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Critical Disability Studies: Theory and Practice

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**Race and Disability in Urban Education**

“Normal theory” proposes that diagnoses of disability originate from certain bodies, behaviors, and abilities’ deviation from what is deemed "normal '' or "typical" within a society or culture. This socio-cultural standard is constructed through power dynamics, such as ableism, racism, and other forms of oppression. Unsurprisingly, in the United States, Black and Latine children are underdiagnosed, misdiagnosed, and overdiagnosed with learning disabilities and mental illnesses at overwhelmingly disproportionate rates. This paper aims to explore some of the complex factors that influence these statistics, especially in urban education settings. I would like to acknowledge that the term “urban” lacks a universal definition. Nonetheless, it often carries negative connotations when brought up in the context of schooling; referring to densely populated, underfunded, and underperforming institutions made up of minority students.

Although I will be discussing shortcomings of the modern public school system, I do not believe that these issues are produced by or reflect the intentions of any number of individuals operating within the system. Additionally, I do not aim to monolith the experiences of people of color, but due to the current research available and the scale of this review, my discussion specifically centers Black and Latine children from low-income backgrounds. The following will examine how intersectional issues of race, class, and disability manifest in the development and classification of non-normative behaviors and cognitive styles in children. Further, I will analyze the ways in which the structure and application of special education programs exacerbate pre-existing racial prejudice and achievement gaps in schools, as well as offer interventions to combat these issues.

Before delving into the complexities of diagnostics, it is imperative to examine the systemic roots that enable and empower the racial and socio-economic disproportionalities in the development of disability. There are a variety of explanations behind the likelihood of a child presenting with a mental illness or learning disability; these causes are often attributed to either genetic, or environmental factors. According to the biological perspective, these disorders are products of dysregulation and abnormality in the nervous system and endocrine system.1,2 While a child may have an increased genetic vulnerability to developing a given condition, the diathesis-stress model posits that tracing disorders’ etiology requires a conjunctive examination of the individual’s environment.3 That which a child experiences or is exposed to in the early stages of their neural development has the capacity to profoundly alter their physiology, this is especially salient in the case of stress.4

As supported by the 2021 poverty rate for Black and Hispanic people recording as over twice as high as white Americans’,5 race and socio-economic status in the United States is inextricably linked. Those living in poverty are exposed to a host of biopsychosocial factors that permanently influence their physical and neurocognitive functioning. Among these are proximity to waste facilities and toxicants, inadequate access to proper nutrition, and chronic stress. 6 When a child faces prolonged, unmediated adversity — such as existing in a white supremacist society as a person of color, their stress responses are over-activated which can impede their brain and body’s ability to form and function properly.8 Notably, toxic stress often results in damage to the endocrine and nervous system, as well as disruption in neural formation which, as previously cited, can precipitate the development of learning disabilities and mental illness. Divorcing academic contexts entirely, it can be seen that the conditions children of color are disproportionately exposed to put them at an elevated risk of neuropsychological challenges within and outside the traditional learning environment.

By no means do all children of color have learning disabilities or mental illness, especially not by virtue of their race alone. Nonetheless, it remains impossible to produce statistics that provide an accurate estimate of these disorders’ prevalence across this demographic. The numbers generated to assess behavioral and academic success are arbitrary at best and steeped in anachronistic beliefs and measures. The IQ test, for instance, was originally developed to identify learning disabilities, however, the test was co-opted by eugenicists and weaponized against disabled people and people of color to *prove* these communities were inherently less intelligent9. Even over a century later, following critiques of its problematic and unrepresentative nature, IQ tests are still given out, as well as its correlates; state mandated standardized testing in public schools. Students’ scores on these sorts of tests have been found to vary significantly based on race and socio-economic status10. These tests do not adequately measure intelligence within or outside the classroom, yet the scores serve as reinforcements to the state and broader society that their underperformance is the result of under-intelligence bred within a failing school system. These scores do not take into account any alternate forms of socio-academic intelligence, or factor in socio-cultural and environmental context.

Countless testimonies have proved that Black and brown children’s struggles in the classroom are consistently overlooked or inaccurately attributed to not otherwise relevant causes. Unfortunately, many schools in densely populated, low-income districts are given sub-adequate local and state funding. Consequently, staff are often underpaid, undertrained, and overworked.11 Teachers are not responsible for, nor equipped to identify the specific symptoms a given child may exhibit, and subsequently diagnose them. When these teachers are assigned dozens of children per class, it is even harder to expect them to be able to devote the kind of time and attention it takes to address the individual needs of each student. That being said, children are very perceptive, and especially moldable during the formative years of their education. The effects of instructor biases have not only the capacity to influence students’ academic trajectories, but the construction of their self-concept as well.

