Normalization, Social Integration, and Community Services

Edited by
Robert J. Flynn
and
Kathleen E. Nitsch

NORMALIZATION, SOCIAL INTEGRATION, AND COMMUNITY SERVICES

NORMALIZATION, SOCIAL INTEGRATION, AND COMMUNITY SERVICES

Edited by

Robert J. Flynn

and

Kathleen E. Nitsch
Department of Psychology
Purdue University School of Science
Indiana University-Purdue University at Indianapolis

pro-ed

5341 Industrial Oaks Boulevard
Austin, Texas 78735

Library of Congress Cataloging in Publication Data
Main entry under title:

Normalization, social integration, and community services.

Includes indexes.
1. Handicapped—Services for—Addresses, essays,
lectures. I. FLynn, Robert J. II. Nitsch,
Kathleen E.
HV1568.N67 362.4 79-26670
ISBN 0-89079-120-1
(previously 0-8391-1524-5)

pro-ed
5341 Industrial Oaks Blvd.
Austin, Texas 78733

10 9 8 7 6 5 4 3 87 88 89 90

Contents

Contributors viii
Preface xi

Part I
THE NORMALIZATION PRINCIPLE
Systematic Statements and Clarifications

Introduction 3
chapter 1 A BRIEF OVERVIEW OF THE PRINCIPLE OF NORMALIZATION
Wolf Wolfensberger 7
chapter 2 THE NORMALIZATION PRINCIPLE
Bengt Nirje 31
chapter 3 DENMARK
Neils E. Bank-Mikkelsen 51
chapter 4 THE DEFINITION OF NORMALIZATION
Update, Problems, Disagreements, and Misunderstandings
Wolf Wolfensberger 71
chapter 5 RESEARCH, EMPIRICISM, AND THE PRINCIPLE OF NORMALIZATION
Wolf Wolfensberger 117

Part II
THE NORMALIZATION PRINCIPLE
Implications for Legislating, Implementing, and Evaluating Community Services

Introduction 133
chapter 6 ANTI-INSTITUTIONALIZATION
The Promise of the *Pennhurst* Case
David Ferleger and Penelope A. Boyd 141
chapter 7 RIGHT TO SERVICES IN THE COMMUNITY
Implications of the *Pennhurst* Case
Frank Laski 167

chapter 8 TOWARD THE REALIZATION OF THE LEAST RESTRICTIVE EDUCATIONAL ENVIRONMENTS FOR SEVERELY HANDICAPPED STUDENTS
Lou Brown, Barbara Wilcox, Edward Sontag, Betty Vincent, Nancy Dodd, and Lee Gruenewald 177

chapter 9 THE MARRIAGE OF SPECIAL AND GENERIC EARLY EDUCATION SERVICES
Charles Galloway and Phyllis Chandler 187

chapter 10 RESEARCH ON COMMUNITY RESIDENTIAL ALTERNATIVES FOR THE MENTALLY RETARDED
Laird W. Heal, Carol K. Sigelman, and Harvey N. Switzky 215

chapter 11 VOCATIONAL HABILITATION
A Time for Change
David J. Pomerantz and David Marholin, II 259

chapter 12 COMPREHENSIVE VOCATIONAL SERVICES
John DuRand and Aldred H. Neufeldt 283

chapter 13 NORMALIZATION AND COMMUNITIZATION
Implementation of a Regional, Community-Integrated Service System
Michael F. Hogan 299

chapter 14 SUPERMARKET OF SERVICES ALLOWS DEPENDENT ADULTS TO AVOID INSTITUTIONS
Martin Judge 313

chapter 15 NORMALIZATION, PASS, AND SERVICE QUALITY ASSESSMENT
How Normalizing Are Current Human Services?
Robert J. Flynn 323

Part III
CONCLUSION

chapter 16 NORMALIZATION
Accomplishments to Date and Future Priorities
Robert J. Flynn and Kathleen E. Nitsch 363

appendix A NORMALIZATION BIBLIOGRAPHY
Kathleen E. Nitsch, Althea Armour, and Robert J. Flynn 395

Author Index 411
Subject Index 419

chapter 4

THE DEFINITION OF NORMALIZATION Update, Problems, Disagreements, and Misunderstandings

Wolf Wolfensberger

THE DERIVATION OF THE MAJOR CURRENT FORMULATIONS OF THE NORMALIZATION PRINCIPLE 72
Miscellaneous Early Definitions That Were Minimally Elaborated or Utilized 72
The Danish Formulation 73
The Swedish Formulation 74
Further Discussion of the Scandinavian Normalization Formulations 76
The Evolving Wolfensberger Definition 79
CONTROVERSIES ABOUT NORMALIZATION AND THEIR SOURCES 83
Failure to Relate to Any of the Major Definitions of Normalization 83
Confusion Among Competing Definitions 85
Alliance With One Major Definition and Rejection of Others 86
Failure to Understand One of the Major Normalization Formulations 86
Adherence to Theoretical Systems That Clash With Normalization or Some of Its Implications 88
Miscellaneous Misinterpretations, Misconceptions, or Critiques Regarding Normalization 89
Normalization as Humanization 89
Normalization as Cure 90
Normalization as Mainstreaming 91
Normalization as Single-Path and Monolithic 92
Normalization as Only Applicable to the Mildly Impaired 94

Normalization as Demanding "Normalize or Perish" 94
Normalization as Unrealistic 95
Normalization Lacks Evidence 96
Miscellaneous or Mixed Issues 96
Concluding Reflection on the Sources of Controversy 100
OUTRIGHT PERVERSIONS OF NORMALIZATION 101
SOME CLARIFICATIONS 105
Differentiating Process and Outcome 105
Differentiating Degrees of Normalization 106
Differentiating Physical from Social Integration 108
Recognizing That Normalization Corollaries May Clash With Each Other 108
CONCLUSION 112

Chances are that before 1968, very few people in North America had heard the term *normalization* used in a human services context. The majority of those who are now familiar with the term have probably encountered it some time since 1972. Thus, as far as word use in human services goes, the term is quite new—although many people dispute the newness of the theoretical concepts that underlie it.

Today, we are confronted with confusion about the meaning of normalization. Neither ardent supporters of the normalization principle nor its impassioned opponents can agree among each other as to what it is they agree with—or even what they disagree on—in either their support or their opposition. So, when someone either advances or opposes the principle of normalization, one now has to ask the question, "normalization according to whom?"

This chapter addresses the meaning of the term *normalization*. Unfortunately, the term is derived from the culturally common and familiar word *normal,* which already has well-established meanings in the minds of practically every citizen. For this reason, it was probably a rather serious strategic error to use this term in the first place, rather than a less familiar term or neologism that would not have evoked familiar, but inaccurate, perceptions and meanings.

THE DERIVATION OF THE MAJOR CURRENT FORMULATIONS OF THE NORMALIZATION PRINCIPLE

Miscellaneous Early Definitions That Were Minimally Elaborated or Utilized

Years before the term *normalization* gained wide publicity and usage, a number of writers had employed it. However, without exception, these

early uses were of a fleeting nature, were invariably of tangential relevance or role in the writer's work, and suffered from lack of definition, clarity, and theoretical elaboration. In fact, it can probably be said that not one single early user of the term elaborated it theoretically.

The earliest use of the term *normalization* that I could find in the human service literature was by Maria Montessori, in a passage in the 1966 English edition of *The Secret of Childhood.* Suspecting a translation artifact, I obtained an original 1950 edition of *Il Segreto Dell'Infanzia,* and found, to my surprise, that the term was indeed used there in the Italian as "la normalizzazione del bambino" (p. 291). However, the term occurred only once, and in a tangential, sporadic way, and quite literally meant to return or "convert" a child to what is "normal." Of course, this usage was based on the fact that in Rome, during the first years of the twentieth century, Montessori's educational program did enable children who had been labeled mentally retarded to pass school examinations for entry into regular grades.

A few years later, Shakow (1958), the noted researcher on schizophrenia, wrote an article for a Swiss journal that would be rather obscure even to specialists in North America. The article was entitled "Normalisierungstendenzen bei chronisch Schizophrenen: Konsequenzen für die Theorie der Schizophrenie," which translates as "Normalization tendencies in chronic schizophrenics: Some implications for the theory of schizophrenia." The "normalization tendencies" described by Shakow were concerned with the observation that people with schizophrenia might possess certain functions that could reach a normal capacity and that, therefore, could be capitalized upon during treatment.

In 1964, Mack Beck, a Canadian leader in psychiatry and mental retardation, used the phrase "normalization of social experience for the retarded child..." in a discussion printed in the proceedings of a special national conference on mental retardation (Department of National Health & Welfare, 1965). The term was used only once and in connection with the point that "...educational services for the retarded should be carried out to the maximum extent within the normal stream or within the normal school" (p. 211).

Olshansky, a prolific writer on the philosophy of human services, especially vocational ones, used the term *normalization* in discussing the concept of "passing" for former psychiatric clients in an article entitled "Passing: Road to Normalization for Ex-Mental Patients" (1966).

