

Confessions of a Mad Professor: An Autoethnographic Consideration of Neuroatypicality, Extranormativity, and Education

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Background/Context: *This article considers issues related to the intersection of mental health and education. Typically, in both educational and noneducational settings, atypical mental health conditions are described and treated as “disorders.” The author challenges conventional understandings of mental health and how to address it, particularly in school settings.*

Purpose: *The argument in this article is designed to make a case for greater understanding of extranormal mental health makeups and reconsider current understandings of normalcy. Focusing in particular on the experience of living with Asperger’s syndrome, this article orchestrates narrative data and prior scholarship to argue that conventional notions of normalcy require reconsideration as more is understood about the spectrum of possible makeups in broad and diverse populations. The author argues that notions of normalcy are social constructions and that reconstructions of conventional notions of normalcy could provide more inclusive settings for a wider range of people.*

Research Design: *This article employs a version of narrative inquiry, autoethnography, to explore issues related to the intersection of mental health and education. The author describes, reflects on, and interprets a body of experiential knowledge both to illuminate the experience of living with an extranormative mental health makeup and consider the degree to which it serves as a deficit or disorder, as is commonly presumed. These experiences are placed in the context of empirical data from other studies to frame an argument regarding the spectrum of neurological makeups and its place in efforts toward inclusive and multi-cultural education.*

Conclusions/Recommendations: *The article closes with an argument for constructing contexts for supporting, understanding, appreciating, and respecting a wider range of neurological conditions in school settings.*

This article uses a version of narrative inquiry called autoethnography (Riessman, 2008) to explore issues related to the intersection of mental health and education.¹ Typically, in both educational and noneducational settings, atypical mental health conditions are described and treated as “disorders.” I argue that greater understanding is needed of extranormal² and neuroatypical³ mental health makeups. To make my case, I focus on the personal experience I have had living with Asperger’s syndrome. I orchestrate narrative data and prior scholarship to argue that conventional notions of normalcy require reconsideration as more is understood about the spectrum of possible mental health profiles in broad and diverse populations. From my perspective, notions of normalcy are social constructions, and reconstructions of conventional notions could provide more inclusive settings for a wider range of people.

I open the article with an extended narrative describing my own awakening to my neuroatypicality in conjunction with my daughter’s diagnosis of Asperger’s syndrome and related extranormative aspects of her mental health profile; Page (2009) noted that many parents learn of their own place on the Asperger’s spectrum when getting their children diagnosed. This narrative is intended to serve as a framework for subsequent consideration of the genetic dimension of mental health conditions and the relation between traumatic experiences and mental health. Following this narrative introduction, the article explores questions related to what constitutes a “normal” mental health makeup and considers how mental health affects both ability and disability. I argue that it is important to deliberate what it means to be typical and atypical in terms of mental health and mental illness. The article concludes by considering the educational context of mental health, and implications of this autoethnographic reflection for the establishment of educational inclusion.

MY WORLD OF MENTAL ILLNESS

Welcome to my world: a world of mental illness. My story began long ago, but took on urgency in the fall of 1999 when I was giving a talk at the annual convention of the National Council of Teachers of English in Denver. I was presenting material with which I was very familiar, and I

knew nearly everyone in the room, including several doctoral students I'd flown to the conference with grant money I had at the time. It was their first opportunity to see me speak in the public sphere, outside our more familiar working relationship in my campus office. Prior to the talk, I had enjoyed lunch with a close friend, and I looked forward to giving the talk and discussing it with my friends, colleagues, and students.

Immediately as I began my talk, however, I knew that something was wrong. Normally—a term that soon took on new meaning for me—when speaking, I have little trouble finding the next word or phrase. But as I stood in front of the audience, I groped for words that weren't there. Even if I had found them, I would have had difficulty speaking because my throat was tightening more with each word I tried to speak. The room began to spin, and I along with it. I felt faint and short of breath. A friend told me later that I had turned absolutely white as my heartbeat pounded down my efforts to speak, suffocating not only my words but my attempt to breathe as well.

In midsentence, about two minutes into my talk, I said that I needed to step outside and asked one of my graduate students to finish my talk—an absolutely ridiculous request given her utter lack of preparation for taking the stage. I then left the room and collapsed on the floor, my back against the wall in the conference center hallway, struggling to breathe and drawing odd sideways glances from stragglers on their way to hear talks, perhaps mine. A friend from the session—who had intervened and given a brief version of my talk, thus relieving my student of the impossible situation in which I'd left her in my desperation to get away—appeared shortly to check on me and help me gather myself to figure out what to do next.

You may recognize this experience as a full-blown panic attack. I realized later that it wasn't my first, but it was without question my most dramatic, public, and frightening. At the time, I considered it to be a break-down, but my wife later convinced me that it was a break-through. I had experienced a degree of anxiety that had never overcome me in my many years of teaching thousands of high school English classes and hundreds of university classes, and in the course of giving scores of academic presentations. To that point, anxiety had never manifested itself in such a terrifying manner. The panic attacks I experienced in Denver opened the door to me for a new way of understanding myself and, eventually, family members who share my genetic makeup.

But I digress; in Denver, I wasn't done yet. After I called home to talk about my experience, my wife arranged for a local pharmacy to issue me a prescription for alprazolam, a medication designed to reduce anxiety, and I made it through the day in my hotel room. The next morning, I

attended a small meeting of people connected with my grant—all people I knew well, liked, and trusted—and I had yet another panic attack when I tried to speak. I left the meeting and made arrangements to leave the conference early. In the van to the airport, I sat next to a friend who asked me, as friends do, how my conference had gone, and I replied by sharing the details of what at the time was a frightening, bewildering, embarrassing, and crushing experience. She responded to my cascading story of failure with extraordinary empathy: Her brother and son, she told me, were bipolar, and she urged me to recognize that I needed medical help. For the duration of the half-hour ride to the airport, my companion provided me counseling and support that got me through the trip and helped to settle me for the plane ride home. I'm not a religious person, but her presence in the van seemed at the time to be providential.

There remained one major obstacle: boarding the plane. I have always been claustrophobic and acrophobic, and these fears of enclosed spaces and heights have made me, among other things, afraid of flying. Indeed, I had had a difficult plane ride from Atlanta to Denver over some relatively mild turbulence, the first sign that my frame of mind was ripe for a panic experience. Fortunately, the alprazolam enabled me to make the trip, and just as fortunately, a second act of providence bumped me from the waiting list up to first class rather than forcing me to cram my 6-foot 5-inch frame into an economy seat for the four-hour trip, with the panic attacks I'd experienced creating an anticipation that once the plane was in midair, I would urgently feel the need to get out.

Arriving home did not end my ordeal. The conference took place the weekend before Thanksgiving, and I was not able to teach for the rest of the semester except for a ceremonial visit to my classes. I was formally diagnosed with generalized anxiety disorder and prescribed a daily dose of paroxetine, known as "the detachment drug" because it helps one disassociate from the fears and fixations caused by social anxiety.⁴ By the beginning of the following semester, I was able to return to driving my car without the panic that followed from hurtling down the road trapped inside a cramped metal tube, a feeling that affected my initial efforts to get behind the wheel that winter, even with the systemic anxiety medication at work in my body. I was also able to teach my new classes, surviving the predictably rocky start and ultimately the semester without incident, and even flying to the spring AERA conference and delivering a talk before a ballroom full of people, a performance that I find astonishing in retrospect.

