Normalization, Social Integration, and Community Services

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Contents

Part III
CONCLUSION

chapter 1

A BRIEF OVERVIEW OF THE PRINCIPLE OF NORMALIZATION

Wolf Wolfensberger

Until about 1969, the term "normalization" had never been heard by most workers in human service areas. Today, it is a captivating though chameleon-like watch-word.

For all practical purposes, the concept of normalization owes its first promulgation to Bank-Mikkelsen, head of the Danish Mental Retardation Service, who phrased it in terms of his own field, as follows: "letting the mentally retarded obtain an existence as close to the normal as possible." He was instrumental in having this principle written into the 1959 Danish law governing services to the mentally retarded. Interestingly, the first systematic written statement of normalization occurred in the English literature, and was authored by the then executive director of the Swedish Association for Retarded Children (Nirje, 1969). In order to have a systematic statement in Danish and Swedish, it had to be retranslated back from English (Grunewald, 1971a, 1971b). The most extensive elaboration of the principle was published as a text in 1972 (Wolfensberger, 1972) which tried to North Americanize, sociologize, and universalize the Scandinavian formulations, so that they would be applicable to all human services, and be consistent with the social science developments of recent years.

In its North American form, the principle of normalization can be viewed as a meta-theory, or meta-system, in that it is a simple and parsimonious statement, and yet it has many corollaries that affect not only the most clinical and direct services, but also the structural and systemic aspects of service systems. It is applicable to any type of human service

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work or profession, to any type of agency, and to any type of client, but it is most powerful when applied to services to societally devalued people. It subsumes a relatively large number of other human service subsystems, sub-theories, practices and so on, and puts them into cohesion with each other; and it elevates to consciousness many kinds of practices (both good and bad) that service providers and others engage in. Indeed, one of its major benefits is in the area of consciousness-raising, and I will devote a good part of this presentation to how this may take place.

The above applies to the 1972 textbook definition, but there is actually no universal agreement on the definition in the field, and it is almost unbelievable what all is passed off under the banner of normalization. In my work, I use three definitions, all intended to say the same thing, but at different levels of "scientificness," depending on the audience:

1. The use of culturally valued means, in order to enable people to live culturally valued lives.
2. Use of culturally normative means to offer persons life conditions at least as good as that of average citizens, and to as much as possible enhance or support their behavior, appearances, experiences, status and reputation.
3. Utilization of means which are as culturally normative as possible, in order to establish, enable or support behaviors, appearances, experiences and interpretations which are as culturally normative as possible.

The principle of normalization relies very heavily on a number of well-established concepts and theories. One of these is the concept of role circularity. Such circularity can be either positive or negative, depending on the initial expectation or perception that has been imposed on a person by the environment. If the role definition imposed on a person is a negative one, one can speak of that person being devalued, or "deviant," but I want to strongly emphasize that the definition of deviancy that I use is not necessarily that used by others, and different definitions have totally different implications.

In the definition I use, a person becomes deviant by a) being different from others, in b) one or more dimensions of identity, which c) are viewed as significant by others, and d) this differentness must be negatively valued. It is not differentness itself that makes for deviancy in this definition, but *negatively valued differentness.*

If one looks at some of the dimensions that may be viewed as significant and negative by observers, one finds many familiar phenomena that can be arbitrarily classified in any number of ways. My classification is contained in Table 1. The first such category is physical characteristics

Table 1. Sources of a person's deviancy and stigmata

Sources	Examples
1. Physical characteristics, viewed mostly as non-responsible	
A. Primarily inherent:	
Physical features	Height
Congenital handicaps	Albinism
Age	Old age
B. Primarily acquired:	
Physical features	Institutional shuffle
Secondary handicaps	Amputation
2. Behavior, viewed mostly as responsible	
A. Overt:	
Acts	Crime, addictions
Attire	Out-dated fashions
Social associations	Counter-culture membership
Physical associations	Residence, possessions
B. Covert:	
Beliefs	Delusions
Ideas	Atheism
3. Descent, nationality, attribution, viewed as non-responsible	Caste

which may result in a person being devalued. Then there are various types of overt and covert behaviors. It is interesting that sometimes, a covert behavior such as a belief or idea does not define a person as deviant until the person opens their mouth and talks about it. Most interesting of all, to me at least, is the third category, namely, that the person can be placed in a deviant role merely by attribution. He/she may be and look and do like everybody else, but he/she "is one" because maybe their father "was one." A good example of this is the caste system in India. You can look like anyone else, do what anyone else does, believe what anyone else believes, and so on, but still be devalued because your father, your mother, or your lineage in general was untouchable.

In most societies, and across the span of history, devalued people tend to be thrown into a relatively small number of relatively cohesive role images. These role images are those of the subhuman individual, the object of dread or menace, the object of ridicule or pity, the holy innocent, the burden of charity, the eternal child, or the sick person. These role perceptions tend to be highly correlated with various systematic human service approaches (Table 2). For example, if a person is viewed as subhuman, he/she could be viewed as an animal, vegetable or an object; then the service model tends to be one of neglect, custody, or even destruction, and the staff model becomes one of catcher, attendant, care-

Table 2. Socio-historical deviancy role perceptions and resultant service and staffing models

Role perception	Service model	Staff model
Subhuman: Animal, Vegetable, Insensate object	Neglect, custody, destruction	Catcher, attendant, caretaker, keeper, gardener, exterminator
Menace, or object of dread	Punitive or detentive segregation, or destruction	Guard, attendant, exterminator
Object of ridicule	Exhibition	Entertainer
Object of pity	Protection from demands	Member of religious bodies, charitable individual
Burden of charity	Industrial habilitation	Trainer, disciplinarian, work master
Holy innocent	Protection from evil	Member of religious bodies, charitable individual
Eternal child	Nurturant shelter	Parent
Sick person	Medical	Physician, nurse, therapist

taker, gardener, or even exterminator. The fact that the staff are called psychiatrists, social workers, counselors, nurses, or whatever is irrelevant. The real function may be that of exterminator, even though we do not have agency job descriptions of "Exterminator II, Grade 5," for example. Similarly, if a person is viewed as an object of dread or menace, the service model tends to assume destructive characteristics and the staff may become guards, regardless of what they are called. I just read a few days ago where at the Central Islip psychiatric institution, the professional staff actually wore military uniforms up into the 1930s and were greeted with military salutes. (This explains why some lower professional "ranks" in some institutions are called "civilians" to this very day, although no one is aware of the reasons.) Thus, they were in essence soldiers who were hired to be staff. But usually such realities are not seen this clearly because, as I said, the job descriptions do not reveal it, and the service model often disguises it.