The Danish Formulation

To the best of my knowledge, the concept of normalization more along the lines of current use owes its first promulgation to Bank-Mikkelsen (1969), who was head of the Danish Mental Retardation Service for

many years, and who phrased normalization exclusively in relation to his own field: "letting the mentally retarded obtain an existence as close to the normal as possible." He was instrumental in having this concept (though not explicitly in terms of *normalization*) written into the 1959 Danish law governing services to the mentally retarded. According to Bank-Mikkelsen (1976 [chapter 3, this volume]), the statement in the Danish Mental Retardation Act of 1959, "to create an existence for the mentally retarded as close to normal living conditions as possible," was the starting point of the entire international discussion of the concept of normalization.

The relevant Danish terms are *normalisering* (normalization) and *normaliseringsprincippet* (principle of normalization) (Grunewald, 1972). However, just when and where the term *normalization* was first spoken or written in Danish service contexts appears to have been lost to history, probably because of the informal, gradual evolution of the concept and of its service implications.

It should be noted that this formulation 1) is specific to the field of mental retardation, and 2) that it appears to imply a primary concern with outcome ("an existence as close to the normal as possible"), rather than with process, even though it might quite well be argued that such an existence is both process and outcome. Nevertheless, the definition does appear to evoke images more concerned with what eventually happens than with the means that might be employed to achieve that end. Indeed, Danish practice seems to bear this out. Despite the gratifying development of community services for the mentally retarded in Denmark, new and large institutions have been built. There has also been a continued emphasis on developing and/or maintaining high-quality segregated services and on the "good institution" in which the quality of life would be as good as, and perhaps even better than, the quality of life that a retarded person might experience in the community. The fact that an institution is inherently a highly atypical setting reserved for devalued persons, that it certainly projects a dubious image upon its residents, and that even in the best institutions there are peculiar features that would not be encountered in ordinary community living has simply not received the theoretical attention in Denmark that a concern with process, as well as with outcome, should imply.

The Swedish Formulation

Despite its adoption in Danish mental retardation practices, it was not until 1969 that the principle of normalization was systematically stated and elaborated in the literature by Nirje (1969; revised 1976 [chapter 2, this volume]), who was then executive director of the Swedish Association for Retarded Children. This elaboration was contained in a chapter

of the monograph *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel & Wolfensberger, 1969), commissioned by the President's Committee on Mental Retardation. This systematic description was not only the first one in English, but it even had to be translated into Swedish (Grunewald, 1971) in order to become the first major written treatise on the topic in the entire Scandinavian literature. (The parallel translation into Danish appeared in 1972.) In this 1969 chapter, Nirje phrased the principle as follows: "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (p. 181). In Swedish, normalization is the same word as in Danish *(normalisering),* but the principle of normalization is rendered as *normaliseringsprincipen* (Grunewald, 1971).

Although the normalization principle had not been systematically presented in the Scandinavian literature until 1971, its significance (even if not its terminology) had been widely recognized before that, and, in 1967, a new, far-reaching Swedish law governing provisions and services for the mentally retarded, which strongly embodied normalization concepts, was developed and became effective in 1968 (Swedish Code of Statutes, 1967 [4], dated December 15, 1967). Parts of this law were presented and discussed in the above-mentioned chapter by Nirje (1969). However, much as normalization was more an informal concept rather than a consciously-defined term in Danish services before 1968, so too, the Swedish law alludes to, rather than specifies, the principle, as in references to accommodations being "as close to the normal as possible" (Nirje, 1969, p. 190).

Also, many of the current ideological radicalities were absent in the law, as witnessed by the fact that the law was rather soft on segregated schools and that education for severely retarded children (IQ roughly 25–50) below age 7 was permissive rather than mandatory. Similar to Danish developments, Swedish mental retardation services to this day still try to maintain "good institutions," and the rate of institutionalization in Sweden, as in Denmark, is actually higher than in North America, especially if one considers that the real prevalence of severe mental retardation and/or severe functional impairment (for very good reasons) seems to be significantly lower (Wolfensberger, 1972, chapter 9).

The two salient features of the Nirje formulation are that the focus is once more upon mentally retarded individuals; and that, in contrast to the Danish formulation, the wording implies primary stress on means and methods ("making available. . . patterns and conditions. . . ") rather than on outcome. Again, in the teachings and writings of Nirje, both in 1969 and since, considerable stress has been placed on the routines and rhythms of the day, the week, and the year; the provision of settings that

enlarge the ability to exercise autonomy and decision making; and similar concepts. Though not explicitly formulated by Nirje, implied in his work is a primary emphasis on clinical methods and an almost complete silence on what we now call the "interpretation" of devalued persons, i.e., what one might refer to as the normalization of the image, representation, and interpretation of a person (Wolfensberger, 1972; Wolfensberger & Glenn, 1973b, 1975b).

Nirje has taken great pains to emphasize in his teaching that he has never used the phrase "normalization of the person," but rather "the normalization of life conditions." Indeed, the fact that a retarded person might occasionally be restored to normal functioning is de facto underplayed for fear of raising the specter of the misconceptions and confusions surrounding the issue of the "cure" of mental retardation.

Further Discussion of the Scandinavian Normalization Formulations

One of the major difficulties with the Bank-Mikkelsen definition of normalization is that it has been interpreted as being consistent with segregation, the creation of segregated settings for devalued people, and with the continued use of institutions as long as these are structured in certain aspects to be relatively pleasant and homelike. The very fact that ambivalence in the Danish mental retardation services is to be expected about an alternative and more radical view of normalization is made evident by simply studying their institutional population movements (e.g., Bank-Mikkelsen, 1976, p. 250 [chapter 3, p. 68, this volume]). Between 1958–59 and 1974, many community services increased dramatically in Denmark—but so did the number of institutions, which doubled. The number of institutional residents remained approximately the same, which means that as new, smaller and local institutions were initiated, larger and more centralized ones were reduced in size. Within older institutions, one of the very major emphases has been the conversion from dormitories to single rooms. Of course, this has devoured an appreciable sum of money that might otherwise have gone to community residential services. There was a significant decline in the number of residents in special boarding schools (one type of quasi-institution), and there has been a very sizable increase in the number of "school homes," which are segregated mini-institutional residences in which retarded children live while going to a special school, typically on a 5-day per week basis. Thus, such homes may actually segregate doubly, both in the area of education and in the area of domiciliation. There was a drastic percentage (though not a very large numerical) decline in persons in semi-private (and presumably semi-institutional) care homes, and a dramatic percentage but not a very dramatic numerical increase of people in "hostels" (i.e., community group homes). The number of day educational facilities for the mentally

retarded increased greatly, but this entire educational system in Denmark has been heavily segregated and has included the use of large segregated schools for the retarded, which may take up the equivalent of a city block in size, such as one encounters in some of the North American states and provinces. At any rate, in 1974, over 8,000 people still resided in institutions, with less than 700 in hostels! That is a great number of retarded people in institutions, considering that the total Danish population is only about 5 million.

Bank-Mikkelsen (1976) has equated integration with essentially an implementive technicality ("simple working methods") on an equal level with segregation, rather than as an ideological goal. In fact, he stated that segregation might be as effective in moving retarded people toward normalization as integration (pp. 243–244 [chapter 3, pp. 56–57, this volume]). One thought that is missing from Bank-Mikkelsen's analyses is that, in the long run, no good can come of any program, including normalization, that is not based on intimate, positive one-to-one relationships between ordinary (unpaid) citizens and those who are handicapped and who would otherwise be devalued. Strategically, there simply does not exist a better long-term safeguard for the welfare of retarded individuals than a large number of intimate and positive one-to-one relationships between them and other citizens. Very few people seem to realize that valued people are virtually never segregated from society against their will and that one will only see such segregation when people are devalued. The only times that valued people are segregated is when they segregate themselves in order to increase their own status and value. Therefore, if one wants to do away with devaluation, one will have to come to grips with what is, de facto, involuntary segregation.

The acknowledgement of the role of economic politics is also absent from much of the Danish literature. It would help if the Danes themselves were able to note that, in the 1960s, they made a huge capital investment in new, large, isolated and segregated institutions for the retarded, as well as in segregated schools. Obviously, they cannot easily afford to retreat from this commitment.

Similarly, the Swedish mental retardation service system (Grunewald, 1975; 1976, p. 259) is also heavily institution-based, although, relative to its population of about 8 million, it has a much larger community small-residence capacity than does the Danish system. In 1974, Sweden had approximately 300 group homes with approximately 6 or 7 retarded residents each, but over 13,000 people were still in institutions, compared to 2,000 in small settings. Furthermore, the trend toward small institutions continues in Sweden, not merely as a transitional phase in the move from large institutions to totally noninstitutional community residential options, but as a solution that is seen as good, desired, and essentially

"permanent." The trend toward single rooms is even more pronounced in Swedish residential facilities, where about one-half of all individuals now have single rooms (Grunewald, 1976, p. 258). Similar to Bank-Mikkelsen, Grunewald sees integration as having to do "primarily with the technical and organizational possibilities of coordinating services" (1976, p. 253). Grunewald sees integration as a means toward normalization, rather than an end in itself. Interestingly, Grunewald has also repeatedly used the term *integration* to refer to the juxtaposition of retarded persons with other handicapped groups, as in the attachment of sheltered workshops for the mentally retarded to larger service complexes for handicapped people. Within the Wolfensberger normalization formulation, this would be referred to as either "deviant person juxtaposition," or "deviant group juxtaposition," at best, but certainly not as integration. In fact, on the normalization measurement tool PASS (Wolfensberger & Glenn, 1973a, 1973b, 1975a, 1975b), such large service complexes would also be penalized under the rating of "Congregation and Assimilation Potential," which reflects the belief that congregations of large numbers of devalued people have detrimental internal, as well as external assimilation, consequences.

