who are required to adhere to that policy. I emphasise that the medical model is institutionalised in Education Queensland policy *CS-13: Educational*

*Provision for Students with Learning Difficulties and Learning Disabilities* (Queensland Department of Education and the Arts, 2002b). Thus, Education Queensland, as an institution that governs the actions of its employees, has the right to ensure that those employees are fulfilling their job requirements. Accepting or internalising learning difficulties, then, is essentially 'doing one's job', considering that the individual is positioned by the institution by her/his specific code of conduct. The child's body is therefore inscribed by the socio-cultural and political discourses regarding learning difficulties and her/his docility appears to be imminent.

I note here that the stakeholder can and does resist as well, but that would be a different graph and relevant to resistance, which I discuss in Chapter Six. Once the stakeholder works to do her/his 'part' (e.g., fulfil the job description), s/he is contributing to a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187) in which the domination of the child as a 'result' has neither a single nor a specific 'cause' *per se*. I now move to the third step in the transformation of the child as a docile body.

With the first two steps of Figure 3.1 in place, the stakeholders have effectively been 'trained'/positioned to look for children who are not accessing the curriculum. Basically, the child who strays away from the collective, or rational, 'way' of learning is the target for domination because s/he will not be seen as doing 'as well' as the majority of the children in the classroom. In the third and fourth steps, the 'target' needs to be identified, assessed, analysed, formally identified and prepared for remediation if

necessary. I note here that positioning will occur at each and every stage of the child's rendering; however, I provide specific analyses of positioning acts in Chapters Five and Six. Once identified, the child is regulated, observed and assessed continuously until s/he presents the necessary skills to warrant being returned to the general population classroom.

Although Figure 3.1 is intentionally simplified for the sake of presentation and explanation in this chapter, it shows one way in which domination of the child can occur. Moreover, Figure 3.1 allows me to emphasise the parts that power, knowledge and discourse play in the domination and therefore in the docility of the child. In the final phase, the child has been systematically rendered 'docile'. Having been the site of individual and institutional power/knowledge and discourse 'conflict', the child must either accept or internalise her/his systematic 'repair' in order to 'get better' and return to the general population classroom. Thus, the child must submit to docility in order to be re-granted the 'rational' status that s/he lost in the first place. I reiterate that the child does not have to accept and/or internalise the medical model discourses; doing so increases the child's likelihood of being exited from the remedial system because a position of 'compliant' is far less problematic to the school than a position of 'resistant'.

I emphasise here that I am not attempting to portray a binary between children identified as experiencing learning difficulties as 'docile' and children not identified as identifying learning difficulties as 'not docile'. My intention here is to examine the specific context in which I see power

operating in a less covert fashion. That context is the school and that power is the power to 'label' officially a child as experiencing a learning difficulty. The power is implicit not only in the act of labelling, but also in the social maintenance of that label by the stakeholders through their various acts of positioning. Therefore general population students are also the sites of power/knowledge and discourse and thus can be considered 'docile' as well, owing to the multiplicity of factors impacting upon them.

The significance of viewing the child as a 'docile body' in this thesis is both considerable and crucial. It highlights the effects of power/knowledge and discourse upon the individual child by establishing her/his body as an object that is a hostile site of conflicting and competing discourses, subjectivities and institutional regulations. In viewing the child identified as experiencing learning difficulties as a 'docile body', I am acknowledging the aggressive environment in which that child exists. Moreover, I am noting that s/he has little agency or voice when it comes to making decisions about her/his academic future. Power is implicit in both domination and resistance (Foucault, 1980). The child is 'silenced' and therefore rendered irrational because s/he has inadequate understanding of and access to the very discourses working to dominate her/him. S/he has little opportunity for resistance.

The implication here is drawn out in my data analysis chapters as the child is positioned by others (myself included) and any action by that child outside the stakeholders' perceptions (and constructions) of that child is

explained in terms of 'learning difficulty characteristics' rather than as resistance. For example, a child in a general population classroom who has not been diagnosed as experiencing learning difficulties who misbehaves will most likely be positioned by the teacher as 'naughty' and the teacher may work promptly to 'correct' that child's behaviour by employing any number of disciplinary mechanisms. However, if one were to view the same child as a child identified as experiencing learning difficulties, then the view of the misbehaviour may be interpreted as that of 'frustration' as a result of 'struggling' to access the curriculum. This does not mean that the child is exempt from the teacher's behavioural expectations and disciplinary mechanisms. However, the socio-cultural and historical context of the situation provides us with an opportunity to view the child's docility as well as the difficulty for that child to resist the social consequences of the label that s/he has been given.

Ironically, because maladaptive behaviour and learning difficulties diagnoses may have 'failure to access the curriculum' as a commonality, the un-labelled child runs the risk of 'falling behind' in the classroom if her/his poor behaviour continues, thereby presenting the child with the opportunity to be the subject of learning difficulty assessment. One major implication of this possibility is that learning difficulties can be positioned as a panacea if the stakeholders' disciplinary mechanisms falter in any way. Because the learning difficulty label excuses all involved, issues such as behaviour could continue to be a problem.

The particular relevance here is that one of my interviewees was a "Behaviour Management Officer". As a result of behavioural issues, the school assigned funding to hire an individual whose sole task was to work with any children who were exhibiting maladaptive behaviour. In the school, this position was a full-time position that was filled by a fully qualified teacher. The position continues to exist at the school as of the submission of this thesis, although the administrators concede that they 'dislike' the term 'behaviour management officer' and there is little consensus as to what the official title should be.

Interestingly, Education Queensland draws specifically upon research that genders behaviour (Collins, Kenway & McLeod, 1996) and has resulted in a number of *Boys in Education* (Queensland Department of Education and the Arts, 2002-2005) initiatives designed to increase the academic success of boys. Whilst I do not wish to pursue a debate regarding this movement, I have two points to make about it as a result of its relation to my study. The first point is that a gendered view of academic ability excludes a variety of 'other' factors that could play a part in the success and/or failure of the child, whether male or female. The second point is that, of the seven parents in my study, one parent – Anna – had a daughter identified as experiencing learning difficulties. However, out of the children identified as experiencing learning difficulties, Anna's daughter is the only one to have successfully exited back into the mainstream classroom without any more support. The remainder of the children are still receiving assistance from the Learning Support Unit.

This example appears to be a ‘sign of the times’ and to reinforce the necessity to focus upon boys’ education. However, I contend that the individuals have been ‘taught’ to look for gendered differences; thus, if boys are considered inherently to have behaviour problems, then it is likely that by contrast a female student would be more likely to improve, thereby leading one to question whether behaviour plays a part in the ‘identification’ of learning difficulties. It is for this reason that in Chapter Six I have included ‘behavioural’ as one of five potential ‘other’ explanatory frameworks for a child’s inability to access the curriculum.

The child’s docility is a direct result of the coercive power/knowledge and discourse elements that combined to form a typology of that child, thereby dictating her/his elements, gestures and behaviours (Foucault, 1977, p. 138). Ultimately the child/student identified as experiencing learning difficulties has been subjected to the shifting power of discourse. Here the child is the site of various discourses, all of which operate to effect change upon that child and her/his sense of identity whilst providing little – if any – opportunity for resistance. Because it is the ‘established’ ways of thinking and knowing that serve to subjugate the particular child’s knowledge, I wrote above of the dominant way of thinking, or “established régim[e] of thought” (Foucault, 1980, p. 81). This ‘way of thinking and knowing’ is partially responsible for the docility of the child, considering that it represents a dominant and repressive view of the individual child identified as experiencing learning difficulties.

Moreover, the children identified by the teachers and specialists as experiencing learning difficulties can be seen as pliable, considering their placement into a program of remediation is designed to assist them in accessing the curriculum. Therefore the control over the child's education is in the hands of the adult stakeholders as they have 'more' authority in their positioning of the child. The dominant way of thinking is partially responsible for the docility of the child, considering that that child is the site of competing and conflicting discourses as the adult stakeholders establish their power over the child based upon their particular knowledges.

I argue that the medical model is the dominant model used to explain a child's inability to access the curriculum. Although there are various reasons cited and possible for this perceived inability, a majority of people are driven to believe that the professional knowledge of teachers, administrators, doctors and psychologists is most authoritative when determining why the child cannot access the curriculum. With the two sub-sections of this section presented to this point, I have established why and how power/knowledge plays such a significant part in this thesis. They are inextricably linked and each informs the other. Thus, we created language and meaning and therefore discourse, but as a result we are now subjected to the power that centuries of 'privileged thought' have given to those discourses and ways of thinking and knowing.

The ‘ripple effect’ of the sciences that gives them strength is the idea that the individuals involved with those sciences are establishing what is/is not ‘true’ and providing a lens through which we view our world:

“…knowledge is not…a reflection of reality. Truth is a discursive construction and different regimes of knowledge determine what is true and false” (Phillips & Jørgensen, 2002, p. 13).

The expanded number of people who examine the world through that lens results in the increase in the power of the individuals creating that knowledge responsible for explaining what the individual sees when looking through the lens. Thus, the individuals who define what knowledge ‘is’ are obviously best positioned to provide us with the answers to our questions regarding the world, society and even ourselves. Here the doctor can discuss the patient, the psychologist can discuss the schizophrenic, the lawyer can discuss the criminal and the teacher can discuss the child identified as experiencing learning difficulties but very rarely do we observe the reverse. That is, the individuals contributing to dominant ways of thinking also contribute to dominant ways of acting, both of which can be regulated, analysed and – if necessary – manipulated or changed by the institution, or in this case by the school.

When considering the ‘methodological precautions’ outlined above as a basis not only for this chapter, but for this study as well, I endorse the previously outlined ideas as a guide for examining adult stakeholder constructions of the term ‘learning difficulties’. I did not seek to identify

specifically an institution or an individual responsible for the subordination of children identified as experiencing such difficulties. Instead, I sought to focus on an approach that sees individuals and groups, such as the administrators, teachers and parents, accept responsibility for the education of the child identified in this way. This point sits in contrast to a scenario whereby individuals – by their occupation of medical model discourse subject positions – shift blame. This being the case, learning difficulties are a dynamic and culturally situated phenomenon whereby there is a vast number of issues working simultaneously to produce and maintain the learning difficulty typology.

Thus, examining the situation without acknowledging socio-cultural contextual factors would fail to address the multiplicity of issues colluding to establish the 'case' in the first place. In Foucauldian terms:

> [T]o follow the complex course of descent is to maintain passing events in their proper dispersion; it is to identify the accidents, the minute deviations – or, conversely, the complete reversals – the errors, the false appraisals, and the faulty calculations that gave birth to those things that have value for us; it is to discover that truth or being do not lie at the origin of what we know and what we are, but the exteriority of accidents. (Foucault, 1984, p. 81)

Thus, I examined these issues by way of individual narratives of the participants in order to yield insight into the multiplicity of reasons that students identified as experiencing learning difficulties fail to access the curriculum. Moreover, with regard to power relations and their presence within the Queensland regional primary school in which this study took place, the individuals interviewed defined the learning difficulty typology

simultaneously as they described it and worked collaboratively with other individuals within the established regime of thought such as other school professionals, doctors, psychiatrists, psychologists and paediatricians.

At this point, it is important to reiterate the relationship between knowledge/power and discourse. In order to assist with understanding the establishment of the relationship mentioned above, I have developed Figure 3.2 below.

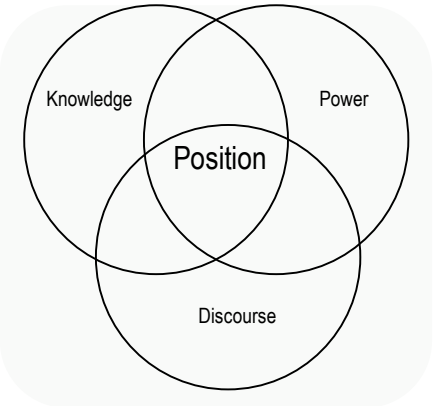



Figure 3.2. The tripartite characteristics of positioning

As I have argued above, the construction of learning difficulties relies upon the individual participants in the study occupying subject positions. Those subject positions are provided by the many and varied discourses operating within this specific socio-cultural context. That is, the conversations with me by the individuals involved in the study – although speaking 'freely' and having volunteered to do so – are governed by the 'rules', both overt and covert, about what can be said at any particular time. Thus, through discourse(s), the individual is able to construct the typology of what a child identified as experiencing learning difficulties *is*. As positioning is a

'discursive event', we are able to establish the 'way' in which the individual constructs her/his knowledge about learning difficulties based upon the discourse(s) s/he draws upon.

If the individual deficit is discursively produced, then the inextricable relationship between discourse and power becomes apparent by problematising the social reality of the learning difficulties label. I draw upon Hall's (1992) summary of the discourse–power relationship below and note that Hall also implicates knowledge in that relationship:

> Not only is knowledge implicated in power; discourse is one of the 'systems' through which power circulates. The knowledge which a discourse produces constitutes a kind of power, exercised over those who are 'known'. When that knowledge is exercised in practice, those who are 'known' in a particular way will be subject (i.e. subjected) to it. This is always a power relation. Those who produce the discourse also have the power to make it true – i.e. to enforce its validity, its scientific status. (p. 295)

In the process of acknowledging that detailed hierarchies exist with regard to institutions such as the regional primary school in which this study is located, it is important to recognise that power relations have been established prior to the individual, such as a school administrator, ever encountering the school as s/he was already a systematic 'part' of the power process when engaging in learning (the professional knowledge) required to fulfil the requirements of the system into which s/he entered. Thus, the hierarchy (of knowledge, in this case) was able to maintain its 'control' over the information through segregated levels and ranks whilst simultaneously maintaining a complex chain of training and authority.

Although this statement suggests a 'top-down' approach to power, I contend that it represents the way in which the Western world has institutionalised power in order to attempt to harness its energy within institutional hierarchies. As such, those power relations that promote subjugation become evident in the *historical*, or *traditional*, way in which institutions have compartmentalised and effectively 'controlled' the production and distribution of knowledge and information. That is, rather than attempt to 'train' the individual through 'corrective' or 'normalising' procedures of the body (e.g., corporal punishment), the individual was indoctrinated into the institution with a notion that his/her 'professional knowledge' carried with it a set of ideals, responsibilities and expectations that set her/him apart from other professionals as well as other individuals. However, that 'professional knowledge' would not have an effective means of exerting power if established ways of thinking and knowing – communicated as discourse through language – were not enacted. Thus, discourse can gain and lose power just like the individual who uses a particular discourse. The continuous interplay of knowledge/power in the form of discourse presents the individual with subject positions that will ultimately influence her/his particular standing in the local moral order.

Therein lies the problem. Keeping with Foucault's "methodological precautions" (1980, p. 96), one is able to examine other 'avenues' of power than those of the 'traditional', top-down notion. In one sense, power does not necessarily follow the 'rules' that we – as members of a Western society

– have created for it institutionally. Moreover, if power is neither centralised nor localised, then it becomes increasingly difficult to resist. If this is the case, then the "established régimes of thought" (p. 81) relying upon medical model discourse(s) as a foundation for the individual deficit typology cannot be seen as solely responsible for the creation and maintenance of that typology. Although I agree that those "régimes of thought" (p. 81) play an important part in the perpetuation of the individual-deficit notion, I argue that, wherever there is power, there will be resistance. That is, if power cannot be isolated within a specific individual or institution, then I must seek not only to examine explanatory discourses other than the medical model, but also to avoid attempting to identify a specific 'who' or 'what' is responsible for the perpetuation of the typology.

*Rationality*

My justification for the effectiveness of this version of a post-structuralist analysis of discourse lies in the notion of rationality. As one of its foundations my study has a strong undercurrent of 'deviance'. The simplified version of what a learning difficulty *is* merely questions the 'difference' between students who are able to access the curriculum and students who are not able to access that curriculum in a general population classroom. I contend that a student's ability to access the curriculum is relative to his/her ability to conform to the educational system's rules and regulations within a specific socio-cultural context. Non-conformity requires 'remediation' in assisting the individual to 'understand' (if not

internalise) the rules and regulations required to move efficiently through the school system.

Rationality's contribution to this study is that it provides a way of regulating an individual's speech and actions within her/his particular social context. The illumination of the implication of rationality here is a result of my social constructionist approach positing that people's actions are intentional, yet they have to negotiate to establish the particular meaning of their action(s) with others in a social context. The assumption is that people want to be considered rational so that they can effectively get their message across. Thus, in a system where meaning is created, we must acknowledge the rules of that social system in order to ensure that we have meaning and that our voice is not silenced.

As Foucault (1977) noted, we establish the normal through the abnormal. That is, we do not go out and actively define what is normal and build our society around that notion; on the contrary, we work out what/who is 'normal' by positioning ourselves as different from those whom we label as 'abnormal'. In Foucault's (1977) research, this is exemplified by the discussion of how the imprisonment and surveillance of prisoners and mental patients occurred in order to analyse and manipulate their bodies simultaneously, thereby rendering them "docile bodies" (1977, pp. 135-169). A body is docile that "may be subjected, used, transformed and improved" (p. 136), and I consider the child identified as experiencing learning difficulties to be such a body.

As a result of informed decision-making by individuals possessing scientific 'knowledge', those patients – and these students – were rendered irrational, in that they were viewed as unable to make their own informed decisions about their bodies and their lives. Thus, the resulting emphasis upon structure and order as a way to control the individual further removed her/him from the possibility of individuality and autonomy. The function of discourse is to discredit the speaking possibilities of those who are marginalised whilst legitimating the speaking opportunities of those in power (Hook, 2001, p. 43). Even though there is an established notion of normal, that notion is a result of positioning ourselves as such and others as abnormal.

However, the 'catch' is that what is ab/normal is culturally and contextually bound and thus changing all the time. This concept of rationality is recognised and embraced by positioning theory and therefore Harré and van Langenhove (1999) challenge the various structures and artefacts of hierarchical power in place that have traditionally subordinated the notion of agency. The concept of rationality is important here because it is through discourse that we present ourselves and seek to be understood and accepted as a result of our speech-act(s):

> The imminent rationales of a particular discourse are misunderstood if one converses outside of the existing conceptual terrain, rendering the converser to a position of irrationality and ignorance and of no importance or real relevance in terms of the discursive parameters of the time. (p. 44)

If one presupposes that at a basic level each individual possesses a notion of ab/normality and ir/rationality, then one can say also that we have a notion of deviance and conformity, for they are inter-related. One major tenet of positioning theory is that, if people are aware of ab/normality or ir/rationality and want their words (which represent their self – or thoughts, opinions, ideals, morals, etc) to have validity (and thus avoid being rendered irrational), then an analysis of their words will allow me to dissect the discourse(s) used in order to determine their 'reason' for a child's learning difficulty (or abnormality).

In this section, I have discussed the Foucauldian concepts of "power/knowledge" (1980); the "docile body" (1977); and the "established regim[e] of thought" (1980). In addition, I have presented the concept of 'rationality'. These concepts serve collectively to question the ways in which learning difficulties have been and continue to be constructed. Moreover, examining learning difficulties through a Foucauldian lens has enabled me to highlight specific instances of domination and resistance as the adult stakeholders positioned themselves and others when discussing learning difficulties.

In the following section, I discuss 'episodes'. Episodes are the social interactions from which one can extract positions, speech-acts and storylines. Although an episode can be considered to be any social interaction in which the individuals involved attempt to convey meaning, the 'episode' forms the basic metaphorical area where the positioning that

occurs in Chapters Five and Six takes place. That is, the episode is where one can look to find the positions, speech-acts and storylines that comprise positioning theory.

**Episodes**

For Harré and van Langenhove (1999), the starting point of positioning theory "…is the idea that the constant flow of everyday life in which we all take part is fragmented through discourse into distinct episodes that constitute the basic elements of both our biographies and of the social world" (p. 4).

Thus, 'episodes' will be discussed here to provide a broad overview of the metaphorical location where positioning acts occur. Episodes can be defined as "any sequence of happenings in which human beings engage which has some principle of unity" (Harré & Secord, 1972, p. 10). *Ergo*, any social interaction in which the participants interact with the intention to communicate can be considered an episode. The importance of the use of 'interact' here is that its premise moves me away from the challenge of attempting to interpret a meaning of an act as uni-dimensional. For example, in this thesis, a speech-act is an act that requires interpretation of the meaning by both the speaker and the hearer. This idea of a speech-act sits in opposition to Searle's (1979) interpretation of it as being defined by the social intention of the speaker (Davies & Harré, 1999). The implication of discussing speech-acts in this section is that the accomplishment of the speech-act is dependent upon both individuals' acceptance of it as such and

this acceptance can be gained only through the joint construction of storylines within that particular episode.

For the purpose of this study, an episode is a one-to-one interview with the administrators, teachers and parents of children identified as experiencing learning difficulties in a Queensland regional primary school. The purpose of the interviews was to determine what the interviewees understand to be the origins of learning difficulties. The resulting storylines allowed me to view how administrators, teachers and parents positioned themselves and others during the course of a conversation about their experiences with those children.

From the above, one can see the social constructionist aspect of positioning theory emerging. That is, human social interaction is perceived as being goal-oriented and restricted by the presence of group norms, thus regulating what can be said or done and by whom within each specific social encounter. Hare and Herbert (1988) describe episodes as "…the natural unit of social activity. During a single episode the participants follow a plan or carry out the actions necessary to complete a task. The beginning and end of an episode is [*sic*] often marked by a ceremony" (p. 4). Thus, each participant in an episode has a distinct initiative, or message, to convey during the course of the interaction. The success or failure of this initiative is based upon the speakers' occupation of metaphorical spaces known as positions. It is through positions and the positioning of others and ourselves that we establish our worldview.

The concept of an episode allows the researcher to break down social interactions, or exchanges, into analysable chunks. That is, even though the dynamic aspect of a position challenges stagnation within a particular role, my study requires that I choose specific 'snapshots' of speech-action in order to proceed with the analysis. The particular episodes in which I engaged were interviews and they can be viewed as 'episodes' for two reasons. The first reason is that it was a social exchange in which there was a discernable beginning and end. In this case, actions such as the formalities of greeting and departing of the adult stakeholder signalled the beginning and ending of the interview sessions. The second reason is that, in each distinct episode, meaningful interaction took place as the participant attempted to convey to me her/his thoughts, feelings and opinions regarding learning difficulties, thereby constructing what a child identified as experiencing learning difficulties is/is not.

**Positions**

In this section I discuss the first of three inter-related aspects that comprise positioning theory. As positioning is a conversational phenomenon and occurs in episodes, it is necessary to discuss here what a position is and how it contributes to understanding the sequence of events that unfold in a particular episode. Positioning theory is comprised of three interdependent aspects: positions, speech-acts and storylines. Of primary importance is the way in which positions, speech-acts and storylines all exist as discursive action. That is, people negotiate to establish themselves and their

viewpoints through language drawing upon discourse. Each interaction consists of positions, speech-acts and storylines and the identification of these components is what an analysis seeks to do. A specific example of the analysis of positioning understood in this way will be presented in both this and the following chapters.

I have drawn on Boxer's (2003) diagram (Figure 3.3 below) in order to illustrate the relationship among positions, speech-acts and storylines and to show that positioning is a dynamic, conversational process. It can be seen that each component of the 'positioning triad' is a discursive process and can be engaged with in order to position either oneself or an 'other'. Moreover, in positioning an 'other', one is ultimately positioning oneself.

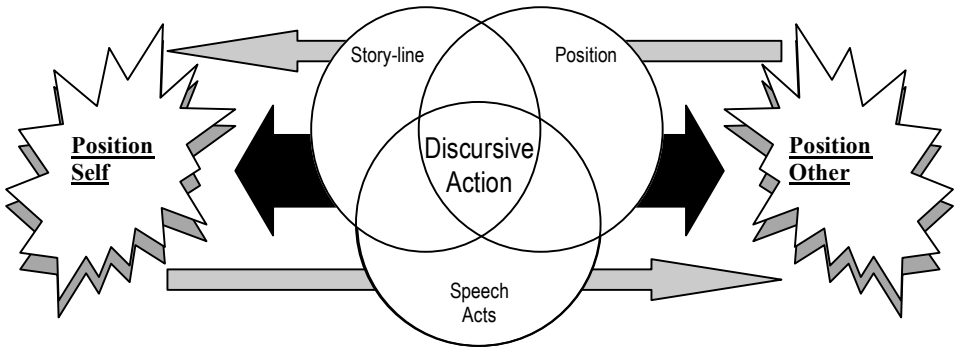



Figure 3.3. The tripartite characteristics of positioning theory (Boxer, 2003, p. 256)

In Figure 3.3, the heavy black arrows represent the initial positions that are taken up by the individuals (first-order positioning) at the initiation of an interaction. The finer grey arrows represent the subsequent positions resulting from the individuals' metaphorical fencing as they negotiate that first-order positioning. However, second-order positioning may not take

place if the individual is content with the position that s/he has taken or been given, and therefore declines to resist such first-order positioning and thereby contributes to second-order positioning. Third-order positioning occurs when an individual who is outside the social interaction comments upon the interaction, thereby employing the act of positioning. An example is the observational and outside view of a sports commentator (Boxer, 2003).

The concept of a 'position' has as its roots several different influences. Generically, it was used in marketing in a way that was similar to that of a military position, where the objective was to locate the product strategically in the best place in relation to competitors' products. However, Boxer (2003) argues convincingly that Davies and Harré's seminal (1990) and subsequent (1999) works on positioning theory utilise a feminist/Foucauldian foundation (p. 255). Considering that Foucault is most often classified as a post-structuralist (Usher & Edwards, 1994) and sometimes as a post-modernist because of his fulfilling Lyotard's (1984) definition of post-modernism – "an incredulity towards metanarratives" (p. xxiv) – I consider positioning theory a post-structuralist re-interpretation of the self. In this context, it is noteworthy that Davies and Harré (1990), building on the work of Foucauldian-influenced feminists, presented the idea that "positioning is an ever-negotiable definition of the self" (Boxer, 2003, p. 255).

Viewing the self in a 'post' sense results in a dynamic view of the self as an "open slate on which persons may inscribe, erase and rewrite their identities as the ever-shifting, ever-expanding and incoherent network of relationships invites or permits" (Gergen, 1991, n.p.). This view of the individual leads to the notion of a 'de-centred subject', or a person who can never be the same self day after day because of discourse, culture, social setting and context, yet that individual retains agency through the ability to choose a particular subject position – a common link among Davies and Harré (1990), the post-structuralist feminists who influenced their seminal work (Hollway, 1984; Weedon, 1987) and Foucault (1972, 1977).

Below I outline briefly the work of Hollway (1984) and Weedon (1987) in order to provide a snapshot of their contributions to positioning theory as well as to demonstrate Foucault's (1972) influence upon their work. Whilst the outline is not meant to be detailed, it is intended to provide the reader with the foundational ideas necessary to grasp the view that positioning theory presents. Foucault's influence upon theories of discourse, the subject and power/knowledge is undeniable and therefore I devoted an earlier section of this chapter to his notion of power/knowledge (1980). This influence is significant in applying positioning theory to a contemporary educational setting where issues of domination and resistance (power) are commonplace and where the stakeholders involved with children identified as experiencing learning difficulties are constantly engaging with discourses that shape and inform their subjectivity in an effort to understand the reasons for and causes of such difficulties.

The Foucauldian influence upon the authors who influenced positioning theory assists in understanding positioning theory as well as in complementing it in this study's establishment of the various ways in which medical model discourses are internalised and reproduced as well as contested and rejected by the stakeholders involved. Thus, the notion of agency in positioning becomes apparent as people can either enact or obstruct the dominance of the medical model depending upon how they position themselves and others discursively.

Foucault's (1972) notion of 'subject positions' is the foundation of the concept of a 'position' in positioning theory. That is, individuals draw upon specific discourses in order to represent themselves and in doing so they create an 'other'. Thus, the establishment of an individual has implications for others involved in the conversation because the subject positions being occupied create parameters within which what can and cannot be said and done is negotiated.

van Langenhove and Harré (1999) draw specifically upon Hollway's (1984) use of the terms 'position' and 'positioning' in her work on the construction of subjectivity in heterosexual relations and note that their usage of those terms "is in line with how Hollway used them" (van Langenhove & Harré, 1999, p. 16). Here Hollway (1984) discussed "positioning oneself" and "taking up positions" (p. 236) as she explained how:

> Discourses make available positions for subjects to take up. These positions are in relation to other people. Like the subject and object of a sentence…women and men are placed in relation to each other through the meanings which a particular discourse makes available. (p. 236)

Hollway's (1984) contribution can be seen as a clear statement of the concept of subject positions that exists within discourse for individuals to 'take up'. In making this contribution she employed an explicitly Foucauldian view of discourse and emphasised Foucault's (1979) influence upon her work. At the same time, Hollway's work has been adopted in contemporary positioning theory (van Langenhove & Harré, 1999). Hence, Foucault's influence on the development of positioning theory and on the concept of positions is both direct and substantial.

Moreover, as Boxer (2003) noted, "Davies and Harré (1990) drew on Weedon (1987)…to develop the idea of positioning theory" (p. 258). For Weedon (1987), an individual is a "thinking, feeling subject and social agent, capable of resistance and innovations produced out of the contradictory subject positions and practices" (p. 125). Her contribution to positioning theory is a result of her elaboration of subject positions within the context of a "male gaze" (p. 112). Here Weedon (1987) draws upon both Foucault's (1972) concept of a 'subject position' and his notion of the 'gaze' – "a technology of power, by which the object of the gaze becomes known to the observer" (Fox, 1993, p. 24).

One implication of the 'gaze' is the objectification of the individual under the assumption that the objectification is for the good of that individual, thereby conceptualising the body "as the proper object of regimen and control" (Foucault, 1979; cited in Freund, McGuire & Podhurst, 2003, p. 7). Boxer (2003) highlights two aspects of the gaze and contends that they are relevant to positioning:

> First, gaze describes the power to watch and judge or arrive at a prognosis. Second, it explains how members of the community that comprises the gaze are able to make statements that are taken as truth by those outside the community. (p. 257)

Thus, the implication of a Foucauldian understanding of power within positioning theory is undeniable. Hollway's (1984) and Weedon's (1987) contributions to positioning theory are clear and explicit, leading in turn to the recognition of Foucault's (1972, 1977, 1980) influence both directly and indirectly upon the development of positioning theory and the concept of a 'position'.

Davies and Harré (1990) illustrate the diversity and complexity of positioning theory when they explain the concept of a subject position as it operates within positioning theory:

> A subject position is a possibility in known forms of talk; position is what is created in and through talk as the speakers and hearers take themselves up as persons. This way of thinking explains discontinuities in the production of personhood with reference to the fact of multiple and contradictory discursive practices and interpretations of those practices that can be brought into being by speakers and hearers as they engage in conversations. (1999, p. 52)

There are numerous subject positions on offer from a variety of discourses; however, the specific discourse that the individual draws upon to present her/his viewpoint will ultimately position that person and the other(s) while influencing/altering the unfolding storyline. Discourses provide subject positions for the participants to take up, but it is the enactment of those discourses that impacts upon the influence of the particular chosen discourse. Consequently, the individual is dynamic and never fixed because of the combination of the array of possible speech-acts that could be made and the multiplicity of cultural, economic, historical, political and social forces acting upon those speech-acts.

**Speech-acts**

In order to conceptualise speech-acts (or the view of language as a discursive tool that has social force) as they operate within the positioning triad, I first establish what 'acts' are to be considered. Slocum and van Langenhove (2003) state that: "Acts are the *meaning-full* counterparts of actions. The act is what is accomplished socially through a particular action, which can be constituted by linguistic and/or non-linguistic discourse" (p. 225; emphasis in original).

Thus, within a social constructionist framework, where action is intentional, a speech-act can be viewed as having an effect just as can a physical act. Each type of action has social consequences, and the analysis of speech-acts assists with determining what some of those consequences are. As Davies and Harré (1999) note, a "conversation unfolds through the joint action of

all participants" (p. 34). These participants are each attempting to make her/his speech-act determinate (speech-action), thereby achieving her/his respective intention and enabling speech-action to become a determinate speech-act only when each individual accepts it (p. 34).

I am wary here of presenting a possible view of causality. It is for this reason that I emphasise that the combination of discourses, positions and cultural, social and historically shifting contexts all act upon the utterance. As a result, one is prevented from making 'cause and effect' generalisations. This ensures that each interaction is viewed in its socio-cultural and historical context with results that cannot be extrapolated owing to the particular components of each interaction.

In discussing acts, Slocum and van Langenhove (2003) use the example of a handshake (as in Table 3.1 following) in order to demonstrate their point that a handshake is a non-linguistic action that can accomplish the act of either sealing a bet or being a greeting (p. 225).

However, the accomplishment of a greeting can occur also with the tip of a hat or with a nod of the head. Thus, when extending the concept of an 'act' to that of a 'speech-action' or 'speech-act', a (linguistic) utterance like a (non-linguistic) handshake can have multiple social forces and therefore accomplish multiple social acts (Slocum & van Langenhove, 2003, p. 225). At the same time, what the speech-act accomplishes is contingent upon the

| Position | Speech and other acts | Storyline |
|---|---|---|
| A cluster of rights and duties to perform certain actions with a particular significance as acts. May also include prohibitions or denials of access to some of the local repertoire of meaningful acts. Positions are realised in current practices, which people can adopt, strive to locate themselves in, be pushed into, be displaced from or be refused access to, recess themselves from and so on, in a highly mobile and dynamic way. (p. 5) | Every socially significant action, intended movement or speech must be interpreted as an act, a socially meaningful and significant performance. A handshake is an intended action. Does it express a greeting, a farewell, congratulations, the sealing of a bet or what? The act is significant only as far as it is given a meaning in the unfolding episode (social interaction) of which it forms a part. Upon interpretation, each act is regulated by the cultural and historical standards for action, or 'rules'. (p. 6) | Social episodes are dynamic, unfolding as people participate in certain ways. Episodes do not unfold randomly. They tend to follow conventional patterns of development, called storylines. Each storyline can be expressed in a loose cluster of narrative conventions. (p. 6) |

Table 3.1. Interdependent aspects of the positioning 'triangle' (adapted from Harré & Moghaddam, 2003, pp. 5-6)

successful negotiation by the individuals involved. Thus, the act of positioning is the assignment of "…fluid 'parts' or 'roles' to speakers in the discursive construction of personal stories that make a person's actions intelligible and relatively determinate as social acts" (van Langenhove & Harré, 1999, p. 17).