We do not have much contact with the object of ridicule role nowadays, but at one time it was a very powerful model. You remember the Bedlam Hospital in London where people came every Sunday and looked at the inmates; the staff would poke the inmates until they would scream so that the visitors would get their money's worth. There was a little bit of this in the film *Charlie,* where the main character played some of the functions of the historic "village idiot."

In contrast, the object of pity and charity interpretation is extremely common today. It even controls entire human service systems. Fund raising appeals with a poster child are really based on a pity/charity interpretation of a handicapped person, as is, to some degree, the whole United Way culture.

When an individual is perceived as an object of pity or charity, people may be asked to give their worthless stuff to the handicapped. Shoes that cannot be worn anymore are given to a poor starving man in the soup kitchen or on the street. Clothes that are thirty years old and out of fashion will be generously donated to be worn by a retarded person. There may be sales of low-utility items that people ordinarily would not buy unless it were out of pity. Pleas for fund raising are usually accompanied by such tear-dripping terms as "worthy cause," "poor unfortunate victim," and so on.

Another very major role interpretation, particularly devaluing when applied to adults, is that of being younger than one's age. Referring to adults as "kids," "boys" and "girls," and even the use, and possibly diminution, of the first name (e.g., Bill becomes Billy) can image an adult as a child. There is even very subtle age-degradation in teaching or engaging people in forms of recreation that are culturally viewed as appropriate for people of a younger age.

The eternal child is particularly prevalent in work with retarded people and, more recently, with elderly people, although they are less viewed as eternal children than as "again children." In nursing homes, they are sometimes called "boys" and "girls" and things like that, engaged in child-like activities, sometimes even given children's toys and dolls.

The first conference of (rather than for) mentally retarded people in the world that we know of took place in the late 1960s in Sweden. To everyone's surprise, the conference participants came up with a list of demands, one of which was that they did not want to go to summer camps. Most summer camps for handicapped people are child-like, and have few culturally valued analogues for ordinary citizens. Handicapped adults are also often said to prefer to associate with children, presumably because they have more in common with them, and so on. The poster child is also relevant here, and can sometimes be outright ridiculous or even dishonest. We recently found the extreme absurdity of a poster child raising money for arthritis. The image of arthritis is not that of a child, and in fact there is only a small proportion of children with arthritis, yet here are people trying to cash in on other people feeling sorry for handicapped children by putting a child's image on an arthritis fund raising appeal. A fund raising circular of the Epilepsy Foundation of America says "there is hope for these children," even though more adults have epilepsy than children.

Of course, today the medical model is extremely powerful. Under this model, the devalued person, or person with a devalued condition, is cast as ill, sick, diseased, becomes a "patient" who is "diagnosed" and gets a "prescription" for "treatment" with some "therapy" administered in "doses" in "clinics," "hospitals," and "treatment rooms" by personnel who are, or are called "doctors," "nurses," "aides," "therapists," who open "charts" on him/her, "staff" him/her, the outcome being "prognosticated," "cure" being the hope, and "chronicity" resulting in despair and withdrawal on the part of the medical service culture.

Readers are invited to review their own agencies, and their own personal language usage and practices, for the presence of any of these "diagnostic signs" of the presence of the sick role of social deviancy. The medical model, though ubiquitous, is terribly obvious. However, it becomes outright funny when it comes to "prescriptive teaching," and children who are described as unable to read are then given "educational therapy," not in lessons but in "doses" such as "six hours of educational therapy," because they "have" dyslexia (which obviously must be contagious because more and more children are getting it). The teacher then becomes an "educational therapist," and hopefully the child's problem will become cured and not become chronic. It used to be that we become old, but we no longer become old, we now become "geriatric." When you look at the literature, it is becoming alarming. Just this morning I ran across a new book which was entitled *Clinical Psycho-Gerontology*. Being old has definitely become a disease and is equated with being ill. The whole culture is orienting itself to this reinterpretation, and this disease now requires segregated, congregated, quasi-medical settings. I am also intrigued that lately, more and more sex education is being taught under health curricula in the schools and by nurses, and I wonder what the unconscious message of that is.

Now if we go a bit into the history of societal reaction to devalued people, we can probably categorize all societal responses into four categories (Table 3). Societies, or individual people, have always wanted to destroy deviant individuals, be it by capital punishment, euthanasia, abortion, genocide, and slaughter. The second broad category is to protect non-deviant people from deviant people. That is what society, and we as service providers, do much of the time. The third category is a reversal of the second in that the society, or majority culture, is seen as evil, and a particular group of people is seen as needing protection from the evilness of its major culture. For instance, some people have labeled retarded people as holy innocents who must be taken out of the evil culture and put into sheltered havens. So we may see services of this nature where the innocent, the harmless, the defenseless can be protected

Table 3. Four characteristic historical categories of societal response to people judged deviant

Categories	Examples
Destroy deviancy	Capital punishment, abortion, euthanasia, genocide
Protect non-deviant from deviant people	
Rejection	Architectural barriers
Repression	De-individualization
Restriction	Driver's license
Segregation	Institutions
Confinement	"Intermediate care"
Punishment	Revenge, brutalization
Ejection	Ship of fools
Protect deviant people from non-deviant people	
Segregation	Havens
Reverse deviancy	
Restoration	Prosthetic supports
Rehabilitation	Education
Reintegration	Adaptive dispersal

from the evils of the larger world. The first institutions in the 1870s and 1890s were not erected because the retarded were seen as a social menace, but in order to give them asylum from the public. In only twenty or thirty years after that, the approach reversed, and the retarded became reinterpreted as a menace, and society as needing protection from them. Finally there is the reversal of deviancy by restoration, rehabilitation, and reintegration, and that is also what a great deal of human service work tries to do. This is what normalization is about in essence.