However, in a later publication, Grunewald (1977) clarified his concept of integration as taking place on three levels: physical, functional, and social. In essence, his definition of physical integration is equivalent to the same term in Wolfensberger's work, although the image issues are not touched upon. However, in introducing the new concept of functional integration, Grunewald refers to a combination of arrangements that would be included in PASS under "utilization of generic resources," as well as "socially integrative social activities," namely, aspects of participating in the generic services of the community in a way that is not segregating, even though it may not necessarily be personally integrative. Grunewald defines social integration essentially as the equivalent to what Wolfensberger has termed *person integration,* which is constituted of actual personal contact with valued people, which is something that even a great many withdrawn or alienated nonhandicapped people would not necessarily experience.

One trouble with this whole issue is that in Scandinavia, as in other countries, some people are unwilling to label large segregated facilities as institutions; and, in analyzing service patterns, it is very difficult to see how one can speak of normalization when the statistics do not even adequately reflect a clear definitional differentiation between facilities that are larger or smaller than those of even large-family size or that are of a segregated or integrated nature.

From the discussion of the Danish and Swedish conceptions of normalization, it should be amply clear that the Wolfensberger formulation

presented below differs in important, and, in some instances, in essential, respects from the two other formulations.

The Evolving Wolfensberger Definition

Deeply influenced by Bank-Mikkelsen and Nirje, and the work in Denmark and Sweden, I attempted from about 1969 onward to define normalization in such a way as to meet the classical criteria of an elegant theory; namely, a parsimony in formulation coupled with the maximum amount of explanatory and predictive power. After some initial fixation on mental retardation, I perceived 1) that the principle could easily be generalized to all devalued persons, 2) that it could cohesively concern itself with both means and outcomes, and 3) that it would be able to subsume many concepts and theories that previously had existed disjointedly and in smaller scope. It soon became apparent that, aside from clinical means and clinical outcomes, the issue of systemic means and systemic outcomes could easily be accommodated and, indeed, *should* be subsumed in a new formulation so as to approximate further the desiderata of parsimony and generalizability.

I began to write on the topic as soon as I returned from a trip to Denmark and Sweden in the spring of 1969, where I was most cordially hosted and tutored. However, I had great difficulty in getting my papers accepted in American journals. As a result, I concluded that in order to achieve publication of what I considered to be a fundamentally important body of material, I had to bypass the dominant journal editors and write a book, which, after being rejected by innumerable publishers, eventually was accepted for publication by the Canadian National Institute on Mental Retardation. Before its publication in 1972, one of the papers that I had long and unsuccessfully tried to have published was finally accepted in very altered form (Wolfensberger, 1970) in the *American Journal of Psychiatry*. It focused primarily on the implication of the normalization principle to mental health services.

In order to further specify normalization applications to human services and to be able to quantitatively evaluate the extent of such applications, Linda Glenn and I developed a two-volume tool called Program Analysis of Service Systems (PASS). It was used in Nebraska for some years, revised, published (Wolfensberger & Glenn, 1973a, 1973b), used more generally, and revised again (Wolfensberger & Glenn, 1975a, 1975b). It has proven indispensable in illustrating the meaning of normalization, and even though many thousands of copies have been sold, most people who have critiqued normalization theory have failed to refer to this tool.

For the purposes of a North American audience, and for broadest adaptability to human services in general, I proposed, in 1969 (though

not published until 1972), that the definition of the normalization principle be: "Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible." I have slightly changed this definition in my teachings so that, today, I use the formulation: "Utilization of means which are as culturally normative as possible, in order to establish, enable, or support behaviors, appearances and interpretations which are as culturally normative as possible." For less formal teaching purposes, I also often use a less awkward phrasing: "Use of culturally normative means (familiar, valued techniques, tools, methods), in order to enable persons life conditions (income, housing, health services, etc.) which are at least as good as that of average citizens, and to as much as possible enhance or support their behavior (skills, competencies, etc.), appearances (clothes, grooming, etc.), experiences (adjustment, feelings, etc.), and status and reputation (labels, attitudes of others, etc.)." When I am asked to explain normalization to a lay audience in a few seconds, I sometimes refer to "the use of culturally valued means in order to enable people to live culturally valued lives."

A brief, updated, general overview of normalization is contained in Wolfensberger (1977a [chapter 1, this volume]), and an updated, but less brief, overview that emphasizes environmental and architectural implications is found in Wolfensberger (1977b).

Perhaps one of the most common misconceptions about the principle of normalization, at least as formulated here, is that it implies that a person should be fitted to the statistical norm of the society. In other words, some people see normalization as having been achieved when a person is or does something the way most people are or do. However, this is a naive and invalid interpretation of the principle as I have formulated it.

In order to understand this issue clearly, three phenomena are of importance.

1. The phenomenological and expectancy norm in a society is not necessarily identical with the statistical norm. In other words, what people would not be surprised to encounter in society, or what they would highly value but rarely encounter, may not be what actually prevails. Thus, a phenomenon may fall well within the range of that which is normative, even though it may only be rarely encountered in the culture. Narrow bow ties were popular in North America in the 1950s, but a young adult who had never seen one would probably not even look twice if he encountered a man wearing one. Few unmarried adults lead lives of consistently virtuous chastity, but one certainly would not say that a person who does was devalued or falling outside the range of normalization.

2. Some of the above phenomena can be explained simply by the following fact: that which is expected is quite often that which is valued, even though that which is valued is not necessarily expected statistically and may not necessarily occur very often. Similarly, the concept of the "norm," even in its common sense, applies not only to the statistically common, but also to that which may be uncommonly encountered, but which is internally idealized.
3. A phenomenon that is both very common and generally valued can actually be *de*-normalizing when it occurs in the life of a devalued person. For instance, family homes or ordinary apartment houses adjacent to cemeteries are not only fairly common in our society, but they are also quite often valued because of their quiet location and the fact that many of the cemeteries resemble (or perhaps even are) parks. At the same time, however, it is devastatingly de-normalizing for an elderly person to have to live in a special residence that is adjacent to a cemetery. Yet a remarkably high proportion of nursing homes are located in close juxtaposition to cemeteries and to other death-imaged facilities such as hospitals, funeral parlors, and coroners' offices. Obviously, the valued phenomenon here is not a normalizing one *for a devalued person;* just about the only circumstances that would make the location of a nursing home next to a cemetery a normalizing measure would be if death became a societally valued condition, or if juxtaposition of elderly people to death imagery and death expectancy was so uncommon as not to constitute an issue-making pattern.

Some of the above issues become clearer upon examination of Table 1. This type of schematization was not present in the 1972 *Normalization* text, an omission that has permitted the excessively statistical interpretation of normalization. However, the 1973 edition of PASS corrected this problem, although critics have tended not to take note thereof. I hope that this chapter clarifies 1) that measures under any of the three columns, not only those in the statistical norms column, of Table 1 would be normalizing, and 2) that for people who are already devalued, or at risk thereof, a measure generally becomes more normalizing as it moves to the left of the table. Some key assumptions (with extensive empirical support, however) include the following: that a person will benefit maximally from those measures that reflect and/or capture his/her highest values and ideals; that a person will relate optimally to that other person whom he/she perceives as representing, embodying, or carrying his/her idealized values; and that most people in a culture agree, at least to some extent, with a majority of other members on at least the theoretical desirability of certain idealized norms. For example, even people who practice

Table 1. A clarification of some of the determinants of normalization

Cultural values	Process of socialization	Cultural norms	Process of internalization	Statistical-behavioral norms
Constitute a society's idealized standards of the desirable		More specific rules based on values		Empirically-observed, regular patterns of behavior, traits, and appearances
Highly general		Infused with a moral imperative or "oughtness"		Produced because most people believe in, approve of, or conform to most cultural norms most of the time
Derived from broad human experience and specific historical development		Prescribe generally expected behaviors, traits, or appearances for specific situations		
Invested with a "sacred" character		Sanctions are either positive (honor) or negative (opprobrium)		
Rarely attained by any one person		Include folkways, mores, and laws		

oppression will generally idealize liberty; even people who practice deception will idealize truth.

These and other implications become clearer in the following analysis of normalization critiques.

CONTROVERSIES ABOUT NORMALIZATION AND THEIR SOURCES

It appears that sources of controversy about the principle of normalization spring from one or several of five sources: 1) failure to relate to any of the major definitions; 2) confusion among competing definitions of the principle; 3) alliance with one of the major definitions and rejection of the other ones; 4) failure to understand one of the major definitions; and 5) adherence to systems, or a view of the world and/or human services, that clash with at least some of the assumptions or implications of one or all of the major definitions. These five sources of controversy, as well as a sixth miscellaneous category, are discussed below.