Positioning is a conversational phenomenon as speech is considered to have social or "illocutionary" force (Davies & Harré, 1999, p. 34) because conversation is a form of social interaction that yields social products, such

as interpersonal relations (p. 34). As Table 3.2 below indicates, the illocutionary force of an utterance is what is achieved *in* saying something, whilst the perlocutionary force is what is achieved *by* saying something (van Langenhove & Harré, 1999).

| Force of utterance | What is achieved | Example |
|---|---|---|
| Illocutionary | What is achieved *in* saying something | Congratulating someone |
| Perlocutionary | What is achieved *by* saying something | Pleasing the recipient of the award |

Table 3.2. Illocutionary and perlocutionary force of an utterance (van Langenhove & Harré, 1999, p. 17; emphasis in original)

It is through positioning theory that it is possible to examine what the speech-act accomplishes for both the speaker and the hearer, given that a speech-act positions both. Indeed, it can even position an 'other' (someone who is not present). In this thesis, the primary focus is upon the ways in which the administrators, teachers and parents position the child identified as experiencing learning difficulties in their construction of her/him. However, I also focus occasionally upon the positioning that occurred during the interview between the stakeholder and me in situations where it is deemed warranted as a result of the storyline and/or the context.

In positioning theory the concepts of perlocutionary and illocutionary acts assist in establishing respectively *what* the speech-act accomplished and *how* the speech-act accomplished its task. If – from a social constructionist standpoint – our actions are intentional and goal-oriented, then one can further understand the act of positioning as a deliberate move to express an individual worldview.

For Davies and Harré (1999):

> [A] conversation unfolds through the joint action of all the participants as they make (or attempt to make) their own and each other's actions socially determinate. A speech-*action* can become a determinate speech-*act* to the extent that it is taken up as such by all the participants. (p. 34; emphasis in original)

The notion of *determinate* refers to the concept of rationality discussed above. That is, the clarity and intelligibility of the speech-act operate on a spectrum ranging from immediate, where it is recognised and accepted, to not immediate and questionable to "radically indeterminate" (Tannen, 1990; cited in Harré & van Langenhove, 1999, p. 16). The implication of determinate speech-acts is that they are required in order to convey viewpoints/subject positions successfully in social interaction. Thus, the speech-act must 'make sense' as it exists within the socio-cultural context in which it occurs. Otherwise one runs the risk of being rendered irrational, thereby limiting, and being limited in, what one can or cannot contribute to the conversation.

**Storylines**

Storylines present the final aspect of the positioning/speech-act/storyline triad that requires explanation. Within a particular conversation, or episode of human interaction, several storylines or themes are developed simultaneously. However, the interpretation of those themes is dependent upon the individuals involved. Davies and Harré (1999) consider the presence of numerous storylines to be "braided" (p. 39) and explain that

storylines are organised around "various poles, such as events, characters and moral dilemmas" (p. 39). Moreover, "Cultural stereotypes such as nurse/patient, conductor/orchestra, mother/son may be called on as a resource" (p. 39).

The concept of a storyline is essentially that of the socio-cultural and historical context in which the social interaction takes place and that "implicitly or explicitly link[s] the past with the present and future" (Slocum & van Langenhove, 2003, p. 225). What this means is that there are three key features of social interactions that must be taken into consideration when attempting to understand the construction of social and psychic phenomena (Harré & van Langenhove, 1999). These three considerations are what I refer to in this thesis as the social, cultural and historical context. I highlight these three key features here because they represent the forces that impact upon a statement and shape the power of that statement, thereby influencing the available or potential positions, speech-acts and storyline(s). Thus, no statement is ever 'neutral' (see "Power/Knowledge" above; "The Concept of Discourse" below).

A storyline is a way of highlighting the themes emerging – for each respective participant – from the social exchange taking place and therefore provides insight into the ways in which the individuals perceive themselves to be located. However, the implicit and explicit power that permeates within discourses means that the 'neutrality' of the discourse used by the individuals involved with the conversation is impossible. Therefore, as each

individual occupies a subject position, s/he is subjected to that discourse as the two function interdependently to create meaning. Since meaning is not achieved until all parties involved agree, the recognition of the socio-cultural context is necessary in order to illuminate the abstract borders regulating the social interaction (norms and mores).

The possibility of an act becoming 'determinate' relies upon the recognition and validation of that act by members of one's culture and the context within which the statement takes place. Moreover, "knowledge of the past and insight into the current conversation are necessary as well" (Harré & van Langenhove, 1999, p. 6), considering that what has been said ultimately affects what can be said, and what will be said as well as how that statement will be received by others.

By focusing upon the three features of social interaction, one is able to establish a glimpse of individuals as they work to position themselves and others and as they proceed eventually to positioning and re-positioning. Re-positioning is what affects the local moral order, or who can say what and at what time. Here the implication of Foucault's (1980) concept of power/knowledge for this study is that some speakers will have more power than others because of the knowledge they possess. That is, the discourses one has access to – and draws upon – will directly influence one's ability to negotiate meaning. Ultimately, the discourses one chooses impact upon the student identified as experiencing learning difficulties.

This is done either by way of individuals subscribing to and therefore promoting the idea that learning difficulties are 'in the head', or by people questioning the origin of learning difficulties as 'something' that may have been social. Without seeking to establish a nature–nurture binary, I emphasise that there is a very large number of ways that the interview texts could have been read and that a majority of the participants displayed ambivalence about the origin of learning difficulties, often contradicting themselves. The points of ambivalence were of particular interest to me as it was there that the shifts in storylines often occurred and equipped me to view the discourses operating 'behind the lines' that enabled the individual to 'make sense of' learning difficulties.

In the process of episodes being broken down into storylines for the sake of analysis, the concept of a storyline provides a method for linking the dynamics of social interaction with the broader frameworks grounding the interaction. In this case, that broader framework is the socio-cultural and historical contexts of the speakers. During an exchange the 'social force' of what we say is dependent upon those contexts and the historicity of the social interaction always impacts upon the possible exchanges of the individuals. If there are different interpretations of individuals' storylines and the meaning or understanding is not negotiated, then there may be issues of contention when two 'stories' diverge into separate and different meaning and interpretation.

In order to provide an example of positions, speech-acts and most importantly storylines, I draw upon the example that Davies and Harré (1999) provided. Although I have paraphrased this story here, I have retained the specific information necessary to emphasise the detail of a storyline.

Davies and Harré (1999) provided the example of a woman and a man who are attending a conference in a foreign city. The woman is ill and both agree that they will leave the conference to search for a chemist to buy medicine for the woman. After traipsing around a foreign city on a winter's day and finding no chemist, the two agree that it is time to end their search. At this point, the man makes a speech-action apologising to the woman for 'dragging her' all that way when she is ill. To this, the woman replies that he did not *drag* her; rather she made a *choice* to go. Davies and Harré (1999) note that the episode continued through a further number of cycles and that one aspect of the conversation included the man's dismissal of the woman's stance as hyper-sensitive and characteristic of feminists and minority groups. Although this statement does not necessitate description in detail here, it is required as background when I explain below four possible speech-acts and storylines associated with this episode.

Below I establish how the man's statement was not made determinate because of the second-order positioning that the woman engaged in. A speech-act becomes determinate and therefore accomplishes its tasks only when the individuals involved in the exchange agree. In other words,

anyone can perform a speech-action as it is just speaking, but a speech-act becoming determinate, or establishing its meaning, relies upon the other(s) involved and their acceptance of that act. This is essentially positioning, the meaning-making process of speech-actions. Although this is a brief story about two individuals engaged in a social interaction, each speech-act had intention and consequence. Thus, even though each person had an idea about the theme of their journey together, it was not until they spoke about it that their respective interpretations of it became evident. That is, it was not until the man's apology that the positioning occurred and then it is only through the context of the story that we can find who did what positioning.

In relation to the episode outlined above, I have identified two specific storylines while recognising that there are two more that will be discussed below. All in all, there are four storylines and they are: medical treatment; paternalism; joint adventure; and feminist protest. Firstly, I write of a 'medical treatment' storyline and then follow an explanation of that storyline with one of 'feminist protest'. In the 'medical treatment' storyline, the act of apologising is first-order positioning, in that the man positioned himself as well as the woman. Specifically, in apologising, the man was positioning himself as one who is caring and trying to help. He is trying to express sympathy by linguistically taking responsibility for the situation. However, in positioning himself as the 'nurse', the man adopts a position that may carry with it characteristics such as 'dominant' or 'strong' and therefore imply leadership. Simultaneously, the woman as 'patient' is presented with the opportunity either to accept this positioning and thus

allow the man to 'take care' of her or to reject the position and renegotiate the first-order positioning.

In this exchange, the woman chooses the latter because the former carries with it the idea that she is helpless and unable to take care of herself and therefore at the mercy of a man given her predicament. The issue of contention in the exchange is that the individuals are positioned with respect to two different and seemingly competing storylines. The woman's rejection of the man's positions re-positions both of them. The man now has to choose whether or not to accept his positioning of being 'paternalistic'.

Davies and Harré (1999) analyse four storylines identifiable as a result of the perspectives of both the man and the woman:

1 Man's storyline: medical treatment (p. 47)
2 Woman's view of man's storyline: paternalism (p. 47)
3 Woman's storyline: joint adventure (p. 47)
4 Man's view of woman's storyline: feminist protest (p. 47).

By identifying the storyline, one can then view the relative speech-acts and positions that can be found within them. Harré and van Langenhove (1999) assert that entering the analysis from the viewpoint of the storyline has a number of advantages, one of which is that the storyline assists in making sense of what has been said and what it has or has not accomplished. Below I extend the analysis of the man and woman's interaction to highlight briefly their speech-acts and positions and to emphasise that Davies and Harré's

(1999) example above exemplifies that a position is a real conversational phenomenon rather than an "analyst's tool" (p. 47).

The implications of this line of thinking are many. However, for the sake of this study, the idea that people can and do position themselves and others in conversation carries with it the idea that absent others can be positioned as well. Thus, in examining the positions of the adult stakeholders, I am also examining the ways in which those stakeholders position the child identified as experiencing learning difficulties. By examining the positions that are occupied, I sought to identify the discourses that the individuals drew upon in constructing that child.

In respect of the storylines identified above, I now identify the speech-acts and positions that occurred within them. I refer to the storylines above by number for sake of convenience and note that an interview text from my study will be analysed in the following chapter in order to provide the reader with an example of the methodological foundation for the data analysis conducted in Chapters Five and Six. I note here that Davies and Harré (1999) use the term "indexical offensive" (p. 47) to denote when a position is challenged. In keeping with my positioning theoretical approach, I do likewise in this particular section of the study. 'S-A' denotes a speech-act and 'W' and 'M' 'woman' and 'man' respectively.

In the following list, the first part of sentences 1-4 is the position(s) and the second part is the speech-acts:

1 M = nurse; W = patient. In the first storyline, man's S-A = commiseration (p. 47).

2 M = independent, powerful man; W = dependent, helpless woman. In the second storyline, Man's S-A = condescension. The indexical offensive is M to W (p. 47).

3 Joint positions for M and W = travellers in a foreign land. Woman's S-A is a reminder in relation to the storyline (p. 47).

4 M = chauvinist pig; W = righteous suffragette. Woman's S-A = complaint. The indexical offensive is W to M (p. 47).

In order to summarise the above information, I have developed Table 3.3 following. This table is to be considered the specific episode from which the positions, speech-acts and storylines were extracted. This table is useful in guiding the analysis of episodes, in that it provides a format for viewing and analysing acts of positioning. Below I tabulate the information above into a cohesive whole in order to provide the reader with the format that is more complex than, yet similar to, the tables used in Chapters Five and Six to present Davies and Harré's (1999) analysis of the stakeholders' utterances.

In the table, as with the previous two illustrations of a positioning analysis, the primary point is that "people can be living quite different narratives without realizing that they are doing so" (Davies & Harré, 1999, pp. 47-48). If the woman in the example had neglected to reply to the man's comment, then neither would have engaged in the positioning as the man's single utterance would remain unquestioned and his local moral order would stand.

| Whose storyline? | Position of man | Position of woman | Speech-act | Story-line |
|---|---|---|---|---|
| Man's storyline | Nurse | Patient | Commiseration | Medical treat-ment |
| Woman's view of man's storyline | Independent, powerful man | Dependent, helpless woman | Condescension | Patern-alism |
| Woman's storyline | Traveller in a foreign land | Traveller in a foreign land | Reminder in relation to the storyline | Joint adven-ture |
| Man's view of woman's storyline | Chauvinist | Righteous suffragette | Complaint | Feminist protest |

Table 3.3. A positioning grid of the woman's and the man's exchange

I stress here that words in the form of utterances do not carry determinate social meaning (p. 48). This is particularly important because the utterance needs to be placed within the context of the respective narratives in order for meaning to be achieved. Ultimately, as Davies and Harré (1999) note:

> One's beliefs about the sorts of persons, including oneself, who are engaged in a conversation are central to how one understands what has been said. Exactly what is the force of any utterance on a particular occasion will depend on that understanding. (p. 48)

The implication of this constructionist view of social interaction is the emphasis upon the socio-cultural and historical forces that have influenced the speaker(s). Moreover, considering individuals are continually working to establish meaning in a conversation, the idea is that there are unwritten 'rules' which normatively constrain what can and cannot be said and at what time. Thus, working to get one's point across is ultimately dependent upon the ability of the other to receive that point. Efficient communication means

that the least amount of second-order positioning has taken place as a result of the initial speech-act. As I have mentioned that positioning theory carries a social constructionist foundation, I address that foundation in the following section and establish how it contributes to this study of the construction of children identified as experiencing learning difficulties.

**Social constructionism**

In this section, I explain social constructionism, the belief that reality is created in conversation drawing upon discourse(s), and justify it as an effective conceptual tool for this study. Below I present the social constructionist model as Figure 3.4 in order to show that positioning as a discursive practice happens within a local moral order. That is, each conversation occurs within a framework comprising a local system of rights, duties and obligations, a local moral order and either public or private actions. This framework is considered to be the unwritten 'rules' regarding social interaction given that our speech and action are normatively constrained by a social notion of both 'normal' and 'appropriate'.

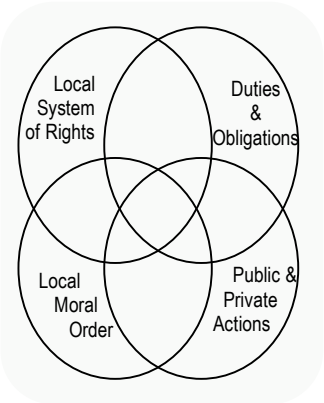



Figure 3.4. The social constructionist model as it relates to positioning theory (Boxer, 2003, p. 259)

Many researchers (Berger & Luckman, 1966; Coulter, 1979; Gergen, 1985, 1994; Harré, 1986; Harré & Gillett, 1994; Harré & van Langenhove, 1999; Shotter, 1975) have addressed the notion of the socially interdependent nature of social life. Berger and Luckman (1966) used the term 'social constructionism' in their book *The Social Construction of Reality* to describe how individuals and groups co-create their respective realities and how those realities came to be reflected in social practice. Although this approach, which examines how social phenomena are created and maintained by interdependent acts between and among individuals and groups, was formally labelled in 1966, it was not until Schneider (1985) wrote an essay about the condition of social constructionism for the *Annual Review of Sociology* that it "was recognized as a legitimate discipline" (p. 118). Thereafter, it came to be considered a dominant trend in the 1980s (Holstein & Miller, 1993). The emphasis upon social constructionism is how a co-created reality can be reflected in a social practice. In this thesis, I question how an abstract truth, such as the concept of a learning difficulty as an individual deficit, can become a part of the taken-for-granted assumptions of the adult stakeholders.

Social constructionism is introduced within this section because it contributes significantly to positioning theory (Harré & van Langenhove, 1999) and represents my particular philosophical approach to this study noted in the previous paragraph. Discourse analysis, as theory, will be addressed in the following section; discourse analysis as method will be addressed in the following chapter.

As a result of positioning theory's ties to social constructionism, two notable constructionist premises are evident:

> i. What people do, publicly and privately, is intentional, that is, directed to something beyond itself, and normatively constrained, that is, subject to such assessments as correct/incorrect, proper/improper and so on.
>
> ii. What people are, to themselves and to others, is a product of a lifetime of interpersonal interactions superimposed over a very general ethological endowment. (Harré & van Langenhove, 1999, p. 2)

From these two social constructionist premises, one can establish three main points. These three points are presented below and are intended to present the reader with basic tenets of the particular type of social constructionism that I employ by way of positioning theory in this study and that drives this particular section:

- Individuals are goal-oriented.
- An individual's behaviour is normatively constrained, or subject to societal judgement(s).
- An individual's subjectivity is the result of a lifetime of interpersonal interactions with other individuals.

Within a social constructionist framework the individual's actions and speech-actions are goal-oriented; the individual speaks and acts with a purpose. However, in speaking and acting, the meaning that the individual ascribes to her/his action is neither coherent nor understandable until the recipient responds to that action, thereby validating it. Moreover, what people say and do are regulated by the social norms that dictate increments of in/appropriateness. What people are 'to themselves and to others'

presents a philosophical premise that portrays an individual's identity as being fluid. That is, the individual develops an identity through a lifetime of interpersonal interactions, yet each representation of that individual is contextualised. The individual is constantly defining her/himself whilst being defined by others.

One specific contribution of social constructionism, and thus of positioning theory, is that there is no 'centred self'. Within the ever-changing social situations are located shifting and relative truths. Hence, the contribution that positioning theory makes, with its emphasis on position rather than role, is that it may be more difficult to target an individual or group for domination if that individual or group is not a 'fixed' target. In addition, because positioning theory is a contemporary concept and designed to transcend the static notion of role, it may account for the past/previous domination of individuals who were fixed within their particular roles. Here the implication is that it was much easier to objectify individuals in pre-modernity and modernity because of the rigid, rational and structuralist ways of thinking and knowing that prevailed and that reproduced themselves through individuals sacrificing agency for the sake of role. Thus, a social constructionist approach such as positioning theory emphasises the multiplicity of possible interpretations of any particular text. Because the objective is not to disclose a single truth about learning difficulties, positioning theory presents a challenge to dominant ways of thinking and knowing that have constructed the individual in a way that dominates and her/him.

There are numerous 'types' of social constructionism; they are most often characterised as being somewhere on the spectrum between 'strong' and 'weak' (van Langenhove & Bertolink, 1999). Burr (1995) asserts that there is not one specific description that covers all social constructionist approaches because they are too diverse. With this in mind, rather than exploring the many and varied versions of social constructionism, I have chosen to establish the similarities among the various approaches, which traverse the spectrum of social constructionism ranging from 'strong' to 'weak', as well as to locate my particular social constructionist approach. In this study, I am not attempting to prioritise a fixed meaning or concept (such as learning difficulties) or to compare that concept with a reality that is 'out there' and independent of the individual; rather, I am examining the emergence of a term and investigating its operationalisation and hence its function within a specific community of adult stakeholders.

The contribution that social constructionism brings to positioning theory is evident when examining positions, speech-acts and storylines. Because an individual is seen to speak or act with intention, the idea is that there is purpose in that action and the individual retains some aspect of agency, thereby being able (to some extent) to control the positions s/he finds her/himself in. The importance of agency as discussed above in the 'de-centred subject' section is important because the idea that an individual speaks/acts with intention implies the individual possessing some capacity

for choice – hence Davies and Harré's (1999) use of the term "choosing subjects" (p. 41).

Furthermore, the implication of a 'choosing subject' for this study is that its usage aligns me with neither 'strong' nor 'weak' social constructionism. It situates me 'somewhere in between' so that I am not positioned as 'strong' or 'radical' by averring that everything is a construction and there is no possibility for mutual meaning (thus incurring a potential charge of nihilism), and I am not positioned as 'weak' in that I ascribe to a social constructionist viewpoint that moves well away from rationality and the possibility of a single truth. This is discussed further below.

The normative and societal constraints of the goal-oriented individual which I wrote of above are important because of the reasons below when examined from the perspective of positioning theory. Those constraints regulate, or guide, social interaction. Therefore, they dictate when a speaker is rational, irrational or somewhere in between. The implication of this is that, if a person is operating effectively with the proper decorum, the chances are good that both the speaker and the hearer will accept their relative positions. If the speaker is irrational, then s/he will most likely be positioned as such and her/his contribution to the conversation will be either limited or unaccepted. In the third instance, the individuals are working to re-position themselves in order to communicate. This notion links to my sub-section on "rationality" earlier in this chapter as a person's actions establish meaning only within the parameters of the given socio-cultural context in which they

occur and the 'norm' in one society may not be the same in another. In addressing specifically the relation of these constraints to social constructionism, it is evident that an individual is more likely to 'fit' within the local moral order if s/he plays by the 'rules' of that particular moral order; there are unwritten social guidelines that ground the individual in her/his ability to communicate and that therefore build meaning for her/himself and with others.

The 'social' aspect of social constructionism alludes to the idea that meaning-making is neither an individual nor a solitary process. Thus, the conception of something as 'constructed' carries with it the implication that it was 'built' with purpose or deliberation. To contemporise an old saying, 'it takes two [or more] to tango'. That is, "words, as utterances[,] do not carry determinate social meaning" (Davies & Harré, 1999, p. 48). The implication is that a speaker may have a certain meaning in mind when making an utterance, but that meaning needs to be negotiated socially by both the hearer and the speaker. Moreover, in order for the speaker's intention to be completed and thus become determinate, the hearer and the speaker must agree. All of this negotiating occurs within the socio-cultural context which provides the rules of and for social interaction. Therefore, each interaction is regulated by the societal norms that exist. In order for an individual to communicate effectively, s/he must successfully navigate the normatively constrained socio-cultural conventions.

As a basis for understanding my social constructionist approach, I draw upon Burr (1995; cited in Phillips & Jørgensen, 2002, pp. 5-6) in order to provide Table 3.4 following depicting the four premises shared by all social constructionist approaches and in doing so acknowledge Gergen's (1985) influence upon Burr's (1995) work.

In this study, I have questioned the stakeholders' taken-for-granted assumptions regarding learning difficulties. Thus, the four premises in Table 3.4 assisted not only my understanding of the social constructionist framework, but also the articulation of what my study attempted to accomplish. I draw specifically upon each of these premises in order to relate them explicitly to my study. The first point is relevant because learning difficulties are questioned as a possible product of discourse. This is because they are considered a taken-for-granted assumption within the school where this study took place. The second point is relevant because it establishes that we and our thoughts, opinions and belief systems do not exist in isolation; rather, we are continuously working to establish meaning using our experience and cultural rules regarding what is good/bad, proper/improper, etc. The third point is relevant because it illustrates how learning difficulties can become incorporated into one's belief system as a taken-for-granted assumption. Thus, the very thing we may try to deconstruct may be a result of our interactions in the first place. Finally, the fourth point is relevant because it establishes that our actions are grounded in the rules of the particular social settings in which we find ourselves.

| **Premise of social constructionism** | **Elaboration/explanation** |
|---|---|
| A critical approach to taken-for-granted knowledge | Our knowledge of the world should not be treated as objective truth. Reality is accessible to us only through categories, so our knowledge and representations of the world are not reflections of the reality 'out there', but rather are products of our ways of categorising the world, or, in discursive analytical terms, products of discourse. (Phillips & Jørgensen, 2002, p. 5) |
| Historical and cultural specificity | We are fundamentally historical and cultural beings and our views of, and knowledge about, the world are the "products of historically situated interchanges among people" (Gergen, 1985, p. 267). How we view the world is historically and culturally contingent: our worldviews and our identities could have been different, and they can change over time. Discourse is a form of social action that plays a part in producing the social world – including knowledge, identities and social relations – and thereby in maintaining specific social patterns. (Phillips & Jørgensen, 2002, p. 5) |
| Link between knowledge and social process | Our ways of understanding the world are created and maintained by social processes. Knowledge is created through social interaction in which we construct common truths and compete about what is true and false. (Phillips & Jørgensen, 2002, p. 5) |
| Link between knowledge and social action | Within a particular worldview, some forms of action become natural, others unthinkable. Different social understandings of the world lead to different social actions, and therefore the social construction of knowledge and truth has social consequences. (Phillips & Jørgensen, 2002, p. 6) |

Table 3.4. Four premises shared by many social constructionist approaches (adapted from Phillips & Jørgensen, 2002, p. 5)

As this section has provided an introduction to the social constructionist approach that I employed in this study, I now present an overview of Gergen's (1995) concepts of endogenic and exogenic ways of knowing. The relevance and importance of these two terms to social constructionism and therefore to this study become apparent in the Constructionism *vis-à-vis* Constructivism sub-section below where I discuss the similarities and difference between social constructionism and constructivism in order to situate this study within a social constructionist framework.

*Exogenic and endogenic viewpoints*

In establishing a working definition of social constructionism, one must recognise the impact and influence that traditional, modernist notions of knowledge have had upon the field of enquiry. The establishment of 'truth' was often performed through either the endogenic or the exogenic viewpoint of the individual. I draw heavily on Gergen's (1995) notion of a "social constructionist orientation to knowledge" (p. 23), which he describes as a "radical break with both the exogenic and endogenic orientations to knowledge" (p. 23). These 'orientations' are discussed below in order to clarify their meaning and establish their contribution to this section as well as to this thesis.

Gergen (1995) asserts that the exogenic and endogenic orientations have in common a dualist foundation because they coincide with the notion that the mind and the world are independent of each other:

> The endogenic tradition is similar to the exogenic in its dualist foundations: [b]oth agree that mind and world are independent, and that knowledge is a mental state – an enhanced state of representation in the exogenic case and of reasoning in the endogenic. (p. 18)

Although similar in their foundations that present the mind and world as separate yet 'real' entities, the exogenic and endogenic approaches differ in their construction of knowledge.

- From the exogenic perspective, knowledge may be considered – and gauged by one's ability to provide – an accurate representation of nature in the mind.
- From the endogenic perspective, knowledge may be considered – and gauged by one's ability to provide – an accurate representation of the mind as it operates in nature.

Gergen (1995) elaborates upon this distinction:

> Thus, the exogenic theorist is likely to focus on the arrangement of environmental inputs necessary to build up the internal representation. In contrast to this emphasis on the environment, the endogenic theorist often places chief emphasis on the human being's intrinsic capacities for reason, logic, or conceptual processing. (pp. 18-19)

In this thesis, the unification of the mind and the world occurs through social constructionism as it presents a view of a dynamic, social world in which dynamic individuals are working together to create meaning. Thus, the mind–world divide can be overcome if one is to consider that the mind and the world are interdependent and both created by language in action drawing upon discourse. The reason for drawing attention to these two ways of knowing is directly related to the sub-section below where I highlight the similarities and differences between social constructionism and constructivism.

Ultimately, I argue that social constructionism overcomes the mind–world dualism in its focus upon language, whereas constructivism tends to be more aligned with an endogenic way of thinking because of its emphasis upon the mental processes of people as well as their construction of knowledge that takes place within the individual mind (Gergen, 1995). The endogenic perspective, then, aims to "sharpen one's capacities for thought" (Gergen, 1995, p. 19) and is linked directly to the development of cognitive skills and rational thinking that would allow the individual to negotiate and understand the world, whereas the exogenic perspective would see the same individual improving her/his capacity for thought through imprinting or representing the environment upon the mind.

In this sub-section I have discussed the notions of endogenic and exogenic orientations in order to show that a social constructionist approach has assisted me in overcoming the inner world–outer world dualism that is the foundation of traditional approaches to enquiry regarding the concept of knowledge. Moreover, the social constructionist approach has enabled me to avoid both objectivity (exogenic), thereby detaching myself from the world in order to observe it, and solipsism (endogenic), thereby focusing entirely on the individual and neglecting to account for the influence that the world exercises upon that individual. In the following sub-section, I discuss the similarities and differences between constructionism and constructivism in order to assert that social constructionism is an appropriate and powerful

conceptual tool to use in the exploration of adult stakeholder constructions of the term 'learning difficulties'.

*Constructionism vis-à-vis constructivism*

In recognition of the fact that there may be confusion between the two similar, yet separate, terms 'constructionism' and 'constructivism', and that by contrast some scholars view constructionism and constructivism as being synonymous (Spivey, 1997), I provide this sub-section in order to address the similarities and differences between the two whilst simultaneously asserting that social constructionism is my chosen approach considering its implications for overcoming the mind–world dualism that is prevalent in constructivism. Here I present Gergen's (1989) assertion in favour of constructionism: "The invitation [of social constructionism] is, that...[we] treat social relatedness (as opposed to isolated minds) as a reality of preeminent significance" (p. 478).

I have presented Table 3.5 following to highlight the similarities and differences between constructionism and constructivism. My reason for doing so is that the constructivist approach presents a cognitive view of the self in relation to knowledge. Thus, from the social constructionist perspective, both exogenic and endogenic views of the individual are overcome, whereas the constructivist view aligns with an endogenic view concerned with the way in which the cognitive functions of the individual internalise the outer world and represent it within themselves.

Rather than attempting to position constructionism as intellectually superior to constructivism, I am attempting to emphasise my reason for choosing constructionism. In doing so, I acknowledge criticism of extreme forms of constructionism as being completely relativist and therefore preventing the ascription of meaning to anything. The inherent danger in this way of thinking is that it results in a nihilistic viewpoint that renders action futile.

Constructionism stands in contrast to constructivism in its assertion that individual and group interaction is the site of meaning-making, whereas constructivism begins with a notion that the individual is the site of meaning-making as her/his mind interacts with the world. Hruby (2001) explains that radical constructivists do not consider anything existential beyond the reality of the individual. Thus, an individual reality is the only thing that can be known. This is an important point when establishing social constructionism – and its focus upon the making of meaning as being socially, rather than individually, established – as an appropriate conceptual tool for this research.

Hruby (2001) states that the other end of the constructivism equation is what is referred to as 'critical constructivism'. Here the implication is that there still exists some reality that is independent of the individual, yet the question remains as to whether or not it can ever truly be known. Although my major criticism of constructivism is its cognitivist origins, I note here that social constructivism can be seen as similar to social constructionism and is therefore worth mentioning specifically. Although I discuss social

| | Social constructionism and social constructivism |
|---|---|
| **Similarities** | • Critique the empiricist paradigm of knowledge generation.<br>• Challenge the traditional view of the individual mind as a device for reflecting the character and conditions of an independent world.<br>• Question the authority traditionally accorded to 'behavioral science' as well as educational procedures consistent with this account of knowledge. |
| **Differences** | • The major difference is the alliance of radical constructivism with the dualistic formulations (mind-world separation) traditional to Western epistemology, and the constructionist attempt to break with this tradition.<br>• Radical constructivism is, in present terms, an endogenic theory. The primary emphasis is on the mental processes of the individuals and the way in which they construct knowledge of the world from within.<br>• This account of knowledge is so fully interiorised that it begins to offer the constructivist a means of escaping the charge of (a Cartesian, or mind-body) dualism. That is, by staking the entire epistemology on an account of the interior, the 'exterior' can be erased from concern and the theory can be viewed as monistic. The implication here is that, if everything occurs inside the head of the individual, one can never know or relate to what is going on in that individual's head. Each issue one deals with is 'in the mind', thereby excluding exogenic factors. Thus, social constructionism establishes meaning as established in conversation that is created by and creates the individual and the social world. |

Table 3.5. Constructionism *vis-à-vis* constructivism (adapted from Gergen, 1995 and Phillips & Jørgensen, 2002)

constructivism here, I emphasise the notion that the premise of constructivism, whatever the form, is upon the cognitive functions of the individual.

Social constructivism, like social constructionism, focuses upon a notion of social collaboration in making meaning and establishing knowledge. Standing in contrast to Piagetian theory, Vygotsky (1978) developed social constructivism as a way of addressing the notion that learning and its social context were separate entities. Thus, rather than learning being a compilation of knowledge in the mind by the learner, Vygotsky (1978) contended that cognitive functions had as their origins social interactions:

> Every function in the child's cultural development appears twice: first, on the social level and, later on, on the individual level; first, between people (interpsychological) and then inside the child (intrapsychological). This applies equally to voluntary attention, to logical memory, and to the formation of concepts. All the higher functions originate as actual relationships between individuals. (p. 57)

Although social constructivism established a view of the individual as part of a collective community of learners engaged in meaning-making, it retained a cognitivist perspective which viewed the products of interaction as ultimately remaining in the head of the individual. The crucial concern that I have with this approach is that it viewed cognitive functions as social, but emphasised the individual mind as the site responsible for the collection and maintenance of knowledge that is necessary for the individual to be a part of her/his community. Thus, the cognitive function of the individual in social constructivism is still given priority and this sits in contrast to social constructionism where the individual and the social world are inseparable as her/his knowledge is seen as fluid and dynamic, just as is the individual who possessed the knowledge.

For the sake of proceeding with my argument in favour of social constructionism, I present the major difference between constructionism and constructivism (Hruby, 2001) as being that the former is considered a sociological description of knowledge, whereas the latter is considered a psychological description of knowledge (Berger & Luckman, 1966; Burr, 1995; Gergen, 1995). According to Gergen (1995), knowledge is constructed by individuals engaging in social interaction and meaning can be achieved only by acknowledging social interdependence and recognising that the meaning of each act is dependent upon the socio-cultural and historical context in which that act occurs.

In this sub-section, I have discussed the similarities and differences between constructionism and constructivism. I have asserted that constructionism is a more appropriate tool for this study than constructivism because of the former's focus upon the interdependence of the individuals as they work together actively to create meaning in their specific social, cultural and historical contexts. In the final section below, I discuss the concept of discourse and demonstrate the part that it plays in my conceptual framework.

**The concept of discourse**

In this study, the concept of learning difficulties is constructed and communicated during the interview process. Although there is an 'official' institutional discourse regarding learning difficulties as an abstract truth in Queensland (e.g., Education Queensland's CS-13: Educational Provision for

Students *with* Learning Difficulties and Learning Disabilities [emphasis added]), it is the administrators, teachers and parents who will ultimately determine what learning difficulties are by using medical model and other discourses to establish their subjective view of them. In this way, learning difficulties become 'real' because of the consequences that they hold for the child identified as experiencing them. By investigating positions regarding the concept of learning difficulties, I sought to understand how administrators, teachers and parents occupied specific discourse subject positions and how those subject positions provide an explanation of the construction of learning difficulties. Moreover, I sought to illustrate how positions, speech-acts and storylines are a discursive action because they occur as individuals occupy subject positions in conversation.