Since deviancy is socially, subjectively, and variably defined, and varies from culture to culture and time to time, it is relative. *It is not within the person;* it is within the imposed social roles, the values, and the perceiver's interpretation. Therefore, deviancy can be reduced or eliminated either by a) changing the perceptions or values of the perceiver, or b) minimizing the differentness or stigma of deviancy that activates the perceiver's devaluation. These are two equally valid and important approaches. Sometimes, people tend to emphasize one over the other, and much of our clinical work or training focuses on parts of the second aspect, while the work of changing societal perceptions and values which actually perpetuate the need for the direct clinical services is neglected. Many of the problems of handicapped and elderly people are really not primarily and initially personal, clinical shortcomings; they often become that only as a result of rejection, isolation, separation,

congregation, destructive role expectancy, and so on. Then, indeed, elderly people do become senile, disoriented, and so on, even though these characteristics need not invariably be intrinsic signs of aging as our culture and the bulk of the professionals make them out to be.

The definition of normalization that I want to elaborate here is the second one. One of its components is "the use of culturally normative means," which refers to familiar or valued techniques, tools, and methods. Why are culturally valued tools important even if they have nothing to do with the outcome? Because if a culturally devalued or alien method is used in human service, its image of oddity and devaluation transfers to the person or group served—perhaps even to the server. If we were only concerned with outcomes, we could use cattle prods and electric shock and get powerful behavioral results—but the person to whom the cattle prod is applied will tend to be seen as an animal. We simply have to take into account that the imagery of the service means and methods will transfer to the person. There are many problems with this reality in human services, particularly in the area of mental health. I believe that much of the current public alienation from that field comes not from the menace image of mentally disordered people, but from the public's rejection of the mental health system, because the public is not able to understand and/or relate to its means, methods and tools (Wolfensberger, 1975). So there is very little popular support. At any rate, normalization places as much emphasis on methods as on outcomes.

Secondly, the means are to be used in order to enable a person to enjoy life conditions (such as housing, clothing, education, health, and so on) that are at least as good as the average citizen's. The question is why at *least* as good. This implication derives from the "conservatism corollary" of the normalization principle, which says first of all that many or most people are deviant in some way, but usually in few or minor ways so that they are not placed into deviant roles and are not really hindered in their functioning. But as deviancies and stigmata increase in number, severity, or variety, they tend to have a multiplicative rather than additive image impact upon observers. To borrow from the mathematical expression of the factorial, if there is one stigma or one deviancy, this might be expressed as 1!, or 1×1. Now suppose there are two stigmata or deviancies, then the expression might approximate something like 2!, or $2 \times 1 = 2$, which is a 100% increase in the deviancy impact. But if the number of deviancies or stigmata goes to three, it becomes 3!, or $3 \times 2 \times 1 = 6$, so the impact jumps from two to six, or 300%. Of course, that dynamic is not mathematically exact, but something like this seems to happen.

Let us suppose that a man is mentally retarded, has a speech impediment, needs glasses, and has an odd hairdo. The impact of all this is

beginning to add up. And suppose further that the person limps and also wears shabby clothing. At that point, as he walks by on the street, even though you may have never seen him in your life before, you know there is something very wrong with this person. The person gets stereotyped on sight, and relatively correctly so.

This whole process is true not only for the number of stigmata within a person, but also for the number of stigmatized persons within a group. If six individuals were walking downtown alone, it would not make any difference if one of those persons limped, one had an odd hair-do, another had odd clothing, etc. People with one or another of these oddities are seen on the street all the time. But when there are three, four, or more oddities in a group of five, six, or ten people, the *whole group* becomes stereotyped. This impact has happened to me several times. When I saw such groups walking or driving by, it took me literally less than one second or one glance out of the corner of one eye to say, oh, they must be from some group home, some institution, or something like that. Other people, including the public, may not be so conscious of the impact and the response, but the perceptual reality is the same. Therefore, the conservatism corollary of normalization says: the more the number, severity, and/or variety of deviancies or stigmata, or the more the number of deviant persons in a group, the more impactful becomes the reduction of one or a few of the stigmata in the group, or of the number of deviant people in the group, or of the stigmata or deviancies at least being balanced off by positively valued manifestations.

For example, there is nothing wrong with an ordinary citizen working in a cemetery or funeral parlor, but it is image-jeopardizing for a person who is elderly or mentally retarded. When you go to a nursing home for elderly people and the whole nursing home is decorated with funeral flowers, that is not very good. It would not do you any harm to have such flowers in your home, or in a funeral parlor, or in the church; but in a nursing home where people are already death-imaged it can be devastating. Similarly, work relating to animals, such as running a pet shop, is a perfectly honorable occupation for valued people. But it does not do retarded people any good to have the image of being animal-like, of being able to "talk to" animals, of "working well" with animals out on the farm, and so on. Handicapped people making things for other handicapped people, such as repairing wheelchairs and manufacturing prostheses, reinforces the public's already negative expectations: "Isn't it wonderful what they do *for each other,* their own kind." It is good work, clinical outcome-wise, but it is image-jeopardizing work. Similarly, it can be risky for handicapped or retarded or elderly people to make children's toys, and thus be associated with child imagery. For any number of handicapped people, it can be very dangerous to engage in activities his-

torically associated with particular handicaps, or with sheltered workshops, or with institutions. For example, it is a devastating perpetuation of a stereotype when blind people work on caning chairs and making brooms. I am amazed at how much clown imagery is found in human service settings for devalued people. I am becoming more and more conscious of it, and now I find clown images practically in every other human service for devalued people that I visit. At first I did not look for it; now I do and now I see it. Now what is it that is being said when I walk into a psychiatric unit and the biggest thing that hits me in the face is a clown portrait about five feet high hanging on the wall? Many types of woodwork have historic images of sheltered workshops and institutions; so does salvage work, of course. Then there is upholstery, shoe and mattress repair—the classics of institutional work. Finally, of course, fake work may be all right for competent railroad workers and printers; it is not all right for the image of people already devalued for their supposed incompetence.