FAMILIES AND MENTAL HEALTH

At the time of my crisis, I was part of a household disrupted by an explosive series of episodes related to my daughter's ongoing mental health issues.⁵ Mental illnesses tend to run in families, not necessarily as complete inherited packages, but often as threads of symptoms that appear, to different degrees, across generations. A friend of mine from college wrote me a few years ago to tell me about his son, who'd always been a "normal" kid until symptoms of bipolar disorder disrupted and ultimately ended his first year of college. I saw my friend again recently, and he shared his awakening to some realities about his family. Upon his son's initial diagnosis, he was interviewed by doctors about his family history, and he testified that his son's condition was the first time he knew of in which anyone in his extended family had exhibited atypical mental tendencies. As his acceptance of his son's condition grew, so did his awareness that his pristine family portrait included details that he had not seen, understood, or acknowledged prior to his son's crisis. There had been, for instance, a few suicides that he had previously attributed to other causes but, in light of his son's experiences, began to view as psychotic breaks that were frighteningly similar to those his son had gone through. My friend's recognition that his family was less normal than he'd initially presumed resembled my own awakening to issues of mental health in my family that I had never been willing to connect as indicative of genetic patterns.

My daughter's major meltdown occurred throughout the fall preceding my own difficulties in Denver, when she was in her first year of high school. She'd always been a bit different from the other girls from school, who were obsessed with boys and more boys while she was obsessed with Japanese culture through the portal provided by Pokémon and the world of anime. As a preschooler, she had begun presenting symptoms of Tourette's syndrome and anxiety, and beginning at roughly the same time, we began providing her with therapy to address the anger she showed toward her younger brother. She spent more time with her computer than she did with flesh-and-blood people and constructed vast virtual communities in which to create relationships and share her anime drawings, fanfiction stories, and other online interests.

But in her midteens, she began responding violently to her difficulties in meshing with her material environments. In particular, she responded to my career move from Oklahoma to Georgia with a consuming rage that exploded in our house with numbing regularity. I'll condense this part of the narrative for the purposes of brevity, but eventually, and during the course of many frustrations, misdiagnoses, and behavioral strug-

gles at home, we learned that she had been exhibiting a panoply of extra-normal mental health conditions, including generalized anxiety disorder, a depressive mood disorder, Asperger's syndrome, Tourette's syndrome, obsessive-compulsive disorder (OCD), and oppositional defiant disorder. The expression of anger, we learned, often serves as a symptom of clinical depression, a different manifestation from the more common association of depression with sadness. These conditions were addressed with a combination of medication and counseling, although not to the extent that our household ever felt safe or secure. To give but one of many illustrations: She slammed the door to her room so often and so violently that the entire door frame eventually fell out of the wall. That and the many holes kicked in the walls of our house were just a few of the consequences of her outbursts that made life in our home unnerving and precarious.

I did not accept her diagnoses of mental illness easily or quickly. My wife and I had disagreed from early in our daughter's life about whether she needed interventions. My wife, who had greater familiarity with mental health issues than I, was concerned that our daughter had an extra-normative makeup and would benefit from counseling and medication. I in contrast had been raised to believe that if I had a problem, it was my job to get over it and get on with things, and I applied this principle to my parenting. I took pride in having this disposition and had little patience for those who dwelt on personal shortcomings or relied on excuses such as claiming depression as a reason for lacking gumption or any corresponding achievement. Our disagreements over how to address our daughter's difficulty in sustaining friendships and other peculiar relational issues were difficult and produced significant strain on top of the stress involved with living with a challenging child. Ultimately, I had to acknowledge that I had been wrong all along—that my wife's recognition of my daughter's differences as reflecting an extranormative and, for her, disabling mental health condition was right, and eventually in accord with the diagnoses we got from doctors. A related recognition, similar to that of my friend whose son's bipolar condition emerged when he went away to college, was perhaps more difficult: that much of what contributed to my daughter's condition had been passed to her genetically through me.

My daughter's first hospitalization occurred a month before my experience in Denver. I recall feeling deflated when her general condition was classified as "mental illness," which I had previously associated with lunatic asylums, serial killers, and other dramatic images of the mentally ill. It was only when I recognized that I shared many of her conditions and characteristics that I accepted that if she was mentally ill, then so

was I. This was quite a seismic acknowledgment given the beliefs I'd been engrained with in my family of origin regarding weakness and vulnerability and the need to overcome them through acts of will.

The diagnosis that I live with chronic anxiety, coupled with my growing understanding of my daughter's condition, taught me a lot about myself. I realized that my many sleepless nights rehearsing, over and over, some action I would carry out the next day was a sign of OCD, which by coincidence the paroxetine serves to diminish. I also came to understand that my vocal and physical tics classified me as having a mild strain of Tourette's syndrome, which helped to explain why I constantly pick at and bite my fingernails and engage in countless other twitches and tics, mostly with my hands, and why I had learned to disguise my vocal tics by channeling them through coughing sounds.

I also began to understand why I would rather write than read, because when I type, my hands and mind are occupied, and I therefore express my physical tics through a set of productive and satisfying actions. In contrast, when I read—or watch TV, or sit through meetings, or attend lectures or talks—I am physically unoccupied and so pick at my nails, go into endless tapping routines with my hands or feet, and otherwise present symptoms of Tourette's syndrome. Most people associate Tourette's with sensational cases of people who shout profanities when they hear certain “trigger” words, and yet the syndrome requires only the presence of both vocal and physical tics. When I express my tics through means that others find socially acceptable, I can appear relatively normal to others and thus less disruptive and distracting.

In retrospect, I realized that I had always presented symptoms of Tourette's syndrome, although not as dramatically as do those whose conspicuous cases first brought public attention to the condition. I had always thought that I was just antsy, or lacked the discipline to control my nail-biting, or could explain my behavior through some other conventional explanation, often emerging from my deep-seated belief in the value of willpower. My belief in the ability of willpower and discipline to overcome weakness soon fell by the wayside, along with other simplistic notions of human behavior and how to regulate it in either myself or others.

MENTAL HEALTH AND ITS RELATION TO EXPERIENCE

A recent survey by CNNMoney.com (“Best Jobs in America,” 2009) found that “college teacher” is third in its ranking of “Best Jobs in America.” On an A–F scale, they found that the “low stress” of the profession rates a “B.” Their representation of the profession as relatively unstressful belies the

experiences of most people whom I've known among the professoriate. Perhaps my narrative will suggest at least some reasons why this is so.

Through counseling, I came to the recognition that I had gone through a 20-year period of unrelenting pressure at the highest levels of the greatest life stress lists. In the fall of 1981, when I was a 28-year-old high school English teacher in the Chicago area, I experienced a growing rage over what I saw as the self-serving corruption of my work environment by the school administrators. During this intense period of emotion, which was amplified and driven to ferocious levels by my OCD, I became seriously ill with a sinus infection that migrated to my kidneys and developed into a disease known as nephrotic syndrome. The illness caused my kidneys to divert protein from my blood to my urine, producing anemia that rapidly added roughly 30 pounds of water weight to my slender frame, a bewildering and grotesque physical transformation that left me barely able to recognize myself. In addition, the anemia served to enervate me physically, emotionally, and intellectually, to the point where I had little energy to function.