*The dynamics of discourse*

Although the term 'discourse' is considered problematic from some perspectives, in this chapter and the rest of the thesis it has been generally defined in a 'post' sense that is discussed in the following chapter. My intention here is to move away from the linguistic investigation of 'realistic' views of language and into more abstract forms of language use in which power relations are implicit. Thus, discourse is viewed as: "A coherent, self-referential body of statements that produce an account of reality by generating 'knowledge' about particular objects or concepts and also by shaping rules of what can be said and known about those particular objects and/or concepts" (Moore, 2005, n.p.).

The effectiveness of viewing discourse in this way is that it presents the possibility of the stakeholders having some control over their respective realities and hence agency. This is particularly important when I discuss in Chapter Five the domination of the medical model and examine in Chapter Six the interplay between the individual and the dominant discourse where resistance to the reductionist view of the individual occurred. The domination of the individual by the medical model discourses impairs that individuals 'rational' status. Thus, s/he is often socially immobilised by the particular 'label' that s/he carries; her/his voice is more readily silenced and her/his agency is easier to limit.

When examined within the context of this study of adult stakeholders' constructions of learning difficulties, it becomes evident that a particular 'truth' regarding learning difficulties is not my focus. As above, the use of discourse is dynamic and the creation of a single, accurate meaning is not possible. Chapter Two presented the literature regarding the establishment of learning difficulties and how its roots can be found within a Cartesian dualism that underlies the medical model. In that chapter, I asserted that, regardless of whether or not learning difficulties are 'real', they become real through the social processes of the parents, teachers and administrators owing to the consequences of the label 'learning difficulties' that has been institutionalised by Education Queensland. Without discourse providing subject positions for individuals to take up and power being implicit within those subject positions, learning difficulties could not have the 'truth effect' that they do in Education Queensland policy and in its schools.

Thus, in seeking to understand the concept of discourse, one is encouraged by Potter and Wetherell (1987) to avoid a 'realistic' view of language that would consider discourse as a part of cause-and-effect pathways to actions, beliefs and events (p. 34). In viewing discourse as a part of dynamic texts that can be read in a variety of ways, one is able to understand the concept that meaning is not 'fixed'. Rather, meaning is dependent upon the individual(s) and there are numerous interpretations of any given text. Often the social consequences of a text are what give discourse its power. It is for this reason that an examination of stakeholders' constructions of learning difficulties can expose some of the particular discourses operating at the site of the individual identified as experiencing such difficulties. The identification of these discourses can then be used to attempt to explain how certain attitudes are developed and what they accomplish (their social consequences).

*Discourse and community*

In order to illustrate the relationship between discourse and positions, speech-acts and storylines, I have created Figure 3.5 following:

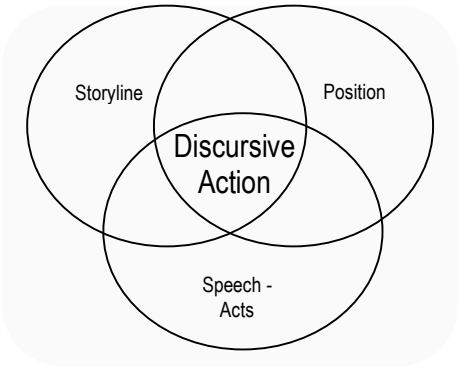



Figure 3.5. Positioning is a discursive phenomenon

From the figure above, one can view how the three inter-related aspects of positioning theory work are reliant upon discourse. Discourses provide subject positions for individuals to occupy; speech-acts are the utterances that position those individuals; and storylines are the particular 'pattern' that the conversation unfolds as individuals perform acts of positioning. Thus, the identification of the positions, speech-acts and storylines requires one to investigate conversation as a social phenomenon that is goal-oriented and in which the power to speak is not fixed.

In this section the notion of a 'discourse community' arises as the particular discourses that have shaped and informed the user's subjectivity will also inevitably provide the capacity for that individual to operate within specific social realms whilst being prevented from or limited in operating in others. Thus, upon seeking to explain our world we must draw upon discourse which is not neutral as it assumes power based upon the socio-cultural context in which the discourse is used and the previous historical force that the discourse carries with it. Here one can view the Foucauldian influence upon this thesis in examining discourse, power and the subject (Foucault, 1977). Thus, even if it were possible to describe a reality that exists 'out there', as soon as we attempted to explain and describe it, it would become a

discursive event, thereby being subject to analysis as well. In the most basic sense, individuals – themselves socially constructed – are socially constructing a notion of reality as they interact within a given social environment. As a result, people can be considered both producers and products of discourse.

As positioning theory is social constructionist in nature and the act of positioning – speech/acting in order to achieve a goal, thereby establishing oneself – is a discursive phenomenon (Wetherell, 2003), I have drawn on Potter and Wetherell (1987) to understand the notion of discourse as it operates within a social arena. They present the notion that "people use their language to *do* things…[such as] request, persuade and accuse" (p. 32; emphasis in original). This view of language aligns with a social constructionist view as individuals draw upon discourse in order to accomplish a particular goal. Thus, the 'function' of language is always part of the emphasis of discourse analysis, yet Potter and Wetherell (1987) stress that "function…cannot be understood in a mechanical way" (p. 32). This is because "function involves [the] construction of versions, and is demonstrated by language variation" (p. 33).

In focusing upon the strength of a discourse analytical approach rooted in social constructionism, I assert that discourse is paramount in the social constructionist arena. This point is emphasised by Harré and van Langenhove (1999): "Not only has discourse become a firmly established

topic for study in its own right, it has also become a key-concept in the new theoretical developments sometimes called social constructionism" (p. 1).

Thus, language becomes the vehicle through which individuals negotiate and create reality; reality is created in conversation drawing upon discourse. Moreover, the construction of knowledge is historically, culturally and contextually situated; in any given situation the creation of 'reality' relies upon the use of language and thus language can be viewed as 'real' when seeking to analyse a particular contextual snapshot. In this study, the concept of learning difficulties was constructed through inter-communication during the interview process. Although there is an 'official' institutional discourse regarding learning difficulties as an abstract truth in Queensland (i. e., Education Queensland's *CS-13: Educational Provision for Students with Learning Difficulties and Learning Disabilities*), it is the administrators, teachers and parents who will ultimately determine what the term 'learning difficulties' means based upon their subjective experiences with individual children/students identified as experiencing such difficulties. In this way, learning difficulties become 'real' because of the institutional, or social, consequences that they hold for the child identified as experiencing learning difficulties. By investigating positions regarding the concept of learning difficulties, I seek to understand what discourses administrators, teachers and parents draw upon in order to construct learning difficulties.

*Discourse analytic technique*

Although the specific discourse analytic technique that I employed in this thesis is discussed in the following chapter, I preface that discussion here, given the diversity of definitions of discourse as well as of discourse analytic methods. I draw upon Phillips and Jørgensen's (2002) assertion that there are four specific similarities among all versions of discourse analysis. These similarities are provided below in point form and establish the philosophy of discourse as it is used within my positioning theory approach to the interview texts:

- Language is not a reflection of a pre-existing reality.
- Language is structured patterns of discourses – there is not just one general system of meaning as in Saussurian structuralism but a series of systems of discourses, whereby meanings change from discourse to discourse.
- These discursive patterns are maintained and transformed in discursive practices.
- The maintenance and transformation of the patterns should therefore be explored through analysis of the specific contexts in which language is used in action. (Phillips & Jørgensen, 2002, p. 12)

In order to investigate the positions mentioned above, I have chosen social constructionism and discourse. As a conceptual tool, a social constructionist view of language and discourse allows me to recognise how the creation of the concept of learning difficulties, by the stakeholders involved with children identified as experiencing learning difficulties, is a discursive process. Because the participants' realities are represented in the discourse of conversation, a social constructionist framework assists in

acknowledging the multiple realities of the interviewees as they position themselves and others relative to the concept of learning difficulties.

Thus, my particular approach investigates the specific discursive forces informing a speech-act that serve to make it either operational and accepted or irrational and rejected. This is done by focusing upon the discourses that an individual uses to establish what a child identified as experiencing learning difficulties is/is not. Furthermore, discourse shapes and informs subjectivity, thereby permitting the individual to express her/himself within the specific social interaction and de/limiting what can be said by that particular individual. As Davies and Harré (1999) note: "[A]n individual emerges through the process of social interaction, not as a relatively fixed end product but as one who is constituted and reconstituted through the various discursive practices in which they participate" (p. 35).

Thus, the individual does not exist in isolation and her/his identity is shaped and developed discursively through social interdependence. In a post-structuralist sense, the idea that an individual's individuality is continuously changing coalesces with Lacan's (1975) notion of the 'de-centred subject'. The implications of a theory of discourse that does not ground the individual as a fixed being are evident when I discussed the notion of 'rationality' above and it becomes clear that the domination of individuals becomes more difficult if that individual is not labelled or rendered irrational ('fixed' or static), two acts that reduce the social opportunities of that individual. If

someone is seen as static, then the implication is that s/he can be more easily become an object of domination.

A dynamic view of the individual who is potentially self-determinate and hypothetically able to resist the dominant ideological perspectives that surround her/him presents a more open and accepting viewpoint in which the focus shifts from the examination of 'those people' (deviance, abnormality) to the examination of the social forces that work to create 'those people' (social justice, equality). With regard to this thesis, rather than label – and therefore restrict the social opportunities for – a child as experiencing learning difficulties, I sought to question how the concept of learning difficulties was created and maintained by the participants.

In this study, the analysis of discursive texts for evidence of positioning yielded a deeper understanding of the dynamic, contextualised situations facing the administrators, teachers and parents involved with particular children identified as experiencing learning difficulties. If the contextualised factors influencing learning difficulties discourses are explored, then one may gain a better understanding of how those discourses can be linked with issues in education such as subordination and marginalisation. Thus, one can see how a social constructionist approach to language and discourse is advantageous here because it allows me to problematise the conceptualisation of knowledge in order to investigate the ways in which discursive practices create the social realities of the aforementioned administrators, teachers and parents.

## Conclusion

This chapter has focused upon the key aspects of the conceptual framework that I employed to study adult stakeholder constructions of learning difficulties in a Queensland regional primary school. I presented nine distinct sections: 'role theory'; the 'de-centred subject'; 'power/knowledge'; 'episodes'; 'positions'; 'speech-acts'; 'storylines'; 'social constructionism'; and 'the concept of discourse'. Within those sections, I established how that particular concept contributed to my conceptual framework. Ultimately, I have drawn out what I believe to be the implicit power relations that can be found in the act of positioning oneself and another in order to identify particular discourses of domination and resistance being used in the construction of the child identified as experiencing learning difficulties. In the following chapter, I present the 'research design' in order to establish the methods used to gather, analyse and represent the data that were collected for the purpose of the study from relevant documents and the 18 adult stakeholders.

# CHAPTER FOUR

# DESIGNING RESEARCH INTO POSITIONS ABOUT LEARNING DIFFICULTIES

*"When I use a word", Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean – neither more nor less". "The question is", said Alice, "whether you can make words mean so many things". "The question is", said Humpty Dumpty, "which is to be master – that's all".*
(Carroll, 1906, p. 124)

**Introduction**

The previous chapter presented the key interdependent concepts of positioning theory, social constructionism and discourse analysis as constituting the foundation of the study's theoretical framework. Central to the understanding of positioning theory are the notions of *position*, *speech-act* and *storyline*. Moreover, the importance of discourse analysis as theory was introduced as being paradigmatically situated within social constructionism, in order to establish that individuals 'position' themselves and others discursively.

This chapter situates the study within a qualitative, interpretivist and post-structuralist methodological framework that uses positioning theory to achieve its purpose. That purpose is to determine what particular discourses were drawn upon in order for adult stakeholders to construct the concept of learning difficulties.

Ultimately, my qualitative/interpretivist/post-structuralist research design represents the various discourse subject positions that I occupy in order to 'make sense' of my social world. Therefore this multi-faceted approach shaped and informed my subjectivity while impacting upon the decisions I made regarding my particular role in the research, as well as what 'types' of knowledge the study produced. In acknowledging this point, I am highlighting that there is a variety of ways in which any particular text can be read. The implication of this statement is that the combination of my subjectivity, the discourses that inform my particular ways of thinking and

knowing and the stakeholders' words have resulted in an 'original' text that makes a contribution to knowledge conceptually, methodologically and empirically.

In this chapter, I discuss how my study contributed to these areas as I present my information in five key areas:

1) The methodological underpinnings of the research
    a) A qualitative research orientation
    b) Interpretivism
    c) Post-structuralism
2) Data collection
    a) Document study
    b) Semi-structured interviews
3) The data analysis strategy
4) Applying the data analysis strategy
    a) Documents as texts
    b) Interview transcripts as texts
5) Identifying strengths and potential limitations of the study
    a) Coherence
    b) Participant's orientation
    c) New problems
    d) Fruitfulness
6) The ethics and politics of the study
    a) Procedural
    b) Relational.

Together, these areas are the foundation by means of which I engaged with the research questions in order to present the analysis of the data in Chapters Five and Six. In the following section, I discuss the methodological underpinnings of the research in order to establish what particular paradigms contributed to my thinking and knowing as I identified and analysed adult stakeholder constructions of learning difficulties in a Queensland regional primary school.

**The methodological underpinnings of the research**

In this section, I discuss three concepts that have contributed methodologically to my exploration of stakeholders' positions. I begin with the general classification of this study as being qualitative in nature. I then move to discuss the study's interpretivist and post-structuralist dimensions. The contributions of these three dimensions are complementary and interdependent because they provide a philosophically coherent and consistent way of viewing the creation of meaning. Positioning theory as presented in Chapter Three is interwoven with these three dimensions of the research design, in that it provided me with a conceptual apparatus that focused upon the situated and contingent character of meaning as it was created in conversation and through dialogue. In addition, it provided a platform for examining the discourses that individuals used in order to create meaning about the concept of learning difficulties.

*A qualitative research orientation*

Strauss and Corbin (1990) define qualitative research as "any kind of research that produces findings that are not arrived at by means of statistical procedures or other means of quantification" (p. 17), whilst Goodson (1992) presents qualitative research as being "…concerned with the broader contexts of stories, contexts which shape, locate, and ground stories so that insights into the meanings of stories are accessed" (p. 243). Proceeding from those definitions, the study's data analysis is strongly qualitative and focuses intensively upon reality as being socially constructed and upon the

stakeholders' language – using discourse – to create their particular 'truths' regarding 'learning difficulties'.

Accordingly I have eschewed the notion that there exists a single truth that can be arrived at using 'objective' methods; I contend that there are multiple truths and that those truths are grounded in the concrete social experiences of the participants. Therefore my particular qualitative approach to learning difficulties was not intended to discern whether or not they were 'real'; rather, I sought to understand the ways in which they became 'real' for the stakeholders involved with the study through their life experiences.

In order to address specifically how and why my study can be considered qualitative, I have drawn upon Neuman (2000), who compartmentalised the "qualitative style" (p. 16) into eight key points. Essentially, the characteristics of a "qualitative style" approach to research focus upon:

1) The construction of social reality; cultural meaning
2) Interactive processes and events
3) Authenticity
4) Explicit acknowledgement of the researcher's values
5) Context
6) Few participants
7) Thematic analysis
8) Researcher's involvement. (adapted from Neuman, 2000, p. 16)

With regard to the construction of reality, this qualitative study focuses upon reality as it is created and negotiated in conversation; I consider 'meaning' to be socio-culturally and contextually situated. Thus, certain aspects of this study could be replicated to some extent, but the results would be entirely different considering the dynamic composition of

individuals and the possibility of an infinite number of interpretations of any given text.

The stakeholders were considered to be working collectively and individually to create and re-create learning difficulties. When an interviewee and I met, the interview fundamentally became an interactive process that was a meaning-making event. My qualitative investigation of the stakeholders' lifeworlds in a semi-structured interview setting permitted me to witness temporarily the construction of learning difficulties during that particular social episode.

In this study, the primary focus is upon the narratives of those individuals as they position themselves and others (as a speech-action) when constructing the concept of 'learning difficulties'. In attempting to provide a fair and honest view of the social life of the stakeholders, I worked to provide a "candid portrayal of social life that is true to the experiences of the people being studied" (Neuman, 2000, p. 16). Therefore a qualitatively authentic and nuanced representation of the participants is sought to be provided here, with the understanding that my particular interpretation is not final.

With regard to 'values', I have not attempted to conceal my personal beliefs. I have reiterated my viewpoints several times in this thesis as a way of acknowledging my subjectivity. In addition, I have contributed specific sections (see "Personal positioning" in Chapters One & Seven) to the establishment – and sharing – of my voice in order to 'position' myself

within the qualitative study. I acknowledge openly that I, like the stakeholders, am a site of competing and conflicting discourses; I celebrate the fact that my individual value system influenced directly the choices that I have made regarding this research.

In Chapter Two of this thesis, I established the educational context in which children were identified as experiencing learning difficulties; in Chapters Five and Six, I present the adult stakeholders' constructions of such difficulties. My purpose in investigating these two areas is that they are complementary in their capacity to construct and re-construct the child, thereby contributing to the child's docility. Because the context contains the 'rules' for action and speech-action, it is invaluable in assisting with the derivation of meaning from social actions, in the process highlighting the study's qualitative character.

In keeping the number of participants relatively small, I was able to focus intensively upon the 18 stakeholders who engaged in the interview process. Given that each person's voice has been represented in this study with a qualitative orientation, I have attempted to provide thorough and accurate portrayals of the individual lifeworlds of the participants. In addition, this allowed me to become immersed in my data and the smaller number of participants ensured that I could engage comprehensively with their texts.

In this study, I have not searched for 'absolutes' or results that can be extrapolated to the greater population. Rather, I have worked to identify clusters of qualitative information about learning difficulties in the form of storylines that occurred within specific contextual social exchanges. That is, it was necessary to discern what particular discourses were operating within that cluster in order to establish how the adult stakeholders were constructing learning difficulties.

As a researcher examining the lives of adult stakeholders in order to establish how they construct learning difficulties, I am enveloped in the research process to such an extent that my part in this study is direct and unavoidable. In applying positioning theory to the study, I am not exempt from its conceptual rules. Thus, positioning occurs in the act of interviewing and, as such, it must be presumed that the interviewee and I engaged in acts of positioning that inevitably altered the course of the conversation. Whilst attempting to find out how the stakeholders constructed learning difficulties, I was actually constructing them as well – just as I have in this study – and they were also constructing me. This reciprocal positioning is consistent with the study's qualitative character.

In this sub-section, I have discussed how and why my particular study can be considered to be qualitative in orientation. That particular orientation as outlined above focuses upon the socio-cultural and historical context in which the researcher and the research participants work to create meaning. Thus, a qualitative orientation adds value to the study, in that it emphasises

the existence of multiple and subjective truths that are created and re-created in social interaction. In the following sub-section I present the study's interpretivist dimension.

*Interpretivism*

In this sub-section, I discuss an interpretivist framework and illustrate why this study can and should be placed within that framework. I present the implications of interpretivism for the study's research design. At the outset, however, I note that my particular interpretivist approach is aligned with a post-structuralist way of thinking, in that it focuses upon the social constructions of reality that are completed in and through language in use that draws upon discourse. That is, both interpretivism and post-structuralism consider meaning to be produced, negotiated and re-produced by individuals.

An interpretivist approach encourages attempts to understand people's actions as they occur in specific local contexts. For a general definition of interpretivism, I draw upon Neuman (2000), who described the interpretive approach as: "[T]he systematic analysis of socially meaningful action through the direct detailed observation of people in natural settings in order to arrive at understandings and interpretations of how people create and maintain their social worlds" (p. 71).

Neuman's (2000) quotation flags two important points that reinforce and justify the location of this study within an interpretivist framework. The first point is that social action is considered to be "meaningful": social action "is the action to which people attach subjective meaning" (p. 71). The second point is that people are viewed as 'creators' of meaning within their particular social worlds.

Neuman (2000) notes also that "human action has little inherent meaning" (p. 71). This comment situates this study in opposition to the notion of a 'truth' that is external to the individual; we create meaning rather than discover pre-existing meaning. This point links with the contribution of social constructionism, as outlined in Chapter Three, to this thesis. In the construction of their social worlds, individuals are viewed as active participants who speak and act with purpose; that purpose has to be communicated within a specific local moral order and does not have meaning until it is negotiated by the individuals involved. This act of 'negotiating' meaning as the individual works to establish her/himself is known as positioning.

This study can be considered interpretivist because of its alignment with a particular way of thinking that views the creation of reality as a social event and that turns away from the notion of a reality that exists 'out there', that is separate from the individual and that can be discerned by objective methods. Simply, we are subjective human beings who are constantly engaged in the production, negotiation and re-production of meaning in our everyday lives.

In order to clarify further the contribution of interpretivism to this study, I describe some of its major characteristics below.

If one is to view 'interpretation' as the attachment of subjective meaning to a specific observation or phenomenon, then my particular approach attempted to establish the multiplicity of layers of meaning that each individual contributes to that interaction, thereby leading to an understanding – however provisional – of the learning difficulties phenomenon.

As in Chapter Three, I draw attention to the notion of agency when seeking to explain my particular interpretivist approach. Understanding individuals as having some possibility of and opportunity for choice, voice and therefore resistance is associated with a view of individuals and institutions as dynamic, which in turn carries with it the recognition that individuals are, for the most part, unpredictable because of their thoughts, feelings and desires. 'Traditional' science does not account for socialised processes in interaction. It is for this reason that cause-and-effect explanations of human behaviour will not be found within this study. The focus instead is upon exploring how the adult stakeholders work to construct and interpret the socio-culturally and contextually situated phenomenon known as learning difficulties.

Viewing individuals as predictable and grounded by objective and universal 'rules' or 'truths' leaves little potential for action outside prescribed ways of thinking and knowing; the individual, as a result, loses agency because her/his particular reality is not acknowledged. By contrast, an interpretivist approach that assumes individuals to have intention and subjective meaning aligns with the post-structuralist notion of the de-centred subject as well as with the view of the individual as dynamic and constantly engaged in acts of positioning.

Although I have sought to establish my particular approach to this study's research design as qualitative, interpretivist and post-structuralist in nature – three approaches that oppose the notion of a single reality – the study acknowledges learning difficulties to be 'real' because of their social consequences. Regardless of whether I believe that such difficulties are 'real', they are real because the subjective experiences of the participants have deemed them to be so. Thus, it is possible to have numerous interpretations of any particular phenomenon. With regard to learning difficulties, there are multiple explanations of its origins and the relative truths of the stakeholders in this study prevent a fixed explanation of learning difficulties from occurring.

I acknowledge also that the study's use of interpretivism warrants specific views of reality and knowledge as addressed above. Hughes (2001) describes the world as existing within our particular interpretations of it instead of being something separate from ourselves and awaiting discovery.

He asserts that "**…**rather than simply *perceiving* our particular social and material circumstances, each person continually makes sense of them within a cultural framework of socially constructed and shared meanings, and that our interpretations of the world influence our behaviour in it" (p. 35; emphasis in original). Thus, as the social worlds are constantly shifting and changing, then so too are the meaning systems established within those worlds. This requires continuous negotiation by the individuals involved in the web of social relations.

As mentioned above, reality is created by individuals who negotiate the meaning of actions and speech-actions. Individuals position and re-position themselves in the light of their particular interpretation of the situation or world. Knowledge is socially constructed and therefore reliant upon an individual's understanding of the local socio-cultural and historical context in order for that person to participate effectively in the creation of meaning.

My research has resulted in the production of knowledge that is often characterised by intimate insight into a specific cultural phenomenon rather than large-scale generalisations. In using an interpretivist approach, I am inclined to use a qualitative research orientation as described above and my task is to "…understand socially constructed, negotiated and shared meanings and re-present them as theories of human behaviour" (Hughes, 2001, p. 36). Thus, my emphasis is upon an interpretivist understanding of a particular social phenomenon known as learning difficulties in order to present a deeper understanding of that phenomenon. By applying a

qualitative research orientation, I have attempted to understand the values and actions of the participants as they positioned themselves and others. By focusing intensively upon the authenticity of the voices involved, rather than upon comprehensive and objective representation, I am deploying a micro-level focus that engages with meaning-making at the level of immediate social effects and/or consequences.

Furthermore, an interpretivist approach has guided my thinking by providing me with an alternative way of investigating the social worlds of adult stakeholders as they engaged with the construction and co-construction of learning difficulties. These stakeholders actively interpret the world rather than passively accept a pre-existing world through their subjective interactions with others. Moreover, they are considered to have intentions in their interactions and the success of enacting those intentions relies upon the favourable combination of positioning acts necessary to accomplish the task.

The contribution of an interpretivist approach to this study is twofold. Firstly, it allows me to focus entirely upon the social construction of 'meaning' (e.g., 'reality' or 'knowledge') within a specific local context where I questioned the discourses behind people's 'taken-for-granted' assumptions regarding learning difficulties. Secondly, it allows me to acknowledge that people are engaged continuously with conflicting and competing discourses that enable them to produce an account of reality. Although individuals, and therefore reality, knowledge and meaning, are

dynamic rather than fixed, momentary glimpses of their social worlds can yield rich and meaningful data that can assist in understanding that social world – at least temporarily.

*Post-structuralism*

In this sub-section, I define the concept of post-structuralism in order to establish how and why my particular study is aligned with a broadly post-structuralist framework. Rather than attempt to cover every aspect of the 'posts' (e.g., post-colonialism, post-fordism, post-marxism, post-modernism and post-positivism), I acknowledge that this thesis is situated within a "post space" (McDougall, 2004, p. 91).

Chagani (1998) distinguished between post-structuralism and structuralism: "Poststructuralism…is a reaction against structuralism which claims that there are universal structures of language, and that these structures are ultimately the determining factors of life and thought" (p. 3). One of the main tenets of a post-structuralist approach is its rejection of 'fixed meaning'. Thus, the very act of labelling and describing post-structuralism is a *catch-22*; to attach a label to a 'post' way of thinking and knowing is to contradict the central premise of that particular way of thinking and knowing. Walker-Gibbs (2003) provided a useful summary of a post-structuralist approach when she wrote: "I would argue that poststructuralism's emphasis is more on the notion of a linguistic and textual universe….[W]e need to reject essentialist notions of meta-

narratives and the conception of reality as being easily defined and non-fragmented" (p. 70).

In this study, a post-structuralist view of the individual has implications for each individual involved in the study because of the fragility and frailty of our relative truths that are co-created and that exist only momentarily within a specific social, cultural and historical context. Lye (1996) considers post-structuralism to be "…a set of theoretical positions, which have at their core a self-reflexive discourse which is aware of the tentativeness, the slipperiness, the ambiguity and the complex interrelations of texts and meanings" (p. 1). Thus, post-structuralism itself is not a theory (p. 1) and therefore cannot be deployed in isolation within this study.

It is for this reason that I have chosen to complement post-structuralism with a qualitative research orientation as well as with interpretivism. The contribution of the three approaches is encapsulated in positioning theory as I focus upon the use of discourse to create texts and the analysis of those texts to establish meaning. By highlighting the post-structuralist concepts of meaning, power and identity, I am able to present positioning theory as a way of grappling with the intimate interplay between individuals and discourse as they work to construct learning difficulties.

Kenway and Willis (1997) described the importance of meaning, power and identity to post-structuralists when they stated that:

> …meaning, power and identity are always in flux. They shift as different linguistic, institutional, cultural and social factors move and stabilise together. The emphasis in poststructuralism is on the discourses which make up social institutions and cultural products….[I]t is through discourse that meanings and people are made and through which power relations are maintained and changed. A discursive field is a set of discourses which are systematically related. (pp. xix–xx)

Thus, this study's focus upon a qualitative and interpretivist approach aligns closely and effectively with post-structuralism as I have focused upon knowledge, power and discourse in the establishment of 'relative truths' within the study. The study's methodological strength derives from its deployment in combination of qualitative, interpretivist and post-structuralist approaches. Together, they form a powerful lens that is wide enough to understand the broader picture regarding learning difficulties, yet sharp enough to focus upon the complex and numerous intricacies of the social worlds in which learning difficulties reside. Effectively, a focus upon de-centred subjects and the meaning that they create regarding learning difficulties allows me to understand better how the construction of that meaning occurs and to view some of the social consequences of the learning difficulties label.

**Data collection**

In this section I outline and justify the data collection process that I employed for this study. In particular, I first discuss the study of electronic and printed data and I then present the notion of spoken data. For the

former, I focus upon the process of collecting data in relation to the three sections addressed in Chapter Two (i.e., "Education Queensland", "The 'difficulty' in defining 'learning difficulties**"** and "The evolution of the medical model in constructing learning difficulties"), whereas for the latter I focus upon the semi-structured interviews as a way of gathering spoken data.

*Document study*

In this sub-section, I discuss the process that I conducted in order to identify relevant documents that would assist me with framing the research and providing answers to my research questions. Ultimately, I chose documents that contributed to my understanding of the fields in which my study is located and assisted me with identifying and contributing to current debates within those fields. On the one hand, I focused primarily on 'current' research that had taken place in the past 10 years; on the other hand, the task of excavating several hundred years' worth of literature that contributed to dominant ways of thinking and knowing about the body necessitated that I delve into literature that could be considered archaic in contemporary educational settings.

Ultimately, the selection of documents was based upon their capacity to contribute to my knowledge base regarding Education Queensland, the concepts of learning disabilities and learning difficulties and the medical model. The Education Queensland electronic media and policy statements were interrogated intensively in order to understand better the particular

educational context in which children are formally and systematically educated and where they are determined to be able/not able to access the curriculum. In order to reduce the vast quantity of Education Queensland documents, I focused upon the four areas of curriculum, pedagogy, assessment and reporting. With these four areas in place, I could then read with intention and scan texts to consider whether or not they were appropriate to my study based upon their relationship with any of the areas.

There was a multiplicity of learning disabilities and learning difficulties documents that were layered and complex. The selection of these documents required intensive deliberation because the two terms were often used interchangeably and a variety of institutions, organisations and groups – both internationally and nationally – have adopted separate and dissimilar ways of operationalising the terms. As a result, I selected documentary data for learning disabilities and learning difficulties in the areas of a broad historical overview, the Australian context and the Queensland context respectively. Focusing on the specific documents in this way made the information manageable and enabled me to pay close attention to specific information that was an essential component of understanding the learning difficulty and learning disability terms and their respective meanings.

The medical model documents were the most comprehensive and far-reaching of the three groups of documents. Although it is a metaphor for a way of thinking and knowing about the body, the medical model is a powerful apparatus of domination that has been perpetuated and enacted for

centuries. In order to isolate and therefore organise the information regarding the medical model, I compartmentalised that information into five components as identified by Freund, McGuire and Podhurst (2003). Thus, whenever I engaged with documents I was able to search for, and extricate, specific chunks of information that could contribute directly to one or more of the five components of the medical model. In addition, being able to recognise the five components of the medical model made the model itself more transparent in the documents reviewed; it became easier to find – and hence to demystify and deconstruct - once I established 'what' to look for.

The ability to judge a document's potential contribution to the study was essential and continuously refined as I engaged predominantly with books, journal articles and policy statements. Because the selected documents would shape and inform the way in which I represented the data within them, it was important to "mine" (Merriam, 1998; cited in Harreveld, 2002, p. 170) the data from the chosen documents in order to "uncover meaning, develop understanding, and discover insights relevant to the research problem" (p. 170). Thus, engaging with numerous information mediums was a necessary and appropriate endeavour for me because it assisted me in isolating and specifying the particular research topic that I have pursued in this study as well as the particular primary data sources that could contribute most effectively to the study.

*Semi-structured interviews*

In this sub-section I introduce the semi-structured interviews – considered to be one of the three main interview methods used in qualitative research (Schensul, Schensul & LeCompte, 1999) (the other two methods are structured and un-structured interviews). The semi-structured interview allowed me to focus upon particular areas of interest whilst having substantial flexibility in scope and depth. Therefore the depth of the interviews was upheld by the maintenance of the 'construction of learning difficulties' as an investigatory guide whilst the interview process itself remained flexible in order to permit participants to emphasise the specific issues that they found to be the most relevant to the discussion.

In particular, I sought to establish whether or not the categories that I had selected for analysis as detailed in Chapters Five and Six were appropriate for classifying and presenting my information. Ultimately, the paper, electronic and spoken data for Chapter Five were robust, but the data for Chapter Six were sparser and needed to be re-configured in the light of the spoken data collected. As a result, the categories included in Chapter Six evolved from the actual episodes and therefore served to epitomise 'real' examples of resistance, rather than a pre-determined criterion (in line with my personal notion) of resistance.

In total, I conducted and audio-taped 18 face-to-face, semi-structured interviews between 30 September 2003 and 30 August 2004. Each interview was with an administrator (N: 4), a teacher (N: 7) or a parent (N: 7) and intended to be approximately half an hour in length, with a one-hour timeslot being allocated to each participant during a mutually agreed upon timeslot. My shortest interview was 27 minutes, whilst my longest interview was 53 minutes. Table 4.1 below presents the participants' pseudonyms used in Chapters Five and Six as well as their respective classifications:

| **Administrators** | **Teachers** | **Parents** |
|---|---|---|
| Sean | Elisabeth | Chad |
| Max | Kirk | Liv |
| Kate | Jayson | Marie |
| Artie | Kelly | Anna |
| | Anni | Jack |
| | Richard | Tom |
| | Ray | Tori |

Table 4.1. Participants' pseudonyms and classifications

As can be seen in Table 4.1, I interviewed seven parents of children identified as experiencing learning difficulties, seven teaching staff and four administrative staff, giving a total of 18 participants. Of the seven teachers, two were Support Teachers: Learning Difficulty (ST:LD). Because of the specificity of their position that could potentially reveal their identity, I have placed them under the umbrella term 'teachers'. One teacher was transferred by the school from her classroom teacher status to that of 'behaviour management officer'. Since this teacher was relocated to an office in the administration block, I have categorised her as one of the 'administrators'. Thus, the classification 'administrators' comprises the

principal, the deputy principal, the guidance officer and the behaviour management officer. Again, these are single positions where the identification of the person's job description could potentially jeopardise that individual's anonymity. For this purpose, 'administrator' is used to signify any of the above four individuals.

The interviews with the administrators took place in their respective offices in the school's administration block, while the interviews with the teachers took place in their respective classrooms. Of the seven parents, five met me in the school's Learning Support classroom. The interview with Thomas took place in the school library, whilst that with Anna required me to visit her in her home. The reason for this was that she had recently begun a new job which required her to work a 9 am – 5 pm day. Therefore, she could not be interviewed during school hours but her wish to participate in the study warranted the making of alternative interview arrangements. In each instance, the interviewee and I occupied a private space that was generally quiet and free from interruption.