The implication of it all is that with a choice from among a continuum of options around the cultural value mean, the more positive (or "conservative") option is the most adaptive in normalizing a stigmatized person or group. With a devalued person, it is often more adaptive to reinforce, or suggest, the more conservative response or option. Now that is a powerful, subtle, and generally nonaccepted corollary of the normalization principle.

Finally, our definition says "to as much as possible support the person's behavior, skills, competencies, experiences and appearances." Appearances refers to socially interpretive images, grooming, and status and reputation.

The many fine points that in a short hour I unfortunately cannot cover include some cautions and caveats. For example, normalization does not necessarily mean doing what every one else does. It may not necessarily mean that a normalization implication is moral or immoral. There may be some things that may be culturally normative and valued that may not be considered moral by a lot of people. Normalization does not mean being like everybody else, because you can be or do something which, even though it is not viewed by everyone as common, may still be viewed by most people as culturally acceptable. Even such things as the old-fashioned virtues may not be widely practiced any longer but, if you found them practiced, no one would find them bizarre or even offensive. They would be somewhat still within the range of what our culture would expect or value.

An important aspect of the normalization principle is the distinction between implications in the realm of interactions with people (what people do to, with, and for others in direct service involvement, teaching,

Table 4. A schema of the expression of the normalization principle on three levels of two dimensions of action

Levels of action	Dimensions of action	
	Interaction	Interpretation
Person	Eliciting, shaping, and maintaining socially valued skills and habits in persons by means of direct physical and social interaction with them	Presenting, managing, addressing, labeling, and interpreting individual persons in a manner emphasizing their similarities to rather than differences from others
Primary and intermediate social systems	Eliciting, shaping, and maintaining socially valued skills and habits in persons by working indirectly through their primary and intermediate social systems, such as family, classroom, school, work setting, service agency and neighborhood	Shaping, presenting, and interpreting intermediate social systems surrounding a person or consisting of target persons so that these systems as well as the persons in them are perceived in a valued fashion
Societal systems	Eliciting, shaping, and maintaining socially valued behavior in persons by appropriate shaping of large societal social systems, and structures such as entire school systems, laws, and government	Shaping cultural values, attitudes, and stereotypes so as to elicit maximal feasible acceptance of cultural differences

counseling, healing, personal social contact, life sharing, living with and so on), vs. the interpretations of people or groups (what people think and feel, tones of address, tones of voice, images, meaning, expectancies and attitudes). I submit to you that the structure of societal services, including its clinical interactions, will be derived from the images society has of the people served. What will be done in the area of interactive work fifty to a hundred years from now will be determined fundamentally by what is done today in the realm of interpretations. Therefore, we really should take a hard look at our priorities and emphases, our money, our services; we quite often trade off the positive interpretations of devalued persons for the sake of quick and "easy" clinical services and presumed benefits.

The normalization principle must also be looked at in terms of its implications at three levels of social organization (see Table 4). At the level of the person, the clinical direct one-to-one level, we do, among others, what I just listed: teaching, healing, loving, etc. We must also

Table 5. The two integrations and their sub-components

- Physical Integration
  - Proximity of service to population
    - Local proximity
    - Regional proximity
  - Access of service to clients, workers, public
  - Physical context of site
    - Physical resources accessible for potential integration
    - Program–neighborhood harmony
  - Congregation, and assimilation potential
- Social Integration
  - Socially integrative interpretations
    - Program and facility labels
    - Building perception
      - Function congruity image
      - Building–neighborhood harmony
  - Deviancy image juxtaposition
  - Deviancy program juxtaposition
  - Socially integrative program structures
    - Deviant persons juxtaposition
      - Staff deviancy juxtaposition
      - Client and other deviancy juxtaposition
    - Socially integrative social activities

work via and on the primary and intermediate social systems: the structure of a sheltered workshop, its hours, its manpower model and so on. These are all either of an interactive or of an interpretive nature. The third level is the societal level: normalizing societal structures and positive cultural attitudes and values. And so we have six boxes in the table, and sometimes when we have more time, we spend as much as a day reviewing the implications of just one box. Most of the current clinical services are in the realm of skills and habits of individuals (the first box).

One of the major implications particularly in the interpretation dimension on the systemic level is the whole issue of societal integration of devalued people. Integration has at least 14 components, as shown in Table 5. It thus is not as simple as some people assume. A lot of people over-simplify when they equate mainstreaming with integration. For one, we strongly differentiate between physical and social integration. Physical integration consists of at least four major sub-dimensions, which subdivide in turn, and which are physical facilitators (favorable preconditions) to social integration. We can have social integration even though some of these are lacking, but when you think that thousands of services over scores of years have not had and do not have many of these preconditions, you can see where the likelihood of social integration actually taking place is greatly reduced. You can see where the proximity of

Table 6. Some of the less obvious implications of the normalization principle

1. Enhancing the cultural stereotype of a deviant group is often more important than even sizable short-term or local clinical benefits.
2. Elimination of negative deviancy image juxtaposition, and enhancing the "representation" of persons is often as important as normalizing their behavior; e.g., choosing workshop task on basis of image rather than income.
3. Use of "conservative" (more valued) alternatives from a range of normative options.
4. Avoidance of deviant person juxtapositions: staff-client, client-client, client-public.
5. Age separation, and age-appropriate structures.
6. Dispersal instead of congregation of deviant persons.
7. Physical placement of services into culture-typical contexts.
8. Dignity of risk.
9. De-emphasis of staff-client distinctions.
10. Separation of the domiciliary function.

a service for devalued people to the general population of the service area can be important, as can proximity and access to potentially socially integrative resources such as stores, schools, recreational facilities, and so on. Then there is the size of the client groups: when you have 14,000 people congregated in one spot (remember Milledgeville, Ga.), it is almost impossible to socially integrate. It may happen that you have 200 devalued people in one city block in New York City, and no one thinks anything of it. In a typical family residential neighborhood, once you have a house with eight devalued people in it, you had better go six blocks away before you set up the second group home. We have slides of services on streets where almost every single house is a group home of a different agency (each for devalued people), and almost all remaining houses are cat houses or funeral parlors.