I entered the hospital for nine days of observation and ultimately a biopsy, after which I was prescribed a steroid-based medication, prednisone, that I took for many months. Through the effect of the steroids, I took on a bloated and distorted look that lasted beyond the duration of the treatment. The medication made me extremely ill tempered—I exhibited the “roid rage” often attributed to athletes who use steroids to add muscle mass—and made it difficult for me to sleep; while under the medication's grip, over the course of several months, I slept for perhaps three to five hours each night. Compounding this problem was the cumulative effect of the drugs, such that each daily dose seemed to aggravate the feeling I awakened with, leaving me psychotic and unpredictable, much like an alcoholic or methamphetamine addict. This illness recurred three times over the next 15 years, each time in conjunction with long periods during which I became increasingly infuriated over administrative fraud and corruption where I taught, each time in a new school or university where I'd hoped to escape the manipulations of the last. These relapses necessitated months-long steroid treatments that produced the same emotional fury and physical deformation in me and that took a heavy toll on me personally, and consequently on my family.

This illness was only the beginning of the stress that built up over the next two decades. I had been scheduled to begin my doctoral studies in the fall semester following my first episode of nephrotic syndrome but had postponed them in the spring when my fiancée began to lose her eyesight as a consequence of the diabetes she'd contracted at age 11. To relieve her of the stress of supporting my doctoral studies while

struggling with her own health, I decided to teach high school for another year while we waited to learn the extent of the debilitation of her vision and her ability to work while I was in graduate school. We got married on July 10, and on August 30, on the night before school began, she died in her sleep. Her autopsy went on for many months and in the end produced the conclusion that she had simply died, without cause or reason. Even with mostly supportive friends and colleagues—one exception was the teacher who insisted that my department chair fire me because I was struggling so greatly in the classroom—I survived a very difficult year personally and professionally and, the following summer, began my doctoral studies. I attended the University of Chicago full time for five consecutive, deeply intense quarters and completed my degree over the next five years while teaching high school English full time.

While teaching full time and completing my doctorate, I remarried, and my wife and I had two children. I also changed high school jobs to teach at a school closer to the University of Chicago, losing all job seniority in the process. I also experienced the death of my father-in-law, a loss that was very hard on my wife especially and on me as a friend and admirer of this accomplished and kind man. After completing my doctorate, I left the high school setting and began my university career at the University of Oklahoma; survived the tenure track amidst dysfunctional office politics and the pressures of publication; coedited an archival research journal; and moved to a new position at the University of Georgia, requiring me to give up tenure for the first two years and to uproot a family who had grown to enjoy life in Norman, Oklahoma. This move was resented throughout our home, and in particular triggered routine explosions of anger from our daughter, who, like most on the autism spectrum, has great difficulty with change. My experiences with debilitating anxiety thus represented the culmination of two decades of stress that I had attempted to sublimate, leaving me, in the thin air of Denver, speechless and terrified.

LIVING WITH ASPERGER'S SYNDROME

In the wake of these events, I accepted, along with my diagnosis of an anxiety disorder, Asperger's syndrome as part of my makeup. Asperger's is a condition within the autism spectrum. Like any syndrome, Asperger's consists of a set of symptoms available from a larger menu, rather than having particular invariant characteristics. Not every case of Asperger's is like every other, and people diagnosed with the condition might instantiate the syndrome in very different ways. My nephew, for instance, shares the same diagnosis as my daughter. Pervasive developmental disorder is

the broad classification within which all autism spectrum disorders fall. Both my daughter and nephew have been diagnosed with PDD-NOS, or pervasive developmental disorder—not otherwise specified. To most observers, however, my nephew appears more autistic, whereas my daughter presents more traits of Asperger's. The diagnosis strikes me as best considered a heuristic rather than a rigid statement of a condition, given the wide range of variation within the available spectrum.

I would also argue that there is a relational dimension to how one presents symptoms, given how my daughter's greatest manifestations came following our move to Georgia. Valsiner (1998), for instance, argued that the development of personality has a strong relational nature; personality does not develop in a vacuum, but in transaction with the people, social structures, cultural practices, and other phenomena with which people engage. Hjörne, Larsson, and Säljö (2010), in considering the well-being and social adaptation of students in school, found that "deviant student behavior is typically explained by 'causes inside the child, rather than describing and analyzing them as contextual and relational problems' (p. 87). They continued,

The social language that dominates the discourse, and that is taken for granted by the participants as an unproblematic tool for reaching consensus, focuses on shortcomings of the children. Thus, the speech genre developed in this context mainly consists of negative descriptions of children's capacities, while the practices in school are never analysed in a critical fashion. (p. 88)

The discursive representation of the child, then, fits intertextually with the Cartesian division of mind and matter such that relational aspects of health, including mental health, are typically not considered when the behavior of children is addressed in school settings. It is the child, not the institution, that needs to be remedied. A relational approach to mental health contests this assumption because, as Hjörne et al. (2010) concluded, "The social language employed implies naming an individualising children's problems; a multifaceted and complex situation is transformed into a dysfunction within the child, rather than an opportunity for the school to adjust its pedagogical practices to support the child" (p. 89). Understanding mental health relationally shifts attention to the ways in which the settings of education are constructed, a point to which I will return later.

Our experiences of researching the syndrome and enrolling our daughter in a series of programs for young people with Asperger's helped me to realize that the trail of her atypical mental makeup always

led directly back to me. I have never gone to the trouble of getting diagnosed, but within my family, which knows the syndrome well, it's accepted that I am a high-functioning Asperger's case. I do not exhibit the full range of Asperger's traits; I was a reasonably good athlete, for instance, playing football and basketball and competing in various events in track while in high school, playing one year of small-college basketball, and remaining physically active throughout my adulthood. In certain contexts, I also have reasonably good people skills, as evidenced by the fact that I am often asked to chair professional committees. I think that I have taught myself these skills deliberately to overcome their absence in my natural repertoire of interactional abilities.

But my narrow range of interests, blunt and direct way of communicating, materialist orientation to the world (I am, like many people with Asperger's, an atheist), concrete engagement with my reality (my youthful love of literature has been superseded by my adult interest in history, and there are good reasons that I entered the social sciences rather than the humanities for my doctoral studies), ignorance of and mystification with many social rules, difficulties with small talk, and ability to engage in intense and detailed persistence with a problem from which I hate to be interrupted are indicators that I occupy a place toward the fringe of the spectrum. I suspect that a few decades from now, the distinction between normative and extranormative, between "having" a syndrome and "not having" one, will be far less clear-cut than it presently is. Rather, the field will recognize a spectrum of normative to extranormative, one that spirals in many directions, that includes the range of traits or symptoms of a condition or syndrome, with a larger gray area for people like me who exhibit symptoms of the syndrome to various degrees without necessarily presenting sufficient quantities to suit current-day diagnoses of "having" it.

Asperger's syndrome often serves as the nexus for whatever other neuroatypical conditions a person might exhibit, providing the central mental state through which other extranormative conditions present themselves. Depending on where one is positioned within the wide range available with this condition, a person can be relatively high functioning, as I generally am, or severely socially and emotionally out of synch with those around them. The description of Asperger's syndrome at the WebMD Web site provides a concise and accessible account of what it involves:

Children with Asperger's syndrome typically develop a good to excellent vocabulary, but they usually lack the social instincts and practical skills needed for relating to others. This can result in

poor communication skills. They may not recognize verbal and nonverbal cues or understand social norms, such as taking turns talking or grasping the concept of personal space. They may have difficulties with accent, tone, and pitch, which can make their speech sometimes odd or difficult to understand. And they may have a hard time expressing their own feelings and perceiving others' feelings. Children with Asperger's typically try to form friendships, but they may have difficulty making friends because of their social awkwardness.