Failure to Relate to Any of the Major Definitions of Normalization

Many people refer to *the* normalization principle despite the fact that there are at least three major definitions that are quite different in some of their implications. Indeed, some people use the term unaware of any of these, or any other formal definition, and make up all sorts of definitions themselves. Typically, such definitions are vague, imprecise, idiosyncratic, and mostly fodder for rhetoric and fruitless controversy. For instance, some people, especially those who for various reasons wish to emphasize that "normalization is nothing new," have pointed to various scattered, positive, humanistic statements about the handicapped in the literature as being informal formulations of the normalization principle. Actually, all these references have involved only some of the corollaries of the normalization principle or even refer to competing thought systems. Thus, various other people who either dislike the term *normalization* or who have not understood its major definitions to date, have suggested the following terms as preferred substitutes: normalcy, humanization, (re)habilitation, socialization, individualization, personalization, self-fulfillment, self-actualization, equalization, sharing, dignity, freedom, maximum opportunity, optimization, citizenship, equal rights, growth, developing to full potential, maximizing human potential, status enhancement, integration, mainstreaming, and even reality therapy. Actually, the one term that comes closest to capturing the meaning of normalization, that is, at least the Wolfensberger definition, would be (re-)valuation, in the social sense.

An example of an idiosyncratic definition is a proposal (Burton, 1976) that normalization be defined as "the best quality of life and train-

ing available within the limitations of their (retarded people's) handicap."

Failure to relate to any of the major formulations of normalization is also revealed by the selection of titles included by the Council for Exceptional Children in its 1978 bibliographies entitled *Normalization—Mentally Retarded* and *Normalization—General/Aurally/Visually Handicapped/Physically Handicapped/Emotionally Disturbed.* A person interested in compiling a normalization bibliography, or in learning about the principle of normalization and its literature, would be starkly disappointed in taking recourse to these two listings. Very few of the references included have anything to do with normalization, and one can only wonder what conceptualization of normalization must have underlain the choice of some of the items; it can only have been a Pollyannish one.

The interpretation of normalization as referring to normal (as with the use of normal surroundings and circumstances, even to the possible exclusion of "nonnormal" prosthetic environments) is exemplified by Tennant, Hattersley, and Cullen (1978). However, it is rather characteristic of the status of the normalization critique literature that these authors do not devote a single reference among their 18 to any kind of a definitional source.

Presumably, one can infer that one writer who referred to "narmalization" (sic) was not relating to any of the major normalization formulations.

Some failures to relate to any of the established formulations are hard to understand, especially if they come from people who must have had important exposures to at least one of the formulations. An example is a peculiar formulation by Throne (1977) who, previously (1975), had critiqued normalization:

> Normalization, meaning (in this discussion) interdisciplinary programming for the mentally retarded under as normal conditions as possible, implies that the interdisciplinary staff must constantly keep in mind the cost, in human values, of the programmatic gains which it is calculated, expected, or hoped, will accrue from deliberate and systematic maximization of development of the mentally retarded (p. 17).

Another puzzler is the casual comment by Sloan and Stevens (1976, p. 298) that normalization "had its genesis in the early years of the Association's history," meaning by that the history of the American Association on Mental Deficiency (AAMD), which was founded in 1876. From its origins, the Association was tied to institutionalism, and, in part, even to the destruction of retarded people, since at least one of its co-founders (Kerlin) was one of the great "indictors" of the retarded. Even the

pioneer to come closest to promoting normalization, Samuel Gridley Howe, certainly did not formulate it except by allusions to bits and pieces—and he purposefully dissociated himself from the Association.[1]

One human service worker told me that he worked in an agency that claimed to be rooted in the principle of normalization, but that he knew no one within that agency, himself included, who had read the *Normalization* (Wolfensberger, 1972) text. This sort of occurrence is quite common and can lead to such situations as one director of a program saying "In our normalization program, we use real pennies for tokens to reinforce good school work—just like in the normal world." However, at a certain point, the use of a program concept as broad as normalization without reference to at least one major theoretical formulation thereof may well constitute perversion, rather than naiveté, intellectual laziness, or honest error.

Confusion Among Competing Definitions

Of the three major normalization definitions reviewed in this chapter, Nirje's definition is probably the most commonly cited one. In the majority of instances where any of the three formulations is cited, it is impossible to tell whether the writer (or speaker) is aware of the other formulations, or, if aware, whether the important differences among them are recognized. Thus, when a serious attempt is made to teach normalization (e.g., Burton, 1976), the author may "go under" in failing to interrelate the three formulations with each other and with various critiques of the normalization principle. An example of the confusion of the major normalization definitions occurred in Knight, Zimring, and Kent (1976) who attributed the Nirje definition to me, instead of citing my reformulation of it. (They corrected this error in their 1977 publication.)

Anderson, Greer, and Dietrich (1976) essentially invoke the Nirje formulation, but interpret normalization primarily in terms of normal residential and living environments. They state correctly that normalization would be achieved largely through a continuum of services and programs that can accommodate the highly individual needs of retarded people. They do not explicitly reject any of the competing formulations, but do accept as granted that at least some severely retarded persons must be institutionalized, but that, even then, normalization would be achieved if the living conditions approximated the patterns of the "mainstream society."

---

[1]Sloan and Stevens (1976, p. 203) also refer to Humphreys' presidential AAMD address (Humphreys, 1949) as being a commentary "on what was called several decades later 'Normalization.'" In essence, Humphreys did call for many (by no means all) measures that would be consistent with the Wolfensberger formulation of normalization including societal inclusion and a service continuum.

Since so many people equate "normalization" with "normalization" (so to speak), it is no wonder that they confuse competing definitions, even if they are aware of them. Such confusion can lead to problematic formulations that are worse than clear-cut acceptance of one definition accompanied by rejection of others. For instance, a California Senate resolution (No. 30, July 26, 1972) "declares rights of mentally retarded persons as to opportunities for normalization" as follows:

> RESOLVED BY THE SENATE OF THE STATE OF CALIFORNIA THE ASSEMBLY THEREOF CONCURRING;
>
> That the Legislature hereby declares that the mentally retarded person has a right to as normal a life as possible despite the severity of his handicap and should be afforded the same basic rights as other citizens of California of the same age;
>
> and be it further RESOLVED, That "normalization" is defined to mean that despite any limitations, each retarded individual shall be provided the maximum opportunity to participate in usual living experiences including education, work, and social activities that permit development to his highest potential;
>
> and be it further RESOLVED, That such opportunity for "normalization" is the birthright of every citizen and a proper investment for the good of society.

Similarly, the U.S. Senate Bill S.462 (Report No. 94-160) of May 22, 1975, which amended the Developmental Disabilities Services and Facilities Construction Act, included a hybrid definition of normalization: "'Normalization principle' means the principle of helping mentally retarded and other developmentally disabled individuals to obtain an existence as close to the normal as possible, particularly through the use of means that are as culturally normative as possible to elicit and maintain behavior that is as culturally normative as possible." Thus, major elements of the Danish and Wolfensberger definitions are incorporated, as if to make certain that what one may not cover, the other one might.

Alliance With One Major Definition and Rejection of Others

Alliance with one major definition of normalization together with rejection of competing definitions, can, or at least could, be a rather clear-cut affair that constitutes an adequate basis for discussion and for agreeing on what to disagree about. Unfortunately, such clear-cut disagreements are few.

Failure to Understand One of the Major Normalization Formulations

Numerous critiques of normalization, and, indeed, numerous efforts to promote normalization, are based on erroneous interpretations of one of the major normalization definitions.

Throne (1975) has claimed that normalization means only that people would be treated "normally," but that this still leaves them handicapped. First of all, this claim focuses only on the means/process part of normalization, and ignores the outcome part. Second, normalization does not only mean "normal" treatment, but preferably "valued" treatment. Third, it would not exclude entirely those means that are nonnormative if the conflict between means and ends can be resolved so that the likely outcome more than outweighs the damage inflicted by nonnormative means. Fourth, Throne is gravely mistaken on the clinical level in claiming that impaired people will never learn to act normally by being treated normally. Often, the impairment itself is only the result of denormalized treatment in the first place. True, only a small proportion of retarded people are apt to become nonretarded from normalized treatment, but many are apt to become quite normalized in specific areas, e.g., appearance, demeanor, and certain competencies. Thus, Throne's article, though persistently quoted by others, stands as an example of the common confusion of means and ends.

The exclusive equation of "normative" with "typically prevailing" is also exemplified in Howell's (1976) discussion of environments for handicapped people, in which she makes the statement that "adopting the principle of normalization to the production or modification of environments for the developmentally disabled person will *not* necessarily promote optimum growth for these individuals" (p. 163). (Howell's position also implies (erroneously) that technologies of the environment are more important than cultural traditions and values or the resultant image and role benefits which the latter confer upon handicapped persons.)