Some implications of the principle of normalization are unexpected and controversial. Because of the shortness of time, I will address some of the less obvious normalization implications listed in Table 6. I have mentioned the instances of stereotypes sometimes being more important than the clinical service itself, as well as the conservatism corollary. Another controversial issue is the relentless juxtaposition of deviant persons to each other, which may include the common tendency of devalued staff working with devalued clients. I am told that we have institutions in New York State where twenty physicians out of twenty work there because they might not be able to work anywhere else. Consequently, that projects a very bad image upon the clients whom they serve.

Many types of age separations are important. In some instances, it is damaging for people of different ages to be served together. For example, it is not very good to have handicapped children in a nursing home

for elderly people, as it does not enhance the image of either group. Neither does it help to have a special education program for handicapped teenagers of secondary school age in a school building where otherwise only primary school-age, non-handicapped children are being served. That interprets the handicapped teenager as being like the younger children. For the most part, these images/messages are unconscious both in the minds of the sender and the receiver, but that only makes them that much stronger and more dangerous.

Dispersal is one of the cornerstones of integration: never congregate more devalued people together in one spot than the surrounding social systems can absorb! There is no point in arguing with the surrounding social systems that they must absorb X number of devalued and stigmatized people. If they cannot, or will not, then it behooves us to give attention to dispersal of devalued people into smaller groups, to enhance their social acceptability and assimilation.

One very subtle normalization implication is de-emphasis of staff/client distinction while enhancing the status of the clients. Staff should work with devalued people by using culturally familiar and valued roles.

Separation of the domiciliary function means that most people live in one place, go to school in another place, go to work in another place, go to church in another place, and go on vacations in many other places. Services to devalued people typically put several or even all these functions into one residential facility. Hence, the image of the total institution, which includes the domicile, the church, the school, the hospital, recreation, even your cemetery all "conveniently" situated on one campus. It is important that services to devalued people structure the same culturally normative separation of functions as prevails in equivalent valued analogues for valued citizens, so that each function takes place in the same type of analogous cultural setting as it normally would.

For our remaining time, I will talk about imagery and interpretation. To start off with, negative imagery (see left column of Table 7) is infinitely more likely to be attached and projected upon devalued people than positive imagery (right column). For example, elderly people in our society are relentlessly imaged as being ill, dying, incapable, impaired, weak, even evil, etc., because in our society, we value health and vitality. We have very few positive images of elderly people. The other day, for the first time ever, I saw an advertisement in a department store which showed a dignified old man. Up until that time I never consciously realized that in most advertising, the models used are either children or young adults. One practically never sees the image of an elderly person, thus the unconscious message is that being old does not sell anything. Even clothing for middle-aged people is being advertised and sold by

Table 7. Deviancy image juxtaposition: culturally prevalent images and their polarities

	(−)	(+)
Virtue	Sin/diabolicness/evil	Virtue/angelicness/divinity
	Irresponsibility	Responsibility
	Criminality/corruption	Lawfulness/morality
	Pity/charity	Respect/entitlement
Beauty	Ugliness/disorder	Beauty/order
	Darkness/blackness	Light/white
Life	Illness/death	Health/vitality
	Incapacity/impairment/weakness	Strength/power
	Oldness	Youth
	Decay	Growth
	Subhumanity	Humanity
Quality	Bottom/down	Top/up
	Left	Right
	Worthlessness/discard	Value

showing young adults wearing it. We value beauty, not ugliness, subhumanity, animality, sin, corruption, and on and on. There are deep cultural archetypes about blackness and darkness vs. whiteness and lightness. Even in the scriptures, there is the constant image of "children of darkness" and "children of light," "out of the darkness and into the light," etc. Darkness and blackness is bad, lightness and whiteness is good, and so you find these and other imagery such as pity, charity, and irresponsibility, attached to devalued people.

There are many objects or activities which reflect these images, and which get attached to human services (Table 8). For example, the image of vice may be found among boarding houses, burlesque shows, massage parlors, movie houses, drive-ins, bars, and casinos. In a moment I will explain how many of these vice image entities get attached to many people. The images of menace, jails, shackles, restrictive windows, caution signs, decay, dirt, discard, garbage-collection boxes, etc. get attached to devalued people in at least four different ways (see Table 9).

One of these is by where the money for the services comes from, and another one is who runs or regulates the service. In Nebraska, the tobacco tax goes for the institutions. In Syracuse, there is a group home for boys that is funded by a law enforcement agency—which says something about the boys who live there. There used to be a federal funding category called "services for the totally and permanently disabled," and in Syracuse, there is a group home for blind people that used to be funded by that money. By being funded by this money, the image of "permanently and totally disabled" was thrust upon those blind people in that home. In New York, the Mental Health, Mental Retardation, and Alco-

Table 8. Objects and activities which often constitute negative image juxtapositions

1. Vice: bawdy house, burlesque show, massage parlor, adult movie house, drive-in, bar, casino, race track.
2. Menace: jail, shackles, restrictive windows, fence, caution sign, keys on belts.
3. Decay: filth, dirt, disorder, discards, garbage, collection box, dilapidated house.
4. Disease: prosthetics, handicap, clinic, hospital, nursing home, rest home.
5. Death: cemetery, mortuary, morgue, casket factory, "dead-end," "one-way," and "no exit" signs, exterminator.
6. Animality: most animals, zoos, animal names, cages.
7. Triviality: silliness, frivolity, toys, recreation facilities.
8. Grotesqueness: gargoyles, clowns, circus, carnival, mardi gras.
9. Want: poverty area, ghetto, slum, public housing.
10. Separateness, rejection: "do not enter" sign, railroad tracks, warehouse.
11. Hopelessness: calling a children's hospital after St. Jude; calling a handicapped child "Jude."