Children with Asperger's syndrome often have limited and very focused interests. They are often most comfortable with fixed routines, and they do not like change. They may lack coordination, exhibit unusual facial expressions, body postures, and gestures, and be somewhat clumsy. Many children with Asperger's syndrome also have trouble with fine motor skills, such as handwriting. They may also have trouble with gross motor skills, such as riding a bike.

Children with Asperger's syndrome will have some of the traits typical of the syndrome. But each child with Asperger's presents a different picture. Some will have less pronounced traits, and others' traits are more noticeable. Each child will have individual interests, likes, and dislikes. All children with Asperger's syndrome have severe trouble in social situations. ("Asperger's Syndrome," 2008)

Simply stated, people with Asperger's syndrome are often cognitively advanced and socially delayed. They are, to varying extents, psychologically insulated from other people and living in their own worlds. They typically have the capacity to engage in work requiring extraordinary attention to minutiae and patience in carrying out tasks that people within the normal range would abandon because they cannot sustain attention to tedious detail. My daughter's computer art, for instance, often requires that she color a large image pixel by pixel, a feat of seemingly stupefying dullness that she undertakes with a ferocious fixation and incomprehensible speed. She can then talk to me about it endlessly without having the social skills to realize that I am not interested in the details of her passion, although as she matures, she is increasingly attentive to other people's social cues, in large part because she has specifically been taught how to read other people through the interventions we have provided.

In much current writing about Asperger's syndrome, such intense concentration in a limited area is a sign of the condition's debilitating effects on its host. Painter (2006), in a recent book on the syndrome, began her overview as follows:

The key deficit found in children and adolescents with Asperger's Syndrome (AS) is their lack of social skills. They do not know or use the basic social skills that come more naturally to other people (Krasney et al., 2003). They often do not have a full appreciation of the social "rules" of interaction. . . . AS is a psychological disorder that falls under the umbrella of autism spectrum disorders. . . . The deficits that these children show are thought of as falling on a broad continuum. (p. 13)

It's hard to consider this characterization as anything but a "deficit" view of Asperger's syndrome. In this view, being normative is desirable, and falling outside the typical range indicates a *disorder*: a condition that is not only abnormal but deficiently and disadvantageously so. And yet from the perspective of those with Asperger's, neurotypicals—people within the normal range—are incomprehensibly obsessed with conforming to social rules, adherence to which wastes time and energy that could better be put toward singular, more useful, and often relatively asocial ends: mastering the details of the vast Pokémon universe, building monumental and complex structures with Legos, repeatedly watching every episode of *The X-Files*, and otherwise achieving total immersion in a narrow, esoteric area of interest. With such a necessary and compelling project demanding my urgent and unabated attention, who cares if I am still in my unmatched pajamas or haven't brushed my hair in three days?

This difference in perspective raises interesting questions regarding what constitutes a normal frame of mind and what it means to fall outside that normal range. As Ortiz (2008) maintained, Asperger's syndrome can, under the right circumstances, provide one with tremendous resources that, when effectively harnessed, can result in people of highly productive and exacting performance. My daughter, for instance, has had the benefit of two dedicated parents who have put abundant resources into understanding and supporting her development without disturbing the potential qualities that her condition has provided for her. Both she and my nephew have also responded well to medical interventions that have created possibilities for them to be amenable to the sorts of interventions they have been provided.⁶ My nephew has been through a behavior modification program that my sister has acknowledged was sufficiently severe that she had difficulty watching it, yet that has also

made life more satisfying for both her son and their family. My daughter has participated in a drama-based program designed to teach interactive skills, and a life skills program designed to teach her how to live independently. This pragmatic instruction has come in conjunction with counseling, medication, and other means of support. I stress here that these are important qualifiers; those who exhibit greater autistic tendencies or who lack strong and persistent interventions and support prove more difficult to channel toward a normal range of functioning. Had she grown up under other circumstances, she might well have ended up dead or living only the most marginal of existences. I have no illusions about the challenges of raising and educating a child with Asperger's syndrome or comparably extranormative psychic and emotional makeup.

Now  years old and a veteran of several interventions through which she has accelerated her emotional development and learned a functional set of interactive social skills, she works for a self-publishing company designing books, a position that builds on her advanced literacy skills and her inclination and ability as an artist. I assume that other people in her company have more extensive social lives outside work and are more at ease around the water cooler or coffee machine. Actually, because she works with such intensity that she forgets to take breaks and detests being interrupted when she is locked into a task, my daughter rarely gets to the water cooler—and she has such fierce concentration that she doesn't need caffeine to stimulate her to get her job done.

Like many people with Asperger's syndrome, and like me, she was a "little professor" as a child and has grown to have a vast and delightfully esoteric vocabulary and understanding of English syntax. And like many with Asperger's, she flunked out of college. She attended the Savannah College of Art and Design for one year but got sidetracked by projects that consumed her to the point that she neglected her assigned work. For instance, she became dedicated to translating manga (graphic novels) from Japanese into English as part of a "scanlation"⁷ project for which she served as an unpaid editor. This obsession, along with her immersion in related types of activities, occupied time at the expense of her required studies, and her singular focus on the projects that interested her rather than on her schoolwork ultimately led to her academic probation and then dismissal from the college. An academic washout, then, she is among the most articulate people I know, and her fluency with language exceeds that of many doctoral students I have taught or scholars whose work I have edited.

QUESTIONING NOTIONS OF NORMALCY

My consideration of the experiences I have outlined has led me to question established notions of what it means to be “normal.” Returning to the case of my daughter, is she truly in “deficit” relative to others? Does she have a “disorder,” or does she follow her own order, and quite well, our wasted tuition payments notwithstanding? Without a doubt, her sense of responsibility differed from ours: She felt a responsibility to work on those projects that she felt inexorably drawn to, whereas we felt that she was abrogating her responsibility to attend to the schoolwork for which we were paying private university tuition fees. I do not intend to underestimate the problems that an atypical neurological makeup can cause both for the individual who presents it or the people who invest much in both his or her immediate needs and life trajectory. I ultimately am of two minds in considering our daughter’s situation. In one sense, she exhibited a tremendous dedication to projects in which she had clear expertise and ability and toward which she showed an admirable commitment, and thus showed less of a disorder and more of a degree of potential for the sort of productive life she could eventually achieve. And yet in another, she betrayed our trust and acted irresponsibly by not attending to the studies that we were financing and that we hoped would provide her with both immediate happiness and the foundation for a fulfilling personal and professional life beyond college.

I also must stress that conscious, rational thinking is not available to all who fall outside the normal range. The ability to reflect on behavior and recognize its relative appropriateness is not accessible to all, no matter how dedicated the parents and their efforts to secure effective help from mental health professionals. I have friends who are as loving and committed a set of parents as I can imagine. Their son has been diagnosed with Asperger’s syndrome along with bipolar disorder, schizoaffective disorder, OCD, oppositional defiant disorder, reactive attachment disorder,⁸ and other conditions possibly originating in in utero malnourishment and the conditions in which he was housed as an infant awaiting adoption in Colombia under impoverished circumstances. His behavior has long been problematic, and he has been committed to psychiatric hospitals a half-dozen times. But in the last two years, his dangerous behavior has increased, and recently he was arrested following his commission of multiple violent felonies. When our kids were teenagers, his parents and I would exchange stories, such as the time their son went into the bathroom to even out his sideburns and emerged hours later with a shaved head. Funny stuff indeed. And cathartic for us as well, given that often the only way for parents of such children to maintain an even

keel is to exchange stories of their children's behavior with other parents who "get it" when it comes to mental health.