An amazing number of distortions and misinterpretations have been packed by Rhoades and Browning (1977) into a very brief (1-page), but also very sharp, critique of the Wolfensberger formulation of normalization (Wolfensberger, 1972; Wolfensberger & Glenn, 1973a, 1973b, 1975a, 1975b). One of the distortions is that we attempt to eliminate deviancy by eliminating it from the public's awareness—as if reduced awareness were equivalent to the creation of new values toward a group of people. Furthermore, they attribute to us the belief that isolated independent community living is the goal of social integration. This totally ignores the great pains we have taken in PASS to stress that integration is only achieved when the devalued person has interactions with nondevalued (and better yet, valued) people without being devalued in the process. PASS certainly would penalize misery-laden social isolation. Perhaps one of the distortions most painful to me in the critique by Rhoades and Browning is the equation of social integration with mainstreaming, which I have never made in my published or spoken work, and which I

have specifically rejected in published form (cf. Wolfensberger, in Soeffing, 1974). In the 1975 edition of PASS (Wolfensberger & Glenn, 1975a, 1975b), we also rejected the nouning of adjectives to describe people, such as the description of deviant people as "deviants," and PASS also clearly rejects as undesirable such usage as employed in some of my earlier work. The above list by no means exhausts all of the distortions contained in this brief article, but I long ago decided that I would not respond to every distortion of my work. Particularly puzzling is why the critics cited the 1973 edition of PASS rather than the vastly more advanced 1975 edition, which must almost certainly have been known to them.

Raynes, Pratt, and Roses (1977) have stated that I had claimed in the *Normalization* text (1972) that institutions are *invariably* custodial. Quite to the contrary, I documented the enormous achievements of Scandinavian institutions; but what I did claim, or imply, was that institutions are invariably nonnormalized, at least if one applies the Wolfensberger formulation of normalization.

Adherence to Theoretical Systems That Clash With Normalization or Some of Its Implications

It is surprising how few cohesive formulations exist in human service that lend themselves to rigorous translation into broad human service structuring. For instance, some formulations are noble, but vague, and do not generate clear-cut applications. Other formulations apply only to narrow service areas, e.g., psychotherapy. While the Nirje and Bank-Mikkelsen normalization formulations only address the mentally retarded, it is clear that they can be applied universally if one only substitutes the words "handicapped" and/or "devalued."

The Wolfensberger formulation, specifically, has claimed and demonstrated (e.g., through the work done with PASS) universal applicability to human services. Readers are invited to reflect how few other systems there exist that lay the same claim or, indeed, have rigorous universality even if they do not claim it. Yet all the bad things that happen to devalued people are derived from a relatively small number of universally recurring dynamics; and all the constructive things that should be done can similarly be based on a relatively small number of principles.

Furthermore, it is probably impossible to identify any theory of relationship or service to handicapped and/or devalued people (except those that would be widely viewed as inhuman in Western civilization) that would not also overlap rather extensively in practice with any of the three major normalization formulations. At least this appears to be true if competing (nonnormalization) theoretical formulations were rigorously stated and faithfully carried into practice.

One system that is often claimed to be opposed to normalization is Christianity—but it shares one problem with normalization: people disagree on its definition, and often do not study, or listen to, competing formulations. The fact is that probably any formulation of Christianity would very extensively agree with any of the major formulations of normalization. I will not belabor some real and some purported areas of disagreement, since I am doing that in a book tentatively entitled *Judeo-Christian Perspectives on Human Services* (Wolfensberger, in preparation, a).

Zipperlen (1975) has probably presented the most cultured critique of normalization yet, and also one of the longest, compared to the numerous trivial one- and two-page critiques. Her critique is one of the few examples of the pitting of a well-elaborated system against normalization, namely the Camphill system that is, in turn, derived from anthroposophy. However, it may be noted that 1) the Camphill system differs more from the Wolfensberger than the Nirje formulations, and 2) the differences are more modest than may appear. If a Camphill establishment that were rigorously based on its stated principles were evaluated on the normalization ratings of PASS, it would probably score very positively, and much more positively than the vast majority of human service settings today. Also, Zipperlen's critique is marred by two problems. First, it did not make recourse to the PASS publications that would have clarified certain points. For instance, the critique failed to note that normalization calls not only for attention to a person's behavior and appearance, but also to the physical and social environment. Second, some of the critique is not aimed at normalization at all, but at other material taught in some of the workshops with which I have been identified.

Miscellaneous Misinterpretations, Misconceptions, or Critiques Regarding Normalization

Normalization as Humanization Perhaps one of the most common misinterpretations of normalization is that of its being humanization, i.e., that normalization is a statement that a person is human. While there is certainly a great deal of overlap between the two concepts, normalization is really much more specific in that it has a vast array of both general and specific implications, such as that the human person at stake is also a developing organism, is capable of growth and adaptation, and should be advanced to high positive status in the eyes of others. The humanization concept by itself does not necessarily imply this, since people who believe in humanness are divided on growth and/or social status. There are numerous human service and social reform movements that advance the "humanization" of certain groups, but that continue to

engage in practices that do not necessarily interpret such groups to the public in a growth-oriented fashion, or that at least are not highly oriented to enhancing the social image and status of such groups. Finally, any number of service measures implied by the normalization principle have really little or no bearing on "humanization" in almost any sense of that already extremely vague term. Normalization not only strives for humanization in relationship between the server and the served, but also between the person being served and his/her larger society.

Normalization as Cure An old and obvious area of confusion is whether normalization means that a person is to be "made normal"; and relatedly, whether normalization implies a "cure." For instance, Daniels (1974) proposed that the word "socialization" be employed because retarded people are more apt to become more social than more normal.

It should be noted most emphatically that the meaning of normalization in a sense of "making someone normal" plays only a limited and highly circumscribed role in any of the above formulations. As mentioned before, Montessori used the term, apparently only once (1950, 1966), to refer to the restoration of disadvantaged children to normative functioning, with heavy emphasis on normative functioning and inclusion *in the schools*. While Danish and Swedish clinical services have indeed performed what would previously have been (and in North America would still be) considered miracles, the Scandinavians have been remarkably modest and reticent in their claims and bend over backward in emphasizing normative means and normative life conditions, rather than "normality" in functioning.

Another point commonly made by a number of leaders in normalization (e.g., Nirje), and formally stated in a major international symposium on normalization (International League of Societies for the Mentally Handicapped, 1977), is that one should normalize environments and not people. Expressions that imply that *people* can be normalized are labeled "misconceptions" (p. 6).

This particular interpretation probably has at its roots a desire to avoid the impression that normalizing people means that they will become normal. However, it appears to be intellectually untenable to deny that normalization can indeed normalize people. Otherwise, how would we manage to interpret all of the following examples of normalization as being only normalizations of the environment: motivating a person to get up in the morning at a typical getting-up hour, performing an operation on a person so as to eliminate or reduce a cosmetic stigma, teaching a person a number of social courtesies that will enhance that person's getting along with and improving his/her social status in the eyes of others, and providing a person with intensive early education that will result in significantly higher social and intellectual functioning than would have been the case otherwise?

In my own work, both written and spoken, I have always emphasized that handicapped or devalued persons might quite well achieve a nonhandicapped and/or nondevalued functioning and status—to some degree depending on the type of the initial handicap or devaluation that is involved. Even in the case of retarded persons specifically, I would not rule out a genuine "normalization of the person," in the sense of normalization as an outcome. However, I would emphatically not define the attainment of such an outcome as being the exclusive essence of the concept, because 1) the concept stresses optimality of means as well as optimality of outcome, and 2) the optimal outcome of an issue for a person may very well be a statistically subnormative functioning. In other words, the optimal outcome for a particular handicapped person might very well be to function at a severely or moderately handicapped level.

It is especially in this controversy regarding "normalization of the person" that the historical roots of the normalization principle in the field of mental retardation become clear. In that field, few people manage to walk consistently along the narrow middle path between hopelessness and irrational and simplistic aspirations for "cure." The valid, but narrow, middle path implies that, on the one hand, aggressive programming *can* result in near-miraculous progress, especially if such programming is initiated early in life. In fact, a young child's mental retardation might even be reversed. On the other hand, even with optimal programming, many retarded people will still remain retarded, especially if programming started later in life. Furthermore, since mental retardation is not a disease but a "final common pathway" of a large number of causal processes, one cannot meaningfully speak of "the cure" of mental retardation. However, one *can* speak either of the reversal of mental retardation or of the cure of medical conditions that lead to the impaired brain functioning that, in turn, results in intellectual impairment.

Often, it seems to be the failure to untangle the above facts that induces people to avoid the conceptualization of "normalizing a person," either because they fail to recognize that there is much that can be normalized about a person even if that person does not attain normal intelligence or because the fact that mental retardation can actually be reversed in some people is unacceptable or unknown to them. Yet, if people who reject the view that persons can be normalized were able to pry themselves away from the Bank-Mikkelsen or Grunewald formulations with their mental retardation orientation, it would immediately become obvious to them that, in *other* areas of human service, any number of people could be restored to "normality" by various normalizing measures ranging from operating on a crippled hand to giving a poor family an adequate income.

Normalization as Mainstreaming The term, and to a major degree the concept of, *mainstreaming* evolved quite apart from normalization.