The purpose of the interviews was to collect spoken data that could either complement or contest the documentary evidence that I had collected previously and establish a cohesive body of knowledge that would enable me to engage with the research questions. In order to guide the collection of the interview data, I composed a semi-structured interview schedule (Appendix C) and ensured that each participant had a copy of it at least one week prior to the day of the interview.

In this sub-section I have provided a brief overview of data collection in the forms of electronic and written data as well as in the forms of spoken data. In the following section I present my data analysis strategy in order to establish and justify how I analysed the data that I collected.

**The data analysis strategy**

In this section, I outline and justify the strategy underpinning the study's data analysis. In order to do so, I draw upon Harreveld's (2002) notion of "tidying up" (p. 178) the data. The 'tidying' stage is considered to be the phase where one prepares the data for analysis before moving on to its actual analysis. While this section outlines the particular strategy for preparing the data analysis, the following section addresses the application of that strategy.

As soon as I began to gather the documentary data, I constructed an organisational system that allowed me to access those data according to whether they were written or electronic. I gradually built a register of the data in order to ensure that they were in a safe location that I had little problem accessing. For this purpose, a locked filing cabinet in my office worked. There I was able to store written files and to access them at my leisure while I stored electronic files on my personal computer that was password-protected.

Upon completing the act of organising the documentary data, I then worked to categorise those data. At this stage I had to make several decisions that would impact upon the future direction of the study. Originally I chose to collect data that specifically related to Education Queensland, learning disabilities and learning difficulties, the medical model and parental involvement. The learning difficulties component of the research grew to an extent that was not envisaged initially, so that an initial parental involvement component was omitted from later stages of the study. This explains why my Human Research Ethics Committee Certification Statement (Appendix A), and my information sheet and consent form (Appendix B), include references to parental involvement. Similarly, an earlier focus on the transition experiences between primary and secondary school of children identified with learning difficulties reflected in Appendix A was subsequently not pursued. (These are both areas of research that might well be revisited in the future.)

Having arrived at the major categories for information classification, I created my semi-structured interview questions (Appendix C). At this point I had the school's consent and support to conduct the study. Because I was focusing upon the inclusion of parents in the study, the school assisted me by printing my information sheet and consent form on school letterhead and posting them to the parents from the school. This method of 'reaching the parents' is important to highlight because I was not legally able to access directly the telephone numbers and/or addresses of the parents to conduct the study. I received my first telephone call within one week of the letters

being sent out to 38 parents and immediately began scheduling and conducting interviews.

The transfer of data from a physical location (audio-tape) to an electronic location (Word™ file) was time-consuming, but allowed me to access and analyse the interview data more rapidly upon completion of the process. In the penultimate version of this study, I had three distinct general categories of the data: "the dominance of the medical model in relation to learning difficulties"; "resistance to the medical model of learning difficulties by 'other' explanatory frameworks"; and "maladaptive behaviour as a learning difficulty". Each category was electronically colour-coded within the transcriptions of the interview text that took place within 24 hours of completion of each interview. I engaged with the text in whole and in part a large number of times with different purposes, ranging from obtaining a 'general feel' for the interview as a whole to seeking a specific, isolated example of a discourse used in language.

Those three major categories required numerous readings and re-readings, each with a different focus. The readings looking for medical model discourses occurred first because that model was dominant within the stakeholders' viewpoints and therefore easiest to locate. Upon locating those discourses, I electronically highlighted the sentences or paragraphs in which they were found using the colour red. I conducted the same process for the 'other' explanatory frameworks (blue) as well as for the 'behaviour' classification (orange). Eventually the "maladaptive behaviour as a learning

difficulty" category was subsumed by the "resistance to the medical model of learning difficulties by 'other' explanatory frameworks" category. This was a result of the further refinement of the study in response to the ways in which the stakeholders discussed behaviour. 'Behaviour' has since become a heading in Chapter Six because maladaptive behaviour can be viewed as being a cause of a learning difficulty prognosis, rather than a result of actually 'having' a learning difficulty.

In searching specifically for data that aligned with one or more of these – initially three, subsequently two - categories, I excluded certain data and put them aside for further investigation if deemed necessary. In addition, a focus upon evidence of "values, beliefs, assumptions, perceptions, interpretations, representations of the self and representations of others" (Harreveld, 2002, p. 178) was necessary because the constructions of learning difficulties relied upon those attributes in the form of participants' subjectivities. Because subjectivity is shaped and informed by discourse, an individual's expression of voice and identity through dialogue is especially revealing of the discourses that s/he is drawing upon to perform those expressions.

Having arrived at two final categories of information (i.e., the 'medical model' and the 'other' explanatory frameworks'), I intensified my focus upon the data and examined the specific instances where individuals could be seen to subscribe to either the medical model or an 'other' explanatory framework for a student's perceived learning difficulty. This information

was organised, categorised and stored on my personal computer and continued to expand to include subsequent interpretations that emerged as I continually re-engaged with the data in the light of the study's research questions.

**Applying the data analysis strategy**

In this section I present the data analysis strategy that I employed with regard to the documents and interview transcripts selected for analysis. Those particular items serve as sub-headings within this section and contribute to the orientation of the reader to the information that will be found in Chapters Five and Six.

My conceptual framework established that meaning is not fixed and that there is an infinite number of possible interpretations for any given text. I understand the term 'text' to be broad as it encapsulates conversations, written words and pictures. In order both to create and to interpret a particular text, one must occupy subject positions within discourse(s). The occupation of those subject positions will result in the momentary, or contextualised, production of 'reality'. However, in the 'post space' within which this study is situated, reality too can be considered a text. Thus, there can be no final interpretation of any text. Below I present how I arrived at my necessarily provisional interpretation of the texts analysed for this study.

*Documents as texts*

In this sub-section I introduce the way in which I critically approached the documents selected and analysed in this study. While the process for choosing documents was provided in the section above, the current sub-section deals specifically with the interpretation of the documents used in this study as texts. Although a document is not regarded as a conversation *per se*, it can be considered to position the reader (van Langenhove & Harré, 1999a). It is presumed that the author of the text ascribed meaning to the words contained within that text in order to convey particular viewpoints. These viewpoints can come in a variety of forms (e.g., assertions, questions and suggestions) and can accomplish a variety of tasks (e.g., an argument, scepticism and praise). Thus, positioning analyses can be applied to documents as texts, as well as to interview transcripts as texts, because in each case the author/speaker draws upon particular discourses in order to position her/himself and the reader/other speaker.

In order to analyse and engage critically with the documents as text, I established that there were two major ways of 'reading' the text: 'reading with the grain' and 'reading against the grain' (Seed, 1993; Spivak, 1985, 1995). Although there are not distinct delineations between when I read 'with' as opposed to when I read 'against' the grain of a particular text, whenever I identified an apparent tension or contradiction within the text, I could be seen to be moving away from the dominant ideology being represented within that text and therefore to be challenging the ideology's 'authority' by exploring subordinate discourses within the text.

In positioning terms, I refused the first-order positioning, whereby I was positioned by the author to receive the information in a certain way and to arrive at the same particular conclusion that s/he did. In rejecting that positioning act by the author of the text, I essentially engaged in second-order positioning, because I rejected the position on offer in order to (re)position myself. Here, as I comment upon the first- and second-order positioning that occurred, I am engaging in third-order positioning, whereby I report on positioning acts and in doing so essentially reposition the individuals involved in those acts.

My point about 'reading against the grain' and the acts of positioning and re-positioning when engaging with a document as a text can be exemplified citing Education Queensland policy. Throughout this thesis I have problematised the phrase "students *with* learning difficulties and learning disabilities" (Queensland Department of Education and the Arts, 2002b, n.p.; emphasis added). A reading 'with the grain' of this particular text – *CS-13: Educational Provision for Students with Learning Difficulties and Learning Disabilities* – would essentially confirm to the reader that there are students in the Queensland education system who experience learning difficulties and learning disabilities. In addition, that education system has policies in place to ensure that those students have every opportunity to access the prescribed curriculum. Among the subject positions on offer for the reader are discourses such as diversity, equity, equality and school accountability (for the education of those children, rather than for the

'difficulty/disability' itself). Thus, the system has positioned itself as being committed to social justice issues that impact upon the educational experiences of the child as *student*.

However, in choosing to italicise the word 'with' in the previous paragraph, I have attempted to illustrate how a seemingly superficial phrase can reflect and represent an entire ideology or way of thinking and knowing that contributes to the belief that learning difficulties and learning disabilities are inherent in the individual. For example, I use the term 'students identified as experiencing learning difficulties' throughout this thesis in order to eschew occupying a subject position within medical model discourses that portray learning difficulties as inherent in the individual and that accelerate the domination of the child while facilitating her/his docility.

Thus, a reading 'against the grain' of the above text enables me to identify reification, whereby the concept of the learning difficulty/disability is made 'real' and the medical model discourses responsible for physical reductionism and constructing a specific aetiology are given effect. Accordingly one can view the discourses of domination, objectification and subordination as the child is created through language and represented in a particular way that is detrimental to her/his capacity for agency, voice and choice.

Ultimately, the major documents as texts analysed for this study are considered to be monological (Bakhtin, 1981) and/or one-sided. Thus, the dominant way of thinking and knowing about learning difficulties/disabilities is perpetuated through these texts that have effectively closed down many of the possible alternative explanations of phenomena such as learning difficulties/disabilities. In opposition to monological documents such as those of Education Queensland (see Chapter Two; see above), I have read them critically to ascertain the links between Education Queensland policies and medical model discourses. I have attempted to 'open up' these texts in order to argue that there is a definitive link between the policies and the discourses, thereby providing a potent means for the exercise of subordinating power upon the child. One logical corollary of this point is that the child becomes an effect of domination.

In this sub-section I discussed the concept of 'documents as texts' as well as how I approached the reading and analysis of a given text. The deployment of reading 'with' and 'against the grain' allowed me to articulate my interpretation of some of the tensions and contradictions that can be found within a given text. Below I discuss the analysis of 'interview transcripts as texts' in order to show the reader one way among many (Harré & van Langenhove, 1999; Harré & Moghaddam, 2003) of interpreting and analysing positions, speech-acts and storylines as they occur in semi-structured interviews.

*Interview transcripts as texts*

In this sub-section I focus upon the notion of 'interview transcripts as texts' in order to present a sequential and strategic method of interpretation that can be used to analyse data in the form of interview transcripts. As Potter and Wetherell (1987) noted: "…the term 'text'…[includes] not only writing *prima facie* but also the written record of the spoken…" (p. 1).

The conversion of data from audio-tape (spoken) format to transcript (written) format enabled me to view, categorise and compartmentalise those data as I described above in the "Data collection" section. In addition, the interview transcripts as texts proved to be more accessible than did the audio-tapes alone in terms of engaging with a positioning analysis. Given that the act of positioning is a discursive phenomenon, the transfer of spoken words into written words facilitated the identification and analysis of positions, speech-acts and storylines within the particular interviews as *episodes*.

The first step in performing a positioning analysis is to recognise that positioning theory is embedded in method. That is, one must engage extensively with the selected text in order to work out what the specific components of that text are. In my engagement with positioning theory, I found that an inductive approach worked best because it is not possible to predict what positions, speech-acts and storylines will emerge from an episode before that episode has taken place. In this way, I have learned about positioning theory by applying it practically in ways that were not

possible through an entirely conceptual engagement with positioning theory (Harré & Moghaddam, 2003; Harré & van Langenhove, 1999). This is not meant to devalue those conceptual resources, for they are the foundation upon which I constructed my understanding of positioning theory; rather, it is meant to emphasise the intensive focus on and the familiarity with the texts that are required to retrieve the necessary classifications of information about positions, speech-acts and storylines.

As I discussed in the "Data collection" section, the texts needed to be read and categorised in order to identify key concepts that the positioning theory analyst wishes to pursue. Thus, several readings of the texts in their entirety took place so that I could categorise the information that was relevant to the adult stakeholders' constructions of learning difficulties and that could assist in responding to the research questions. For this reason, it was worth 'breaking' down the entire text into distinct episodes. Because episodes are considered to have a formal beginning and ending that is marked by ceremony, interviews themselves can be considered to be episodes (van Langenhove & Harré, 1999), as they were in this study. Thus, I engaged in a total of 18 episodes with administrators, teachers and parents that yielded a multiplicity of positions, speech-acts and storylines. A selection of these positions, speech-acts and storylines is presented in the two following chapters.

Upon establishing what was/was not an episode, I selected pieces of text within those episodes for analysis by searching for language use that reflected people 'going with the grain' of medical model discourses. Key words such as "biological", "neurological", "physiological", "deficit", "behind" and "lacking" were considered to be words that indicated the presence of medical model subject positions. By contrast, I also searched for examples of the adult stakeholders 'going against the grain', whereby they used key words such as "social", "emotional", "environmental" and "behavioural". These key words were considered to reflect 'other' explanatory models for a student's difficulty in accessing the curriculum.

After completing text selection that was set against the backdrop of broader ideas such as the medical model and other explanatory models, I identified the storylines by focusing upon the "conversational history and the sequence of things already being said" (Harré & van Langenhove, 1999, p. 6). In examining the things that had already been said, I was searching for patterns of thought represented on paper. Thus the continuation (flow) of ideas necessitated identification, as did the breaks and pauses in the text. This is because the flow and/or the breaks can often signify competing and conflicting discourses. Thus, storylines grow out of the analyst's intensive interaction with the text. Labelling a storyline is open to the way in which that analyst interprets the information in the text. However, a storyline's label should encapsulate the relationship between the individuals being positioned, as well as account for the positions that have been identified.

In order to determine the particular positions that were present in the storyline, I first worked to identify the storyline and then to identify the characteristics that the individual was displaying within it. I asked myself guiding questions, such as "What devices is the person using to account for her/himself and/or the other person?". Here the process of labelling positions helped me to identify particular 'parts' that the individual was occupying in that storyline. Because positioning oneself inevitably positions others, the positions can be identified and named and then 'checked' for accuracy by seeing if the positions complement one another when juxtaposed.

Although I advocate beginning an analysis at the storyline, positioning as a discursive phenomenon requires that close attention be paid as well to the utterances that drive the storyline. Thus, I had to determine which utterances either opened or closed the previous storyline in order to establish the positions within it. From this perspective, a speech-act can be considered to assist the individual with her/his act(s) of positioning and of collectively creating the many and varied storylines within a particular episode. Here I often questioned what discourses were employed to shift to/from a particular storyline. Accordingly, utterances can function as active moves to position oneself and/or another.

Now I present a sample analysis in order to illustrate positioning theory in action. I constructed the format for Table 4.2 below in order to facilitate the analysis of the data – a process that is necessarily intensive and time-

consuming. The table permits one to see the three inter-related aspects of positions, speech-acts and storylines in text and permits the analyst to check for consistency within the analysis. This can be as simple as ensuring that the presentation of the information and the labels used are logical and coherent. The table has been developed to reflect the interdependence of the three components of positioning theory and is not meant to imply a particular way, or order, of reading the text. It follows immediately after the presentation of the interview excerpt; this format is used consistently throughout Chapters Five and Six.

> Elisabeth: My understanding of learning difficulties is that there have always been…kids who weren't able to learn as well as other kids. That may be due to trouble with hearing or seeing, or dysfunction mentally….[T]hose kids will always require a little bit of extra help.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Elisabeth | Helpless: unable to assist the child | "…there have always been…kids who weren't able to learn as well as other kids" | 'survival of the fittest': naturalisation of unequal outcomes in the classroom |
| Child | Physically/mentally dysfunctional: dependent and afflicted for life | | |

Table 4.2. A sample analysis of Elisabeth's utterance

Upon being asked, "What does the term 'learning difficulties' mean to you?", Elisabeth presented a 'survival of the fittest' storyline. That is, her speech-act, "…there have always been…kids who weren't able to learn as well as other kids", naturalised the unequal outcomes of the students in the classroom, and in the process placed Elisabeth within a medical model

subject position. In this instance, Elisabeth can be seen as engaging in physical reductionism because her second speech-act, "That may be due to trouble with hearing or seeing, or dysfunction mentally", isolates the inability to learn within the child, using neuro-biological factors to account for that child's inability. The child has now been positioned as being physically/mentally "dysfunction[al]". Because the child is going "always [to] require a little bit of extra help", s/he is also positioned by Elisabeth as one who is dependent; s/he cannot "help" her/himself in the classroom. In responding to the question, Elisabeth positions herself as being 'unable to assist the child', and this position is supported by her speech-acts demonstrating her subscription (in this particular instance) to the belief that learning difficulties are inherent in the individual. This resulted directly in the construction of her 'survival of the fittest' storyline.

Such positioning is mutually beneficial for the teacher and the student. The child cannot be blamed because it is not necessarily her/his 'fault' and Elisabeth cannot be blamed for the child's learning difficulty because it is essentially a legitimate medical condition that is considered to prohibit learning. Thus, Elisabeth's construction of learning difficulties in this particular instance has neglected to take into consideration factors such as the child's social life, the teacher's individual ability to instruct and the possibility that the curriculum being delivered is not compatible with the child.

In the account above I have demonstrated briefly how a positioning analysis of an interview is completed. The first step in performing the analysis consisted of making explicit what particular attributes Elisabeth assigned to herself and to the child identified as experiencing learning difficulties in order to determine what storyline was being played out. Preceding (what had been said previously) and subsequent flows of Elisabeth's speech-acts, as utterances, were scanned with a view to identifying what particular discourses Elisabeth was employing in order to position herself and the child.

This data analytic strategy is an appropriate research tool for this study of adult stakeholder constructions of learning difficulties for two major reasons. Firstly, the strategy assists with the extraction of finely nuanced patterns of thinking and knowing about learning difficulties that are embedded in, and reflective of, broader patterns of thought. Secondly, the strategy allows me to focus on how those broader patterns of thought are enacted and/or challenged at the level of the individual who is attempting to 'make sense' of the learning difficulty phenomenon. Together, those two advantages of my discourse analytic strategy facilitated the selection and analysis of documents 'as texts' as well as interview transcripts 'as texts'. In addition, this strategy provided a cohesive method for analysing the data in order to respond to the study's two research questions.

In this section I demonstrated the application of the study's data analysis strategy. The main element of that strategy was that documents and interview transcripts could be treated as 'texts' from which a provisional and temporary understanding of particular institutional and individual constructions of learning difficulties could be achieved. However, this understanding is possible only after a thorough and intensive focus upon the discourses that the institutions and individuals drew upon to construct learning difficulties. In addition, I presented a sample analysis of actual interview text in order to demonstrate my adaptation of positioning theory's capacity to function as a tool for identifying and analysing the interplay between the individual and a particular discourse. In the following section, I identify and evaluate the strengths and potential limitations of the study.

**Identifying strengths and potential limitations of the study**

In this section, I use four criteria, presented as sub-sections, to interrogate the strengths and potential limitations of the study. I have chosen the criteria from Potter and Wetherell (1987) in order to guide my reflexive thinking regarding the study's potential contributions to knowledge: "coherence" (p. 170); "participant's orientation" (p. 170); "new problems"; (p. 171); and "fruitfulness" (p. 171). Together these four "analytic techniques" (p. 169) can be used as a way of confirming the results of this study by focusing upon individual uses of discourse to construct meaning about learning difficulties.

*Coherence*

The basic premise of "coherence" (Potter & Wetherell, 1987, p. 170) is that the analysis "should let us see how the discourse fits together and how discursive structure produces effects and functions" (p. 170). This point emphasises the need to provide a thorough and complete analysis of the data that will encourage the reader to accept the analyst's interpretation of them. The reader does not necessarily have to agree with the analysis in question, but that analysis has to be consistent and understandable. This is because an individual is more likely to take the text 'seriously' "[i]f the explanation covers both the broad pattern, and accounts for many of the micro-sequences…" (p. 170). This is what Potter and Wetherell refer to as "confirmation through exception" (p. 69). They assert that, for the data analysis to be taken seriously, "it ought to make sense of *both* the pattern regularly found in the data and the exceptions" (p. 69; emphasis in original).

In this study, I provided an analysis of the adult stakeholders' constructions of learning difficulties that is consistent with my theoretical framework; my particular interpretation and analysis of their stories attempted to 'make sense' of the learning difficulties phenomenon. In addition, my positioning analysis of documents as texts and interview transcripts as texts interrogated both the broader patterns of discourse that can be found in relation to learning difficulties and the concrete and specific experiences of adult stakeholders with children identified as experiencing learning difficulties.

In examining the specific moments of interplay between the participant and her/his particular discourse, I was able to glimpse momentarily how macro conceptualisations of learning difficulties influenced micro level understandings of learning difficulties. Moreover, I was able to understand provisionally some of the specific challenges facing parents, teachers and administrators as they struggled to make sense of the concept of learning difficulties. Thus, my analysis is coherent because it employed the above strategies in order to provide a thorough and comprehensive portrait of some of the many and varied discourses that were set in juxtaposition at the level of the individual stakeholder.

*Participant's orientation*

The practical significance of the study of discourse and the determination of this study's credibility and trustworthiness are demonstrated in the ways in which the individual's words are represented. Potter and Wetherell (1987) assert that: "We are not interested in the dictionary definition of words, or abstract notions of meaning, but in distinctions participants actually make in their interactions and which have important implications for their practice" (p. 170).

There are essentially two types of 'orientations' to be found in a particular research project, that of the analyst and that of the participant. Whilst the analyst can identify points that s/he considers to be "consistent" (Potter & Wetherell, 1987, p. 170) and "dissonant" (p. 170), these points are secondary to what the participants consider to be "consistent and different" (p. 170). The participants are the ones situated within the social world and

engaging with learning difficulties as a social practice on a regular basis. This means that the participants' insights are invaluable as they provide a window through which one can view and attempt to understand the learning difficulties phenomenon. The benefit of the participants' orientations taking centre-stage is that it provides first-hand, experiential accounts of the learning difficulties phenomenon.

Focusing primarily on the orientation of the participant is an essential step in gaining access to a social world in which I would typically be viewed as an 'outsider'. That is, exploring the meaning that the participants created and re-created linguistically effectively allows me to provide an analysis of the social processes associated with the transformation of an abstract truth into a concrete experience. One potential limitation of this study is the particular discourses to which individual participants had access. From that perspective, it can be assumed that there are 'other' explanatory frameworks for explaining learning difficulties that did not present themselves within this study. However, I have no reasonable foundation from which to include any explanations other than those that were communicated to me by the participants. As a result, this study is distinctive and situated, and it is neither possible nor desirable to predict what positions, speech-acts and storylines would emerge from the perspectives of different participants. At the same time, the study's focus on the orientation of the people who did participate in it has yielded invaluable insights that attest to its methodological strength.

*New problems*

In seeking to understand more comprehensively the learning difficulties phenomenon, I have examined the subject positions that the stakeholders have occupied when constructing that phenomenon. By deploying my particular conceptual and methodological framework, and using discourse analysis to attempt to uncover some of the levels of deeper meaning in the interview texts, I have been able to respond to my research questions in a thorough and comprehensive manner. This approach is in keeping with the creation of "new problems" (Potter & Wetherell, 1987, p. 171) as a result of responding to current research problems, which is considered to be an essential component of a discourse analytic strategy. In this way, a text is never fully interpreted. Potter and Wetherell consider that the creation of "new problems, and solutions" provides "further confirmation that linguistic resources are being used as hypothesised" (p. 171).

In respect of this study, the creation of new problems regarding the conceptualisation of learning difficulties at both institutional and individual levels means that the focus upon language in action drawing upon discourse can be viewed as constructing a particular reality that is both accessible and 'tangible' as a text. The problems that emerge as a result of engaging with such a text demonstrate that the analysis is comprehensive because 'new problems' signify the creation of new questions. One particular strength of this approach is that it creates the possibility of a continuing dialogue regarding learning difficulties. However, one drawback is that the

individual seeking a concrete truth (closure) about learning difficulties will be left wanting when engaging with a study such as this.

*Fruitfulness*

Potter and Wetherell (1987) identified the fourth criterion of methodological confirmation of discourse analysis as being perhaps the "most powerful" (p. 171) because it "refers to the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations" (p. 171). This point resonates strongly with the part that this thesis has played in analysing categories of 'other explanatory frameworks' in the participants' explanations of learning difficulties. The identification of positions, speech-acts and storylines allowed me to view the linguistic construction of learning difficulties first-hand. As a result of this study, I was able to incorporate the data gathered from the participants in order to establish that discourses of domination and resistance are closely linked with learning difficulties discourses. The implication of these findings is that they contribute significant depth and breadth to a research field that is full of tensions and contradictions.

One possible limitation here is that the creation of categories of resistance to the medical model effectively thrusts those forms of resistance into the limelight, thereby making them a potential target for domination. One could view the identification of those alternative explanatory frameworks as 'naming the opposition'. Once identified, the opposition is at risk. The strength of this study is that it provides a possibility for optimism and

resistance to a subordinating apparatus of power, yet that resistance is limited in scope owing to its minority status.

The four criteria discussed above used to confirm discourse analytic findings are considered to "allow for a stringent examination of any claims" (Potter & Wetherell, 1987, p. 172). Although non-experimental work and qualitative research are often considered "less rigorous than the standard alternative" (p. 172), the discourse analytical research completed for this study has undergone what Potter and Wetherell consider to be a "…searching and critical examination, on a variety of levels…" (p. 172). That is, the particular strength of this study is that the combination of positioning theory and discourse analysis enabled the study to focus upon the creation of meaning at the macro and micro levels in order to identify and interrogate the concept of learning difficulties conceptually and methodologically. In doing so, the study problematised the learning difficulties construct as a consequence of exploring the ways in which learning difficulties discourses impacted upon the social experiences of the adult stakeholders. This can be considered a significant strength because it enabled the questioning of taken-for-granted assumptions about learning difficulties that can often be associated with marginalisation, stigmatisation and domination. In the following section, I discuss the ethics and politics of the study.

**The ethics and politics of the study**

The purpose of this final section in the chapter is twofold: to discuss the 'procedural' and the 'relational' ethical and political components of the research. The 'procedural' sub-section focuses upon the bureaucratic processes that shaped and informed the conduct of this study, while the 'relational' sub-section focuses upon the tensions and contradictions – and their necessarily provisional resolution - associated with the study as it sought to explore the social worlds of complex and dynamic individuals. In combination, these sub-sections constitute my engagement with the ethical and political dimensions of the research.

*Procedural*

This research conforms to the ethical guidelines as outlined by the National Statement on Ethical Conduct in Research Involving Humans (2001) and adhered to by Central Queensland University. The first step in ensuring compliance with the Statement was to apply for ethical clearance. I applied for, and received, ethical clearance from Central Queensland University in order to proceed with, and complete, this study. This clearance is attached as Appendix A and was valid until August 2004. This date occurred after the finalisation of the data collection.

To gain access to the Queensland regional primary school in which the study took place, I met the principal, deputy principal, guidance officer and head of special education to discuss what I wanted to study and how I intended to go about that study. The school was very forthcoming and it

was agreed that I would have access to any administrator, teacher or parent who volunteered for the study. Because the study was in one school and did not involve children/students, I was not required to obtain ethical clearance from Education Queensland. However, I did receive written endorsement of my project from the principal of the school; this endorsement was included in my successful ethical clearance application to Central Queensland University.

During the semi-structured interview stage, each interviewee was given an information sheet and interview schedule at least one week prior to the interview. The information sheet clearly informed her/him about the intent of my research as well as her/his rights regarding the decision to participate or not to participate in the research (see Appendix B—Information Sheet). The interview schedule listed possible questions that would arise during the interview. Prior to the initiation of the actual taped semi-structured interview, participants were asked for permission to tape the conversation, and to sign a consent form (see Appendix B – Consent Form). They were informed that they were free to withdraw from the study at any point without consequence. As of the submission of this thesis, none of the 18 interviewees has requested that her or his interview data be withdrawn and I have not been made aware of any social, psychological or emotional consequences resulting from the interview process.

Although I adhered strictly to the institutional ethical guidelines and considered myself to act in a morally responsible manner when engaging with the participants, it is appropriate to note that the particular framework within which this study is located leads me to problematise the notion of 'ethics'. This problematisation is a direct result of the post-structuralist opposition to 'fixed' meaning. Thus, in order to analyse the concept of ethics, one must examine the prevailing discourses of 'good' and 'bad' as well as 'just' and 'unjust' – discourses that are fashioned by and situated within specific socio-cultural and historical contexts. Within the context in which this study took place, it was completed in an ethically sound manner.

*Relational*

Considering that I have investigated elements of people's personal and social lives, I am aware of Preston's (1996) assertion that all of life is interconnected. The implication of that assertion for this study is that we are aligned with one another in a variety of ways that might not be obvious, but that may carry un/intentional social consequences. More importantly, "we have ethical obligations because our lives take place in a web of interdependent relationships" (p. 68). Thus, anyone engaging in any form of research obligates one to recognise the impact that one may have upon the research process and the research participant. In other words, positioning myself as a researcher is one thing, but positioning myself as a researcher and drawing upon ethical discourses in doing so is another thing; as Bibby (1997) notes, "Even entirely self-interested researchers…have to be

committed…to safeguarding the welfare of those on whom the research is done" (p. 3).

From this perspective, I am aware of the procedures and protocols that were outlined above and that are grounded in contemporary notions of 'ethical treatment' of participants, and I have adhered to those protocols not only out of requirement, but also out of a personal desire to see equalised power relations within a social justice framework of critical thinking. Below I outline two key factors that have assisted me in maximising the relational dimension of the study and in minimising risk to the participants and note that power – as discussed in Chapter Three – underlies each of the two points. These points – anonymity and voice – are described prior to my discussion regarding one specific ethical consideration that has bothered me throughout the course of this study.

Anonymity

The first step in decreasing the possibility of risk to the participants is through anonymity. As my conceptual framework established that words are actions and therefore have consequences, I am aware of the potential impact that an individual's words about a contentious topic such as learning difficulties could have in a professional atmosphere where third-order positioning is prevalent. By 'third-order' positioning, I am referring to the 'outside' individual providing commentary on a social exchange between other individuals and/or groups. Generically, this could be viewed as 'workplace gossip' as people position themselves and others in their account

of the event. Thus, if the individuals were not anonymous, then the potential is there for them to become subjected to positions that may negatively affect the value of their work and their work relationships, thereby impacting negatively upon their social experiences.

Therefore I sought to ensure that the participants were each provided with a pseudonym in this study. In some cases, the individuals chose their own pseudonyms. In other cases, the participants did not choose their pseudonym, yet chose the option of being represented as a member of the opposite sex. Although these were subtle efforts to maintain anonymity and protect the voice of the participant, they were also moves towards equalising potentially one-sided researcher–researched relations. Ultimately these 'subtle efforts' appeared to ease the minds of individuals.

Notably, my method of providing the participant with a choice regarding gender and/or name was well-received, especially by those working in 'solitary' positions where labelling them as 'principal' or 'guidance officer' would easily lead to their identification. It is for this reason that those two particular positions were labelled collectively as 'administrators' and why Support Teachers: Learning Difficulty were labelled as 'teachers'. Despite the apparent paradox of considering anonymity as a relational strategy, it served its intended purposes of maintaining integrity between research participant and researcher.

Voice

The second way in which I maximised this relational dimension of the research and minimised risk to the participants was by emphasising their 'voice'. My particular emphasis upon voice in this sub-sub-section is to establish that recognition of voice acknowledges someone's presence as s/he works to establish her/himself in conversation. As Erchick (2001) noted:

> …voice contributes to and becomes a part of the forming of self, personally, socially, epistemologically in one's ways of knowing, and professionally. Being more than a sound made, the words used, and the way they [those words] are used, voice becomes a meaning sent, a window into who we are, and when heard, a validation of presence. (p. 154)

There is a resonance here with positioning theory's focus on the way in which the individual's speech-acts are considered formations of self as the individual positions and re-positions her/himself and others in conversation. Thus, we identify ourselves and our particular thoughts and beliefs about the world through our voice as we draw upon discourse. Therefore, the notion of voice plays a considerable part in the ethics and politics of research if one is to consider the historical issues of power and representation that have effectively silenced the 'researched' and led to such concepts as the "ignoble savage" (Barnett, 1975) and the "other" (Said, 1978). In presenting the interviewees' words in this thesis, I am not giving them a voice; rather, I am presenting their voices in a particular forum where they may not have been heard previously and I am attempting to understand what those voices have said about learning difficulties.

The implication of voice for this study is directly related to the notion of agency. Although I have discussed notions of the 'de-centred subject' and agency in the previous chapter, I present them here also because listening to an individual acknowledges her/his presence. Thus, fostering the individual's voice is an essential element in preventing domination and subordination. This is because acknowledging one's voice as an expression of identity implies that one has the potential to speak against dominant ways of thinking, knowing and acting that could render the individual 'docile'. In this study, I focused upon the voices of the parents, teachers and administrators in order to identify what particular discourses they used to construct the concept of learning difficulties. In doing so, the stakeholders also established the typology of a child identified as experiencing learning difficulties. Since learning difficulties are considered 'real' because of their social consequences (e.g., labelling and stigmatisation), constructing a typology regarding those children was simultaneously positioning them. This presented an ethical dilemma for me that I discuss below.

One may consider it ironic that I advocate the importance of voice and consider issues of domination and subordination as mechanisms of power that can and do work to 'silence' specific individuals, yet I have excluded the very individuals whose voices most need to be heard – those of children identified as experiencing learning difficulties. I raise this issue here in order to present it as one 'ethical dilemma' that I faced during my research journey. The particular part of the dilemma that pains me is that I have felt at times as though I were contributing to the silencing of the child through

my omission of their voices. The parents, teachers, administrators and *I* engaged in positioning of ourselves, one another and ultimately the child identified as experiencing learning difficulties. Thus, I am reminded of the implicit power relations underlying this study considering the relative ease with which the stakeholders and I discussed the trials and tribulations of those students. It is for this reason that I explain why those children's silence is more effective in this study.

The silence of the children identified as experiencing learning difficulties is both unintentional and intentional. On the one hand, when my research topic was first developing, I designed the study to focus on the views of adults rather than to require input from their children/students. It was not until after I began collecting the data that I realised that the children's voices would have been beneficial and, by then, it was too late to engage with the necessary research protocols that would have permitted their inclusion in the study. In addition, the exclusion of children was to some extent offset by the richness of the data collected from the three groups of adult participants.