But after he was involved in a serious car accident in which he sustained a traumatic brain injury that left him with permanent deficits in cognition and short-term memory, their son increasingly became a threat both to family and strangers, no matter how desperate his parents became in their all-consuming efforts to help him. When I argue for inclusiveness for those who fall outside the normal range, I do so with the recognition that some behaviors fall outside what's acceptable as manifesting simple cultural or neurological difference and constituting a real and demonstrable threat to others, including loved ones.

I'll shift to my own manifestations of Asperger's to consider the question of norms in relation to mental health. My social skills—my ability to anticipate the needs and expectations of others—are better than those of most people on the Asperger's spectrum, although I've nonetheless been told that at work, some people find me "difficult." If you too are difficult, you know that this term is often applied to people who have trouble or a disinclination in conforming to someone else's view of how to behave or to someone else's agenda for a group such as an academic department. I find many normative ways of behaving to be disingenuous and downright dishonest; one trait of people with Asperger's is that they are (at times painfully) straightforward and guileless. Being indirect and suggestive makes little sense to us; it is like other pretenses that lead to misunderstanding, even if indirectness is a sign of politeness in many contexts, especially among the middle and upper social classes (Delpit, 2006). Those with Asperger's are also typically inept at, and cannot understand the reason for, small talk, a tendency that others might interpret as being aloof or ill mannered, even as we find small talk to be insincere and irrelevant.

Being direct can violate standards of propriety and therefore can lead to one being constructed as "difficult," especially in such settings as, in my case, the U.S. Southern culture of manners (see, e.g., Wilson, 2006). Again, the question concerns the value of social rules, which vary from culture to culture and so are social constructions (Rogoff, 2003). Whose rules provide the center of gravity for considering what counts as appropriate behavior? Why are those who don't understand or follow those rules viewed as being in deficit, of having a disorder? Who is responsible for establishing a social norm, when different norms obtain in different settings? Upon what basis is one's behavior determined to be in deficit relative to a norm, rather than following a different norm? Under what circumstances should anomalous behavior be treated as deviant (Smith, 1978)?

A dramatic illustration of the problems that we experienced with norms came when our daughter was, in line with our health maintenance organization (HMO) medical plan in Oklahoma, sent to a psychologist who administered a Rorschach test as part of her evaluation. Using standards provided by the *Diagnostic and Statistical Manual of Mental Disorders* for evaluating a person's responses to the inkblots (American Psychiatric Association, 1994), he concluded that her interpretations of the inkblots fell so far outside the normal range of response that she required hospitalization.⁹ To put it mildly, I contested this opinion with considerable vigor. I could not understand how there could be "correct" interpretation of an inkblot, just because most other people saw such a pattern when called upon to identify one. My own background in semiotics (e.g., Smagorinsky, 2001) led me to conclude that any text is open to multiple interpretations. The fact that a deliberately random image could have an official meaning struck me as preposterous and a distortion of the purpose of conducting mental evaluations. More relevant to my purposes in this article, the psychologist's insistence on a standard response to an abstract image seemed to me to take the idea of human normalcy to an absurd level and imposed on our family a judgment that we felt was unwarranted and pernicious.

The question of what constitutes a norm is a central consideration in any effort to understand issues surrounding mental health. Because the identification of Asperger's syndrome is a relatively recent development, it is hard to say with conviction whether older people, such as software pioneer and philanthropist Bill Gates and economic expert Lawrence Summers, present the syndrome, although both appear symptomatic in terms of their notoriously poor people skills combined with their brilliance in narrow fields (Summers, for instance, was granted tenure at Harvard at age 28, one of the youngest professors to earn tenure in Harvard's history). Claims that this person or that had Asperger's syndrome are often contested, as in disagreements over whether brilliant eccentrics such as Albert Einstein should be included among Asperger's exemplars (Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001; James, 2005).

ABILITY AND DISABILITY

I am confident that having Asperger's is probably a key to whatever success I've had in my field. My own academic progression perhaps indicates how a general education can misassess the potential of people with narrow interests. My grades and academic performance have elevated with each step I have taken academically, from high school to college to my

M.A.T. program to my doctoral program to my scholarly career. I believe that the increasing narrowness of my programs of study, along with my delayed maturation, has been a major part of that progression, which is the opposite of that of most people, who excel early and get thinned out as the demands of academic programs increase.

As my career has unfolded, people have often complimented me on my “work ethic” and attention to detail, and early on, I appreciated their acknowledgment of these qualities. But now I see my ability to work long and intensive hours, and to finish virtually any task well ahead of schedule and in considerable detail, as being a function of Asperger’s. My ability to complete work quickly and efficiently is, I believe, a consequence of having Asperger’s in conjunction with OCD. The fact is that I *have* to finish things off or my anxiety becomes exacerbated. This trait is not an indicator of high character, but rather a part of my makeup that’s built in as part of my “disorder” and my narrow range of interests. Once, when I was teaching high school and was invited by another school to give a talk, the woman who introduced me listed some of my achievements and then turned to me and asked, without affection or irony, “Don’t you have a life?” My answer is that yes, I’ve got one, it’s just more narrow than that of most people and focused on things I do well and enjoy, which happen to be of the scholarly sort.

At times my “disability” and lack of a life, in conjunction with other factors, have produced periods of unusual accomplishment. During the spring and summer of 1993, I had a relapse of nephrotic syndrome as I built up an uncontrollable rage over the governance of my work setting. My meltdown in Denver was still six years off, and I was not taking any medications that would help me become emotionally detached from this situation or prevent me from obsessing about it, and my illness returned. I was again prescribed prednisone to treat my kidneys. This time, I took it for the duration of an Oklahoma summer, a long and relentlessly hot time of year in which, in the flat, cloudless, and open terrain of the region, temperatures typically ascend to triple digits. Given that prednisone increases my own body temperature, I felt as though I was boiling in my own blood throughout the endless summer season. Sleeping only a few hours a night and being nearly incapable of relating normally with other people, I resorted to work, writing maniacally and with only rare breaks for nearly the entirety of each day’s 20 or so waking hours. This work was published in 1994 and 1995: three books, four book chapters, and 11 journal articles. Asperger’s and OCD on steroids: If it doesn’t kill you, it makes you stronger; but it might kill you.

I can’t say that I recommend this combination, no matter how impressively it inflated my vita. My family suffered, and I often wondered if I

would survive any given day, much less the full course of the treatment. At the time I had no idea that others would consider me to be mentally ill, even though they surely considered me to be crazy. According to the National Alliance on Mental Illness (n.d.), “Mental illnesses are medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life.” It’s important to understand that what is regarded as a mental illness today might be considered not so tomorrow. Until 1973, for instance, the American Psychiatric Association regarded homosexuality as a mental illness and described it as such in its *Diagnostic and Statistical Manual of Psychiatric Disorders (DSM)*. This decision came long after Hooker’s (1957) landmark study provided the evidence that ultimately altered the profession’s views on the status of sexual orientation with respect to mental health.¹⁰ (See McCarthy & Gerring, 1994, for an analysis of the ideological nature of the *DSM*.)