To my knowledge, Bank-Mikkelsen and Nirje have rarely, if ever, used the term. I have never used it, although I may occasionally refer to a person functioning in the mainstream of society. Yet many people (e.g., Robinson & Robinson, 1976) use *mainstreaming* as if it were synonymous with normalization, even using phrasings such as the following: "normalization (mainstreaming)..." or "mainstreaming (normalization)...."

Social integration is a normalization corollary and is carefully delineated in the *Normalization* text (Wolfensberger, 1972) and even more so in PASS (Wolfensberger & Glenn, 1973a, 1973b, 1975a, 1975b). *Mainstreaming* is a term without a rigorous common definition, and, indeed, is commonly a codeword for dumping and perversion. I have predicted the failure of the kind of mainstreaming that is currently so popularly practiced (see Soeffing, 1974).

Normalization as Single-Path and Monolithic A common criticism leveled at the principle of normalization is that it imposes a single solution upon every problem and thereby deprives clients of variety and choice as well as individuality. In examining, and largely rebutting, this argument, a number of major points are important.

First, there is the fact that at least the Wolfensberger definition of normalization does not simply call for the option that is chosen by the single largest group of people in the culture. Instead, it calls for options that either fall within the statistically normative range, or, and even better, fall within the *supranormative* valued end of the continuum of culturally valued options. Here, we are fortunate that North American society is more pluralistic than many others and that many more options exist for almost everything than in most other cultures. Indeed, there are many regional variations, and even a phenomenon that tends to occur more specifically in one region may still be accepted as neutral or even valued in other regions. For instance, a house in the Spanish style would be found more commonly in the American Southwest, but would still be considered suitable and perhaps even charming in other parts of the country. Another good example is personal dress, where individuals have an almost astronomic number of normative choices and ways of expressing their personality without any loss of individualization. Thus, in our culture, there is such great diversity that every issue has a number (and possibly a very large number) of solutions that fall into the culturally neutral, or even positively, valued range. Thus, one can say that the common is normative, but that the normative is not necessarily common.

A second major point relevant to the argument is the fact that only too often devalued people are *forced* into deviancy and are denied real choices for culturally appropriate circumstances. Even where a choice appears to exist, it is often a phony one. For example, elderly people are

often said to want to live in segregated congregate high-rises and similar ghettos. Indeed, only if cheap, subsidized high-rise living is the major alternative offered by society to nursing homes on the one hand, and to the lack of meaningful services to support independent life in one's former normative and integrated dwelling on the other, then the segregated deviancy setting of the high-rise becomes a welcome choice for many elderly people.

Thus, for the largest number of devalued persons, the *right not to be different* in certain dimensions of living is actually a much more urgent issue than the right to be different. When we recall that the overwhelming response of society to devalued people is segregation, expressed partially by its confinement of vast numbers of citizens to institutions and partially by sequestering devalued people in other nonnormative settings, we realize that the right not to be segregated and institutionalized (which is almost equivalent to being made different, or more different) is really a bigger issue than the restriction of individual choice, which, left to itself, would more often than not result in a choice of something that would fall within the range of the cultural norm anyway.

Third, it will, of course, come down in many instances to the questions of whether or not a person *wants* to be accepted, whether or not a service worker *wants* a person or group to attain acceptance, and what price one is willing to pay in the pursuit of that goal. No society, and not even any one person, extends unlimited acceptance to all behaviors, and society imposes limitations on a large variety of individual choices, although some societies do this much more so than others. Thus, the very nature of the social process also requires that individuals deny themselves certain options and choices, and this applies as much to devalued persons as to valued ones, even though devalued persons may be at a disadvantage in many respects. Moralizing exhortation by itself that people should be more accepting will not resolve this problem, while social change agentry is highly apt to bring about at least some improvements.

In sum, then, the uniformity and de-individualization argument is patently ill-informed, and is probably a reflection of an inadequate understanding of the normalization principle. In contrast, an unresolved, and to some degree unresolvable, dilemma is the conflict between the culturally normative right to choose (which itself is consistent with the normalization principle) and the fact that what is chosen may very well be inconsistent with the normalization principle, although it may not be illegal. A very common example of this conflict is that between age-appropriate and culture-appropriate personal appearance on the one hand, and the right to choose inappropriate appearance on the other. Thus, some devalued (e.g., mentally handicapped) persons may deliberately choose to be poorly groomed and inappropriately dressed. The fact

that they deliberately and consciously exercise such a choice is itself culturally normative, even though the content of their choice (i.e., their social appearance and image projection) is not. How to resolve instances in which two normalization corollaries clash is addressed in a later section.

Normalization as Only Applicable to the Mildly Impaired A very common, misconceived critique of normalization is that it only applies to mildly impaired people. This critique seems derived from two false notions, either that one can do little or nothing for severely impaired persons and/or that normalization is not normalizing if it does not result in complete restoration.

Aanes and Haagenson (1978), and Anderson, Greer, and Dietrich (1976) are among those who endorse the view that there is a high inverse relationship between the applicability of normalization techniques and the level of functioning, and that normalized methods are least applicable to the most impaired individuals. While it is quite likely that some such negative correlation does exist, it probably is much lower than most of its proponents realize. The problem is that, even to begin with, many people are not willing to even try (not to mention, exhaust) normalized methods when working with individuals perceived as very different.

Normalization as Demanding "Normalize or Perish" I suspect that it is from a failure to study the normalization literature (i.e., the major formulations, and material related to their implementation) that has resulted in many people mistaking normalization for some perversion thereof that they (and I) have observed. Thus, many people are under the impression that normalization implies the imposition of grim, unrelenting demands that can or even will bring clients despair, misery, or emotional breakdown. This view is very common and close to the other misconceptions of normalization as monolithic, all-or-none, or only suitable for less impaired people. An example of such a critique is Schwartz (1977) who charges that normalization places "an undue burden upon the retardate's (sic) psychic structure by exposing him to constant and repeated frustration of enormous magnitude...." (Interestingly, the only reference cited in this two-page critique was Freud.) Obviously, normalization does just the opposite in affording a person "success" in any number of forms, from decent housing, decent treatment, and dignified forms of address to successful interactions with the physical and social environments.

The latent danger in the "normalize or perish" critique must be recognized: it is a potential or actual pity attitude and often hides a call for (presumably) protective institutionalization. In one instance where program leaders viewed normalization as grim, handicapped adults were immersed in recreational programs as a life-style, and were thus denied an

adult image as well as the opportunities to earn self-support, to escape life-long poverty and dependency on agencies, or to attain adult self-concepts.

Normalization as Unrealistic Another misconceived critique appears to be either related to the above notions or is derived from failure to understand *any* of the three normalization formulations, and that is that normalization is "impractical," "unrealistic" (e.g., Simmons & Tymchuk, 1976), or "idealistic" (obviously in the pejorative rather than positive sense of the term) (e.g., Schwartz, 1977).

The critique by Vitello (1974) (less than the equivalent of one page in length) seems to fall into the same category by implying that normalization had been tried before and by listing all sorts of cautions—as if it were the application of normalization that were to be feared, rather than its perversions, as discussed further below. Phrases, or titles of speeches or publications such as "Normalization Gone Too Far?", or "Beyond Normalization" (one can be found in Rosen, Clark, & Kivitz, 1977) also imply that normalization has already been here, and now that we have seen it, and know what it can and cannot do, we can move on to something better.

In the late 1970s, in one of the many legal suits over the rights of retarded people, one of the lawyers for the defense waved a copy of the Wolfensberger (1972) *Normalization* text (which has a big red circle on the cover) in front of the court and shouted something to the effect that "this book, produced by social engineers, has been accepted in the same way that teenagers accepted hula hoops in the 1960s."

Many of the responses to the principle of normalization remind me of Conolly's 1847 (1968) observations on the response of his contemporaries to the proposals of moral treatment and the abolishment of forcible physical restraint. In 1838, a Mr. Hill from Lincoln Lunatic Asylum had declared that "in a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of lunacy whatever." Conolly continues:

> This sentence, when published in 1838, was declared, even by those most inclined to the new system, to be too decided, and likely to produce a bad effect; but fortunately the lapse of eight years has proved its perfect truth, by its adoption as a principle in all the most important asylums in the kingdom. But the upholders of the old system received the announcement of a doctrine so startling as if there were something atrocious in proposing to liberate those who were unfortunate enough to be insane; and for years after restraint had been actually abolished, the non-restraint system was declared *"utopian"* and impracticable; then declared to be practicable, but not desirable; and at length, when every other argument has failed, those who have so strenuously opposed it come forward and claim it as their own system,

which they have been practising for years, excepting that it is carried a little further.

Normalization Lacks Evidence Because of the importance of this false claim, it is dealt with in chapter 5 (Wolfensberger) of this book, "Research, Empiricism, and the Principle of Normalization."

Miscellaneous or Mixed Issues Mesibov (1976a), in three short pages, implied that normalization has become a deeply established and widely practiced principle when, in fact, it is a constant struggle to secure even the most modest compliance with almost any of its implications. Mesibov further stated that normalization is not necessarily improving public attitudes, even though normalization has barely even begun to be implemented, and many of those normalization implications that can be expected to improve public attitudes have very clearly been stated as requiring a long time (Wolfensberger & Glenn, 1975a, 1975b), perhaps even generations. In fact, the rationales behind many PASS ratings are based on relatively well-established, but long-term, systemic public attitudinal change mechanisms.