On the other hand, the exclusion of those voices presents a very clear message. The message is how easily a child can be dominated through individual and institutional positioning. That is, the individual and institutional ways of thinking and knowing regarding children identified as experiencing learning difficulties are dominant to such an extent that the child is effectively silenced upon attaining the 'learning difficulty label'. As a result, s/he is excluded from her/his educational decision-making because

of the irrational space in which s/he resides owing to the learning difficulty diagnosis.

**Conclusion**

Thus chapter has dealt with the research design constructed in order to explore adult stakeholders' constructions of learning difficulties in a Queensland regional primary school. I discussed the methodological underpinnings of the study in order to locate the research in a qualitative, interpretivist and post-structuralist 'space'. In addition, I introduced the data collection and analysis techniques as well as provided a sample positioning analysis to demonstrate the application of theory in practice. I concluded with the strengths and potential limitations of the study as well as the ethics and politics of the research as a means of showing the potential contributions that this study can make, in addition to the potential limitations that may have impacted upon the study and the research results. In the following two chapters, I apply this research design extensively in order to examine the concepts of domination (Chapter Five) and resistance (Chapter Six) as enacted in the participants' positions, speech-acts and storylines.

# CHAPTER FIVE

# THE DOMINANCE OF THE MEDICAL MODEL IN RELATION TO LEARNING DIFFICULTIES

*Clint: Learning difficulties. Do you think that they could be a 'here today; gone tomorrow' trend?*

*Sean: They [learning difficulties] will be around forever. And research tells us that 20% of kids will experience learning difficulties in our system. So they are going to be around forever, I think.*

## Introduction

The purpose of this chapter is to present the medical model as an "established regim[e] of thought" (Foucault, 1980, p. 81) in the context of the constructions of students identified as experiencing learning difficulties by parents, teachers and administrators in one Queensland regional primary state school. That is, I wish to analyse the ways in which the adult stakeholders in the study utilise one or more of the five components of the medical model described below in order to construct the child identified as experiencing learning difficulties. I note here that each component stands alone in that it is not necessary to subscribe to more than one component in order to subscribe to the medical model. This is perhaps one reason for the medical model being such a powerful mechanism of domination because its own power is not isolated; rather, that power is diffused through five components, each of which is enacted by different individuals.

In analysing the data in this chapter, I focus on the parents, teachers and administrators – as adult stakeholders in the child's education – in order to draw out the discrepancies and resonances within and across their voices. That is, the positioning analysis of the interview data has revealed that people often attribute a child's learning difficulty to the medical model by way of subscribing to one or more of its five components outlined here. In the chapter, the medical model – a western modality, or something used in the treatment of a disorder, for the treatment of disease – is presented as an 'established regime of thought', or a generally accepted and often unquestioned way of thinking and knowing about learning difficulties. In

subscribing to a medical model 'way of thinking and knowing', the parent(s), staff members and child are thereby exonerated from responsibility for that child's 'failure' to access the curriculum.

As I established in Chapter Two, the medical model is the foundation of learning difficulty/disability discourses in Education Queensland and therefore represents a dominant discourse. I intentionally use the term 'dominant' to flag two key aspects of the content of this chapter. The first implication of the use of the term 'dominant' is that the medical model discourses used by the individuals in their interviews are more vocal and powerful than other explanatory framework discourses in this study. Therefore those discourses can be considered to be 'dominant' as they have been given the power by the stakeholders' subscription to them. As a result, those discourses can present themselves as 'dominant' with less resistance by the voices of the participants who enacted them as 'taken-for-granted' assumptions. The second implication of the use of 'dominant' is that the term alludes to domination. In this study, taking the medical model components for granted, as the stakeholders generally do in their interviews, leads to domination of the child because it renders her/his body 'docile' by preventing her/his voice from being heard and by limiting that child's agency.

A brief recapitulation of the medical model as presented in Chapter Two is that it is a dominant way of thinking and knowing that comprises five major assumptions about the body. Those five assumptions are represented as

'components' of the medical model in this thesis: the Cartesian mind–body dualism; physical reductionism; specific aetiology; the machine metaphor; and the notion of the body as an object of regimen and control (Freund, McGuire & Podhurst, 2003). Each of these components is relevant in viewing the medical model as an 'established régime of thought' because this way of thinking and knowing about learning difficulties by the stakeholders has social consequences, or "concrete implications" (p. 223). As I noted above, one need not subscribe to more than one of the medical model components in order to align oneself with the medical model way of thinking and knowing. This is one reason why the medical model is able to dominate the available subject positions of the stakeholders. Thus, it is far 'easier' to slip into the 'default mode' of locating the difficulty within the child as being a 'natural' thing to do than it is to locate oneself in an oppositional subject position.

In organising the chapter, I used the five 'components' listed above as headings and the voices of the participants as sub-headings. My justification for this organisational strategy is as follows. As discussed in Chapter Four, upon completing the interview transcripts, I reviewed the data firstly to identify text that reflected medical model ways of thinking, and secondly to locate evidence of 'other' or 'alternative' ways of thinking. The third category 'behaviour' was later subsumed by the other two ways of thinking which are now represented by Chapters Five and Six respectively. This reiteration of my methodological approach is important to note here because the five components are tied directly and iteratively with the

findings of my data analysis. That is, I began with a close textual reading of the data; I followed this with a focus on relevant theoretical literature; and then I combined the two elements by using the five components gleaned from that literature as a conceptually informed framework for organising my analysis of the data in this chapter. As a result, the five components of the medical model provide a skeleton to which I can attach the flesh that is the information from the participants. The voices of the participants have accordingly been categorised in a manner that demonstrates explicitly how and where they identify with medical model discourses.

I contend that an in-depth examination of the intersection of knowledge, power and discourse may yield insight into some of the contextual events contributing to the perpetuation of the notion that children identified as experiencing learning difficulties have a deficit *within*. Moreover, the proposition that discourse, power and knowledge are inextricably linked allows me to utilise those concepts as tools of analysis within this chapter in order to demonstrate that and how individuals subscribing to the individual deficit model are contributing to the dominance of the medical model.

As an over-arching 'way of thinking and knowing', the medical model has penetrated the contemporary educational institution in which this research took place. It has done so to such an extent that many individuals have internalised medical model discourses without question and are often reproducing the 'child deficit' typology using one or more of the five components listed above and discussed at length in Chapter Two. Often the

individual's reproduction of the dominance of the medical model was carried out by way of her/his occupation of subject positions linking an inability to 'access the curriculum' to a physiological deficit inherent in the child.

As established in Chapters Three and Four, discourses provide opportunities for participants to adopt subject positions such that they support/contest/reject a particular stance within the course of their interview(s) with me. Rather than focusing entirely on the interpersonal 'positioning' (between the interviewee and me) that might attempt to establish a local moral order about who has the 'right' to say 'what' and at what time, I have utilised positioning theory in a way that allows me to attend directly to the broader 'patterns of thought' exhibited by the participants in the study. In this chapter, I am searching for moments when the interplay between the medical model discourse(s) and the participants yields the individual's version of 'what' a learning difficulty is/is not.

When applied to the school as an institutional setting, the medical model can be criticised for its trademark disregard of social and psychological factors influencing a student's inability to 'access the curriculum'. In disregarding 'other' explanatory factors for that inability, the school becomes a site of maintenance and perpetuation of "established régimes of thought" (Foucault, 1980, p. 81) that contribute to the child's domination and docility. Thus, if a single way of viewing the child is already established and institutionally reinforced, then resistance of that specific and particular

way of thinking and knowing becomes problematic. Adding to the difficulty of resistance is the very concept of power as permeating rather than being fixed. Because there is no broad and unilateral effect of power, there is no single institution or individual to which or to whom I can attach 'blame'. As a result, a specific 'cause' of learning difficulties becomes difficult, if not impossible, to determine. However, I can identify momentary traces and trails left by the voices of the participants as they visit the concept of learning difficulties in their respective interviews. Ultimately, their constructions are what enabled me to engage with my first research question: "In what ways is the medical model's dominance enacted in the adult stakeholders' constructions of children identified as experiencing learning difficulties?".

In responding to that question, I seek to illustrate the variety of ways in which individuals construct the term 'learning difficulties' and to link the ways in which individual representations of the term overlap in order to form a particular 'knowledge' about that topic. In this chapter, the stakeholders, although interviewed separately, contribute – both singly and collectively – to the dominance of the medical model way of thinking responsible for domination of the child. Thus, the notion of "a strategy without a strategist" (Dreyfuss & Rabinow, 1983, p. 187) becomes apparent as the various individual voices are united by a specific way of thinking and knowing about learning difficulties that relegates the deficit to the child.

Although I have used this chapter to establish the dominance of the medical model, I present it in the following chapter as being fallible. By 'fallible' I mean that the nature of the child deficit typology as an "established régim[e] of thought" (Foucault, 1980, p. 81) is without neither flaw nor challenge. Aside from the various criticisms mentioned previously (i.e., the 'flaw'), the individual participants in this study produced glimmerings of resistance of the medical model (i.e., the 'challenge'). By 'glimmerings of resistance', I refer to the 'other explanatory factors' for children who fail to 'access the curriculum' proffered by the participants during the course of their interviews. Those 'glimmerings of resistance' are presented in Chapter Six. As one purpose of this study is to encourage other individuals to question their underlying assumptions regarding learning difficulties, I argue that the presentation of alternative explanations for students' inability to access the curriculum simultaneously provides a challenge to a dominant way of thinking and knowing about learning difficulties and highlights the flaws of the medical model as those explanations exemplify that a medicalised approach to education may not always – if ever – be the best one.

In this introduction to the chapter, I have established that I am presenting the dominance of the medical model in this chapter through the voices of the stakeholders. In addition, I have highlighted that power is implicit and implicated in both domination and resistance; 'domination' is the major concept driving this chapter while 'resistance' is the focus of the next chapter. In discussing domination in this chapter, I work to illustrate that none of the stakeholders involved is considered to have intentionally

attempted to dominate the child identified as experiencing learning difficulties. Rather, each individual is reproducing a dominant way of thinking and knowing about learning difficulties that results in the rendering of that child as a 'docile body'.

This chapter consists of six sections. Each of the five components of the medical model has its own section in which the stakeholders' voices are represented and this is represented in Table 5.1 following (as explained in Chapter Four, all participants selected or were assigned pseudonyms for the duration of the study). Each section is specifically designed to show how an individual's words contribute to the broader aspects of domination of the child. That is, each section highlights specific instances where the individual subscribes to a different component of the medical model way of thinking and knowing when explaining the cause(s) of learning difficulties. Each of the individuals represented in this chapter is involved in creating the 'child deficit' typology that is representative of unequal forces of power that serve to dominate the child's 'body' by rendering it docile. The basis on which those particular individuals – whose pseudonyms are listed in the table below – were selected for this chapter is their use of metaphors and other linguistic constructions to discuss learning difficulties that are representative of one or more of the five medical model components. In addition, the chapter concludes with a sixth section, relating to the school's Special Needs Committee. The purpose there is to synthesise the adult stakeholders' subscription to those five components through a focused analysis of their constructions of a powerful policy device with considerable

impact on the lives of students identified with learning difficulties and with strong resonance with the medical model's fundamental assumptions.

| **Medical model criteria/Special Needs Committee** | **Administrators** | **Teachers** | **Parents** |
|---|---|---|---|
| Mind–body dualism | | | Anna |
| Physical reductionism | Kate; Sean | Anni | Thomas |
| Specific aetiology | | | Thomas; Marie |
| The machine metaphor | | Elisabeth; Anni | Marie |
| Regimen and control | Max | Kirk | |
| Special Needs Committee | Kate | | |
| | N: 3 | N: 3 | N: 3 |

Table 5.1. The intersection of stakeholders, the medical model components and the Special Needs Committee

**Mind–body dualism**

In this section, I present the voices of stakeholders who subscribed to the medical model way of thinking and knowing about learning difficulties by way of the 'mind–body dualism'. The foundation of the 'mind–body' dualism is the assumption that there is a "clear dichotomy between the mind and the body; physical diseases are presumed to be located within the body" (Freund, McGuire & Podhurst, 2003, p. 220). Although this way of thinking is often traced back to Descartes's separation of the mind and the body (Korten, 2002), it has been linked practically through 18th and 19th century medical practices that altered the way in which the body was viewed and treated. These practices were written about extensively by Foucault

(1973), who conceptualised the 'clinical gaze' as the way of directly observing, manipulating and altering the body, thereby rendering it docile.

*Anna*

Below I present a positioning analysis of text from Anna's interview. Anna is a married mother of two whose daughter was identified at the conclusion of Year Two as experiencing learning difficulties. In Year Five, her daughter Jessica (a pseudonym) was removed from receiving any learning support, yet re-entered the support program in Year Six. During the writing of this thesis, Anna contacted me to inform me that Jessica was no longer considered to be experiencing learning difficulties. At that time, Jessica was in Year Seven. The interview excerpt below is part of Anna's and my episode.

> Clint: How did you feel when your daughter was identified as experiencing learning difficulties?
>
> Anna: How did I feel at the time? I cried. It is hard to deal with.
>
> Clint: What was it that made you upset?
>
> Anna: That she was struggling in school because I do not know how it feels because I have never struggled. I felt terrible at that time because I could not help her. There is nothing I can do to help her up here [pointing to head], is there?

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Anna | Helpless | "I felt terrible…because I could not help her" | Grief |
| Jessica | One who needs help | | |

Table 5.2. Anna's positioning of herself and her daughter (a)

In the above excerpt the storyline is grief. Anna positions herself as helpless and Jessica as one who needs help; her speech-act accomplishes an expression of sympathy. Although it is debatable as to whether Anna is referring specifically to her daughter's mind or her daughter's body (e.g., Jessica's head) when she states that there is "nothing" she "can do to help her up here", the implication is that there is a dualism between the mind and the body. This dualism implies that learning difficulty is a physical disease that can be located within Jessica's body and therefore excludes her 'mind', or her social, psychological and emotional states of being that may impact upon her learning. The 'site' of the struggle is considered by Anna to be within Jessica and therefore Anna's positioning of herself exonerates her daughter and herself from the responsibility for the perceived learning difficulty.

Anna's positioning of Jessica as one who needs help brings to light two important points. The first is that Anna does not have either the knowledge or the ability to "help her [Jessica] up here"; Anna wants to help her daughter, but expresses her belief that she is unable to do so. The second point is that, in wanting to "help" Jessica, Anna will be required to comply with the necessary professionals in order to do so; thus, the use of a medical model discourse has a social consequence. I emphasise that Anna's positioning of her daughter is one contribution to the processes that render a child docile. The school identified Jessica as experiencing learning difficulties. At some point, Anna accepted and/or internalised the

discourses that locate the difficulty within the child. As a result, Anna feels helpless and does not resist the label that her daughter has been given.

In this section, I have focused specifically upon the mind–body dualism that separates the mind and the body, thereby leading to the body being rendered docile as it is viewed as the site of disease. Anna's distinction between her daughter's physical and psycho-social states locates the learning difficulty disease within Jessica's body. Neither Anna nor Jessica is responsible for the learning difficulty and the proper institutional regimes of treatment will be enacted in order to find "help" for Jessica. This particular situation assists in explaining the domination of the medical model because it isolates the child's inability within the child and effectively maintains a binary between the physical body and the social body, thereby excluding the latter. In the following section, I present four of the stakeholders' voices in order to show their subscription to the notion of physical reductionism.

**Physical reductionism**

The notion of physical reductionism is the idea that illness can be reduced "to disorderly bodily (bio-chemical or neurophysiological) functions" (Freund, McGuire & Podhurst, 2003, p. 221). As a result of reductionism, other explanatory factors such as those that are social and/or psychological are excluded (p. 221), thereby neglecting to question the impact that social and psychological factors have upon the individual. When viewed in the light of the stakeholders' comments, reductionism provides a way of viewing the 'problem' as inherent in the individual. This view of the

individual is congruent with the mind–body dualism, in that the two form a view of disease that "is localized in the *individual body*" (p. 221; emphasis in original). Despite the overlap between the two, the mind–body dualism is the dichotomisation of the mind and the body whereas reductionism is the separation of the mind and the body combined with the reduction of the individual into "disordered bodily function" (p. 221). The implication of this kind of thinking and knowing about learning difficulties is that its exclusion of 'other' factors isolates the 'problem' within the child, thereby exonerating both individuals and institutions from responsibility for that 'problem'.

*Kate*

An analysis of an excerpt from Kate's interview text is presented below in order to show her subscription to the physical reductionist component of the medical model. Kate has more than 25 years of educational experience; she taught in the classroom for 10 years prior to moving into educational administration, where she spent the remainder of her years before retiring in 2005.

> Clint: …[I]f you have advice for parents or teachers…in relation to students identified as experiencing learning difficulties, what would it be?
>
> Kate: To try and identify the problem as early as possible. That's a multi-faceted one…because often with teachers it is easy to identify the problem but then you've got to go through that grief cycle often with the parents and they have to accept that there is something wrong with their child and that is difficult.

Above Kate is performing a tripartite positioning; in positioning herself, she is positioning simultaneously the teachers, the child identified as experiencing learning difficulties and the parents of that child. In order to present my analysis of this excerpt, I have developed Tables 5.3, 5.4 and 5.5 below.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Kate | Facilitator | "identify the problem as early as possible"; "something wrong with" | Early detection; ownership |
| Child | Site of problem | | |

Table 5.3. Kate's positioning of herself and the child identified as experiencing learning difficulties

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Kate | Facilitator | "identify the problem as early as possible"; "it is easy to identify" | Early detection; discovery; competence |
| Teachers | Competent locators of learning difficulties | | |

Table 5.4. Kate's positioning of herself and the teachers

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Kate | Facilitator | "identify the problem as early as possible"; "they have to accept" | Early detection; acknowledgement |
| Parents | Parents of a child *with* learning difficulties | | |

Table 5.5. Kate's positioning of herself and the parents

In the 'early detection' storyline, Kate positions herself as a 'facilitator', in that she is advocating the early detection of learning difficulties by the teachers who are positioned as 'competent locators of learning difficulties'. For Kate, finding the "problem" is not the issue; the issue is facilitating the "grief cycle" of the parents as they "struggle to accept that there is something wrong with their child". Thus, Kate's utterance positions the parents as 'parents of a child with learning difficulties'. The distinction to be made is that they are no longer 'just' *parents*; a new set of duties and responsibilities will befall them when they finally 'accept' their child's learning difficulty. In stating that "there is something wrong with" the child, Kate is absolving herself, the teachers and the parents from responsibility for the child's perceived learning difficulty. Thus, physical reductionism as used by Kate presents the child as the 'owner' of the learning difficulty and this too will have social consequences as the child is the site of learning difficulties and therefore subject to a 'new' educational routine (categorisation and remedialisation). As 'owner' of the learning difficulty, the child has been reduced to a 'problem' that requires an institutional 'solution' and the social, psychological and emotional aspects of the child have not been addressed.

In labelling Kate as a "facilitator", I am playing on this term. Although Kate can be viewed as facilitating the acceptance of the learning difficulty by the parents, she can also be viewed – in domination terms – as facilitating the labelling, delivery and acceptance of the learning difficulty label. Because the concept of learning difficulties is an abstract truth,

Kate's facilitation of their identification is without question and the medical model remains unchallenged. Learning difficulties as intrinsic to the individual are 'real' for Kate and they exist within the child. In seeking to "identify the problem as early as possible", Kate is facilitating the reproduction of a physically reductionist view of the individual because the child is being analysed directly in order to ascertain in what ways s/he is not achieving. The teachers are competent in their ability to identify "the problem", which Kate considers to exist within the child.

*Sean*

Sean's voice is presented here in order to demonstrate his subscription to the medical model by way of a physically reductionist view of the child that locates the deficit within that child. At the time of the interview in December 2003, Sean had 26 years of experience "in the Department [of Education]" and had spent two years at the school where the study took place. He left the school at the conclusion of the 2004 school year.

> Clint: Was there anything confusing to you or stressful for you during the interview? Also, is there anything else that you would like to add before we conclude [the interview]?
>
> Sean: The only thing that I feel when I talk about these issues is my own emotions in reaction to these issues. They are just day-to-day things that we deal with and I can manage. I think the LD [learning difficulty or learning disability] kids are the ones who…really feel it in our system because they are often square pegs in round holes and the assumption is made that we can continue to squash and shape them to fit into those holes. My belief, the older I get and the longer I am in this business, I think, "No, you can't do that. That's not right". You wouldn't say to a deaf person, "Stop being deaf"; we don't say to blind people, "Can't you see, what's wrong with you, can't you see, fix it up". So we'll get there.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Sean | Sympathiser | "LD kids…really feel it" | Concern |
| Child | Incompatible | | |

Table 5.6. Sean's positioning of himself and the child identified as experiencing learning difficulties

Sean's storyline above is one of concern, with the associated positions of Sean being sympathetic to "the LD kids" and the child(ren) identified as experiencing learning difficulties being 'incompatible' with "our system". Sean's speech-act that the "LD kids…feel it" highlights systematic or institutional inequality. This supports my assertion that Sean is sympathetic in his utterance "[t]hat's not right" with regard to the 'squashing' and 'shaping' of the child(ren); for Sean, the person is 'just that way' and the institution cannot change that by attempting to mould the individual into something that s/he is not. Ironically, it was the institution that identified the child as experiencing learning difficulties in the first place.

Thus, Sean's example regarding blind and deaf people presents a view of the person as possessing an inherent deficit. When the child identified as experiencing learning difficulties attempts to access the curriculum in "our system", s/he is incompatible. For Sean, 'squashing' and 'shaping' the child(ren) is not the answer, yet the inability still remains with the child. The "LD kid" as opposed to the 'non-LD kid' is viewed by Sean as having the deficit, and it is that deficit that prevents the child from 'fitting' within the system. Sean presents learning difficulties as a disordered bodily function – similar to that of blindness or deafness, thereby demonstrating physical reductionism by locating the inability within the individual body.

Sean's view shows the hostile site of competing and conflicting discourses that the child's body can become. If the child does not 'fit' in the system, then the child is subjected to processes that will shape and mould her/him. The shaping and moulding of that child present ways of institutionally regulating the child's body. Sean does not necessarily agree with the system, yet he subscribes to the very concept that empowers the systematic domination of the child identified as experiencing learning difficulties.

*Anni*

Here I present a segment of an episode between Anni and me. Anni has been teaching as a classroom teacher in the Education Queensland school system for 10 years and began teaching as soon as she completed her teaching degree. Anni describes her first year of teaching as "traumatic", considering that she taught some "extremely high-flying LD [learning difficulties] boys" whom she was "not trained to deal with". However, at the time of the interview, Anni displayed poise and confidence as she discussed her teaching ability as well as her experiences with children identified as experiencing learning difficulties.

> Clint: Do you find that you are more sensitive to the issues of the students identified as experiencing learning difficulties?
>
> Anni: Probably. I guess it depends on the child himself. If they're 'shitty' or if every day they make your life a misery, it's really difficult to be as compassionate as you are to the ones you can see trying. [T]here are ones [children] that come every day and just try…and try and just can't get it; it just doesn't seem to click upstairs. Then you have got the others that – yes, it is not clicking, but they've just given up and they are not interested in trying at all. They have thrown the towel in already.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Anni | Capable; 'Judge' | "just can't get it; it doesn't seem to click upstairs" | Effort |
| Child | Innate inability | | |

Table 5.7. Anni's positioning of herself and the child identified as experiencing learning difficulties (a)

Anni's storyline is one of 'effort' as she positions the child identified as experiencing learning difficulties as one who has an innate inability; regardless of the child's effort or lack thereof, that child is still not 'clicking' "upstairs". The use of the metaphor "upstairs" here presents physical reductionism, in that the learning difficulty is located within the child. Although the term "upstairs" can refer to either the physical head or the mind, it represents a view of a learning difficulty as inherent in the individual. Anni's speech-act referring to "upstairs" reflects the naturalisation of learning difficulties; some children 'get it' and some children do not. The difference for Anni lies in the effort that the child does/does not put into schoolwork. Thus, Anni's focus upon the effort of the child who doesn't 'click' "upstairs" positions her as one who is capable of judging the child's effort because she can "see" the difference between children 'with' learning difficulties who "try" and those who do not.

Anni's assertion that it is "really difficult to be as compassionate as you are to the ones [children identified as experiencing learning difficulties] you can see trying" shows that the view of the child through one lens of the medical model can have social implications for that child. I note that Anni's construction of 'effort' will have specific consequences for the child who do/do not appear to fulfil her criterion of "trying". It would appear that

Anni wants to be compassionate to all children who do not 'click'. However, the children who do not 'click' and do not "try" are at a disadvantage in Anni's classroom because they are viewed as having "thrown in the towel already".

In a boxing match, when one fighter is being dominated by another fighter, the trainer of the losing fighter has the option – if not the duty – to throw a towel into the ring, effectively forfeiting and therefore ending the fight. In seeking to draw meaning from Anni's assertion in relation to the 'towel' comment, I have established the following explanation. If the child has a learning difficulty that is present "upstairs", then each interaction with the curriculum in its various forms in the classroom can be viewed as a 'fight'. For Anni, the child who 'tries' is the 'fighter' who continues in the face of adversity and, for that, Anni has more 'compassion'. However, the child with learning difficulties who does not try is viewed as having 'quit'. S/he no longer controls her or his mind in the fight against learning difficulties and has disengaged from the curriculum, thereby 'throwing in the towel'.

The medical model 'way of thinking and knowing' about learning difficulties presents the child as a body to be regulated and more importantly judged in the classroom by her/his teacher. As a result of viewing the child identified as experiencing learning difficulties through the physically reductionist lens of the medical model, Anni establishes a binary within that particular group; there are children identified as experiencing learning difficulties who try, and children identified as experiencing

learning difficulties who do not try. Thus, for Anni, learning difficulties are 'real' and the child who has them must 'try' in order to avoid making her life "a misery". The implication here is that Anni must control and regulate the children identified as experiencing learning difficulties in order to maintain her compassion for them.

In terms of domination, the child's label becomes one effect of power. Anni's use of a medical model discourse has aligned her with a physically reductionist view of the child and it is evident that this view has shaped and informed her subjectivity. Rather than questioning the processes that led to the child's label, Anni has taken learning difficulties for granted and is reproducing a typology of the child identified as experiencing such difficulties as possessing an inherent deficit that affects not only the child but also Anni's ability to teach and to be compassionate towards that child. In an educational setting, this is one among many crucial ways in which the domination of the child by the medical model is accomplished.

*Thomas*

Thomas is a father of three children, one of whom was identified in Year Two as experiencing learning difficulties and who has since been re-diagnosed and labelled as having Autism Spectrum Disorder (ASD). Although Thomas's voice is presented in the "Specific Aetiology" section below, I use his voice here as well in order to highlight a parental example of the physically reductionist view of the child identified as experiencing learning difficulties.

> Clint: What is the hardest thing for you, as a parent of a child identified as experiencing learning difficulties?
>
> Thomas: The hardest thing would be with his peers, when you stand there and you watch him and he doesn't have a clue. Now that they are older boys…they talk about 'older boys' things.…[I]n the last 18 months…they are all growing out of little boys and they are growing into young boys, so their conversations change and what they talk about; [Johnny] has no clue. So he is so left behind the eight ball, and I find that is the hardest thing – seeing the reality of it. I can't change that; I can teach him, I can try to help him, but I can't change that.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Thomas | Helpless | "The hardest thing…he doesn't have a clue" | Lament |
| Johnny | Clueless | | |

Table 5.8. Thomas's positioning of himself and his son (a)

Thomas presents a storyline of lament as he tells of his first-hand observation of Johnny not having "a clue". For Thomas, "the reality of it" is the "hardest thing". Thomas positions himself as helpless and positions Johnny as one who is clueless with the utterance that "he is so left behind the eight ball….I can't change that", simultaneously naturalising the learning difficulty and clearing himself of responsibility for his son's failure to access the curriculum. Thus, for Thomas learning difficulties are real and they reside within his son; he is unable to help him.

The use of the "left behind the eight ball" metaphor reflects the physically reductionist viewpoint. To be 'behind the eight ball' means to be in a position from which one is unlikely to escape. In the billiard game of 'eight ball', the object is to pot the balls in sequential order one through eight, with the eight ball unable to be touched until it is the last ball on the table.

Because hitting the eight ball prior to the sinking of the other balls forfeits the game, one physically positioned 'behind the eight ball' is at a major disadvantage and is in imminent danger of losing that game. Thomas's use of "behind" as a preposition establishes that Johnny is not as far advanced as he should be. The reason that Johnny does not have "a clue" is because of his perceived inherent deficit, something that Thomas "can't change"; Thomas did not put Johnny in that location, and he can only "try to help him". The 'eight ball' metaphor is physically reductionist as it locates the problem within the child and the child is therefore 'behind' in his learning and at a major disadvantage in the 'game' of accessing the curriculum. Thus, the child's ownership of her/his learning difficulty has put her/him in a position from which there is little opportunity for escape.

One implication of this view of Johnny is that his father has accepted the "reality" of the learning difficulty and views Johnny as being 'behind'. Thomas has internalised the established way of thinking and knowing about learning difficulties that perpetuate the domination of the child and contribute to her/his docility. There is little doubt that Johnny "has no clue". Having accepted that he "can't change that", the responsibility for Thomas is to now to "teach" his son and "try to help him".

**Specific aetiology**

The notion of a specific aetiology is the belief that "each disease is caused by a specific, potentially identifiable agent" (Freund, McGuire & Podhurst, 2003, p. 221). Although the 'doctrine' is attributed to Dubos (1959), he

noted that one drawback of the theory was that it was often insufficient in providing a complete account of the causation of disease. Below I present two examples of individuals subscribing to the medical model by way of Dubos's "doctrine of specific etiology" (1959, pp. 130-135).

*Thomas*

Thomas speaks again:

> Clint: What is his [Johnny's] diagnosis as of today?
>
> Thomas: His diagnosis today is Autism….I do believe that his LDs [learning difficulties] are [can be] contributed from [attributed to] the Autism, seeing as Autism is coming neurology [neurologically] from the brain and understanding how we take things in and process [and] all the rest of it. I've always seeked help; always tried to find the answers. My biggest question has been, "Well, why can't he learn?"

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Thomas | Doctor | "contributed from the Autism" | Cause and effect |
| Johnny | Patient with a learning difficulty | | |

Table 5.9. Thomas's positioning of himself and his son (b)

Above the storyline is 'cause and effect'. Johnny is positioned as 'patient with a learning difficulty' and Thomas identified that learning difficulty as a result of Autism. Because Thomas views Autism as "coming neurology [neurologically] from the brain", he is temporarily engaging in physical reductionism. However, in identifying the Autism as the specific 'cause' of learning difficulties by way of his speech-act "are contributed from", he is presenting a case for an aetiological foundation of learning difficulties. Thus, Thomas is positioned as 'doctor' as Johnny plays host to a specific agent that is potentially responsible for his perceived learning difficulty.

In Thomas's attempt to identify a specific agent, external factors influencing the body are omitted. The emphasis upon understanding the 'origin' of the learning difficulty reflects a structured medical approach, whereby one begins broadly and narrows down to the specific details which may recover the 'truth' about the ailment. By identifying those details of the ailment, one can then establish a treatment routine that will seek to isolate and remove the problem.

The complication with the identification of one specific aetiological factor (Autism) as the single cause of the disease (learning difficulty) is the exclusion of external factors and the potential for objectification of the individual. If the learning difficulties are attributed to Autism, and if Johnny 'has' Autism, then the logical corollary is that Johnny's Autism needs to be treated in order to treat the learning difficulties that result from it. Thomas believes in his theory of an Autism–learning difficulties 'link' and refuses to entertain the possibility of any social factors as explanations for Johnny's inability to access the curriculum:

> Thomas: I was working with a child psychologist under Queensland Health and he kept trying to send me to parenting programs and pick [apart] my marriage, and pick [apart] all these other things that…I had been through with [Johnny] and they were really irrelevant to the situation now.

The belief in a 'specific' cause of learning difficulties that originates in the child protects both the parent and the school (and also the child) from fault. In the excerpt above, Thomas's resistance of the child psychologist is functional in that it maintains the domination of Johnny by the stakeholders

who live and work with him. Thomas's resistance of the psychologists maintains the domination by the medical model, and more specifically the notion of specific aetiology. Firstly, Thomas is certain that Johnny's learning difficulties are caused by Autism, something that is a result of the "neurology" of the brain. If Johnny represents the site of learning difficulties, then the psychologist's attempt to "pick" other aspects of the child's life appears "irrelevant". Thus, Thomas has effectively excluded social, psychological and emotional factors influencing his child, instead believing that learning difficulties are a result of Autism. Johnny has therefore been constructed and re-constructed through an ongoing process of parental and professional dialogue that has effectively silenced his voice and presented his Autism as a 'part' of him that requires a child-centred focus in order to help him.

*Marie*

In this sub-section, I draw on Marie's voice. Marie is a mother of two boys, one of whom was identified in Year Two as experiencing learning difficulties and who has received assistance from Learning Support since that time. When asked to comment on the possible 'origin' of a learning difficulty, Marie responded:

> I don't know what it was, but I did something….I should have either identified it earlier or gone into labour sooner. He was two weeks late in being born; maybe oxygen didn't get to him fast enough or something.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Marie | One who is responsible for her child's learning difficulty | "I did something" | Culpability |
| Timmy | Victim | | |

Table 5.10. Marie's positioning of herself and her son (a)

Here Marie is searching for a specific cause of her child's perceived learning difficulties. The storyline is culpability as Marie positions herself as having been 'responsible' for her son's learning difficulties. The speech-act "I did something" accomplishes Marie's acceptance of responsibility and thus positions her son as 'victim'. Marie mentions several possible causes (i.e., absence of early identification, not going into labour sooner and lack of oxygen) of the learning difficulty. It does not matter that she is uncertain of a specific cause; what is important is that she subscribes to a 'specific aetiology' view that implies that there *is* a specific cause. In blaming herself and seeking a medical explanation of the cause of her son's learning difficulties, she is effectively exonerating the school from the responsibility for learning difficulties. Marie's interview text is unique in this section because she holds herself accountable for her son's learning difficulty. This is in contrast to the texts of the other participants in this chapter who appear to exonerate the adult stakeholders and sometimes the child as well.

Marie's pondering of the 'cause' of her son's perceived learning difficulty is one way in which the 'specific aetiology' operates. The individual is encouraged to look within in order to find the cause of the dysfunction. In this case, the look 'within' is twofold and serves to remove the identifying

institution from the responsibility for the learning difficulty. Marie first looks within herself in order to attempt to explain the reason for the learning difficulties that are within her son. In trying to identify a specific causal agent, Marie is neglecting to look 'outward' and conceive of the possible social-emotional and historical contextual factors that have combined to make possible her son's diagnosis.