Mental illness remains a human construct that is designed to separate normative from extranormative psychic makeups in order to provide appropriate treatment for those who fall outside the normal range. At times, these diagnoses can be beneficial, such as when a person has extremely atypical characteristics that can lead to harm to oneself or others. Yet at other times, the designation of one as having a mental illness can produce stigmas long associated with insanity that themselves become at least as debilitating as the extranormative condition itself. I will treat these issues as I work through points that I feel are worth making from the perspective of an educator with an atypical neurological makeup.

TYPICALITY AND ATYPICALITY

The notion of typicality follows from the diagnostic need to identify what is normal and what is not. And so homosexuals were, not so long ago, officially viewed as atypical—and in their case, sick and deviant by the psychiatric community in addition to the opprobrious treatment administered to them by society at large—because their sexual orientation did not exhibit the opposite-sex attraction that characterizes the majority. As Baynton (2001) argued, notions of “disability” have been used for exclusionary purposes throughout U.S. history. In addition to the construction of homosexuals as deviant and subnormal, those within the mainstream have conflated difference, disability, inferiority, and evolutionary degeneration to discriminate against racial minorities, specific ethnic groups,

immigrants, the physically impaired, women, and other groups who deviate from the established norm. In one dramatic example, Baynton noted that Down syndrome “was called Mongolism by the doctor who first identified it in 1866 because he believed the syndrome to be the result of a biological reversion by Caucasians to the Mongol racial type” (p. 36). Historically, then, those with extranormative mental makeups fall within a broad category of people who have been hierarchically constructed across the mainstream population as atavistic and deviant.

I believe that opinion toward mental health has turned a healthy corner, although it still has a long way to go before reaching any sort of state of enlightenment. Rather than attempt to comment on the full range of mental health issues that affect society, I’ll restrict myself to the ways in which people are viewed in the context of education. First, however, I need to qualify any remarks I make by stating emphatically that I do not take a romantic view of neuroatypicality as a condition that enables a unique perspective on the world while having no negative consequences. The World Health Organization (2001) reported that about 7.5 million children in the United States—12% of all children under 18—are neuroatypical, with nearly half of that population at risk for more serious problems. Jamison (1999) found that 20% of high school students had strongly considered committing suicide during the year prior to his study, with most having drawn up a suicide plan; suicide is the third leading cause of death of teenagers between 15 and 19 years of age, often following from a depressive disorder. I knew from experience with the suicidal tendencies my daughter exhibited as a teenager that the possibility of a child’s suicide is as terrifying a prospect as a parent can face. Indeed, while many of my fellow parents spoke of their lofty goals for their child in life and of their child’s great assets, awards, and accomplishments, I quietly developed my own singular goal for my daughter: that she would get through high school without killing herself.

I thus am fully aware that someone growing up with an extranormative makeup is at risk in many ways. As I have noted, my daughter posed a danger to herself and often to others in our household when she acted out angrily, beginning at age 2, around the time our son was born. A sustained and determined commitment to finding help for her became a focus of our family life, one that often left our relatively healthy son feeling left out in the cold. I would never underestimate the amount of dedication that it takes to help someone who relates poorly to others, who constructs her world in negative and debilitating ways, who has little control over emotional and physical outbursts, whose behavior may pose threats to herself and others, and who faces other consequences of having a makeup outside the normal range. I also know that even the great-

est of efforts to support such a person can be futile. Being normal has its advantages.

Getting proper treatment for the debilitating aspects of an extranormative makeup has its advantages as well. I have come to rely on alprazolam as a preventive measure before boarding planes. Initially I took it before (and, on occasions when it wasn't enough, during) public speaking such as conference presentations. Because it can produce a "dopey" feeling, for public speaking, I found an alternative in a drug in the beta blocker family, one that prevents adrenaline rushes that lead to panic attacks. Along with the systemic medication I take for anxiety, these situational medications have helped me to stay within the normal range of tranquility when such a demeanor is appropriate and have enabled me to carry out my personal and professional responsibilities as well as possible. I am not therefore arguing that extranormative people are simply unique, that their exceptional perspective comes at no cost, and that we should celebrate them rather than treat or otherwise accommodate them. Often being neuroatypical is painful and traumatic for both its carriers and those who surround them.

THE EDUCATIONAL CONTEXT OF NEUROATYPICALITY

My concern thus is how people regard and act toward those who fall outside the neurotypical range, especially in the realm of education. I have an interest in the ways in which people of extranormative makeups are constructed, viewed, and treated in the social setting of school and urge educators to treat them inclusively and without stigma. Vygotsky (1993) recognized this possibility when working in the field of "defeklogija," translated as "defectology." Kozulin and Gindis (2007) located the view of extranormative people as "defective" in the "mechanistic mentality of the 1920s that explicitly compared human beings with mechanisms" (p. 333), with the complementary belief that malfunctions can be diagnosed and corrected. This conception seems to be alive and well today, long after Vygotsky's work in the 1920s Soviet Union. The term *defectology* covered a wide radius of conditions, including impairments in hearing, seeing, and speaking and what was termed mental retardation; my own interests here are restricted to issues of mental health.

Vygotsky (1993) resisted the prevalent mechanistic approach that children with special needs were defective and should be fixed. He instead viewed the question of their condition "as a sociocultural rather than an organic or individual developmental phenomenon" (Kozulin & Gindis, 2007, p. 334). Kozulin and Gindis found that

the essence of Vygotsky's approach to remedial education is in addressing the secondary disability, that is, by countering the negative social consequences of the primary disability. Vygotsky believed that physical and mental impairment could be overcome by creating alternative but essentially equivalent roads for cultural development. By acquiring the psychological tools, disabled children transform their natural abilities into higher mental functions as do their nondisabled peers. (p. 345)

To Vygotsky (1993), rather than "fixing" the "defect" in the child, an educator should strive to minimize or eliminate any environmental factors that could amplify the effects of the original point of concern (cf. Soodak, 2003). This effort might focus on diminishing whatever stigmas follow from being different. It might, for instance, attempt to educate people in the setting about how to view those with extranormative physical or mental makeups and treat them respectfully and in light of their potential. Vygotsky further sought to identify "alternative but equally equivalent roads for cultural development" through the provision of alternative psychological tools (Kozulin & Gindis, 2007, p. 334). Cook (2004), for instance, studied young women with depressive mood disorders and found that they constructed their identities by means of such cultural tools as art, fanfiction writing, and computer-based technologies that were of limited availability to them in school. The notion of providing broader means of mediation would accommodate the special needs and abilities of such children, again requiring changes in the environment so that alternative paths to performance are available to suit the unique interests and abilities of people outside the normal range.

Vygotsky's concern with secondary disabilities remains as vital and insightful today as it did in the early Soviet Union. Children of difference still face negative social consequences of their conditions in the form of secondary disabilities, the negative feelings that follow from the classification of being "disordered" or "impaired," that might ultimately trouble them more than the source of difference itself. Part of any effort to help them achieve quality lives should involve changing the setting in which they carry out their lives and develop the tools with which to manage their relationships: to change perceptions, to allow for unconventional ways of thinking and acting, and to otherwise construct a more supportive and empathic context for children's development (see, e.g., research on bullying, such as Orpinas & Horne, 2006).