Upon entering the classroom, Black and brown kids whose learning styles or behavioral patterns fall outside of normative expectations rarely receive appropriate accommodations. Since disruptive behavior and academic underperformance falls within societal expectations for these children, root causes or other contributing factors are commonly dismissed. This lack of adequate services can put ethnic and racial minority children at risk for perpetuating the disparities which currently exist in the educational and juvenile justice systems. In the place of institutional and individualized support for Black and brown students struggling with academics and interpersonal relationships, punitive measures including suspension and juvenile detention are taken. 12 Black students are suspended at a rate 5 times higher than white students for the same offenses.13 These trends of disciplinary actions can lead to children of color’s disengagement from school, decreased academic achievement, and even dropping out.

While not always, in wealthier white schools, if a student is struggling in the classroom or on the playground, they will often be referred to a specialist for an evaluation. These evaluations typically consist of a series of tests, surveys, and interviews with the children and parent(s) to assess neurological and socio-emotional functioning. These exams are conducted over the course of several hours, broken up into two or more days; a time commitment not readily available to parents working full-time or multiple jobs. Once the results are analyzed, parents receive detailed reports of the child’s diagnoses and recommendations for accommodations in academic and social settings. Unfortunately, communities of color must overcome several barriers in order to receive this care.

These evaluations range from several hundred to thousands of dollars in cost. Furthermore, most insurance providers will only offer coverage if the testing is deemed “medically necessary” — which typically refers to neurological diseases or injuries.13 Due to mass poverty rates and scarce access to medical care, 21% of Black Americans and 19% of Hispanic Americans were uninsured in 2021 according to a community survey of the non-elderly population in the U.S.14  Insured members of low-income communities often receive coverage under Medicaid. This federal funding source is notoriously stingy and makes it even more difficult to access testing locations and opportunities. If low-income Black and brown children are able to make it into these appointments in the first place, they are vulnerable to psychiatrists’ implicit biases and preconceptions. The exclusion of cultural context and tendency to rely on racial stereotypes in the diagnostic process — as well as the DSM-5 criteria itself — leads to countless children being misdiagnosed with illnesses or disorders that align closer with the evaluator’s expectations for someone from their background than with the child’s lived experience.

For example, oppositional defiant disorder, a diagnosis assigned to Black and latine children at far higher rates than white children15, is characterized by a pervasive pattern of hostility, disobedience, and defiance. The criteria for an Attention-Deficit Hyperactivity Disorder diagnosis revolve around inattention, hyperactivity, and impulsivity. The language associated with ODD is highly charged; it implies a child’s malice and an intentional destructiveness, whereas the manifestations of ADHD are more readily forgiven as the condition is often viewed externally from the child. There are significant symptom overlaps between the two disorders, however, the lens through which these behaviors are categorized differ dramatically across racial lines. Symptoms of both ADHD and ODD include irritability, impulsivity, emotional dysregulation, impatience, and more. 16  Whether the child is diagnosed with one diagnosis over the other can at times boil down to the way teachers, parents, and clinicians view the child in relation to their behavior. In ODD, the children are the architects of their own destruction – hellbent on disturbing the peace. In ADHD, the children are passive victims to neurological imbalances that hinder their ability to conform to the rules.

Inaccurate diagnoses, including but not limited to the above, readily lead to ineffective or counter-effective academic interventions, notably including deeply flawed special education programs. In theory, intentionally dedicating space and resources to ensure children with disabilities receive personalized instruction in their schooling experience is a commendable endeavor. In practice, however, this dream does not always come to fruition. In attempting to level out the playing field by providing extra support to those who the system believes need it, they isolate the students from their peers and place them in an environment that has implicit and explicit consequences on their socio-academic development. Special education classes statistically yield lower academic achievement; this reality can be explained by a number of theories including the following. Expectations for students’ literacy and math proficiency are markedly lower 17 — especially for students of color — and when students are not being appropriately challenged, they are at risk of falling behind or getting bored. Additionally, the teachers hired in these position’s expertise is working with students who have special needs, not the subject area they teach; therefore, students in special education programs may not receive as thorough material and pedagogy as their peers.7 Arguably more so than exclusively academic repercussions, the employment of these programs consistently detriment students’ self-esteem and interpersonal skills.

A key tenet of special education is the insulation of disabled children from their non-disabled peers — or depending on who you ask — the other way around. The strong, persistent stigma around special education does not go unnoticed by the students within or outside the program. Being called *special ed* is an insult on the playground; a watered down iteration of r\*tard, shorthand for weird and dumb. The children enrolled in the program are exposed to this rhetoric and inevitably, to various extents, internalize it. Perceived judgment of inadequacy from instructors and peers tells those in special education programs that this is not only true, but an inherent facet of their identity. Combining this messaging with the racial discrimination and segregation children of color are already exposed to increases the likelihood that expectations of underachievement and delinquency will become self fulfilling prophecies.18 One study, using a sample of over a thousand Black children, found that those enrolled in special education programs were significantly more likely to encounter substance abuse, incarceration, and elevated depression, as well as lower rates of high school completion.7