**The machine metaphor**

Freund, McGuire and Podhurst (2003) state that "[o]ne of the oldest Western images for understanding the body is the machine metaphor" (p. 222). According to this metaphor, a learning difficulty would be a 'breakdown' in some area of the efficient operation of the child's machinery. If the child has a 'faulty part', presumably one can isolate and treat, or repair, that part. Thus, the child is compartmentalised and her/his parts become an object of intensive investigation and remediation. The domination of the child in this instance is again that social, psychological and emotional factors are excluded and thus the child is subjected to the rigours associated with repair.

*Elisabeth*

An excerpt from Elisabeth's interview text is the focus of my positioning analysis below. Elisabeth taught in the education system for 35 years and considered herself to be a "dinosaur" in the school. She participated in the study in October 2003 and retired the following year.

> Clint: How are you affected by the external factors influencing [the ability of] a student identified as experiencing learning difficulties…to learn in the classroom?
>
> Elisabeth: Personally…there is nothing much that I can do about it. Like all human beings, you have feelings that come into play when you get to know a child and are in there with him [*sic passim]* for the whole year. Naturally, you feel sorry for that child because he's missing a few pieces of the puzzle, but at the same time there is very little that I can do by the time they get to Grade Seven – especially when it comes to basic reading and writing. I can try to make them feel part of the group; I can give them what extra help I can make available during the day, but to do much more than that is very difficult. At this stage in my life, I do not have as much energy or as much interest as I did when I was starting to teach – it is not going to happen.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Elisabeth | Helpless | "You feel sorry" | Sympathy |
| Child | Deficient | | |

Table 5.11. Elisabeth's positioning of herself and the child identified as experiencing learning difficulties

The storyline above for Elisabeth is sympathy. The speech-act "you feel sorry" suggests intrinsic deficit. With Elisabeth positioned as 'helpless' and the child positioned as 'deficient', the 'puzzle metaphor' surfaces as a way of constructing the child who is not accessing the curriculum. In this analysis, the machine metaphor is conceptualised differently. Rather than an individual component of the child being 'faulty' or needing 'repair', the necessary part or parts is or are missing entirely. The implication of "missing a few pieces of the puzzle" is that the 'machine' cannot run efficiently, if at all. This being the case, Elisabeth is helpless when it comes to those particular "pieces of the puzzle" and therefore "feel[s] sorry for that child". Because a puzzle needs all of its pieces in order to present a complete picture, "missing a few pieces of the puzzle" implies that the child is lacking the essential 'parts' necessary to assist her/him with accessing the

curriculum. Just as a puzzle needs all of its pieces, a machine needs all of its parts. If either is missing one or more components, then it is incomplete and requires attention.

Viewing the child as 'deficient' prevents Elisabeth from being blamed for the child's inability to learn. Although she is sympathetic to that child's situation, there is "little" that she "can do" to help or change the situation; the deficit is within the child. The medical model view of the child means that s/he is not considered to be 'rational' like the other members of "the group" and that therefore that child needs "extra help". Thus, the child who is "missing a few pieces of the puzzle" is presented by Elisabeth as someone who 'doesn't fit' in the classroom. As an object of domination, the child has been compartmentalised and the social effects of her/his label are evident in Elisabeth's response that she is limited in what she can do for that child.

*Anni*

Anni speaks again:

> Clint: Where does the responsibility lie for the issues that you mentioned earlier associated with the education of children identified as experiencing learning difficulties?
>
> Anni: Some of them, you can't fix it [learning difficulties]. Maybe that sounds terrible, but sometimes that is just how we are and you can't fix it [learning difficulties]. It's not either party's fault.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Anni | Incapable | "You can't fix it" | Helplessness |
| Child | Irreparable | | |

Table 5.12. Anni's positioning of herself and the child identified as experiencing learning difficulties (b)

In this particular exchange, Anni presents a storyline of 'helplessness' that establishes the innate nature of learning difficulties. This 'helplessness' extends to the child when Anni comments that "[i]t's not either party's fault"; therefore, both Anni and the child are exonerated from the responsibility for the learning difficulty. In Anni's storyline, she positions herself as 'incapable' of 'fixing' the child identified as experiencing learning difficulties whilst positioning that particular child as 'irreparable'.

At first glance, this specific excerpt may seem to belong in the "physical reductionism" section because of its reduction of the learning difficulty to residing within the individual. However, under further examination, Anni's storyline establishes the learning difficulty as a 'part' of that child because "you can't fix it". In this case, the learning difficulty is the 'faulty' part that Anni cannot fix. The machine metaphor in this case means that the learning difficulty is a "malfunctioning of some constituent mechanism" (Freund, McGuire & Podhurst, 2003, p. 222) that requires repair. Thus, through the process of identifying the learning difficulty and remedialising the child, the child may access the curriculum. However, that child is not repaired *per se*.

With regard to domination, the child identified as experiencing learning difficulties is considered by the teacher to be irreparable. However, as a result of being identified as experiencing learning difficulties, the child is subject to institutional attempts to 'repair' her/him. That is, part of the child can be repaired in isolation from the child; they are not seen as one and the same. These attempts to 'repair' the child begin with her/his labelling and continue with classroom modifications to her/his work, external assistance from either the Learning Support Unit or the Special Education Unit and continued monitoring of the child's ability. The child's label alters the social experiences that s/he has in the classroom. The teacher's positioning of herself as 'incapable of fixing' the child may translate as the child becoming a 'lost cause', resulting in the teacher placing less effort into assisting the child.

One implication of this possibility is that, if the teacher considers the child to be a 'lost cause' and if that teacher gives the child less support or attention, then the perceived difficulty will be reinforced. In other words, by being viewed as having a learning difficulty and by being treated as irreparable, the child has little chance of improving in the classroom and will therefore be rendered docile by his/her label. It is the social effects of a label that allow one to glimpse domination in action. Thus, domination occurs at the point of reception of the learning difficulty label, in that the child is viewed as being 'normal', 'rational' and, most importantly, a 'child', rather than as a child 'with' learning difficulties, until s/he has been thoroughly processed by the institution.

*Marie*

In this sub-section, I present an extract from Marie. Prior to the school identifying her son as experiencing learning difficulties, Marie never suspected her child of 'having' learning difficulties and Marie believed that she

> …was going to have children who were going to grow up to be brain surgeons. The first thing I did when the kids were born was check the length of their fingers to see if they were going to be pianists. I never ever thought of anything like that [learning difficulties]; it was such a shock.

Having established Marie's disappointment above, I turn now to Marie's subscription to the medical model in order to demonstrate how her way of thinking aligns with the 'machine metaphor'. The excerpt below is a continuation of a discussion about Marie's 'transition' from "complete denial" of the possibility of her son experiencing learning difficulties to seeing "more evidence that yes, he did need it [extra help and learning support]".

> Clint: What kind of evidence?
>
> Marie: He wasn't reading on target; he couldn't read a simple three to five word sentence. He couldn't identify simple number constructions: one plus one - he couldn't understand that. I just kept saying, "Well, it will all fit in together; the puzzle will all join up".

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Marie | One who waits/hopes | "It will all fit in together" | Hope |
| Timmy | Incapable | | |

Table 5.13. Marie's positioning of herself and her son (b)

Marie first identifies the operations that her son could not do. This establishes the "evidence" that assisted with her transition to believing that her son was in fact experiencing learning difficulties and did need learning support. The storyline for Marie is one of hope and her speech-act "it will all fit in together" reflects optimism. With her son positioned as incapable, Marie positions herself as 'one who waits' for her son to develop in such a way that he is able to access the curriculum (i.e., the "puzzle" 'joining up').

Marie's "puzzle" metaphor is predicated upon the same foundation as the machine metaphor in its "exclusion of an image of the totality of the body" (Freund, McGuire & Podhurst, 2003, p. 222). An 'unjoined' puzzle represents compartmentalisation of individual pieces. Those pieces need to be studied and ordered in order to establish where and how they fit; the 'joining' of the puzzle pieces will yield a 'complete' picture. When applied to her son, the puzzle represents the different aspects of his in/ability. Thus, a 'joined' puzzle would mean that the individual 'parts' of her son were all operating in unison and that he would no longer demonstrate difficulty in reading or the inability to identify "simple" number constructions.

A mechanised view of the individual has implications for how that individual is treated. I use the term 'treated' to allude firstly to the social consequences of the medical model view of the child (e.g., labelling) and secondly to the institutional treatment that the child will receive as a result of her/his label. The ability to dominate the individual is a result of the compartmentalisation of the individual into parts. Those 'parts' become

subject to scrutiny by 'specialists' who have the ability to 'treat' the faulty 'part' that is responsible for the learning difficulty. Those 'specialists' in this instance are the Support Teachers: Learning Difficulty, who are responsible for providing the "extra help" that Marie's son will receive.

**Regimen and control**

The concept of 'regimen and control' is that the body is subjected to standardisation owing to its incapacity to function as 'it should' according to contemporary conceptualisations of it. In attempting to 'control' either our own, or another's, body, we are constructing it and our constructions of it have social consequences. Thus, a body that is docile needs structure and organisation in order to assist it with its functions. Although I am focusing specifically upon children identified as experiencing learning difficulties as 'docile' bodies, I note that docility as an effect of power can be viewed in the school's general population. As a site of socialisation and a location for structure and normatively constrained behaviour, the school is an ideal location for a study of this nature. This constraint applies as much to the administrators, teachers and parents as it does to the children. However, in focusing specifically upon learning difficulties, I have chosen to investigate a particular phenomenon that learning difficulties represents within a broader educational context, rather than investigate that particular context itself.

When examining the concept of 'regimen and control', I am seeking to illuminate areas of text that establish accounts of individuals' attempts to control the child identified as experiencing learning difficulties. By receiving the learning difficulties label, the child is subject to the institutional apparatuses of control that will serve to (attempt to) 'repair', 'fix' or remediate her/him. The child must succumb to the control of others over her/his education in order to have a chance to return to rationality and to be granted status as a child, rather than a child with learning difficulties.

*Max*

Max has 25 years of teaching and administrative experience. He considers himself to be able to "understand" where children identified as experiencing learning difficulties are "coming from". As a young teacher, Max was attacked during his practicum at what was then referred to as the "sub-normal school". He considered this a life-changing event and explained that it was that incident that led to his pursuit of a teaching career where he could "always help people". Although Max was not badly hurt, he came away with a belief that the attack had occurred as a result of the boy's Down Syndrome diagnosis and his inability to recognise the 'rules'.

> Clint: Learning difficulties. What is the most difficult part for you in relation to them in your current position?
>
> Max: Dealing with the parents. These people will not accept the fact that their child has got a major problem, and they won't help us deal with it. Or they ignore the fact; they will not deal with it at home….[I]t is just 'too hard' for them to deal with that behaviour at home. We just try to manage it at school, and they [the children] just go ape at home; we manage it at school and they just go ape at home.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Max | One who manages children with 'major problems' | "Dealing with the parents" | Disregard |
| Parent | One who will not accept the "fact" about their child | | |
| Child | One who has a "major problem" | | |

Table 5.14. Max's positioning of himself, the parent and the child identified as experiencing learning difficulties

In the quotation above, Max positions himself as 'one who manages' children with "major problem[s]" and simultaneously positions the parent as 'one who will not accept' and the child as 'one who has a "major problem"'. The storyline is 'disregard' and its meaning is twofold. In the first instance, Max considers the parents to disregard the "fact that their child has…a major problem". In the second instance, it appears that Max has disregard for the parents of the child owing to their lack of assistance to Max and the school and/or their inability to "deal with it at home".

In either instance, Max aligns himself with a 'regimen and control' way of thinking about the child. The child identified as experiencing learning difficulties is viewed as having a "major problem". Not only does the "problem" lie within the child, but that "problem" is also uncontrolled by the parent(s). The implication here is that the parents are not doing their part to assist the school with its discipline and punishment of maladaptive behaviour. Rather than being viewed as resistance of a problematic label, the (in)action of the parents is viewed as their being incapable of 'dealing

with' their child's behaviour. The assumption is that the child goes "ape at home".

Because the parents will not "accept the fact that their child has…a major problem", they are considered to be counter-effective to the management of the child by the school. The regimen and control of the child are imperative to Max because it seems that he does not want the child to "go ape" at school as s/he does presumably at home. To "go ape" means to enter a 'primal state' of anger or excitement. Thus, to "go ape" would be to act uninhibited by the social or institutional norms. In entering that 'primal state', one would be less likely to be regulated or to self-regulate and therefore that individual would be very difficult to control. The notion of 'rationality' proves useful considering that acting in an 'ape-like' manner is not appropriate in the classroom and that one engaging in such actions is at risk of being subjected to 'correctional procedures' that will remediate her/him.

The implication for domination in the above example is clear when one views the 'danger' that a maladaptive child represents to the order of the institution. Because s/he can potentially "go ape" and become unmanageable, the child's body becomes a site of more intensive regulatory methods. For Max, the children who exhibit 'extreme' behavioural 'issues' are the ones who need "that behaviour…controlled, so that they can learn". Ultimately, it is Max's perception of the situation that demonstrates how

medical model thinking, focused on regimen and control, easily leads to domination of the child.

*Kirk*

In this sub-section, I present the voice of Kirk. Kirk is a first year teacher who had recently graduated from university and was "doing supply [relief] teaching" when he was offered a position at the school. Kirk told of how he enjoys his job and considers teaching a "career":

> Clint: Specifically looking at the students you teach who are identified as experiencing learning difficulties, do you find that you have different expectations for them in terms of respect, behaviour and outcomes?
>
> Kirk: No, I expect them to have the same amount of respect for me as all the other students; I expect them to behave the same as all the other students. I can understand if they get frustrated because they are having trouble with something, but they need to learn how to deal with that frustration and not let it come out as a behaviour problem in the classroom. I try to help them with it; I do social skills stuff and we have nice affirmations and stuff like that so that if they are feeling frustrated then they can think of that and they don't have to 'go crazy'.
>
> Clint: Has it worked?
>
> Kirk: These ones in here, they don't have the behaviour problems. It seems to be a proactive approach or preventative medicine approach.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Kirk | One who empathises | "I expect them to behave the same as…other students" | Equal expectation |
| Child | Frustrated | | |

Table 5.15. Kirk's positioning of himself and the child identified as experiencing learning difficulties

In the storyline above of equal expectation, Kirk establishes that his expectations of students identified as experiencing learning difficulties are the same as for those students who do not experience them. Kirk's utterance regarding expectations positions him as one who can understand, if not relate to, the experiences of the child identified as experiencing learning difficulties. This is especially important to note because Kirk considered himself to have experienced learning difficulties while in school: "I was never really told I had a LD [learning difficulty] but I think they said I may have had mild dyslexia…". Kirk expects the same respect from each student and believes that it is the frustration of the child identified as experiencing learning difficulties that becomes a "behaviour problem in the classroom". Positioning the child as 'frustrated' justifies the need for regulatory practices in the classroom under the banner of "preventative medicine" that prevent the child from going "crazy".

The concept of the 'need' for regulatory practices is part of viewing the child's body as an object of regimen and control. Kirk comments that behaviour problems may be a result of the child's inability to deal with frustration. Kirk's belief is that "Once you have lost control, that is it – you are stuck". When asked to define "control", Kirk responded, "To start with, you have got to have…good behaviour management. The kids have got to know what is expected; you have…to have expectations and the kids have got to know what your expectations are, and they have got to know what their consequences are". Because Kirk's behaviour management discussion includes all children in his classroom, he is not differentiating between

children identified as experiencing learning difficulties and children who are not identified. However, the child who is identified has frustration to account for her/his misbehaviour. Although the child is treated "the same" as every other child, the way in which Kirk accounts for the child is different and both Kirk and the child must work to regulate the child's behaviour and therefore control her/his actions. This represents one way in which a label – and its associated position - can effect social consequences. Kirk employs "preventative medicine" behaviour management techniques in order to keep the 'LD kids' from going "crazy". Thus, there exists a tension for the child identified as experiencing learning difficulties. Frustration is acknowledged and, even though expectations are the same, there is an apparent implication that if they do misbehave they are more likely to be exonerated than other children.

For Foucault (1977), one of the most efficient ways in which power served to dominate was when the individual self-regulated as a result of internalising the discourses that operated within her/his field of relations. Viewing the body as an object of regimen and control allows one to glimpse the way that the child, positioned as student with learning difficulties, is required to adhere to the same rules and regulations as the other children. However, failure to learn those rules and regulations results in one being rendered irrational; s/he may be viewed as "crazy", which represents the child's inability to "deal with that frustration". The teacher has implemented a behaviour management program as well as "social skills

stuff and…nice affirmations and stuff like that" in order both to regulate the child's behaviour and to assist the child with self-regulation.

Kirk's alignment with the notion of a child identified as experiencing learning difficulties as an object of regimen and control potentially leads to domination because of the reason for Kirk's behaviour management plan. In using "preventative medicine", Kirk is attempting to prevent the children identified as experiencing learning difficulties from "going crazy". Thus, the child is positioned as 'one who goes crazy' and Kirk is positioned as 'one who needs to prevent the child from going crazy'. The child's perceived condition facilitates the domination of the child owing to the necessity for the teacher to 'control' her/him. The child is considered to be irrational; the teacher must ensure that the child's irrationality is regulated.

**Special Needs Committee**

In this section, I discuss the school's Special Needs Committee in order to present a powerful example of how a child can be dominated and rendered docile by a variety of seemingly unrelated forces acting upon her/him. I refer specifically to the way in which a group of individuals – each fulfilling different roles within the school – can meet to create a temporary site of domination, thereby exemplifying the concept of a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187). It is presumed that the individuals who attended the meetings of the committee did not do so with the intention of dominating the child; that result is a product of the

prevailing medical model discourses used to create and re-create the child identified as experiencing learning difficulties.

During the 2004 school year, I worked at the school as a contract teacher in the Special Education Unit. As a result, I was required to attend the meetings of the Special Needs Committee. The committee met fortnightly to discuss different children's various classroom and home situations, behaviour and a variety of other factors that would assist with providing a profile of the child for the group. The group would then discuss areas of concern as well as work to create strategies that could assist both the teacher and the student in the classroom.

The Special Needs Committee comprised of the Principal, Deputy Principal, Guidance Officer, Behaviour Management Officer, Head of Special Education, Special Education teachers, Support Teachers: Learning Difficulty, general staff teachers and teacher aides, each of whom held a position that could, at one point or another, provide a locale for the permeation of a subordinating apparatus of power such as the medical model ways of thinking. In what can be viewed as an ironic twist, I am providing a particular insight into one of the ways in which human interactions serve to create the very thing that they wish to undo. That is, each of the participants in this study – excluding the parents, who were not invited, and Kirk and Jayson, two first-year teachers – attended a Special Needs Committee meeting at one time or another. Given that many of these participants appear in this chapter as being aligned with medical model

ways of thinking, one can understand how a group of those individuals can temporarily locate power in one particular place as those individuals, as capillaries of power, unite to form a mechanism of domination that has social consequences for the child.

The mechanism of domination in this context is the Special Needs Committee. It is responsible for the surveillance of both staff and students and for the identification and remediation of children suspected of and/or confirmed as experiencing learning difficulties/disabilities. It is noteworthy that neither Education Queensland nor its schools diagnose learning disabilities, a sub-group of learning difficulties. That action requires a medical professional's diagnosis. It is then the job of the school to implement remedial programs. The major difference between learning difficulties and learning disabilities is that schools receive separate amounts of funding. Schools generally have the services of ST:LDs, which is extra funding, though based more on school enrolments than on number of identified students labelled. Second, students labelled with learning difficulties do not generate additional funds based on appraisement in the way that students with the major disability levels have under ascertainment.

Accordingly the notion of learning difficulties has social, political and economic components that act upon it. The Special Needs Committee embodies these components because of its focus upon the child as the site of the learning difficulty. Thus, the committee becomes a powerful tool with

the capacity to direct and re-direct the future educational experiences of the child identified as experiencing learning difficulties.

Although the purpose of the Special Needs Committee was to provide a forum that kept staff members informed of current situations with children identified as experiencing learning difficulties and learning disabilities, the committee was convened by the school in order to align with Education Queensland policy on the provision of education to students identified as experiencing learning difficulties and learning disabilities. In this policy, "Schools must assist students whose access to the curriculum is limited by learning difficulties and learning disabilities, to develop competencies in the areas of literacy, numeracy and/or learning how to learn" (Queensland Department of Education and the Arts, 2002b, n.p.). As a result of the current implementation of school-based management in Queensland, the regulatory principles guiding the school are vague. Thus, the school has a certain amount of flexibility in deciding what procedures are in place to identify, assess, classify and "assist" those students. The school where the study took place did not have a specific 'mission statement' regarding students identified as experiencing learning difficulties and/or learning disabilities. Rather, it had a general statement that included all students.

As a regular attendee at the Special Needs Committee meetings, I can attest to the requirements for a) knowledge of difficulty and disability discourses, and b) a feeling of professional obligation to commit to those discourses. Evidence for the existence of this professional obligation to commit to those

discourses includes the point that a majority of the committee members relayed their experiences through personal narratives set against the backdrop of the classroom setting. Thus, during these conversations, the individual was required to occupy numerous subject positions in order to generate an account of her/his experience(s) with a particular labelled child.

Often, in order to relay that particular account and make it relevant to the theme of 'special needs' and thereby to warrant inclusion in a conversation by the Special Needs Committee, an individual committee member would be required to draw upon, and display, difficulty and disability discourses. That way, the individual could communicate effectively and efficiently as well as remain within the group by avoiding irrationality by discussing 'irrelevant' topics. Although I was philosophically opposed to the notion of learning difficulties as an abstract truth, I did follow the unwritten 'rules' of the conversations, and hence of the committee, in order to avoid being rendered irrational.

Because the group was developed around the student identified as experiencing either learning difficulties or learning disabilities, it would have been irrational to challenge the very premise upon which the group was formed. Because schools are accountable for practising inclusion, they must provide appropriately for children identified as experiencing learning difficulties. Thus, going against policy and/or the Special Needs Committee is to resist a dominant way of thinking and knowing about learning difficulties. Resistance in this setting could lead to a variety of negative

outcomes for the individual. From this perspective, the committee becomes an effective instrument of surveillance that can identify which individuals are 'doing their job'. I use the term 'doing their job' to denote that the institutionalisation of learning difficulties naturalises the practice of identifying them to such an extent that an individual internalises them as a 'taken-for-granted assumption', thereby effectively becoming part of the 'strategy'.

Below I analyse Kate's discussion of the Special Needs Committee as a strategic encapsulation of the wider set of constructions of the committee by its various members. My reason for presenting Kate's voice in this way is to demonstrate the collective power that the medical model has in the school and how that power has been diffused throughout the stakeholders in such a way that its identification requires a thorough analysis of the interview text of one of their members.

*Kate*

In this sub-section, I present extracts from the interview text of Kate. The purpose of introducing that text is to show her contribution to the domination of the child identified as experiencing learning difficulties and her specific link to the Special Needs Committee. During my interview with Kate, I posed a question regarding who was responsible for the identification of learning difficulties.

> Kate: Here at the school, we've implemented here [a system], the classroom teacher would identify any child in their class that they feel has a Learning Difficulty or a problem; they then get the records and information on that

> child and bring it to our Special Needs Committee; the committee then sits down and looks at that, looks at *the problem*; and the decision is made there as to whether they believe it should go to the Learning Support Teachers, the Guidance Officer or Special Education Unit. If it goes to the Learning Support Teachers, they will then work with the child, fairly informally at that stage, just to get a feel and get to know the child themselves, then the teacher and the Learning Support Teacher and usually someone from Admin[istration] will make the decision whether we do need to go ahead and make an appraisement on this child and that's when parents are contacted. (emphasis added)

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Kate | Storyteller; reporter | "Here at the school…"; "classroom teacher would identify"; "the committee…looks at the problem" | Identification; processing |
| Classroom teacher | One who identifies | | |
| Special Needs Committee | 'Gatekeepers'; 'labellers' | | |

Table 5.16. Kate's positioning of herself, the teachers and the Special Needs Committee

In the statement above, Kate positions herself as a 'reporter' of the process of identifying and processing a child suspected of experiencing learning difficulties. In doing so, Kate now has the 'right' to provide an account of the process as well as of the individuals involved in that process. Kate's position as an administrator contributes to the 'authority' of her account, given that her particular professional role also permits her to speak freely of the process and the individuals working for her. Kate positions the classroom teacher as one who identifies students who are experiencing learning difficulties – "the classroom teacher would identify any child in the class…" – in a storyline of 'identification'. This move is consistent with

Education Queensland policy and demonstrates that the classroom teacher is an inextricable aspect of the apparatus of power that is the process for identifying students as experiencing learning difficulties; the teacher is the first 'port-of-call' and her/his ability to perform the task of identification is essential to the process and the continued systematic enactment of medical model discourses.

Kate's positioning of the Special Needs Committee is perhaps the most important act of positioning in her excerpt above. The speech-act "…the committee then sits down and looks at…*the problem"* alludes to the immense power that the committee is able to exercise when acting in a cohesive and collective manner. This organised approach within the school to learning difficulties can be viewed as 'efficient' and 'effective', in that it establishes the school's accountability for assisting the child identified as experiencing learning difficulties. However, Kate's speech-act positions the Special Needs Committee as 'gatekeepers' whose responsibility is to 'process' formally the child identified as experiencing learning difficulties. That is, the inception of the child's further docility – keeping in mind that general population children can be considered to be 'docile bodies' as well – begins with that child's identification by the classroom teacher and is formalised by the group's meeting to decide which particular 'avenue' the child will travel or which 'label' s/he will receive.

Thus, the medical model's institutionalisation makes for rapid and efficient processing and labelling of the child – all of which can be 'backed up' by

institutional policies regarding curriculum, pedagogy, assessment and reporting. Kate discusses above a system that is convened by the school to accommodate Education Queensland policy regarding students 'with' learning difficulties and/or learning disabilities. In doing so, she identifies learning difficulties as a problem and establishes the strength of the committee in deciding the fate of the child.

With regard to domination of the child, one can understand how a group of individuals who collectively employ medical model discourses can be considered gatekeepers. That is, this group represents the "established régim[e] of thought" (Foucault, 1980, p. 81) that presents learning difficulties as an abstract truth and essentially prevents the school from bearing blame for the child's inability to access the curriculum. It is processes such as those of the committee that medicalise that inability, thereby "transforming diversity in achievement into individual pathology or 'disability'" (Christensen, 2000, p. 233).

Instead of one lone individual subscribing to the medical model, the Special Needs Committee represents a group of individuals who subscribe to that model. The implication of the collective power of the group is that it is very difficult to resist medical model ways of thinking and knowing about learning difficulties, particularly when they proceed from the individual to the group. The committee can be seen as a machine that creates the child identified as experiencing learning difficulties whilst simultaneously it ensures that a policy of reductionism, and hence of domination, is put into

practice. The Education Queensland policy can be considered dominating owing to the fact that "the problem is seen to lie within the child" (Scott, 2004, p. 5). Thus, the committee reinforces continuously the notion that a child identified as experiencing learning difficulties possesses an inherent deficit. In viewing, constructing and positioning the child in this manner, the school is seen to be doing its job as the policy is enacted, the committee is maintaining the dominant way of thinking and the individuals are ensuring that they are exonerated from responsibility for the child's failure to access the curriculum. This system is therefore very powerful and extremely difficult – for children, parents, teachers and administrators – to resist.

**Conclusion**

In this chapter, I have presented the voices of nine (of a possible 18) different stakeholders who subscribed in one way or another to the medical model way of thinking and knowing about learning difficulties. I outlined the five components of the medical model (i.e., mind–body dualism, physical reductionism, specific aetiology, the machine metaphor and regimen and control) and used those specific components as organisational tools for analysing the data in the chapter. In addition, I included a section about the Special Needs Committee in order to present it as the embodiment of domination operating as a "strategy without a strategist" (Dreyfus & Rabinow, 1982, p. 187).

Throughout the chapter, I utilised positioning theory to engage with the interview texts and to arrive at the conclusions that are found within each particular positioning analysis above. Thus, a thorough positioning analysis of those interview texts permitted me to explore the data in order to respond to the study's first question: "In what ways is the medical model's dominance enacted in the adult stakeholders' constructions of children identified as experiencing learning difficulties?". I respond formally to that question in Chapter Seven. The following chapter presents 'other' explanatory frameworks for the phenomenon known as learning difficulties. I emphasise that the notion of 'resistance' is the foundation of that chapter and designed to provide a counter-narrative to this chapter's focus on the metanarrative of domination.

# CHAPTER SIX

# RESISTANCE TO THE MEDICAL MODEL OF LEARNING DIFFICULTIES BY 'OTHER' EXPLANATORY FRAMEWORKS

*We are without a language with which to address mind–body–society interactions, and so are left hanging in mid-air, suspended in hyphens that testify to the radical disconnectedness of our thoughts. We resort to such fragmented concepts as the biosocial, the psychosomatic, the psychosocial, the somatosocial, as feeble ways of expressing the complex and myriad ways that our minds speak to us through our bodies, and in the ways in which society is inscribed on the expectant canvas of our flesh and bones, blood and guts.* (Scheper-Hughes & Lock, 1986, p. 137)

*Identified children become a number in the system. I think we are in danger of losing sight of them as individuals with different needs and strengths*. (Ray)

## Introduction

This chapter presents some 'other' ways of thinking and knowing about learning difficulties as demonstrated by the adult stakeholders in their interviews. These 'other' ways of thinking and knowing are viewed as a crucial means of resistance to the domination of the medical model. That model, criticised in this chapter for its exclusion of behavioural, emotional, socio-cultural and institutional factors as well as individual strengths and talents influencing the individual, has concrete implications for the child identified as experiencing learning difficulties. Regardless of whether or not learning difficulties are 'real', they are considered to be 'real' because they have been cemented in Education Queensland policy and because many stakeholders consider them to exist as a result of their personal experiences. Moreover, the reification of learning difficulties by the stakeholders in this study has specific social consequences for the child in the school as an institution of domination, control and socialisation, as well as in the home. As I argued in the previous chapter, the voicelessness, domination and docility of the child are some of the major results of viewing that child from the perspective of any of the five medical model components. This chapter is an attempt to identify possible alternatives that can counteract the strength of the medical model as demonstrated in Chapter Five.

By viewing learning difficulties as a socio-historical construction in this chapter, I am focusing upon the discursive, linguistic and metaphorical devices that the stakeholders use to construct and re-construct the child.

They include behavioural, emotional, socio-cultural, institutional and individual strengths and talents as factors in their explanation of the child's failure to access the curriculum. As a result, I have chosen to focus upon those five aspects and to exclude the biological explanation of the stakeholders, which was presented in the previous chapter as being associated with the medical model. Each of those five aspects serves as headings in this chapter. The sub-headings within each section are the voices of the stakeholders who subscribed – *albeit* tentatively and temporarily – to any of these five aspects when attempting to explain the child's inability to access the curriculum.

In addition to the five sections named above, I have also chosen to include a sixth section entitled "Jessica and Johnny". Just as the Special Needs Committee was presented in the previous chapter as encapsulating the medical model, the stories of both Jessica and Johnny (which, like the names of the adult stakeholders, are pseudonyms) are presented in this chapter because they encapsulate the behavioural, emotional, socio-cultural and institutional, individual strengths and talents and ways of thinking and knowing about learning difficulties. These two children's stories consist of competing and conflicting discourses that highlight the necessity of considering the multiplicity of factors impacting upon a child's inability to access the curriculum – even though that 'learning difficulty' is still premised as an abstract truth. Whilst I realise that discussing Jessica and Johnny in this way, without including their voices directly, may lead to a charge of objectification and/or domination being levelled against me, I

contend that in this context an "*ascending* analysis of power" (Foucault, 1980, p. 99; emphasis in original) begins with the child. The key point in this sixth and final section is that the domination of the medical model appears fallible as 'other' explanatory frameworks for Jessica's and Johnny's inability to access the curriculum weave their way into the stories of their parents, Anna and Thomas.

Part of the reason for the domination by the medical model is that it assumes all the dominant speaking positions. That is, the 'taken-for-granted' nature of the medical model makes the process of naming, much less discussing, alternatives to that model problematic. Moreover, in highlighting five 'other' frameworks, I am demonstrating that there are a number of other possible explanations for a child's inability to access the curriculum whilst simultaneously establishing how difficult the medical model is to resist; there is only one medical model, whereas there is a multiplicity of 'alternatives', none of which has risen to the level of a metanarrative and hence to the dominant heights of the medical model.

I realise that this may lead one to conclude that resistance is futile (although I contest this conclusion below). Indeed, part of the domination by the medical model is that it closes down thinking, debate and discussion. The continued internalisation and reproduction of medical model discourses without question will mean that resistance certainly is futile. Even as I compose this chapter, I find extreme difficulty in openly presenting 'alternatives' to the medical model. This is partially due to the large

number of medical model subject positions that are available to me in contrast to the limited number of 'other' framework subject positions that are available.

To elaborate this crucial point, I have used this chapter to identify 'other' explanatory frameworks for a child's failure to access the curriculum. The use of 'other' implies that there is 'something else' as one may ask the question, "*other* than what?" In addition, I use the term 'alternative' with regard to explanations for children's failures to access the curriculum. However, one may ask also, "*alternative* to what?" The answer to both of these questions is "the medical model". Thus, anything said about learning difficulties is still constructed through the frame of the medical model, and there is therefore no single way to resist the domination by that model. Resistance is scattered, elusive and difficult to identify. Nevertheless, because power is implicit in resistance as well as in domination, the same 'rules' apply regarding how power operates as discussed in Chapter Three. Accordingly the 'other' or 'alternative' ways of explaining a child's inability to access the curriculum are presented in this chapter as one possible avenue that an individual wishing to resist can take.

I realise that to name alternatives could potentially make those alternatives a target for the discrediting domination of the medical model, for this already happens with 'alternative medicine' as there appears to be a long chain of literature considering those practices farcical and those practitioners charlatans. Thus, the very nature of identifying categories of resistance

against the dominance of the medical model effectively places those categories at risk of being focused upon and potentially discredited.