To give one example of how changes in setting can produce new self-images for those with Asperger's syndrome, the College Internship Program, which (for a very healthy fee) helps young adults with

Asperger's to learn skills for independent living, emphasizes to its enrollees that Asperger's is as much a gift as a disability. If the disabling aspects of the syndrome can be overcome by learning interactive skills and accelerating maturity in terms of meeting responsibilities outside one's narrow range of interests, then the gift has an opportunity to flower into an enabling characteristic. For this transformation to occur, an environment needs to exist in which those with Asperger's are treated in terms of their potential rather than, in deficit manner, according to the traits that insulate them from others and worldly responsibilities.

One benefit of a programmatic approach to assisting young people with Asperger's and other atypical conditions is that they are in the company with others who share their makeup. When with others with similar neuroatypicality, they feel less peculiar and more at home. They see how people like themselves can be annoying and reflect on how they interact with one another. But primarily, I think, they find a community in which they are not the odd ones. As I have observed this phenomenon, I have concluded that providing such communities is immensely helpful to those who have always been told that they have a disorder, or are in deficit to others, or are impaired. In such programs, they are the norm and can see that they sky does not fall when they and those like them are gathered together. I make this point while also asserting that sequestering these communities from others can reinforce the stigmas that often follow them and can further desensitize neurotypicals to the need to construct more empathic and inclusive communities among the broader population of people. Portes and Smagorinsky (2010), writing in the context of bilingual education, point to Public Law 94-142¹¹ regarding the need to provide students with the *least restrictive learning environment* possible. They argue that sequestering bilingual students in "sheltered" classes limits their learning opportunities. The balance between creating communities of learners with a shared condition and mainstreaming such learners with their presumably "normal" schoolmates remains a difficult one to achieve.

I have thus far focused on stigmas that are assigned to young people believed to be disordered. I also believe that in educational settings, neuroatypical faculty members deserve a more empathic environment. One respondent to this article said that when she has disclosed to colleagues that she has been diagnosed with bipolar disorder, they have been initially concerned, yet over time have begun to treat her as defective. I hope to see the day when people can openly divulge their extranormative makeup and do so without becoming stigmatized and thus treated as disordered and in deficit to others. This sort of "coming out" can in turn help to construct new settings in which extranormativity produces less

shame and thus is more amenable to open acknowledgment.

Most evidence points to the fact that schools—and, I would add, universities—have not yet taken up mental health issues as a critical focus, a problem that has little prospect of being addressed in the current economic climate. Parents and teachers alike express disappointment with the way that mental health issues are typically administered in schools (Dowling & Pound, 1994; Rappaport & Carolla, 1999). In addition, many teachers have little understanding of how to recognize or respond to students with extranormative makeups (Madison, 1996). Only recently has mental health been identified as a reason to develop an individual education plan (IEP) for students. These findings are consistent with our own experiences with having a daughter requiring an IEP to accommodate her special needs. In general, the people at the IEP meetings earnestly hoped to provide her with what she needed, and yet her counselor insisted that we should simply apply a “tough love” approach to our daughter to make her more accountable to the school’s expectations. If accelerating her progress toward suicide had been among her goals, we’d have held her feet to the fire long before we met with her IEP committee. We fortunately were able to develop an IEP plan in spite of her counselor’s evident lack of counseling knowledge. We unfortunately found little follow-up to the plan because the teachers were too overworked to provide the necessary accommodations or maintain routine contact with us to ensure that the plan was in place and working.

Imse (1999) reported that school officials face many obstacles to providing appropriate responses and environments for students who are in need of mental health support, finding that in Colorado schools,

officials have become more sensitive to kids’ mental states [yet] they remain hamstrung about arranging treatment. “We have no place to go with them,” said Clark Bencomo, a counselor at Green Mountain High School. “All we can do is suspend or expel.” “We are oftentimes reduced to putting a kid in a place where they’re safe, but it’s not the right program,” added Kay Cessna, intervention services director for Jefferson County schools. “There are not enough places.” [One parent of a child with disabilities complained], “They don’t have the time, the manpower, and they don’t get it.”

Cook (2004) found this problem occurring in other states as well, reporting that students with neuroatypical makeups are often put in special education programs or disciplined when they act out, either as a consequence of their behavior (e.g., a child with Tourette’s syndrome’s

involuntary profanity) or in response to the taunting they face from their peers (Cooley, 1995; Lewis, Chard, & Scott, 1994; Skiba & Peterson, 2000; Soodak, 2003).

The issue of disciplining students for extranormative behaviors that follow from neuroatypical makeups is evident in the national character education movement. With Joel Taxel, I studied character education programs in the United States (Smagorinsky & Taxel, 2005). Remarkably, there was virtually no mention of mental health in the abundant literature on character education. Especially in the Southern states we analyzed, young people either conformed to the norm of expectations and thus exhibited high character, or they behaved outside the bounds of accepted propriety and were deemed to require character education, often accompanied by punishment.

Yet a mental health professional would surely argue that the problem is not a lack of character and that the solution is not to punish students with mental health problems. Rather, a broader understanding of mental health among students and faculty would contribute to a more sympathetic and less punitive environment for such students in school. This emphasis on providing sympathetic and supportive contexts for young people was more characteristic of Upper Midwestern states whose character education programs we studied (Smagorinsky & Taxel, 2005). Damasio (1994) argued that brain and body are integrally related not just to one another but to the environment. A change in the environment, he found, may contribute to changes in how a person processes new information (cf. Luria, 1979; Pert, 1997); that is, in response to developments in the surroundings, the brain will encode perceptions in new kinds of ways.

Conceivably, then, changes in school climate can contribute to the emotional well-being of students whose mental makeup falls outside the normal range. The therapy for such students is still widely debated. Although medication and counseling have benefited many with extranormative makeups in their relationships with others, the medical approach assumes that a normative mental state is best for all. This criticism frequently comes up in debates about whether medications for attention deficit disorder are prescribed too often for any students who have difficulty focusing in school. Some argue that prescribing such medications is designed more to increase the comfort levels of those around such students than to help those students themselves. At the same time, many parents and students testify to the beneficial effects of a medication that enables a normal range of attention and thus a more satisfying and less frustrating ability to perform on academic and domestic tasks.

Even as I can attest to the beneficial role of medication in assisting

people with extranormative makeups to engage fruitfully with their surroundings, the jury is still out concerning the question of whether people with such diagnoses are sick and in need of medication. Cook (2004) argued that relying simply on medication and counseling is inadequate. Rather, she argued that a broader environmental change that enables an understanding and tolerance of difference and gives young people tools for managing their difference is essential to helping young people construct positive lives for themselves and in turn contribute to a more humane society. Taking a punitive approach to difference, she argued, is regressive and only makes life more fragile for those characterized as different, and more emotionally and cognitively unhealthy for those who surround them. Such an approach is easier said than done, as I can attest from years of personal frustration in trying to understand what was best for our family during episodes of turmoil and challenge, all the while learning to overcome my own socialization to a worldview in which I considered claims of being disordered to be excuses for not getting the job done.

IMPLICATIONS FOR AN INCLUSIVE APPROACH TO EDUCATION

In this article, I have tried to speak from the perspective of a person diagnosed with a mental illness. I do not claim to speak generally for others, and as I have reviewed in my exploration of this topic, there are mentally ill people who are in desperate need of intervention in the form of medication and therapy. The source of their difference may vary from their mother's substance abuse during gestation to hereditary conditions to childhood trauma, and on to many other factors that are no doubt well beyond my experience or knowledge. They might have come from loving and caring families, or from the most brutal of homes or other relationships.