Mesibov further claimed that the normalization principle deals only with service systems, and not with individuals. This statement is also inaccurate insofar as some implications deal with one, some with the other, and some with both, as would be revealed by even a rather cursory perusal of the *Normalization* text (Wolfensberger, 1972), especially the table on page 32 that shows the implications on the individual or primary group versus the systemic level (for a very similar table, see Table 4, p. 17, of Wolfensberger's chapter 1, this volume) and chapters 4 and 5 that are entirely based on this distinction. Perhaps Mesibov confused PASS as an assessment device of service systems with the application of normalization implications to the welfare or adjustment of specific persons. Thus, Mesibov appeared to have confused certain aspects of normalization application with the measurement of agency implementation of normalization.

Mesibov also equated normalization with doing what everybody else does. It is true that the normalization text did not address this issue very well, but the PASS instrument and publications (Wolfensberger & Glenn, 1973b, 1975b) most certainly did, as have any of my more recent publications on normalization. Based on the above misconceptions, Mesibov finally concluded erroneously that the normalization principle does not permit the extension of extraordinary supports, since these presumably would not be "normal."

The astonishing "alternative to normalization" that Mesibov proposes is "cognitive ecology, or positive self-feelings," and measurements of individual development (which is specifically rewarded as good practice in one of the PASS ratings). These alternatives are presented in less than one page.

In a companion piece, Mesibov (1976b) also advanced several factually inaccurate interpretations of the normalization principle and its history. For instance, he equated mainstreaming with normalization, and claimed that Wolfensberger insists on mainstreaming all handicapped children into regular classrooms—which, as mentioned earlier, never at any time has been the case.

Unfortunately, several of the brief responses to Mesibov's article (1976b) are also inaccurate. James Chapman and Dennis Hansen, one arguing pro and one con, both misunderstand Wolfensberger's normalization definition and its implications. Responses by Betty Pieper and Albert Scheiner are by no means comprehensively addressed to all of the relevant points, but are on target. The fourth response by Ruth Sullivan is also relatively on target despite some soft spots. The response by Smucker seems to be totally devoid of awareness of the major normalization formullations.

Beckman-Brindley and Tavormina (1978) claim that handicapped people owe some product or service to society in return for what they receive from it, that proponents of normalization have failed to recognize this obligation, and that the normalization principle has sometimes been "overused." (An interesting phrasing that is really not viably employable within normalization theory, since one can only speak either of degrees of implementation of the normalization principle or of misapplication versus application.) In response, one can seriously argue whether each and every person has obligations toward society. If taken to its logical conclusion, an elderly person who has lost use of faculties and can no longer work or reciprocate intentionally or meaningfully with others is no longer human, should no longer exist, and can or should be put to death; and the same would then apply to all sorts of other impaired individuals, including probably most of the profoundly retarded, and possibly even the severely mentally disordered. Furthermore, quite contrary to the assertions of Beckman-Brindley and Tavormina, normalization proponents have probably been apt to be more overzealous than underzealous in making demands for contributions and social reciprocity from devalued persons. In fact, overzealous proponents are commonly guilty of the assumption that handicapped people are not handicapped, that retarded people are not retarded, and that every handicapped person could do and be almost anything if only provided sufficient role expectancy and opportunity.

Other statements made by Beckman-Brindley and Tavormina that appear to be wide open to skepticism include the following:

1. That a significant number of proponents of normalization demand that retarded people should *always* remain with their families. The

fact is that normalization zealots are likely to call for the relocation of retarded adults away from their families even when the normalization principle might allow for continued residence of a retarded adult within the parental home.

2. That retarded people should *always* work in culturally normative settings. In fact, I do not recall meeting a single normalization advocate or even zealot who has not recognized the need for at least some type of sheltered work conditions and circumstances for at least some retarded persons.

I do agree with Beckman-Brindley and Tavormina that a number of normalization zealots have implied that no retarded persons ever need to reside in settings that are not fully homelike; and there are indeed some zealots who would force sexuality upon retarded people, regardless of their capacity to respond appropriately and adaptively.

The authors advance additional problematic criticisms of normalization, including the peculiar argument that normalization implications would demand financial costs disproportionate to the gains. It is hard to understand how this claim can be made in the face of the funding of snake pits such as Willowbrook that cost well above $30,000 per resident per year (in 1977–78) for instant dehumanization, and the fact that millions of elderly people are being railroaded into incredibly expensive congregate and subsidized housing and nursing homes that are mere death machines. One should really consider whether one can speak of disproportionate cost as long as a program is honest and the gains are real, *and* considering the vast sums of money now being utilized in a systematized large-scale fashion to denormalize and dehabilitate people.

However, Beckman-Brindley and Tavormina are certainly correct in pointing out that the social costs upon the family and the other social systems involved must be considered when normalizing the circumstances of a handicapped individual. Again, I can hardly think of any normalization zealots who would insist that handicapped persons should remain within a family if this *really* meant bringing the family to ruin, or that a handicapped individual should be integrated in a school or work setting if that school or work setting were brought to nonfunctionality. However, what many normalization proponents would say is that many such moves may have not been undertaken with good faith, may have been subject to attempts at sabotage, or may have lacked adequate preparation and support. Thus, the fact that some breakdown is in fact occurring in no way is to be considered proof that there is not a viable normalizing option; and although they reflect a kernel of truth, Beckman-Brindley and Tavormina fail to ask the correct question. For

instance, they pose questions such as "can *this* family maintain *this* retarded person without dissolving its other ties and without extreme cost to one or more of the other family members?". Within an aggressive but realistic normalization framework one would probably rephrase the question as follows: "Have all resources and avenues been considered, explored, and deployed so as to prepare the environment and provide the supports that make it possible for this retarded person to remain in this family without overloading the adaptation capacity of the family or any of its members?"

Clearly, the difference between the two formulations is profound. The former formulation follows a long clinical tradition of putting the burden of deficit and adjustment upon the victims, in this case the handicapped individual in the family; the latter formulation places a strong obligation upon the social system to permit and support adaptations that enable people to be less impaired, or less impaired by impairment. The very same type of analysis can be applied to several other problem formulations posed by Beckman-Brindley and Tavormina.

Aanes and Haagenson (1978) pointed out correctly that many people fail to appreciate that normalization is consistent with goals, outcomes, and ends, as well as with means. However, they then fell into a trap in claiming that normalization as a means becomes important only if the normalizing means are the most effective and efficient method to obtain the normative goal. This conceptualization appears to fail to take into account the entire image issue, which is concerned with the avoidance of deviancy imagery and the bestowing of valued images upon devalued people. Thus, in many situations, it may be entirely desirable to trade off some of the theoretically attainable normative outcomes for the sake of utilizing more highly valued and more positively imaging methods, even if these are not as effective as some less enhancing ones might be.

Aanes and Haagenson further appeared to endorse Throne's (1975) criticism that claimed, among other things, that normalized methods cannot be expected to lead to normalized behavior. Of course, as explained above, this criticism is only fractionally true. If normalized methods were used throughout a person's lifetime, from the onset of the person's devalued differentness or even before, it is highly probable that a great many normalized behaviors would be established. However, hardly any serious thinker would propose that culture-alien and peculiar-appearing methods should *never* be used in order to enhance behavior. At the same time, very little effort has typically been made to convert, translate, and restructure culturally peculiar methods so as to make them more enhancing. An outstanding example of how this might be done was the translation by O. R. Lindsley of the often culture-alien and cold be-

havior modification technology to the more normative "precision teaching." It appears to me that precision teaching might very well be called the culturally most normative version of behavior modification.

While Aanes and Haagenson clearly recognized the difference between means and goals, nowhere did they address the whole issue of trade-offs or relative weightings of methods in relation to their normativeness and likely results. Yet this issue is at the crux of the whole debate of goals versus means, as noted later in this chapter.

A flyer put out by a major university-based mental retardation program, announcing a new slide show and audiotape on "Normalization: A Service Delivery Perspective" (apparently 1978) stated that "normalization, as a human service delivery philosophy, has its roots in the deinstitutionalization movement. This movement...began in the early 1970s."

Misconceptions have a way of compounding. For example, Crnic and Pym (1979) cite the articles by Mesibov (1976a) and by Rhoades and Browning (1977) as making it "clear that the normalization process has certain shortcomings" (p. 13). Feeding off these two misguided articles, they conclude that providing handicapped people with supervision in their community residential setting "compromises the normalization ideal," whereas "strict adherence to normalization principles may at times interfere with retarded individuals' need for help, and consequently their ability to live independently" (p. 16).

Concluding Reflection on the Sources of Controversy

Most of the controversy about the definition of normalization is derived from ignorance about the fact that there are major competing formulations and/or from failure of scholarship in studying the available formulations and their relevant literature. The latter problem may well derive at least in part from failure to take the scientific-scholarly challenge seriously enough for a term that has such a popular-sounding name as *normalization*. I cannot imagine that so much terminological and logical sloppiness would have occurred if people had been confronted by a Greek or Latin neologism instead. How about "orthofactorization"?