Challenging the dominant way of thinking and knowing is to be considered irrational and to be considered irrational is to be stripped of one's ability to legitimate oneself. The lack of ability to legitimate oneself in a particular social setting leads to loss of agency and voice. In this study, the child is on the receiving end of power and, through his/her receipt of the learning difficulties label, s/he has effectively been silenced and rendered docile. Whether or not that child will retain any or some of her/his agency and/or voice, I do not know. However, what I do know is that this chapter is an attempt to examine other explanatory frameworks for the child's inability to access the curriculum that may resist the medical model discourses and that might provide the basis for retaining that child's agency and/or voice.

I realise that the presentation of the medical model as a juggernaut of domination may evoke feelings of depression and may lead the reader to position me as either cynical, pessimistic or both. However, I do not intend – and indeed I am unable – to provide a solution to this dominant way of thinking and knowing about learning difficulties. Rather, I seek to highlight some of the voices of the stakeholders who have chosen not to subscribe wholly to that model. My reason for doing this is to show that there are individuals who do not necessarily agree with the medical model way of thinking and to illustrate some of the ways in which these individuals are resisting that domination.

Although I view the medical model as dominant in this study and I have presented in Chapter Five an analysis of data supporting that argument, I conceptualise the possibility of resistance by drawing upon Foucault's concept of an "*ascending* analysis of power" (1980, p. 99; emphasis in original). When I outlined in Chapter Three Foucault's (1980) 'methodological precautions' regarding power, I discussed how power should not be viewed as centralised and one should not "attempt some kind of deduction of power" (p. 99). Rather, one should "investigate historically, and beginning from the lowest level, how mechanisms of power have been able to function" (p. 100). An 'ascending analysis' allows me to challenge the general perception of power as being hierarchical and negative. A view of power as ascending and productive begins with the general social practices that occur in our daily lives and seeks to examine in what ways those practices contribute to resistance. This multidirectional view of power renders total domination impossible because power cannot be isolated and/or owned – only exercised. Therefore, resistance is possible because power is implicit in both domination and resistance.

Resistance is possible also because the individual is not viewed as being entirely on the 'receiving end' of power. This is because "the individual which power has constituted is at the same time its vehicle" (Foucault, 1980, p. 98). Thus, power cannot accomplish anything on its own; it requires someone to exercise it. An individual can use power to accomplish her or his means, but that individual is also subjected to the same effects of

power that s/he may seek to exert. S/he becomes a link in the chain of power and potentially faces the effects of implicit power that can be found in resistance. As Foucault (1980) noted, "[T]here are no relations of power without resistance" (p. 142). This point emphasises both the importance and the possibility of resistance, given that resistance is "formed right at the point where relations of power are exercised" (p. 142). Therefore domination cannot exist without resistance.

The notion of the "*ascending* analysis of power" (Foucault, 1980, p. 99; emphasis in original), coupled with the proposition that resistance is inextricably linked with power (1980), provides a way of viewing learning difficulties that acknowledges other explanatory frameworks for a child's inability to access the curriculum. These alternative ways of thinking and knowing about learning difficulties are important because they can challenge the dominant views of learning difficulties and potentially counter some of the effects of domination as felt by the child and the stakeholders. In this chapter, challenging the 'traditional' way of thinking about learning difficulties is reliant upon the possibility of resistance. If the individuals who represent the 'other side' of the medical model are viewed as having power as well, then perhaps there is room for some degree of optimism that the child identified as experiencing learning difficulties may retain some of her/his agency and voice.

In Chapter Five the information for analysis was abundant, whereas in this chapter the information was more difficult to come by and required intensive searching for each glimmer of resistance. In searching for those 'glimmers' of resistance, I have chosen to focus specifically upon the voices of the stakeholders who constructed and re-constructed the child identified as experiencing learning difficulties using discourses other than those associated with the medical model. I highlight these acts of resistance in order to present the medical model as fallible; it too has its deficiencies and some of those deficiencies are highlighted in this chapter.

In order to present the information in this chapter, I have developed Table 6.1 below. Each explanatory framework is used as a heading and each stakeholder's name is used as a sub-heading, with the section on Jessica and Johnny synthesising the preceding five frameworks:

| **'Other' explanatory frameworks/Jessica and Johnny** | **Administrators** | **Teachers** | **Parents** |
|---|---|---|---|
| Behavioural | Max | | |
| Emotional | | | Marie |
| Socio-cultural | | Richard; Ray | Marie |
| Institutional | | Richard | |
| Individual strengths and talents | Sean | | Liv |
| Jessica and Johnny | | | Anna; Thomas |
| | N: 2 | N: 2 | N: 4 |

Table 6.1. The intersection of stakeholders, the 'other' explanatory frameworks and Jessica and Johnny

**Behavioural**

In this section, I present a focus on behaviour as an alternative explanation for learning difficulties. I remind the reader of my discussion in Chapter Five regarding whether the learning difficulty is 'real' and the child's behaviour is a result of frustration resulting from that difficulty, or whether the behaviour itself is the cause of the learning difficulty. As an 'other' explanatory framework, behaviour presents a challenge to the domination of the child by the medical model because of its contestation of 'medical' explanations for the child's inability to access the curriculum. 'Behaviour' is viewed as having an effect upon the child's ability to learn, rather than the child's inability to learn being viewed as an intrinsic deficit.

*Max*

Max's voice was presented in Chapter Five and I revisit his interview text here in order to show both that he was ambivalent about the cause of learning difficulties and that he presents a case for maladaptive behaviour as that cause. In the excerpt below, I worked to establish what the term 'learning difficulties' meant to Max:

> Clint: What does the term learning difficulty mean to you?
>
> Max: [It means] Students having difficulty learning through [as a result of]…behaviour that's blocking their learning. These children are trying to learn, but have difficulties for many reasons…and in my department, they cannot learn because of their behaviour and that behaviour can be caused by many different reasons. That behaviour needs to be controlled so that they can learn.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Max | One with authority | "cannot learn because of their behaviour" | Discipline |
| Child | One who needs authority | | |

Table 6.2. Max's positioning of himself and the child identified as experiencing learning difficulties

The storyline above is one of 'discipline'. By considering learning difficulties to be a 'barrier' that is "blocking their learning", Max is presenting behaviour as an explanation for learning difficulties. In positioning the child as 'one who needs authority', Max positions himself as 'one with authority'. In his "department", Max believes that behaviour is the cause of learning difficulties and that behaviour needs to be "controlled". Whilst I realise that this quotation may align with the "Regimen and Control" section in Chapter Five because of Max's 'control' statement, I argue that it belongs here because his statement does not imply that there is an irremediable problem within the individual. The implication of Max's claims is that, if the behaviour can be "controlled", so too can the learning difficulty.

From this perspective, the child's behaviour is the cause of the learning difficulty. Maladaptive behaviour can be viewed as a child's inability to recognise and participate in rational classroom behaviour. Thus, that child's behaviour must be modified and that child disciplined in order to ensure that s/he accesses the curriculum. If the learning difficulty is a result of the child's behaviour, then the 'correction' of the behaviour can potentially 'remedy' that learning difficulty.

A medical model approach would lead one to believe that 'inappropriate' behaviour was a result of the child's inherent inability to learn. If the child is viewed as possessing an intrinsic difficulty, then the behaviour would be considered to be an effect of the difficulty. The resistance in this instance arrives in the form of Max's inversion of this cause–effect relationship. The child's behaviour is the cause of the learning difficulty. Thus, the learning difficulty becomes the 'effect', one alternative way of thinking about learning difficulties is presented and in the process the medical model's dominant status as the only possible explanation of learning difficulties is implicitly contested.

**Emotional**

In this section, I present stakeholder accounts of learning difficulties that align with a view of the emotional component of learning difficulties. As I noted above, the alternatives to the medical model still operate within the logic of that model. Nevertheless, while the 'emotional' component is still clearly associated with the individual child, unlike the medical model's position on learning difficulties there is the possibility that learning difficulties as emotions can be explained in environmental or social terms (emotions are framed by and influence the child's environment, whether at home or at school), and hence that they can be addressed positively and productively.

*Marie*

Marie, who was introduced in the previous chapter, speaks in the following segment. She introduces an 'emotional' explanation that counters the medical model view that learning difficulties can be isolated as dwelling within the child:

> Clint: What do you think causes a learning difficulty?
>
> Marie: I think it is a combination of emotional and psychological factors….Emotionally, my son does have a nervous problem, he is very high[ly] strung and it doesn't take much to make him just lose it – whether it be with temper or whatever. He chews his fingers basically down to his knuckles if he's stressed about answering a certain question the right way.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Marie | Concerned | "my son does have a nervous problem" | Anxiety |
| Timmy | Volatile | | |

Table 6.3. Marie's positioning of herself and her son (c)

Marie's storyline is one of 'anxiety'. Marie's son has "a nervous problem". She positions herself as 'concerned' for her son's 'problem' that results in him being labelled as "very high[ly] strung". As a result of his 'problem' and of being "very high[ly] strung", Marie's son is positioned as being 'volatile', given that it takes very little "to make him just lose it".

In order to justify this excerpt's inclusion here, I draw upon the idea that, if the source of her son's emotional distress can be found, then Marie can 'do something' to address that distress. Thus, if the child's anxiety is an issue that is preventing him from learning, then eliminating the source of that anxiety may lead to a child who is able to access the curriculum.

With regard to resistance, Marie's statements provide a platform for emphasising the interdependence between the child and his environment. This notion stands in stark contrast to a medical model view, whereby the child is the exclusive focus. Thus, Marie counters the medical model's 'inward focus' by presenting her son's "problem" as something that is external to the individual and that therefore holds the potential for a 'solution' to be found.

**Socio-cultural**

In this section, I focus upon individual explanations of learning difficulties that align with a socio-cultural explanation of learning difficulties. A 'socio-cultural explanation' in this instance is considered to be an explanation that includes discussions about society, culture, home life, environment and parents. These broad topics were explored for the purpose of discovering more refined and specific examples of a socio-cultural explanation for a child's inability to access the curriculum.

*Richard*

Richard is a member of the teaching staff and has been at the school for about five years. He has approximately 15 years of teaching experience and has spent a majority of his time focusing on special education. He is currently undertaking a Masters degree in education.

In the beginning of the interview, I sought to establish Richard's belief system regarding the 'origin' of learning difficulties. In asking him to identify a "cause" of learning difficulties, I paid close attention to the discourses Richard drew upon as he responded to my question:

> Clint: What do you think causes learning difficulties?
>
> Richard: Well, learning difficulties is a label. So you want to know what causes the label?
>
> Clint: It is an open question.
>
> Richard: Learning difficulties can be from anywhere. The learning that we do in this school – and any other school I have ever worked in – is socially constructed. The child goes into the school, they are given a curriculum that is socially constructed in a social context and – if that child has all the skills they need to operate in that social context, or that language context, or that cultural context – then chances are they will probably take on board most of the curriculum as it is given to them.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Richard | Commentator | "…curriculum…is socially constructed" | Indetermination |
| School | Deliverer | "They are given a curriculum" | |
| Child | Receiver | "The child goes into the school" | |
| Learning difficulties | Ambiguous | Learning difficulties can be from anywhere | |

Table 6.4. Richard's positioning of himself, the school, the child identified as experiencing learning difficulties and those learning difficulties

Here Richard presents a case for the proposition that knowledge is constructed socially and highlights the importance of recognising that educational experiences – for parents, teachers and students – are culturally and contextually situated. Therefore Richard's speech-act regarding the 'origin' of learning difficulties positions them as being ambiguous; there is

no definitive answer for Richard, who does not "pretend for a minute to have a handle on it [learning difficulties] myself". For Richard the school is a place where conformity to mainstream social, language and culture context is necessary in order to "take on board most of the curriculum". Moreover, Richard is taking up a position of 'commentator' as he reports on the way that he perceives 'the system' to operate. In this instance, the child either "has the skills" and receives the curriculum without modification or does not have the skills and receives the 'learning difficulty' label. Richard positions the school as the 'deliverer' of a socially constructed curriculum and the child as the 'receiver' of that curriculum. One way in which this curriculum 'delivery' is flawed is if one is to view knowledge itself as a construction. If this is the case, then knowledge is culturally and contextually bound and failure to acknowledge this point disadvantages the child who is attempting unsuccessfully to access the curriculum.

One can see how the socio-cultural context plays a major part in determining if and how the child will be able to access the curriculum. Again, if the child, as student, is unable to fulfil the duties and obligations of a student who receives the curriculum, then s/he may need remediation in order to assist her/him in fulfilling those duties and obligations. Moreover, if knowledge is socially constructed, then the individuals who comprise the majority will ultimately decide which knowledge is deemed appropriate in terms of the curriculum and the delivery thereof. It is unequal power relations such as these that can have devastating effects on a child who may

be stigmatised as a result of a label that was applied to account for school, parental or both school and parental failure.

The resistance in Richard's example consists of considering learning difficulties to be "from anywhere". Although this utterance does not necessarily exclude biological factors, it also does not exclude psychological, emotional or socio-cultural – or institutional – factors. This point alone is not enough to view Richard as one who is aligned with an 'other' explanatory framework for learning difficulties. However, when Richard asserts that learning is "socially constructed", he counters the notion of learning – and learning difficulties – as a universal and abstract truth. Thus, Richard has effectively highlighted the proposition that the knowledge in the school is a product of a socio-cultural and historical process. Therefore anyone exhibiting 'difficulty' in acquiring that knowledge does not necessarily have a deficiency; it is possible that the child's lack of cultural capital has rendered her/him irrational and led to her/his labelling.

After Richard's first statement, he provided examples of potential social barriers that can impede a child's ability to access the curriculum:

> Richard: But if they deviate in any way, if they come from a family perhaps where academic learning is not valued, or where perhaps it is seen as insurmountable and the child comes to school with an expectation learned from family that 'school is hard' or 'school is not for us', then they have a very good chance of being labelled.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Richard | Commentator | "if they come from a family…not valued" | Accountability |
| Family | Agent of socialisation | | |

Table 6.5. Richard's positioning of himself and the family of the child identified as experiencing learning difficulties

In the above quotation, Richard immediately draws upon a social contextual factor that could drastically impact on the child's perception of school. That is, Richard positions the family as the primary agent of socialisation for instilling values in the child that will influence the way in which s/he experiences school. If "academic learning is not valued…[or is] seen as insurmountable" in the home environment, then the child's outlook regarding education may be problematic when it is time for that child to engage with the prescribed curriculum. Here one can see how a socially framed concept of education, held by the family and/or the child, can impact upon the child's academic potential. Thus, if the child arrives at school with the belief that school is either "hard" or "not for us", then Richard asserts that this attitude may lead to a diagnosis of learning difficulty.

Richard's statement is a direct challenge to the medical model because it focuses on the external factors that are considered to play a part in the development of the whole child. In this specific case, the family or the home environment is considered to be a major influence upon the child's belief system. A medical model view of the child that situates difficulty in learning within that child fails to account for the influence of family, unless

investigating the genetic or 'medical history' of the family. Richard's specific mention of family moves away from a viewpoint of the child as 'owning' the deficit and resists the reductionist exclusion of socio-cultural factors that affect the child identified as experiencing learning difficulties.

*Ray*

Ray began teaching immediately after finishing university and has spent almost 15 years in the classroom, including 10 years at this school. I began the interview by asking what the term 'learning difficulties' meant to him:

> Ray: Learning difficulties are a construct of the culture we live in. Our western culture dictates that to succeed and be seen as smart, or even coping…you have to be able to read, write [and] be numerate….Most children are able to 'play the game' very well at school, and know what to do to succeed. Those children who have difficulty with literacy [and/or] numeracy the way our culture presents it, or who choose not to 'play the game', are seen as having learning difficulties or behavioural difficulties.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Ray | Referee | "Most children are able to 'play the game' very well" | Performance |
| School | Playing field | | |
| Child | Player | | |

Table 6.6. Ray's positioning of himself, the school and the child identified as experiencing learning difficulties

The above storyline is one of performance. Ray first acknowledges that the definition of learning difficulties is culturally dependent. He then draws upon a "game" metaphor that positions the school as a 'playing field', the child as a 'player' and himself as a 'referee'. The "game" metaphor alludes to the individual's ability to conform to the systemic expectations that s/he faces. Thus, the individual is viewed as a 'player' who needs to 'perform'

well in order to avoid irrationality and thereby be prevented from being able to "play the game". If the student is not aware of the 'rules of the game', then s/he is at risk of being seen as having either "learning difficulties or behavioural difficulties". If Ray is to be considered as a 'referee', then one must consider the role of a referee. The referee is the individual who possesses intimate knowledge of the particular game and is responsible for enforcing – and certainly never questioning – the 'rules' of that game. If the child is not playing the game and is considered to have a learning, rather than a behavioural, difficulty, then it is Ray's job to assist that child with the game.

Ray's excerpt highlights an explicit link with a socio-cultural framework for the explanation of learning difficulties. Ray does not isolate the child as the 'owner' of learning difficulties; rather, he mentions key words such as "western culture" and "behavioural difficulties" when accounting for children who are unable to "play the game". Ray did not specifically isolate learning difficulties within the child, nor did he assert that they even exist. Instead, he presented the child who has difficulty "with literacy [and/or] numeracy the way our culture represents it" as one who is "seen as having learning difficulties or behavioural difficulties".

This point is important because Ray is presenting simultaneously two challenges to the medical model. In the first instance, the 'culture' in which we live is called into question considering that its expectations are translated and enacted by the school as an institution. Secondly, the child who is not

"playing the game" can be viewed as having difficulties with behaviour. Neither explanation includes the notion of an inherent individual deficit.

Ray's resistance against the medical model is evident in his refusal to exclude socio-cultural aspects of a child's life that can be misinterpreted as a learning difficulty. In taking into account the child's cultural capital and behavioural compatibility with the school's rules, Ray has challenged a medical model view of the child. This challenge is powerful because it touches upon the social impact that a learning difficulty can have on a child. Thus, "to succeed and be seen as smart" requires that one 'play the game'. The logical corollary of this rationale is that, if one does not 'play the game', one will not be successful or "be seen as smart" or as 'coping'. There are social consequences associated with the learning difficulty, regardless of how or why the child received that label.

*Marie*

I present Marie's voice again. However, I note that the passage selected is distinctive because it contains elements of 'behavioural', 'socio-cultural' and 'institutional' explanatory frameworks for a child's inability to access the curriculum. Ultimately, I located this particular excerpt here owing to its socio-cultural emphasis. Although the excerpt could have fitted into the above-mentioned sections if divided up, I felt that its strength would best be viewed in this section in its entirety. I present two possible storylines below, both of which stand in stark contrast to the medical model.

Clint: Can you give me a brief background of your son's experience with regard to learning difficulties? How did you feel at the time he was diagnosed?

Marie: He was initially identified in kindy [kindergarten] when he was about four years old. My feeling at the time was complete denial. "This can't be happening; he's perfectly fine and he's on target and…it's everybody else who's finding fault with him because he's misbehaving".

Clint: When you said it was denial, did you blame anyone?

Marie: I blamed myself. I hadn't done something right. I hadn't read enough bedtime stories to him; I hadn't played enough learning games with him.…I blamed it all on myself.

Clint: How long did that last?

Marie: It's still going on.

Clint: Is it okay if I continue asking you about that topic?

Marie: Yeah, sure.

Clint: Can you tell me where the responsibility lies for the child's education in situations such as these?

Marie: I don't believe it's the school's responsibility at all. The school has their responsibility to teach the children and I think that's where the school's responsibility stops. I think, as far as everything, it comes from the home because the home is where you start the learning support – from day one – and you lead into everything from there. The school's responsibility is probably to identify the problems and to explain them to the parent and that's about it.

C: When they identified your son, did they explain to you what a learning difficulty was?

Marie: No. They thought that he was hyperactive, they thought he had Attention Deficit Disorder, they sent him for a barrage of tests that did identify that he was probably Attention Deficit Hyperactive Disorder, which – again – I was in denial. It took me a couple of years to deal with that, but finally the paediatrician said, "Yes, that [Attention Deficit Hyperactive Disorder] is what it is" and I...accepted that and I dealt with it. I still couldn't accept that that had anything to do with his learning difficulties.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Marie | One who doubts | "I still couldn't accept…" | Uncertainty |
| Timmy | One who misbehaves | | |

Table 6.7. Marie's positioning of herself and her son (d)

In this particular storyline, 'uncertainty', Marie is contesting the learning difficulty diagnosis that her son received at the age of four. Marie positioned her son as 'one who misbehaves' and positions herself as 'one who doubts' the diagnosis. Marie could not "accept" the learning difficulties diagnosis because her first response was to attribute her son's learning difficulty to his behaviour. As the storyline unfolds, and as Marie's ambivalence develops, it becomes obvious that she is quite uncertain as to the specific cause of her son's perceived learning difficulties.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Marie | One who is at fault | "I blamed myself." | Responsibility |
| Timmy | Child with Attention Deficit Hyperactive Disorder | | |

Table 6.8. Marie's positioning of herself and her son (e)

In this storyline, Marie presents a storyline of 'responsibility' as she positions herself as 'one who is at fault' for her child's perceived learning difficulties. Although Marie appears to 'give in' at the conclusion of this excerpt – hence the child being positioned as a 'child with ADHD' – she re-enters the 'uncertainty' storyline. This shows not only Marie's ambivalence towards the 'cause' of learning difficulties, but also that the medical model way of thinking and knowing about learning difficulties does not have a firm hold on her positioning.

With regard to the socio-cultural aspect of Marie's storyline, she focuses primarily upon herself and "the home" in order to locate the responsibility for her son's learning difficulty. In blaming herself, the implication is that she could have 'done something' to prevent her son's learning difficulty. That is, had she "read enough bedtime stories to him", or "played enough learning games with him", he may not have experienced difficulty learning. Thus, the child is not the site of the "proble[m]" and Marie focuses 'outwards' in order to highlight the potential socio-cultural causes of her son's learning difficulty.

The challenge to the medical model is twofold. Firstly, Marie's blaming of herself and 'the home' moves away from the "specific aetiology" and the "machine metaphor", two components of the medical model to which Marie subscribed in Chapter Five. Secondly, Marie's 'uncertainty' as to the 'cause' of her son's difficulty learning demonstrates that she is 'fighting' against the domination of her child by the medical model. Thus, Marie's uncertainty becomes an important component of resistance because it means that she is still 'open' to other explanatory frameworks. In this context, the 'taken-for-granted' certainty that the medical model is the only possible rational explanation of learning difficulties and on which the medical model's dominance is posited is under challenge.

**Institutional**

This section addresses the notion that a learning difficulty may be a result of a systemic deficiency and interrogates the possibility of institutional 'failure' in meeting the needs of children. The inclusion of this section is both timely and relevant because the report of the *Ministerial Taskforce on Inclusive Education: Students with Disabilities* (2004) emphasises the necessity for schools to focus on equitable outcomes for students with diverse learning needs. The report considers students *with* disabilities and learning difficulties to be educationally at risk and seeks to locate the education of those particular students within "the broader social and educational reforms bringing rapid changes to our schools and communities" (p.1):

> While there is much to commend Queensland schools in their willingness to respond to the needs of each student, some organisational structures, and core beliefs and practices remain that hinder the provision of quality curriculum and pedagogy for students with diverse learning needs. (2004, p. 5)

I highlight here the importance of the taskforce because it is what I consider to be a major challenge to 'traditional' ways of thinking and knowing about learning difficulties. The taskforce also had to work within a dominant medical model framework in that it presents learning difficulties as an abstract truth as it was established specifically "to provide advice on how to make the schooling system more inclusive for students at educational risk, in particular students *with* disabilities and learning difficulties" (2004, p. 5; emphasis added).

However, the taskforce did draw attention to the proposition that there is a systemic issue with respect to the way that educational institutions view the learner as it highlighted

> …the need to accelerate the transition, from a long tradition of compensatory educational approaches premised on a deficit view of the learner, to contemporary approaches that celebrate diversity and difference, as a basis for building responsive, collaborative, communities of learning. (2004, p. 9)

Therefore my focus upon an institutional framework for explaining learning difficulties is justified partly because the dominance of the medical model is inextricably linked with Education Queensland policy and partly because the Ministerial Taskforce on Inclusive Education: Students with Disabilities (2004) has highlighted the need to overcome the medical model view of the child. This provides a platform for my discussion in this section, as well as a testament to the contribution to the field that my research and other contestations of the medical model can make.

*Richard*

I use Richard's voice again to demonstrate resistance against the medical model in relation to the institutional framework for explaining learning difficulties. The conversation from which the extract below was taken revolved around the notion of "perception" as Richard discussed how an abstract institutional "label" can negatively impact upon a child:

> Richard: Once that child has that label and is designated 'this child has a learning difficulty' and the expectation drops, the child's expectations of themselves will drop. Children are very good at picking those things up. It is a self-fulfilling prophecy. "You are not going to achieve very

well". Ah, 'bingo', what an obliging child, "I didn't achieve very well".

Clint: What areas of the child's life does that affect?

Richard: The whole child, I would think. Their own perception of themselves….When I first started here, this was just generally referred to as 'the unit'. Kids would say, "I have to go, I'm a unit kid now". There is a whole language and culture that comes with it, and we get a lot of kids in the senior years refusing to come because of the stigma attached and refusing to be involved with anything that might be tainted with that 'learning support' thing.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Richard | Historian/Social commentator | "[O]nce that child has that label" | Stigmatisation |
| Child | Obliging | | |

Table 6.9. Richard's positioning of himself and the child identified as experiencing learning difficulties

In the passage above, Richard brings to the fore one of the critical points of this thesis. He highlights effectively part of the plight of the child identified as experiencing learning difficulties. The social consequences of 'the label' are described through Richard's first-hand account. In order to demonstrate the change that has occurred from 'child' to 'unit kid', Richard assumes the position of historian as he relates the way that it was and the way that it is from when he "first started" at the school. Simultaneously, Richard is providing social commentary, in that he remarks on the situation using his experience as the anchor for the story. The storyline is stigmatisation as the children who are identified experience social ramifications that affect the way that they are perceived by the individuals in the school as well as the way in which they perceive themselves. The child is 'obliging', in that s/he eventually 'fits the mould' that the school community has created; s/he has been constructed by others and s/he has apparently forfeited his/her agency

and voice to the power of the dominating label. A direct link here to Foucault's notion of the "docile body" (1977, p. 136) is necessary considering that the child becomes a "unit kid now" and is subject to the institutional, remedial methodologies and practices.

Richard's quotation above aligns with an "institutional" explanatory framework in that it shows several of the social effects of an institutional label. The label is a result of Education Queensland policy and the term 'learning difficulties' has a pejorative connotation because of the social and emotional toll that the "language and culture that comes with it" take on the child.

With regard to resistance, Richard demonstrates how the child's docility is reinforced by the institutional labels that exist. In particular, the 'learning difficulties' "label" renders the child an object of ostracism as s/he engages with the 'learning difficulties' "stigma". An 'institutional' framework for explaining learning difficulties resists the medical model's dominance because it does not consider the child to 'have' a particular issue, problem or deficit in the way that s/he accesses the curriculum. Rather, the school is called into account for its delivery of that curriculum, thereby allowing one to question the efficiency and effectiveness of the very institution that is responsible for labelling the child.

**Individual strengths and talents**

In this section I focus upon the stakeholders' words in order to present the notion of 'individual strengths and talents' as another potential framework of resistance against the medical model. This section focuses upon the individual, just as the medical model does. However, the difference here is that the individual is viewed as having a particular strength or talent rather than as having a specific deficit or deficiency.

*Sean*

In this sub-section, I focus upon the voice of Sean, who presents an alternative way of viewing children identified as experiencing learning difficulties:

> In some respects, when we go through the [appraisement] process, we use the *deficit model* in terms of looking at what they [the child] cannot do, but in other respects, my personal philosophy has always been – and it is shared by many Learning Support teachers…– to also look at their strengths and [to] look at ways to maintain their self-esteem and their engagement of the school within a school environment. (emphasis added)

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Sean | Optimist | "personal philosophy…look at their strengths" | Potential |
| Child | One who has strengths | | |

Table 6.10. Sean's positioning of himself and the child identified as experiencing learning difficulties

Sean presents a storyline of 'potential'. By mentioning specifically "the deficit model" and then asserting that his "personal philosophy" leads him to look for "their strengths", Sean effectively focuses upon what the child 'has' rather than what the child 'has not'. This 'surplus', rather than

'deficit', mentality positions the child as 'one who has strengths' and positions Sean as an 'optimist'; his outlook searches for the 'positives' rather than the 'negatives' that lower "self-esteem". The implication is that, if the child's strengths can be identified, her/his potential can be 'tapped', thereby leading to that child's "engagement of the school".

The relevance of this quotation to 'individual strengths and talents' derives from its positive focus on the individual. The individual is seen as a site of potential that is limited by "the deficit model" approach and as someone whose self-esteem is at risk. Thus, the child has strengths that will allow her/him to access the curriculum. The emphasis here is on individuality and establishing what the child can do. If these "strengths" can be identified, then the possibility exists that they can be focused upon in order to render the perceived learning difficulty less significant or even obsolete. Sean's philosophy resists the deficit 'view' of the individual by focusing on the "strengths", rather than the 'weaknesses', of the child. The medical model is challenged as one is encouraged to look 'outwards' from the child, rather than 'inwards' at the child, in order to identify factors that are making learning difficult for that particular child.

*Liv*

In this sub-section, I introduce the voice of Liv. Liv's son, Chad, was in Year Six at the time of her interview and he was leaving the following year to go to a different school; Chad has been deemed to have "exceptional talent" in the field of Australian Rules Football (AFL) and was invited to

enrol in a school with a strong sport development program. I questioned Liv regarding when and how her son was identified as having learning difficulties:

> [I]n grade one, he was having learning difficulties already….They [the school] sent a letter home saying [Chad] had been assessed and that he would be put into a learning support program. They never…had a meeting; they just sent a letter home….That is all they did.
>
> Clint: Do you think that the curriculum is fair?
>
> Liv: I do think it is a fair curriculum, but I think they need more help. You've got to be assessed; that is the thing that gets me….The assessing process I don't think is very good.
>
> Clint: How come?
>
> Liv: Because if you are experiencing difficulties, I don't know how they could work out how bad[ly] you are experiencing them; they don't come out and assess you personally. I think they have got to take everything into account, their personality…and I really don't think they [the school] do. They need to check out more factors to figure out what is going on…

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Liv | Critic | "I think they have got to take everything into account…" | Exclusion |
| School | Criticism | | |
| Child | Multi-faceted | | |

Table 6.11. Liv's positioning of herself, the school and the child identified as experiencing learning difficulties

The storyline above is one of exclusion. The school is excluding other "factors" that may assist them in understanding "what is going on" with the child. Liv positions the school as deserving of criticism because she does not think that its "assessment" (appraisement) process is "very good". Thus, Liv's speech-act accomplishes a tripartite positioning of herself, the school and her son. With Liv positioned as 'critic' and her son a presumed

result of the 'exclusionary' "assessment", Chad is positioned as being multi-faceted. If Chad is viewed as being 'multi-faceted', then the idea is that there is 'more to' him than the 'assessment' would have uncovered. Liv is expressing little confidence in a system that did not take "more factors" into consideration when it identified her son as experiencing learning difficulties.

The danger to the medical model in Liv's interview text is that she does not accept that the school can know "what is going on" using the method of assessment that they do. Thus, Liv is actively re-constructing the child identified as experiencing learning difficulties as she calls "personality" into play and advocates a more comprehensive way of assessing children. In this excerpt, Liv is emphasising the limited scope of the assessment used to identify a child's difficulty. If this is the case, the child's individual strengths and talents will certainly be overlooked in favour of a medical model view of the child that seeks to identify and isolate the 'problem'.

The key to Liv's voice being located in this sub-section is that her son has received a prestigious invitation to attend a sports development program school. The school's "assessment" isolated specific academic areas in which Chad is not achieving. However, Liv asserts that

> He is…a 'doing' person; he has got to be doing something or he gets bored very easily. He plays sport, he's just sports mad and he'd prefer to play sport the whole time….[S]choolwork is boring for [Chad]; he is a 'doing' person".

Chad's particular strengths and talents can be found on the football field and it appears that his mother encourages his extra-curricular activities. The school's assessment has little room for external activities that may impact upon the child's academic experience; it is narrow in scope and is searching for particular weaknesses in literacy, numeracy and learning how to learn. Being "sports mad" as opposed to 'school mad', Chad demonstrates that a focus on sport has limited his access to the curriculum. In this case, the biological determination of the medical model is questioned as Chad has apparently 'chosen' to hone his sporting skills rather than to do schoolwork that is "boring".

**Jessica and Johnny**

Jessica and Johnny are two children whose parents, Anna and Thomas respectively, participated in this study. These children are considered to be prime examples of the ways in which 'other' explanatory frameworks can contribute to understanding a child's inability to access the curriculum. As such, this section is divided into two sub-sections, "Jessica" and "Johnny", and I focus upon the voices of Anna and Thomas as they relate their experiences with their children and, in doing so, present 'other' factors that potentially contributed to their children's inability to access the curriculum.

*Jessica*

Jessica was first identified in Year One by her classroom teacher as experiencing learning difficulties. Anna was called into the school and told by two teachers that Jessica had "fallen behind". Given that Anna's earlier account of Jessica's learning difficulties can be found in Chapter Five, it can be presumed that she subscribes to the notion of a learning difficulty as an inherent individuals deficit. However, Anna's interview transcript shows that she is a site of competing and conflicting discourses as she contextualised her daughter's learning difficulty as we discussed potential 'causes' of it:

> Anna: I had a lot of problems with my son. Maybe her [Jessica's] learning difficulties are half my problem as well because I have a son that has been diagnosed with a disease and I've spent a lot of time with him; he's a celiac. But, before that, I didn't know what was wrong with him, he was being fed through a gastric tube, so a lot of the time I've been with him and haven't been with her at all. So, I think some of it is my problem as well….If I had been there with her more, she may not have fallen so far behind. Back then…I was here with her, but I was more with him. Because we didn't know what was wrong with him, so I was more concentrating on him. And it's been like that since birth. So, from the time she started school, I had this son that screamed all the time and I didn't know what was wrong with him. So I suppose I, not pushed her aside, but I had things on my mind other than sit[ting] down and doing her homework with her and things like that. So, yeah, half of it is my fault, I feel.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Anna | One who neglected | "I've been with him and haven't been with her at all…my problem as well" | Guilt; accountability |
| Jessica | One who was neglected | | |

Table 6.12. Anna's positioning of herself and her daughter (b)

In the storyline of 'guilt' above, Anna is questioning whether or not the learning difficulties that Jessica is evidently experiencing are a result of not being with her daughter "at all". Therefore Anna can be viewed as debating whether or not she is responsible for her daughter's learning difficulty. Because she is uncertain of the 'cause' of learning difficulties, she positions herself as 'one who neglected' her daughter, thereby implying that, if she could have spent more time with her daughter, Jessica may not have experienced learning difficulties. Although the moral obligations and duties associated with Anna, as a mother of a sick child, do not portray her as 'neglectful', her inability to focus equal attention upon both children causes her to question whether she has neglected her daughter in some way and is therefore partially responsible for Jessica's learning difficulty.