Lee's (2008) views on human adaptation appear to be highly relevant to discussions of providing appropriate settings for those of neuroatypical makeups. She concluded that adaptation is a feature of human life that enables people to evolve their psychological makeup to account for changes in their environments. Lee argued that the notion of adaptation is relevant to considerations of multicultural education broadly speaking (personal communication, October 24, 2009). Standing outside the norm, she found, requires additional forms of adaptation, thus making performances in schools and other mainstream settings especially challenging for the atypical. Understanding the degrees and layers of adaptation required for any cultural group in any setting is central to providing an empathic and supportive environment—and constructing the atypical

as disordered, dysfunctional, and deficient leaves them with few foundations on which to mount their adaptations.

I hope to persuade my readers that mental health is a multicultural and diversity issue. If culture consists of those historically grounded practices and the specific tools through which people enact them to achieve historically established ends (Cole, 1996), then those with extranormative neurological makeups both construct and act within unique cultures that fall outside the current emphasis on race, class, gender, sexual orientation, language, and disability. In our household, we accommodated our daughter by changing how we acted, what we expected of her, how we viewed young people, where we saw her heading, and much else. The mediational tools and social practices and the ends toward which we put them changed the culture of our household, even as we sought, to little avail, to normalize her behavior in advance of the solutions we sought through counseling, medication, and programmatic intervention.

When she enrolled in a program for high-functioning young adults with Asperger's syndrome, the culture of acceptance led her and others to regard their unique neurological makeups as assets, in addition to seeing them as problematic if they hoped to live independently and in peace with their surroundings. Surely these views of social futures and the means by which they are constructed comprise an idioculture—a culture-within-a-culture (see Fine, 1987)—that produces particular ways of viewing and acting in the world. These idiocultures, however, are viewed as odd and ill suited for mainstream performances by too many people in the culture at large. If multicultural and diversity education are designed to provide more inclusive environments for the broadest range of citizens imaginable, then attention to neuroatypicality merits attention within the scope of its purview.

My views of mental health thus concern a range of issues. Biologically, many of us have neurological makeups that produce particular ways of acting in the world. And yet one's neurological wiring only takes on meaning in social settings, and social relationships can help to produce neurological wiring. Consider, for instance, the case of infants who are malnourished or subjected to their mother's ingestion of drugs or alcohol in utero. Consider as well the consequences of an infant's having little human physical or emotional contact and thus being susceptible to reactive attachment disorder. Consider further Vygotsky's (1993) notion of the secondary disability that follows from the ways in which the quality of response in a social setting may produce a greater disability than the neurological condition that sets one apart to begin with. Finally, consider the degree to which a person can become classified or not, given the egregious errors committed in the past within the psychiatric community,

such as the consideration of homosexuality as a mental illness, and the likelihood that the extraordinary range of human biological and cultural ways of being in the world constitute too broad a spectrum to easily determine who is mentally healthy and who is mentally ill.

Inclusive education thus requires an acceptance of a wide spectrum of ways of being. For those whose behavior is dangerous, an inclusive approach would begin with understanding and the construction of appropriate settings, treatments, and support toward a more satisfying social future, even when the prospects for independent living toward that future appear dim. For those who appear odd or abnormal to others, an educational setting designed to allow for a broader consideration of acceptable ways of being would fit within the scope of multicultural and diversity education, with an emphasis on inclusion and respect. If fewer people are considered to be, and treated as, abnormal, deficient, and disordered, education will come closer to realizing its goals for an enlightened society. This understanding can be manifested both in terms of how the broad class of normal people views others, in light of the opportunities availed to neuroatypicals by means of their acceptance by others and with respect to the broadened range of learning opportunities available to them in school. This approach could contribute to a widened vision of what and who are considered and treated as normal, and accommodate a greater range of people in their quest to find fulfillment in their education and their lives.

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Notes

1. See, for example, Christenbury (2007), Rose (2005), and Villanueva (1993) for scholars whose autoethnographic narratives have won the National Council of Teachers of English David H. Russell Award for Distinguished Research in the Teaching of English.

2. I use the term *extranormal* and its derivatives rather than *nonnormal* because terms such as *nonnormal* assume the normativity of normality. I see *extranormal* as a more inclusive term that suggests additional possibilities from having a mental health profile outside the typical range.

3. I use the term *neuroatypical* to contrast with *neurotypical*, the term that those with Asperger's syndrome use for those considered within the normal mental health range (see, e.g., Smagorinsky, Cameron, & O'Donnell-Allen, 2007).

4. Paroxetine-based medications are also prescribed for people experiencing problems with depression, obsessive-compulsive disorder, posttraumatic stress disorder, panic disorder, generalized anxiety disorder, and premenstrual dysphoric disorder.

5. The inclusion of all personal stories related in this article has been approved by the families of those involved or by the individuals themselves.

6. Not everyone agrees that psychotherapeutic medications provide the healthiest or most effective vehicles for assisting neuroatypical people to engage satisfactorily with their environments (see Bentall & Morrison, 2002).

7. Scanlation (also scanslation) is the unauthorized scanning, translation, editing, and distribution of comics from a foreign language into the language of the distributors. The term is most often used for Japanese (manga), but also for Korean (manhwa) and Chinese (manhua), graphic narratives. Scanlations are generally distributed for free via the Internet by direct download, BitTorrent, or IRC. The word *scanlation* is a portmanteau of *scan* and *translation* (adapted from <http://en.wikipedia.org/wiki/Scanlation>).

8. Reactive Attachment Disorder follows from a failure to form normal attachments to primary caregivers in early childhood, possibly due to severe early experiences of neglect, abuse, abrupt separation from caregivers in the first three years of life, frequent change of caregivers, or a lack of responsiveness to the child's efforts to communicate. Those with RAD exhibit disturbed and developmentally inappropriate ways of relating socially in most contexts.

9. This diagnosis, we concluded, was incompetent for a number of reasons: Single-iteration inkblot interpretations are not sufficient for a recommendation for hospitalization; the psychologist placed too much emphasis on the content of the response when the test is designed to foreground other aspects of interpretation; the psychologist himself had an odd affect that we felt could not be overlooked in how a young person might engage with his instructions; and our daughter's precocious vocabulary was not factored into his diagnosis of her articulation of how she interpreted the images.

10. Although homosexuality is no longer officially considered to be a mental illness, gender identity disorder is. This condition obtains when a person's birth sex is not the sex he or she identifies as. Gender dysphoria refers to the troubled feelings that may follow from this condition and how it leads one to stand in relation to others. Gender dysphoria can be experienced by those whose lives are characterized by transsexuality, transgender identity, and transvestism because of problems that may follow from how that orientation is perceived and responded to by others. As Immordino-Yang and Damasio (2007) have found, affect and cognition are strongly and organically connected, suggesting that gender dysphoria may complicate how those affected learn in and out of school.

11. This law is extensively explained at <http://www.nd.edu/~rbarger/www7/pl94-142.html>. Briefly, as this site explains, "This law provided that handicapped children and adults ages 3-21 be educated in the 'least restrictive environment' to the maximum extent appropriate, meaning that they are educated with children who are not handicapped and that special classes, separate schools or other removal of children from their regular educational environment occurs only when the severity of the handicap is such that education in regular classes cannot be achieved."

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