holism Boards serve retarded people; however, it does absolutely nothing for retarded people to be coordinated by mental health and alcoholism boards which, usually, also deal with drug problems. In fact, it does not do *any* of the other three groups any good to be juxtaposed to each other. The mental retardation services in New York are administered by Children's Services. An "Association for Retarded Children" in Syra-

Table 9. Sources of deviancy image juxtaposition

A. Deviancy-imaged program funds or funder
   1. Funds: liquor and tobacco tax
   2. Funder: law enforcement agency
   3. Fund label: rehabilitation for disabled
B. Deviancy-associated administration, coordination, regulation: MH, MR, drug and alcoholism board
C. Deviancy-associated service setting
   1. History: ex-prison
   2. Proximity: red-light district
   3. Association: kindergarten in a university special education building
   4. Facility features: barred windows
D. Deviancy symbol association with, or among
   1. Programs: handicapped logo on door
   2. Symbols: facility sign next to dead-end sign
   3. Persons: MR and aged
   4. Animals: MR and zoo
   5. Names and labels: Sunset Lodge
   6. Activities: OT weaving
   7. Objects: garbage
   8. Products: brooms, made by blind
   9. Processes, rules, regulations: prohibition of matches

cuse operates a sheltered workshop for handicapped adults—which does not do those adults any good. A retarded man who worked there quit calling the ARC to report when he was late for work or ill because he got mad when they answered the phone: "Retarded Children." What is the image of a mortuary owner operating a nursing home? Or of the amazing interlocking ownership of nursing homes and funeral parlors and similar services? There used to be a nursing home owner in greater Syracuse who operated a second-hand shop, and you have to wonder a little bit where all the second-hand stuff came from.

Neither is it image-enhancing to set up service facilities in former prisoner of war camps, or in former houses of ill repute. A very common phenomenon is that we inherit facilities that are in close proximity to devalued settings: a cemetery, crematorium and/or mortuary adjacent or across the street from an old age home—with a drug facility next door, etc. These kinds of image juxtapositions add additional harm and insult to already wounded and devalued people. We have a group home for women in Syracuse that is next door to a whore house. We have adolescents who are at risk with drugs—served across the street from a burlesque theater and next door to a bar which has the reputation of being a gay bar. It does not do those adolescents any good.

Another major area of deviancy image juxtaposition is the names of service facilities, such as calling a regional mental health center the Madden Zone Center, or an institution for the disordered mentally retarded the Batty State Hospital (there are two such in the United States), a high-rise for the elderly Toomey Abbot Towers (on top of a cemetery and next door to a cemetery), a nursing home for the aged called Freezers, a hospital for handicapped children called St. Jude's Hospital (St. Jude being the patron saint of hopeless causes), an alcoholism clinic called Bahr Treatment Center, and so on. I have thousands of such image-endangering service names in my collection, some gross, some subtle. Many of them are literally unbelievable. For instance, when you see what is being said about elderly people by the endless number of crazy, brutal, mocking, devaluing—and yet largely unconscious—facility names, it is unbelievable. Very rarely do we see the opposite of that, which the normalization principle would suggest, such as patriotic or vitalistic images; rarely does one see positive images conveyed through the use of facility names that carry status. In these, as in so many ways, we are selling out the valuation of handicapped people for a mess of pottage by reinforcing the imagery of dependency, menace, handicap, and ridicule.

For example, the names of a number of tests that are often administered to poor inner-city children are the WRIFT, WRIOT, WREST and WRAT. Another example is a fund-raising drive at Syracuse University for muscular dystrophy. Our students succeeded in raising $100,000—a

Table 10. Death image juxtapositions involving services for the elderly in the greater Syracuse area

Facilities built in/on cemeteries:
Toomey Abbot Towers; Vinett Towers; Syracuse University Gerontology Center
Services located adjacent or very close to cemeteries:
Jewish Home of Central NY; Hill Haven NH (Nursing Home); Westvale NH; Toomey Abbot Towers; Van Duyn (County Home); Melrae NH; Baldwinsville Sanitarium; Ross Towers; James Square; Wagon Wheel Senior Citizens Program
Services located in former funeral homes:
Hutchings Geriatric Day Care Center; Twin Elms NH
Services located adjacent to or very close to funeral homes:
Westvale NH; Stafford Manor; Twin Elms Hospital; Minoa NH; Phillips NH (defunct); Legal Services for Elderly (defunct); Metropolitan Commission on Aging
Services located close to county coroner:
Twin Elms
Services in former hospitals:
Castle Rest
Nursing home administrators who are embalmers:
Stonehedge NH;
Mortuary science students employed as orderlies in various nursing homes
Facilities located on "dead end" streets:
York State Manor; Loretto Geriatric Center
Facilities located on 2 "dead end" streets:
Bernadine Apts.
Facilities located adjacent (or nearly so) to garbage dumps:
Brighton Towers; Loretto Geriatric Center; Bernadine Apts.

national record—but this money was raised through the most bizarre things you have ever heard of: raffling off a naked Lady Godiva; raffling off an evening with a porno queen; raffling off an ounce of marijuana. I have compiled the death imagery juxtapositions of services for the elderly just in Syracuse alone (Table 10). At least three facilities are located on dead end streets; one is on *two* dead-ends, and no matter which way you go to visit your old mother or grandmother, it says "dead end" every time. The message transmitted about elderly people in Syracuse is *extremely powerful,* yet all the gerontology professionals and professors we have talked to have denied that this is so, or ridiculed it and us, and said that these things are "just a coincidence." When do coincidences become systematic?