The decision to create a separate classroom for children identified as having special needs likely comes from a place of well-intent — a mutually beneficial arrangement that prioritizes both groups’ academic and socio-emotional development. In many cases, however, the opposite is true. Inclusive education has been proven to increase intellectual and emotional intelligence universally in both groups of students. Eliminating some of the aforementioned barriers created by segregated schooling provides opportunities for children who qualify for special education to close the disproportionate achievement gaps. Standardized testing scores of 24,000 adolescents that met criteria for special education programs revealed that spending 80 or more percent of their time in mainstream classrooms raised their math and reading scores by 18 to 24 points.19 As well, this inclusive model has been associated with higher attendance and graduation rates, along with decreased frequency of behavioral issues and unemployment rates post-graduation for students with special needs. Though the academic response of non-disabled students’ appears less dramatic, their scores have still been found to either increase or remain neutral when placed in integrated classrooms.More importantly, these students demonstrate higher self-esteem and decreased prejudice and fear of difference.20

Reforming special education is a necessary step in disability justice and has the potential to significantly improve the social and academic trajectories of children of color. However, this addresses only a symptom, not the underlying cause. Black and brown children are far overrepresented in special education and this is no coincidence. Many of the issues involving underdiagnosing, misdiagnosing, and overdiagnosing children of color can be boiled down to the systemic racism deeply embedded into our society. Both race and disability are social constructs created and maintained by capitalism. Normal theory suggests that Black and brown childrens’ deviation from whiteness and the standard expectations of academic and social whiteness could classify them as disabled – regardless of cognitive or bodily function. In the work of the disability justice movement, this inextricable relationship between race and disability is examined and addressed in its advocacy.

The disability justice movement is a social and political movement that organizes around 10 fundamental tenets to challenge ableism and build a more equitable society for people with disabilities. These principles recognize and address the intersectionalities between disability and race – among many other marginalized identities; a crucial component in tackling dually racist and ableist systems. One of the primary goals of the disability justice movement is to reduce misconceptions and stereotypes about people with disabilities. Some disability activists have diverging views on the utility and efficacy of special education programs. However, the overarching goal of disability advocates in this field is to break down barriers in education to promote inclusive and accessible environments.

The average American child will spend over 15.5 thousand hours at school by the time they graduate from high school — granted they make it that far. That which they experience throughout these hours can have far reaching, and potentially devastating effects on their self-concept. In order to do our part to make sure these children are receiving appropriate support on a socio-academic level, we must first identify the ways in which racial prejudice and adverse social conditions influence the way Black and brown children learn, and the way they are perceived. Nevertheless, mere acknowledgment will never be enough; to make true change requires completely dismantling the educational policies and stereotypes that contribute to this racial disparity in disability classification and intervention. There are many routes toward this pursuit – I propose we begin by looking to the disability justice movement as well as apply the prejudice habit breaking intervention.

The disability justice movement centers a collective shift in cultural consciousness and institutions. This change will not happen overnight – in the meantime, there must be action taken to ameliorate extensions of implicit bias on individualized levels. At present, only one intervention to reduce unconscious bias has been proven effective long-term. The prejudice habit breaking intervention21 frames bias as a habit that can be broken by increased awareness and concern about bias, understanding one’s own role in reinforcing bias, inculcating motivation to overcome bias. Using results from the IAT (implicit association test) designed to record unconscious bias, participants are shown proof of the strength of their implicit bias. Once participants are faced with, and can acknowledge their individual bias, they are educated on the origins and ramifications of implicit bias, and provided concrete behavioral recommendations to overcome these beliefs. As discussed, teachers and clinicians are traditionally inclined to associate Black and brown children with stereotypes purporting lower intellect and higher deviancy. Confrontation with “objective” evidence that they are guilty of making snap judgments about a person based solely on race has been shown to motivate participants to apply learned cognitive strategies to deconstruct and re-evaluate more objectively. Breaking habits of implicit bias has the potential to significantly reduce the knee-jerk diagnostic fallacies we see today.

This has proven successful with educators and clinicians, however, extending invitations to such an intensive process will likely prove difficult within the target communities. Along with the aforementioned access barriers relating to time commitments and other responsibilities; there are disproportionately strong stigmas surrounding mental health and learning disabilities in low-income communities of color22. This phenomenon is partially explained by common cultural beliefs that frame non-normative behavior and cognition as weakness and failure on the part of the individual or their caregivers. Diagnoses like ODD place the onus on the parents, sending a message to them and their community that their child’s diagnosis is a result of their poor parenting. Nevertheless, similarly to teachers and clinicians, community members shape how children view themselves and their disabilities through the perpetuation of ableist cultural norms. To overcome these barriers, it is crucial to engage the community and address stigma through community resources. Efforts must build upon pre-existing community assets and engage local actors to broaden perspectives through awareness and education dispersed in culturally relevant settings and modalities.

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