Anna's statement momentarily resists the medical model explanation of her daughter's inability to learn as she draws upon a socio-cultural explanation for her daughter's inability to access the curriculum. Because Jessica did not receive as much of her mother's time and assistance with homework, she may have "fallen behind". The school identified Jessica's 'difficulty'. Thus, institutionally, Jessica's label 'made sense'; Jessica was not doing well in school and the requisite institutional practices worked efficiently to identify her. In addition, the school originally requested that Jessica's eyes be checked in order to ascertain whether the learning difficulty was a result of a physical symptom. In each instance, the school was looking at the child as the site of the learning difficulty. The inherent danger to the medical model here is that Anna openly confesses to spending a disproportionate

amount of time with her son, thereby 'neglecting' her daughter and her studies. Thus, the reductionist view of Jessica is/was challenged as Anna brought to light the social impact that health can have upon learning; it may have, in fact, been a biological issue that caused Jessica's learning difficulty, but she was not the 'owner' of it.

This sub-section highlights the necessity to investigate factors that exist outside the school in order to identify potential obstacles to the child's learning. I do not argue the possibility of Jessica struggling to access the curriculum. However, given the context, I am not convinced that Jessica possessed an intrinsic deficit that prevented her from learning. Rather, I am encouraged by the fact that in February 2005 Anna rang me to report that Jessica had been removed from any and all 'extra help'. Effectively, Jessica was no longer considered to 'have' a learning difficulty. This example provides powerful evidence against the automatic assumption that a child is the owner of a learning difficulty and emphasises the necessity for the identification of contextual factors that contribute to or detract from the child's learning experiences.

*Johnny*

In this sub-section, I present the story of Johnny. Johnny was "caught in the net in grade two" according to his father. "The net" refers to one of the formal tests that all children in Queensland take in Year Two; I mentioned it in Chapter Two in the "Education Queensland" section. Johnny's particular story is more complex than Jessica's and the 'ending' is not as optimistic.

Johnny is a strong example of docility as there was a wide variety of competing and conflicting discourses operating to establish him. Thus, I consider Johnny's biography to be extremely de-centred and am concluding this chapter using his story as a sobering reminder of the importance of resisting against the medical model. The quotation below is rather lengthy, but I argue that its inclusion in its entirety strengthens significantly the understanding of one brief attempt at resistance. I note here that Thomas did not challenge directly the medical model as he was looking for answers for his son's difficulties; rather, his ambivalence regarding the cause of Johnny's difficulties allowed the "established régimes of thought" (Foucault, 1980, p. 81) in the form of a school administrator and a paediatrician to ensure Johnny's docility:

> Clint: [Johnny] has recently gone from being identified as experiencing learning difficulties to being diagnosed as being Autistic. Prior to this year – and the past month – no one's ever suggested that he may be Autistic?
>
> Thomas: No. Wait, yes. The Deputy Principal, [Artie].
>
> C: Did [Artie] encourage you to seek help outside of the school?
>
> Thomas: I was under a paediatrician at the time and…[Artie] wrote "Autism", "ADD" and "Asperger's syndrome" because he [Johnny] was just really off. [Artie] said to me, "I've never seen anything like it, [Thomas]". His [Johnny's] behaviour was horrible [and] he was really aggressive to other kids [and] teachers. He had no friends and people stayed away from him because they were scared of him all the time.
>
> Clint: Is that when you went to the paediatrician and even tried changing [Johnny's] medication?

> Thomas: Yes, but it didn't do much. He still got in trouble and he would get these really extreme angers. Then one of the side-effects of the medication was weight-gain in the chest area, so the other kids started calling him 'man-boobies'….So I withdrew him from that and…let nature take its course. Nature took its course, and [Johnny] got worse. But I did take [the] three syndromes on a piece of paper [to the paediatrician] and he said "Oh yeah, [Johnny] could be all of them". I said, "What does that mean?" He said, "He's none of them; he could be all of them". [Then] [h]e said, "…just think of this: he's going to get a licence when he's 18, and even open up a bank account when he's 16, how does that make you feel?" It didn't make me feel real good, because I had no answers and I had a professional paediatrician sitting in front of me – who was probably ready for retirement – and saying those things to [someone] who was just there looking for answers.

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Thomas | One who is ambivalent | "His behaviour was horrible…he had no friends…they were scared of him all the time" | Uncertainty |
| Johnny | Maladaptive; one who confuses | | |

Table 6.13. Thomas's positioning of himself and his son (c)

The dominant storyline above is 'uncertainty'. This is because Thomas is searching for an answer as to why his son is struggling so much with school. In the 'uncertainty' storyline, Thomas's position of 'ambivalent' is a result of his "looking for answers"; Thomas approaches authoritative knowledge in the form of educational and professional advice in seeking those answers to his questions about Johnny's behaviour. Although Johnny is considered to be 'maladaptive', his behaviour has no single explanation and therefore finding an "answer" becomes even more urgent for Thomas. In this kind of situation, it can be understood why a parent would be likely to subscribe to the medical model; its discourses are readily accessible and assuage the

uncertainty that the parent experiences as a result of being told about her/his child's potential problems (i.e., "Autism"; "ADD"; "Asperger's Syndrome").

Thomas was told by the school that there was an inherent deficit in Johnny and encouraged him to seek outside assistance. Although Thomas described his son as always being "a handful at home as a young fella" (even though "he seemed fine…"), he is unsure as to the cause of the evident learning difficulties and proceeds to the paediatrician for some possible 'answers'. As a result, Johnny is re-classified into the category of Learning Disability because of his receipt of the label 'Autism'. This point is important because students are rarely assigned to this category in Years Six and Seven as it is presumed that any difficulties accessing the curriculum would have been 'picked up'. With this categorisation came a change in Johnny's medication that altered his physical body.

In this situation, the school has effectively isolated the problem within the child, the medical community has obligingly confirmed that isolation and the change in medication leads to further social isolation – remembering that previously Johnny had "had no friends". The primary point to make here is that the parent's and school's search for an internal reason for Johnny's perceived learning difficulties has excluded the potential causes of the anger and aggression that may be inhibiting his ability to access the curriculum. The school and medical system formally identified Johnny in a physically reductionist manner and he is now subject to being an object of

regimen and control. In addition, Johnny's situation is further complicated by the fact that his diagnosis appeared to have neglected the possibility that a Year Seven boy with few friends might have unresolved issues that may cause difficulty learning.

The irony is clear when one views this exclusion of potential socio-cultural and emotional factors against the backdrop of Education Queensland's focus on "Boys in Education" (Queensland Department of Education and the Arts, 2002-2005). In addition, the medicalisation of Johnny's mind affected his physical body. Johnny's body became a site of social consequence as his weight increased; Johnny was already positioned as being irrational, but the medication's side-effects further removed him from the possibility of engaging with others as a rational, invited and accepted 'part of the group'. Thus, Johnny's label resulted in 'extreme' irrationality to such an extent that he was eventually institutionalised in a mental health unit of a major hospital.

In this story, I have shown how difficult it is for anyone, especially one parent, to resist the exercise of power of the medical mode by individuals in professional positions who have the ability to categorise and re-categorise the child in a number of ways. Even thought Thomas's storyline of uncertainty encapsulated several elements of the counternarratives to the medical model that have been portrayed in this chapter, in the end that resistance was of no avail in assisting Johnny. That was because the easiest solution for the school, the paediatrician and the mental health unit was to

'look inwards' in order to attempt to discover the underlying reasons for, or the causes of, Johnny's 'problems'. Johnny's voice was silenced as he became further regulated within "established régimes of thought" (Foucault, 1980, p. 81) using the medical model as their explanatory framework and his 'transformation' from a child identified as experiencing learning difficulties to a child *with* learning disabilities appeared to be the *coup de grâce* for any opportunity for 'centredness' that he may have had. Ironically, the medication that was prescribed as a possible 'answer' to Johnny's 'problems' instead exacerbated those 'problems'. Eventually Thomas and his family moved away and were not heard from again.

**Conclusion**

This chapter has presented 'other' explanatory frameworks as counter-narratives to the dominance of the medical model. In doing so, it has provided five different frameworks that emerged from the semi-structured interview data. Those frameworks are "behavioural", "emotional", "socio-cultural", "institutional" and "individual strengths and talents". The purpose of this chapter was to highlight the moments of resistance against the medical model by the adult stakeholders as they occupied subject positions within those five frameworks – moments that were encapsulated and synthesised in the final section's focus on the very different biographies of Jessica and Johnny.

The eight adult stakeholders' voices represented in this chapter have shown that resistance to the medical model is possible. Perhaps as a testament to the strength of the medical model, five of the eight participants represented in this chapter were also part of Chapter Five. Therefore the adult stakeholders can be viewed as competing and conflicting sites of discourses as they struggle to 'make sense' of the learning difficulties phenomenon.

In the next and final chapter of this thesis, I place the 'finishing touches' on the study by summarising how it has addressed the research problem and how I have responded to the research questions. I also highlight the contributions to knowledge that the study makes as well as present some suggestions for further research. Finally, I re-visit the "personal positioning" section that I wrote in Chapter One as a way of establishing 'closure' for this specific text at this particular moment in time.

# CHAPTER SEVEN

# SOME ANSWERS TO THE QUESTIONS

"*What we call the beginning is often the end. And to make an end is to make a beginning. The end is where we start from*". (T.S. Eliot, 1943, p. 54)

**Addressing the problem and answering the questions**

Chapter One presented the research problem to be explored in this study. As a general guide for my investigation, I problematised the phenomenon known as 'learning difficulties' and explored how they are constructed by adult stakeholders involved with children identified as experiencing such difficulties in a Queensland regional primary school. In order to address this research problem, I posed the following two questions:

- In what ways is the medical model's dominance enacted in the adult stakeholders' constructions of children identified as experiencing learning difficulties?
- What 'other' explanatory frameworks are displayed in adult stakeholders' constructions of children identified as experiencing learning difficulties?

These questions signalled the study's focus on the competing and conflicting discourses that the stakeholders used in order to establish what a learning difficulty is/is not.

In Chapter Two, I reviewed contemporary literature in the areas of Education Queensland policy; the process of identifying children as experiencing a learning difficulty; and the 'scientific revolution' that assisted in establishing the medical model way of thinking and knowing. In the "Education Queensland" section, I surveyed current literature regarding four major areas: curriculum, pedagogy, assessment and reporting. I then moved on to "The process of identifying children as experiencing learning difficulties" before delineating the impact of the 'scientific revolution' on contemporary understandings of learning. Throughout these sections, I emphasised the disagreement over terminology in the learning difficulties

field and explained how the medical model had established itself firmly in Education Queensland policy. Moreover, I acknowledged that the current educational system was 'outcomes based' and asserted that in specific and crucial ways this approach aligned with and facilitated the medical model way of thinking.

Chapter Three presented my conceptual framework, centred on a Foucauldian adaptation of positioning theory. I argued that power is implicit in the act of positioning and presented Foucault's "methodological precautions" (1980, p. 96) regarding power. Positions are viewed as being both discursive and fluid (van Langenhove & Harré, 1999); they are not fixed and therefore present the individual with an opportunity to negotiate her/his particular metaphorical 'space' during social interaction. Foucault (1980) considered power to be diffused and operating everywhere and nowhere simultaneously. If one is to view positions as temporary, and power as being neither here nor there, then a position is powerful only in context. Because power cannot be isolated and/or retained, neither can the subject position that the individual occupies.

Furthermore, I established how positioning theory is the unification of discourse analysis and social constructionism. Thus, the conceptual framework was labelled 'post-structuralist' as I sought to deconstruct the 'taken-for-granted' assumptions of the stakeholders who spoke of learning difficulties. Equipped with this framework, I was able to present how an

individual's particular acts of positioning could have social consequences for the child.

Chapter Four outlined and justified the research design. I first presented the methodological underpinnings of the research in order to frame the study and locate it in within a qualitative, interpretivist and post-structuralist 'space'. I then discussed how I went about data collection and analysis whilst providing an example of a positioning analysis. I concluded the chapter by acknowledging the strengths and potential limitations of the study before discussing its ethical and political dimensions. This framework set the foundation for Chapters Five and Six, where I engaged with the stakeholders' texts in order to establish what particular discourses were being drawn upon in order to construct learning difficulties.

In Chapters Five and Six, I addressed the two research questions by way of a form of discourse analysis. In Chapter Five, I presented a 'descending' view of power in order to explain the situation whereby children are being dominated by the medical model as its discourses are enacted by the stakeholders. Within this chapter, I analysed five major components of the medical model – mind-body dualism; physical reductionism; specific aetiology; the machine metaphor; and regimen and control – in order to categorise the stakeholders' positions and establish subscription either to the medical mode or to 'other' explanatory models for a student's inability to access the curriculum. Moreover, I presented the chapter as a meta-narrative because of the relative ease with which one could be positioned by

the medical model and with which it deploys taken-for-granted assumptions: that is to say, the medical model is all too readily positioned as the only 'common sense' or rational explanation of learning difficulties. In addition, I emphasised that the domination of the child identified as experiencing a learning difficulty was a result of a collision of contextual factors that rendered that child 'docile'.

Chapter Six focused upon the 'resistance' that the stakeholders demonstrated during their interviews. In this chapter, I presented an "*ascending* analysis of power" (Foucault, 1977, p. 99; emphasis in original) that attempted to show the traces of opposition to the medical model by the stakeholders. I argued that the medical model's domination was fallible and demonstrated that there were five 'other' explanatory frameworks for explaining a child's inability to access the curriculum: behavioural; emotional; individual strengths and talents; socio-cultural; and institutional. Those five explanatory frameworks are considered to be 'counter-narratives' to the medical model because their use facilitates a refusal to isolate a learning difficulty 'within' the child.

**Contributions to knowledge**

In this section, I synthesise the contributions that this study has made to knowledge. I present the information in three sub-sections: conceptual; methodological; and empirical. The sub-sections reflect the complex scholarly fields in which the study has been located and to which it has sought to contribute new understandings.

*Conceptual*

With regard to this study's original contribution to conceptual knowledge, I combined a Foucauldian perspective of power with positioning theory. Standing alone, positioning theory relies upon a combination of discourse analysis and social constructionism as tools for understanding human social interaction. My emphasis upon power, and my consequent and explicit addition of power to the positioning theory 'equation', are a result of my conviction that power is implicit in the act of positioning. Thus, the persons performing the positioning, and those being positioned, are engaged in a metaphorical 'jousting' match in which power is exercised in multiple directions with diverse effects. In addition, the act of positioning has social consequences that highlight the political impact of such positioning. The study's extended focus on power is therefore a significant extension of the explanatory potential of positioning theory.

*Methodological*

My contribution to methodological knowledge came in the form of my development of the 'position, speech-act and storyline' tables used in Chapters Five and Six. These tables were constructed in order to provide the researcher with a format for analysing text and identifying acts of positioning. I note that neither Harré and van Langenhove (1999), Harré and Moghaddam (2003) nor any of the positioning theorists within their edited books and papers presented their analyses in tabular form. Some of those analyses presented a standard quotation form (van Langenhove &

Harré, 1999, p. 19), whereby the comments of the individuals were numbered and a reference to the number indicated the location of the positions, speech-acts or storylines. Others presented particularly lengthy pieces of text (Davies, 2003), opting to locate the analysis beneath each particular excerpt and 'flag' key points within the text.

In constructing the 'positioning tables', I hoped to provide a way of simplifying what I consider to be a rather difficult and lengthy process of presenting data analysis. Often large portions of text as the object of analysis need to be presented in order to illustrate the 'action' that is occurring within that text. 'Cutting' the text can often lead to 'breaking' the storylines. The provision of the information in tabular form facilitates the ease of presenting the most important aspects of the chosen text. The tables serve as a reminder both to the researcher who can use the framework to guide her/his reading of the text, and to the reader of the positioning theory components that allow one to make sense of the text.

*Empirical*

With regard to my contribution to empirical knowledge, I contend that my analysis of learning difficulties as a situated and politicised construction allowed me to move away from the presentation of learning difficulties as an 'abstract truth' and thereby to question continuously the taken-for-granted assumptions regarding learning difficulties that were prevalent within the adult stakeholders' responses. My study has implications for the

understanding of learning difficulties and for developing and applying policies in relation to them at systemic and school levels.

Systemically, there needs to be a change in the way that learning difficulties are defined, identified and remediated. The current system of labelling is closely associated with long-standing practices of stigmatisation and a deficit view of the learner (Ministerial Taskforce on Inclusive Education, 2004). A political re-construction of learning difficulties needs to take place in order to prevent further domination by the medical model.

At the level of the school, the research findings contribute to empirical knowledge by suggesting that individuals need to question their taken-for-granted assumptions regarding the reasons for a child's inability to access the curriculum. The possibility of change begins at the grassroots level of resistance, where the effects of power can be viewed (Foucault, 1980). In addition, this change is likely to require attention to all apparatuses of school and classroom policy and practice relating to 'learning difficulties'.

**Suggestions for further research: Looking 'outwards'**

In this section, I present my recommendations for further research. It is divided into two sub-sections: learning obstacles; and the contextual child. The sub-sections are united by my desire to encourage individuals and institutions to 're-think' the ways in which they view the child identified as experiencing learning difficulties. This 're-thinking' needs to be framed around a looking 'outwards' from the child perspective in order to discover

potential obstacles that are preventing her/him from accessing the curriculum. Thus, in seeking to make the familiar 'unfamiliar' (Delamont & Atkinson, 1995; cited in Delamont, 2003, p. 8), I attempted to 'de-naturalise' the concept of learning difficulties and to expose the implicit power relations that were operating to produce the 'child with learning difficulties' typology. In seeking to make the unfamiliar 'familiar' (p. 8), I have chosen to present the concepts of 'learning obstacles' as opposed to learning difficulties and the 'contextual child' as a different – and more positive and enabling - way of viewing the issue.

*Learning obstacles*

As I established in Chapters Two and Five, the 'traditional' view of learning difficulties is that they are a result of an inherent deficit within the child. As a result, learning difficulties are often considered to be 'lifelong' and that particular belief system exonerates the school, parents and the child from responsibility for those difficulties. The notion of a 'learning obstacle' is my counter-claim that we should look 'outwards', rather than 'inwards', when attempting to discover 'why' a particular child is having difficulty learning.

That obstacle becomes 'impassable' when viewed as being either 'lifelong' or 'inherent' in the individual. Of course, I recognise that individual constructions of an 'obstacle' will vary. It is for this reason that I am encouraging a view of the child as 'complete' (rather than as being 'deficient' or 'flawed'). In addition, I encourage the adult stakeholder to

collaborate with the child in order to discern what particular obstacles the child perceives to exist. Because the child is situated within multiple contexts, s/he may be able to identify a variety of obstacles, whereas a parent, classroom teacher or school administrator may be not be able to identify any/all of the obstacles.

The logic of including the child in the process of identifying 'learning obstacles' is that the child's voice is the most likely to be silenced within the medical model framework. Beginning with the child and looking outwards aligns with an "*ascending* analysis of power" (Foucault, 1980, p. 99; italics in original). The child can be regarded as one of the primary effects of power because s/he is considered to be the point at which power relations are exercised. That is, the child is the site where power has been exerted by the adult stakeholders who have drawn upon discourses in order to position that child and simultaneously to construct her/him. The child's voice, identity and agency are limited when the label that the child is assigned renders her/him 'docile'. If schools are to align with the goals of *Queensland 2010* as they are required to do (Queensland Department of Education and the Arts, 2002c), and to engage with a 'democratic' approach that "promote[s] social cohesion, harmony and sense of community" (n.p.), then acknowledging the child's voice, identity and agency appears to be an essential step in that process.

In searching for obstacles together, the parents, teachers, school administrators and children are collectively accepting responsibility for the child's difficulty in learning. Consequently, shifting 'blame' is less likely to occur because the power involved with the process is distributed more broadly. This view of 'shared responsibility' can be found in the Ministerial Taskforce on Inclusive Education (2004, pp. 12-13). The potential exists for a 'proactive' approach that identifies relevant issues holistically rather than isolating internal individual deficits. Moreover, the child can play a part in her/his 'construction' and 're-construction', thereby challenging the domination of the medical model and its resulting assignment of 'docility' to the child.

One possibility for further research with regard to 'learning obstacles' is to re-conceptualise the notion of learning difficulties. The view of 'obstacles', rather than 'difficulties', allows one to explore thoroughly the policy, curriculum, pedagogy, assessment and external factors that impinge upon the child in order to present a broader view of the challenges that the child is facing. Although time-consuming, this type of research would be beneficial to each of the areas (i.e., policy, curriculum, pedagogy, assessment and external factors) above as well as to any move towards resisting the domination of the medical model and re-constructing the child encountering learning obstacles.

*The contextual child*

In conjunction with the above view of a child's inability to access the curriculum as a result of a learning obstacle or obstacles, I argue that each child can be considered to be a 'contextual child'. That is, each child as a thinking entity is a product of the *context* in which s/he is defined (or created, constructed and re-constructed). To 'construct' implies control. A practical example of this notion is how a child identified as experiencing learning difficulties is regulated for the purpose of remediation after receiving the learning difficulty label. Thus, how a particular individual is defined dictates how that individual is to be controlled. In addition, because contexts are temporary, so too should be the labels that are employed within them.

The concern that I have with identifying an individual in any particular way is that labels are often static and permanent, whereas individuals are dynamic and located temporarily in a specific context. Thus, I call forward the notion of the 'contextual child'. I present this child as one who is continuously changing as s/he interacts with her/himself, a particular institution and her/his society and culture.

In viewing the child in this manner, I am advocating that any requirement for using the learning difficulties label be re-evaluated. The underlying argument is that a child is never located in the same context. Because there are so many external forces working to de-centre the child, the logical conclusion is that s/he cannot be 'the same person' day after day. As a

result, in order to address the learning obstacles of the child, one must examine the particular context in which both that child and the obstacles are located.

One suggestion for further research with regard to the 'contextual child' is to re-visit the current policies and practices founded upon a medical model view of the child. A thorough examination of the way in which the child is constructed is necessary in order to view what explanatory models or frameworks are being used by individuals and/or the institution. The child needs to be effectively re-constructed in a way that not only includes the child but also excludes reductionist and simplistic explanations of that child's inability to access the curriculum.

More broadly, the looking 'outwards' view of the child increases the necessity for institutional and societal accountability and responsibility. If the child is to be viewed as a 'contextual child', then it is important to acknowledge that we are part of the context that creates and re-creates that particular child. Thus, we cannot be exonerated from either the accountability or the responsibility for the identification of learning obstacles for the child; it may even be that we, as individuals and as members of institutions and societies, are the embodiment of those obstacles.

**Revisiting personal positioning**

At the conclusion of Chapter One, I included a personal note ("Personal Positioning") that articulated my positioning of myself. In that note, I highlighted my personal interests in notions of voice, power, domination, resistance and agency. In addition, I acknowledged that I view myself as a site of competing and conflicting discourses – a view that has implications for me as a researcher, as an educator and as a human being. Although this chapter concludes a three-and-a-half year research project, I contend that it is far from being complete.

Potter and Wetherell (1987) asserted, "One of the primary goals of discourse analysis is to clarify the linguistic resources used to make things happen. However, these resources will not only solve problems, but will also create new problems of their own. (p. 171). As such, this research aspires to open new pathways for dialogue and action regarding learning difficulties. I urge the re-conceptualisation of an education system that locates a difficulty in accessing the curriculum within the child and I encourage individuals to revisit their taken-for-granted assumptions regarding learning difficulties in order to identify and asses the social impact that their particular ways of thinking and knowing about learning difficulties may have upon the child identified as experiencing such difficulties.

In this section, I focus retrospectively upon my positions in relation to this study. I present the information in this section in Table 7.1 below using the same format as in Chapters Five and Six. I have chosen to approach this section using that table because there are two major competing storylines within this thesis. Ultimately, I continue to struggle with regard to my personal concept of learning difficulties. Having analysed the domination of the medical model, I was awed by its presence and amazed at the relative ease with which it 'slipped into' the adult stakeholders' words. However, establishing firsthand that resistance is possible was promising and gave me hope for a more socially just educational system.

Although I seek to resist being 'captured' and positioned by the medical model, I too have been guilty of reverting to the 'default mode', whereby learning difficulties are an insurmountable 'obstacle', and I have resigned myself to working 'with' them rather than 'against' them. The truth – for me – is that it is very difficult and extremely tiring to work 'against', or to resist, the medical model. I have often been positioned as 'irrational' and on the receiving end of power as I questioned the very existence of learning difficulties in both public and private educational contexts.

An example occurred on the day that I drafted this particular chapter. I was concluding my daily run and I came across a parent of a child with whom I worked in the Special Education Unit. We regularly chat and this particular parent asked me how my research was 'going'. As the conversation

progressed, I was asked what my thesis was about. In response, I remained vague because I was aware of the implicit danger to my rationality if I questioned the medical model. Eventually I commented that I wondered whether or not learning difficulties actually existed.

To this statement, the parent replied, "They most certainly do, and I'll tell you why". The parent then related her experiences with her foster child including Intelligence Quotient testing, what the teachers 'told' her about her daughter and the child's history prior to being adopted. I mention intentionally here the child's 'history' because firstly that child is of Aboriginal descent and secondly the foster-parent accused the natural parents of having problems with substance addiction and of losing the child because they could not provide a "suitable home environment" for her. The principal point here is that, while I was seen as being irrational because of my doubts, the voice of the foster-parent represents a stark contrast between my own ambivalence and uncertainty and her complete and unreflexive certainty about learning difficulties. Thus, my metaphorical challenge against the medical model and its associated discourses 'on paper' was realised as an actual social episode in which there was an array of potential socio-cultural and contextual factors that could have been explored, yet the medical model was chosen instead.

**Conclusion**

In the end, my struggle is about how I view learning difficulties. I can be either optimistic or pessimistic, or a little bit of both; my intention here is to demonstrate that I am not exempt from being a site of competing and conflicting discourses about this issue. In order to demonstrate this point, I present a brief identification of the two major storylines that have unfolded in this section as I worked to establish my particular position(s):

| | Position | Speech-act | Storyline |
|---|---|---|---|
| Clint (a) | One who dominates | "Dominance by the medical model" | Pessimism |
| Clint(b) | One who resists | "Resistance is possible" | Optimism |

Table 7.1. Clint's positioning of himself

The purpose of Table 7.1 is to show that I can also be viewed as being ambivalent. The power of the medical model is seductive. In relaxing my 'guard' and working 'with' learning difficulties, I am guilty of the very actions that I have criticised within this thesis. I can be seen to be contributing to the domination by the medical model and therefore as dominating myself as I have often failed to question my own taken-for-granted assumptions. I labelled the first storyline 'pessimism' because to view and admire the dominance of the medical model without challenging it is effectively to 'give up'. Thus, a 'why bother?' attitude presents itself and erodes any optimistic basis that one may have for subsequent action; 'the medical model is everywhere and it is here to stay'.

The other storyline that can be found within these pages is one of 'optimism'. Although resistance is not as tempting because it is irrationality's potential companion, the possibility of resistance is exciting. The idea that our voices can contribute to what I see as being a 'greater good' makes the risk of being rendered irrational worthwhile. In positioning myself as 'one who resists', I am effectively choosing to remain vigilant in my search for obstacles to learning for the contextual child.

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Central Queensland
UNIVERSITY

## Appendix A: *HUMAN RESEARCH ETHICS COMMITTEE CERTIFICATION STATEMENT*

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Australian Vice-Chancellors' Committee and NHMRC *Statement and Guidelines on Research Practice.*

The Committee has considered the project described in a Request for Ethical Clearance and as detailed in this Statement, is pleased to grant ethical clearance for the nominated period of certification:

| | |
|---|---|
| *First-Named Principal Researcher:* | Danaher, Dr Patrick |
| Other Investigator: | Arizmendi, W.C. |
| *Title:* | Adult stakeholder constructions of Learning Difficulties: A reflexive ethogenic case study of the subjectivities influencing the transition of seven Year Seven students to Year Eight |
| *Clearance Number:* | 03/09-104 |
| *Period of Certification (see note below):* | **30 September 2003 to 31 August 2004** |

*NOTES:*

(1) This statement remains current for the period of certification on the condition that the research techniques and procedures as described in the approved *Request for Ethical Clearance* and attendant documentation remain unchanged. Any revisions or amendments must be brought to the attention of the Committee which will determine whether ethical clearance should continue.

(2) In the event the Committee has not received, **within 28 days of the date of this advice**, written advice with respect to these issues/concerns, the request will not be considered further and the project will be deemed inactive. In order to have the project reconsidered after this time, you will be required to submit a further request for ethical clearance.

(3) A further *Request for Ethical Clearance* must be considered and approved by the Committee in order for the project to continue after the end-date noted above. Where research is conducted without a current certification statement, an investigator will be in breach of the University's *Code of Conduct for Research* and the subject of allegations of research misconduct.

**Dr Ken Purnell**
**Chair, Human Research Ethics Committee**
**Date: 02 September 2003**

*Any written information provided to a participant or subject must contain the statement,*
*"Please contact Central Queensland University's Office of Research (tel 07 4923 2607) should there be any concerns about the nature and/or conduct of this research project."*

## Appendix B: Information Sheet and Consent Form

### INFORMATION SHEET

*Dear parent/teacher/staff member:*

Thank you for your interest in this research project. This project has two aims. The first aim is to describe the processes of conducting an inquiry into what people think about the 'appraisement process'. The second aim is to look at, and describe the things that affect twelve (12) Year Seven students identified as having learning difficulties.

The project title is: "*The relative truth: A reflexive exploration of learning difficulties in a Queensland regional primary school"*.

I will gather data – through interviews – about your feelings, opinions, and thoughts about the 'appraisement process'. I would like your help in identifying issues that you think are important for the school community to know about students experiencing 'learning difficulties'.

I would very much appreciate it if you would agree to be interviewed for this project. Interviews will be recorded on audio-cassette tape, and then transcribed. Interviewees can request a copy of the transcript of their own interview but apart from that only the researcher, his academic supervisors and the transcriber will have access to the tapes and transcripts.

When the research report is written up, pseudonyms for persons and places will be used as necessary to protect participants' privacy. Furthermore, all information gathered is confidential.

If you agree to participate, please read the attached Consent Form that you are asked to complete before commencing the interview. Please note also that if you do agree to participate you have the right to withdraw at any time.

Thank you for your attention.

**CONSENT FORM**

Research Project: The relative truth: A reflexive exploration of learning difficulties in a Queensland regional primary school.

Wayne Clinton Arizmendi

Faculty of Education and Creative Arts

Central Queensland University

(Ethical Clearance Number: 03/09-104)

| | | Please put a ring around your answer | |
|---|---|---|---|
| 1. | An Information Sheet has been provided to me; it provides details about the nature and purpose of the study. | Yes | No |
| 2. | I also understand that I can obtain a copy of the detailed research proposal should I desire. | Yes | No |
| 3. | I understand that I have the right to withdraw from the project at any time. | Yes | No |
| 4. | I understand that, when the researcher is quoting from or analysing interview or other material gathered in this research, he will remove information that could reveal participants' or other people's identities. | Yes | No |
| 5. | I am aware that I may ask to examine the transcripts of my interview to ensure they are an accurate reflection of my statements and can change these if deemed warranted. | Yes | No |
| 6. | I agree to have my words used as data for the purpose of this research. | Yes | No |
| 7. | I wish a copy of a summary of the outcomes of the research to be posted to me at the address listed below. | Yes | No |

Signature: …….. Date: ……

Name (please print): ……

Address: ……
…….....

(email) ……..

(telephone) ……...

(fax) ……..

Please contact Central Queensland University's Office of Research (Tel 07 4923 2607) should there be any concerns about the nature and/or conduct of this research.

## Appendix C: Interview schedule

NB: These questions were the ones asked of parents; equivalent questions were asked of administrators and teachers about students in their school/classroom identified as experiencing learning difficulties.

IDENTIFICATION OF CHILD'S LEARNING DIFFICULTY: Can you tell me when your child was first identified as experiencing learning difficulties? How were you notified? What was the process of notification? How did you feel at the time? How do you feel now? What did you know about learning difficulties before your child was identified? How has that knowledge changed since then? Can you tell me what you think the term 'learning difficulties' means? Do you think that a learning difficulty is lifelong? If yes/no, why?

FOUNDATIONS/UNDERSTANDINGS OF LEARNING DIFFICULTIES: Why do you think children experience learning difficulties? What do you think learning difficulties are? What are some examples? What problems are faced by people experiencing learning difficulties?

CHILD'S AWARENESS/UNDERSTANDING OF LEARNING DIFFICULTIES: How and when did your child learn about learning difficulties? What is a learning difficulty to your child? In what ways does your daughter or son express her/his feelings about being identified as experiencing a learning difficulty to you?

PARENT RELATIONSHIP WITH CHILD: How would you describe your child? To what extent did your relationship with your child change after s/he was diagnosed as having a learning difficulty? In what ways are you similar/different in your approach to parenting a child with a diagnosed learning difficulty as opposed to the way you parent a child who is not identified as experiencing a learning difficulty?

PARENT/SCHOOL/COMMUNITY COMMUNICATION/SUPPORT: How do you feel when discussing your child(ren) with other parents? How much awareness do you feel there is in the local community about learning difficulties? Are there times when you feel that other people (including other family members) do not understand the nature of learning difficulties? Is there anything that you would like to see done regarding parents and support or support groups for parents of children with learning difficulties? Do you have any ideas for improving school-parent relations? Do you feel that your relationship with the school is positive? How? Do you think that the school makes enough effort to keep you informed of your child's situation or progress? Do you think that the current efforts to help your child access the curriculum are benefiting her/him? How? In what ways is the current school environment beneficial to your child? Can you provide me with any suggestions for parents who have recently found out that their child is experiencing learning difficulties? What would you like to see done in this school/community regarding the concept of learning difficulties?

PARENT/SCHOOL/COMMUNITY RESPONSIBILITY: Who is responsible for improving your child's ability to access the curriculum? In what ways do parents of children identified as experiencing learning difficulties cope?