It is interesting that while we deny the unconscious systemicness of such devaluations, artists, through their writings, poetry, song, graphics and cartoons, see and proclaim the truth over and over (slide being shown). In Syracuse, the proportion of elderly people that can see a cemetery from their window is very very high compared to non-elderly citi-

zens. If we went to an assembly of non-elderly adults in Syracuse and asked them if they could see a cemetery from their bedroom window, one might see one or two hands; but if we went to an assembly of elderly people and asked the same question, one would see hands go up all over the place. Aren't all these coincidences remarkable?

The principle of normalization is embodied in a tool, the Program Analysis of Service Systems (PASS) (Wolfensberger & Glenn, 1975) that permits one to assess the implementation of the principle in a particular service setting. This evaluation method can be applied to any kind of service to any kind of client (see Appendix A). Of the 50 dimensions assessed, for instance, one ("Function Congruity Image") asks whether the service setting looks like what it is. What it looks like will strongly influence how the people being served in the setting are and will be viewed (slide demonstration).

> This looks like a prison, and it is a prison, so it has high "function congruity image" even though it may not enhance the image of the people living there.
>
> Now this looks like a castle—and it is a castle, built by a millionaire in Toronto.
>
> Most of you would say that this looks like a school and you would expect to find children learning there—but it is really a group home for handicapped adults. It might not look devaluing, but it does look somewhat odd, particularly when one compares it with other homes for adults.
>
> This building looks like a library, and again it projects an image of oddity because—it is also a group home for handicapped adults.
>
> This obviously looks like a school; it used to be an elementary school, and walking in, you might expect to see many children—but what you find instead is a workshop for handicapped adults. Again, an image of oddity is beginning to accumulate which does not enhance the image of these handicapped adults.
>
> This looks like a warehouse. It happens to be a sheltered workshop, so the building is appropriate in terms of matching the function to the image.
>
> However, surprisingly, this church also houses a sheltered workshop. Usually, one does not go to churches to work unless one is a pastor or sexton; therefore, this is an odd image projection.
>
> This looks like an ordinary home—and it is. It is a group home, and it looks exactly as you would expect a home to look.
>
> This one, most people vote as being a professional or physician's office; that is what it used to be, but now it is used as a children's education center. This does not jeopardize the image of the handicapped children being served there—but neither does it enhance them. You might say that it is just on the edge of an oddity image projection.

This looks like a real estate or lawyer's office. It is a neighborhood office of a service agency; in this particular instance, the service setting is appropriate for its function.

Two other PASS ratings look at the age-appropriate and culture-appropriate appearance of clients, respectively. The question here is, does the person look appropriate for his/her age, and does the person look appropriate for the culture that he/she is a part of? (Slides)

Even though this child has Down's Syndrome, his appearance is enhanced by the proper clothing and the way he is groomed.

This is an enhancing image of an adult, because he looks like a serious working adult, even though he again has Down's Syndrome.

This gentlemen who looks like an agency director is 85 years old and mentally retarded. Contrast him to his roommate who looks sloppy with his mouth open and a shirt that does not fit too well and sloppy suspenders. He is the same age, and at the same level of retardation.

This young man is profoundly retarded, but does not look that impaired because he looks appropriate for his age.

This woman in her thirties looks like a teenager, and is not enhanced by age-degrading clothes and grooming.

These physically handicapped teenagers are just a little bit too old for the clothing they have on. The clothes are colorful and pretty, but have just too much of an infantile image. Perhaps if one of the teenagers dressed like that it would not draw too much attention, but when they *all* dress like that, then you get the image of age-reduction.

You can tell from far away that this child has Down's Syndrome—he has the typical soup bowl hair cut which is really not very appropriate at any age.

Not having shunt surgery performed to correct the hydrocephaly of this child is inexcusable; the child's health as well as appearance is jeopardized, and this creates a barrier of rejection for the rest of the life of the person. Compare her to this boy who had the surgery, resulting in a normal-size head.

A quarter to a third of severely retarded adults are obese. This creates a tremendous image obstacle, as well as being a health and vitality problem.

Here is a child with severe epilepsy who is wearing a highly adaptive but minimally visible helmet, something I have not seen in a long time. On the other hand, on my way to work, I have often seen a woman from one of the group homes at the bus stop who wears a huge conspicuous and bizarre football helmet; she goes to work like that on a public bus.

There is nothing wrong with this man; he happens to be a clinical psychologist demonstrating a prosthetic device, but often when we have shown this picture, people have marveled at how good, neat, clean and handsome this handicapped person looks; he looks the way he looks because he was not devalued or de-imaged in the first place.

You can see here the effects of congregation when each person has a cultural oddity. It becomes odd when four or more stigmatized people get together, and the group as a whole becomes deviancy-imaged. Any one of these persons just might be able to pass, but as a group they will never pass.

Look at this handicapped young woman in a factory who is overdressed. When you walk in, you think she is a supervisor who has temporarily taken over for someone who is sick or something like that. Perhaps she has gone too far with her dress, but you see there is a totally different expectancy set because of how she has presented herself. The contrast among people with the same handicap can be remarkable, depending upon whether one appears appropriate for one's age and culture.

The normalization principle is well suited for inclusion in training programs in rehabilitation because it offers students a coherent and synthesizing view; it also provides an evaluation tool that has training tied to it; and a great deal of normalization can be taught relatively easily, and can be easily learned, despite some of its subtleties. It has the benefit of eliciting public support because it draws on culturally established patterns. It has been widely adopted in various localities; in fact, in some of them, it has been incorporated into legislation or regulation. In Quebec, the principle of normalization is becoming the policy of the Ministry of Social Affairs; in California, the legislature passed a resolution endorsing normalization; in Pennsylvania, all community residential services for the retarded must conform to normalization regulations, etc. Increasingly, students in a number of human service professions will be at a great—perhaps crucial—advantage in finding employment if they can furnish proof of normalization competence.

APPENDIX A. A BRIEF OVERVIEW OF PASS AND FUNDET: PURPOSES, USES, STRUCTURE, CONTENT AND MEANING

Adaptive change has been occurring relatively slowly in many of our human services, and the quality of the services rendered has often left much to be desired. One reason is that in the past, we have not been committed to an ideology of strict accountability in human services, nor have we often been required to be genuinely accountable. Merely offering any service, merely being in existence as a service, was considered adequate or even laudable, and what little accountability existed was often more in terms of numbers of clients served, home visits made, counseling sessions given, etc., than in terms of the quality of the service. A second obstacle to service improvement has been that even where an accountability orientation was present, we have not had many social accounting tools available to us.

All of this is rapidly changing, due to the advent of new administrative concepts; new service ideologies; a new consumer activism; a new,

tougher, more scrutinizing attitude among both governmental and voluntary funding agencies toward many human service programs; and new tools. One such set of tools is PASS (Program Analysis of Service Systems),[1] and its companion instrument, FUNDET (Funding Determination).

PASS is a device for the objective quantification of the quality of a wide range of human service programs, agencies and even entire service systems. Examples of services which might be evaluated include child development and (special) education programs, treatment and training centers, special camps, sheltered workshops, clinics, residential homes and institutions, rehabilitation facilities, psychiatric settings, nursing homes, homes for the aged, hospitals, reformatories and corrective facilities, etc. Such services may be addressed to a wide range of human problem areas and deviancies: physical and sensory disability, mental disorder and retardation, social incapacity, poverty, delinquency, addiction and habituation to alcohol, drugs, etc.

In assessing a particular human service program or agency, a team of qualified "raters" (see below) familiarizes itself thoroughly with all aspects of the service, drawing upon a combination of written descriptions of the projects, site visits, and interviews with clients and key administrative and direct service staff. Applying well-defined guidelines and criteria, the raters then evaluate the project on 50 ratings consisting of 3 to 6 levels each. These ratings are statements about various aspects of service quality (speed and convenience of client access to the service, the physical comfort of the service setting, the intensity of relevant programming, individualization, etc.), with the lowest level of each implying poor or even unacceptable service performance, and the highest one implying near-ideal but attainable performance. Each level carries a weight (score), with the highest level of a rating carrying the maximum weight for that rating. While the rating statements are brief, each rating is accompanied by a lengthy narrative which states and explains its rationale, and which provides guidelines as to the scoring of a rating. Specific examples are given which are illustrative of typical performance at different levels of a rating.

The weights received by a service on all ratings are successively summated into a total score for that service, the maximum attainable score

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[1]Wolfensberger, W., & Glenn, L. *Program Analysis of Service Systems (PASS): A Method for the Quantitative Evaluation of Human Services.* (3rd ed.). Toronto: National Institute on Mental Retardation (4700 Keele St., Downsview, Ontario, Canada M3J 1P3), 1975. Vol. I: *Handbook;* Vol. II: *Field Manual.* Obtainable in the U.S. from the Training Institute for Human Service Planning, Leadership and Change Agentry, Syracuse University, 805 South Crouse Ave., Syracuse, N.Y. 13210.

being +1000. In other words, each point is a "millage" of the possible total. The scores of the members of a rating team are consolidated, and the total score represents the quality of the proposed or actual project. This score reflects a number of agency characteristics and/or practices which bear upon service quality, major categories being: adherence to the principle of normalization (as elaborated in the text by Wolfensberger),[2] 73% of the total; presence of other ideology-based service and administrative practices, 13%; and administrative efficiency, 14%. The score reflects both the product (outcome) and the process of a service.

Two interesting and useful features of PASS are that a physical facility score can be extracted from the total score; and the services to be assessed could include not only those already in operation, but also those still in the planning stage.

PASS raters are persons with prior human service sophistication and with extensive training in the principle of normalization and the PASS technique. In order to use PASS validly, they must have studied certain materials, participated in a total-immersion workshop and practicum lasting at least 5 days, and conducted a number of assessments under the guidance of more advanced raters. Raters, however, need not necessarily be professionals. Intelligent, well-prepared consumers of human services, and citizens with volunteer service or other relevant experiences, can also become raters, and can thereby achieve greater effectiveness in their indispensable but too often neglected roles as change agents, and as monitors of agency service quality.

PASS is concerned entirely with service quality in the broadest sense. However, the determination whether or not to fund a service must and should sometimes be based on additional non-quality factors, such as local needs and priorities. For this purpose, an optional rating instrument called FUNDET (for Funding Determination) has been devised. FUNDET is structured, administered, and scored analogously to PASS, but contains only ratings that concern themselves with those (non-quality) factors that may have a bearing on funding merit (e.g., the presence of extraordinary hardship in the service region, the consistency of service processes with funder policies and goals, etc.). For making differential funding decisions, FUNDET can be utilized separately from PASS, or in conjunction with it. For the latter case, a procedure has been worked out whereby PASS and FUNDET scores can be combined in a single score, called PASS-FUND. Service projects can be ranked on the combined criteria of the two systems and thereby facilitate differential selection of human service projects for funding purposes.

[2]Wolfensberger, W. *The Principle of Normalization in Human Services.* Toronto: National Institute on Mental Retardation, 1972.

Initially, PASS was designed to serve simultaneously and equally as a tool for training personnel in the principle of normalization, as well as for assessment. Experience has shown that PASS does serve this training function extremely well, and that participation in a PASS training workshop often brings about radical changes and updating in service ideology and conceptualization—even among senior service workers. (For information on training workshops, inquiries are invited to the Training Institute for Human Service Planning, Leadership and Change Agentry, Syracuse University, 805 South Crouse Avenue, Syracuse, New York 13210. Telephone: 315/423-4264). PASS is issued in 2 volumes and with a set of checklists and scoring forms. The first volume, the Handbook, explains the system and enunciates its rationale and structure. The second volume, the Field Manual, is for the use of raters on assignment, and contains detailed instructions for the assessment of services. The present version of the system is the third edition, additional editions being likely, derived from recent applications of the materials.

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