One remarkable thing about the majority of published critiques of the normalization principle is that they consist of extremely short articles that attempt to resolve an issue that is derived from an incredibly complex theoretical system by means of very brief and superficial points of analysis. These articles tend to range from one to four pages in length. Another remarkable feature is that many of them do not cite bibliographic references to expositions of the normalization principle, and perhaps do not utilize any references at all.

The fact that many of the critics cited above either have failed to understand earlier definitions of normalization or have made up their own and failed to make this clear, does not detract from the fact that the authors involved may have made valuable observations and contributions. For instance, Tennant, Hattersley, and Cullen (1978) point out correctly that many people have one-sidedly emphasized either the improvement of skills of handicapped people or the provision of more normative environments, but that few have done both.

OUTRIGHT PERVERSIONS OF NORMALIZATION

In life, there are mistakes—stupid mistakes and smart mistakes—and then there are perversions that are no mistakes. Also, there is nothing good in the world that will not come under attack—and I mean under hateful attempts to destroy that which is good so that something that is evil may prevail. Thus, it is fully to be expected that some despicable practices will be advanced under the pretense that they reflect normalization. It is because of the enormity of the universal dynamic of perversion that I have given this issue a separate major heading rather than treating it more logically under one of the other applicable headings.

How "mistakes" can reveal themselves to be perversions was brought out in a critique of normalization that attributed to me a claim that was precisely the *opposite* of what I had said. When the error was brought to the author's attention, the author refused to write an erratum, and the editor of the journal (McDowell, 1977) had to write a correction.

An unbelievable amount of perversion is perpetrated in connection with residential institutions, both public and private. Some of these, as they pertain to normalization claims, are documented below.

> *We try to humanize first, then normalize* (Chief of Service in a New York institution).
>
> *Institutions are normalizing, because society has used them for a long time as the normal way/place to treat retarded people* (Director of Staff Development in an Ontario Hospital School).
>
> *Normalization is making the institution as normal as possible.*
>
> *X institution—A place to be normal* (a slogan used by a certain institution).
>
> Interpreting the death of a client due to lack of supervision and concern as the *"dignity of risk."*
>
> *We try to normalize here; we monitor the TV and try to pick the most enhancing shows* (a New York institution).
>
> *Our barber at the institution here once was a retarded resident himself.*

A woman was denied her request for a different and shorter haircut because *it is normal for women to have longer hair.*

It is normal for children to walk to school, so we are building a school on our institution grounds.

Regulations in one institution required that residents' gums be *cleaned out* before each meal, which was referred to as *"oral normalization."*

The Plymouth Center for Human Development in Northville, Michigan (formerly the Plymouth State Home and Training School), a relatively new institution, had been in the news for several years during the late 1970s because of an uninterrupted string of abuses that have rocked the state mental health department and resulted in a series of resignations and reassignments of personnel. None of this would be inferable from the agency brochure which, during this time, included the following statement: "the staff and administration of the Plymouth Center for Human Development are committed to the principle of normalization." Indeed, the Department of Mental Health that has run these "human development centers" has long contained an administrative unit called the DMH Treatment and Normalization System which, however, had apparently done very little to study *any* normalization formulation.

At the Newark Developmental Center for the retarded in New York State, normalization meant renaming buildings Disney Residence, Maple, and (ironically) Liberty.

One recurring perversion is to refer to institutionalization as normalization, and/or to people's living in bizarre institutional settings as normalizing. Examples are found in *Transition,* 1977, *5*(5), 2, and in any number of advertisements for institutions, especially private ones.

One private institution, which includes among its buildings one that houses 300 residents, stated that one of its goals was to help residents achieve maximum normalization, which it proposed to accomplish by serving, "as always," as many people as possible on its institutional grounds.

I have in my files a letter from a parent complaining of the security screening of visitors to the institution where her handicapped son resides. These procedures resemble those that one might expect at a minimal security prison. I also have in my files a letter of explanation sent to the parents by the administrator of the facility. Among other things, the letter says "We ask all parents to comply with this request...not that we wish to know the whereabouts of parents but we must provide as reasonable protection as we can, keeping in mind our policy of normalization."

One proposal for a new small institution, called a "village," claimed "the concept of a village is new and unique" and reflects the principle of normalization in that it provides a "complete residence with recreation

and those other public services normally available in rural villages." The village would also include a horticultural work activities center to serve a "therapeutic purpose," many types of arts and crafts, and a great deal of recreational activities. Major reliance is to be placed on Foster Grandparents to establish a "symbiotic-like relationship between the retired and the handicapped."

One program called itself "an institutional based system of community services: a total normalization program."

I attended a session in which a lengthy presentation was given that professed adherence to the normalization principle, followed by the presentation of a slick planning document for a 400-place institution, which has since become the Ludemann Center in Illinois.

In one state, the construction of seventeen "group homes" on ten acres off an already large state institution was heralded as a normalizing move that enables retarded people to reside in a homelike environment.

An example of (proudly) equating the creation of an unequivocally abnormal and dehumanizing institutional environment with normalization—merely because it replaced an even more degrading institutional environment—is found in a series of reports on the renovation of wards at Belchertown State School, Massachusetts (Knight, Zimring & Kent, 1977; Knight, Zimring, Weitzer & Wheeler, 1977). There is perhaps (I am not sure) some merit in renovating an institution ward, but why does it have to be trumpeted as normalization when one does such things as putting low partitions among the beds in a warren-like dormitory?

One of the many strategies of perversion is to apply the same word to mutually opposed phenomena. Thus, we not only commonly see institutionalism but also the most dumping kinds of deinstitutionalization referred to as normalization or normalizing. In fact, I have read passages that included text as follows: "...deinstitutionalization (i.e., normalization)...", or something very close to it (e.g., Zigler, 1977).

One of the most blatant and certainly evil (though unconsciously humorous) perversions of normalization was perpetrated by the Department of Mental Hygiene of the state of New York. In a memorandum to its key executives across the state, dated February 14, 1975, it said: "The Division of Mental Retardation in its commitment to the policies of normalization and community repatriation is seeking to identify all residents of Developmental Centers (the state's euphemism for its mental retardation institutions) who might be appropriately placed in a Nursing Home or Health Related Facility."

As perverse as claiming that deinstitutionalizing dumping is normalization is the claim that normalization calls for such dumping. An example of the equation of normalization with deinstitutionalization is an article by Cochran, Sran, and Varano (1977), who then blamed normal-

ization for all sorts of problems that have occurred in conjunction with the mindless and dehumanizing deinstitutionalization practices on the current scene. In fact, to my utter amazement, they even equated nursing home placement with deinstitutionalization. They then proceed to cite five case studies of deinstitutionalization abuse, and thus by a chain of inferences and juxtapositions, normalization is not only distorted but also blamed for exactly the kinds of things to which normalization tries to address itself. In many ways, this article is a classical example of "blaming of the victim," normalization having been made the victim by being distorted, and then held accountable for abuses.

Another example of how a superficial understanding and commitment to normalization can lead to perversions and profound errors is an article by Holbrook and Mulhern (1976). The authors begin by correctly pointing out some of the relevant features and rationales of the physical integration ratings of PASS, but then propose, in order to normalize a facility so as to eliminate the need for walls, fences, and other obstacles, to install an electronic surveillance system—which itself would stand in crass violation of culturally valued features, and would score at the bottom of culturally appropriate environmental design and appointments, and perhaps even deviancy image juxtaposition.

A most interesting development that may very well be a gross perversion of the normalization principle is the increasing number of human service agencies that prefer criminal charges against their own clients. For instance, one institution for the mentally retarded pressed charges against one of its residents for pulling fire alarms, upon which the resident was placed in a psychiatric forensic prison unit, and eventually transferred to a facility for the so-called criminally insane. In another instance, in Canada, a small institution for children that is supposed to be a model facility, placed charges against a fourteen-year-old girl which resulted in her transfer to a correctional training school where she committed suicide (*Toronto Globe & Mail,* November 3, 1976).

Of course, perversion of normalization occurs everywhere, including in connection with community services. For instance, one mental health administrator in New York said "community mental health *is* normalization." Somebody else said that normalization means that, if necessary, one uses violence to make nonnormal people normal, or at least to make them act in acceptable ways.

Some human service-related product manufacturers have also jumped on the normalization perversion bandwagon. Thus, we see advertisements for a type of cassette player (Wonder Tape) that state that the machine "can provide the handicapped individual with a friend... which is a true example of the normalization process." How sad: the friendless rejected are given a talking machine, and this mechanical "friend" constitutes normalization!

One interesting critique of normalization falls somewhere between, or on top of, both the perversion category and the failure to understand any normalization formulation. To my knowledge, the New Jersey Division of Mental Health and Hospitals was the first state mental health structure that attempted to introduce the principle of normalization as a genuine program policy into the state service system. Although the implementive measures that were taken were relatively modest and far from radical, they elicited venomous opposition from the New Jersey Psychiatric Association who declared normalization to be "a fraudulent idea," and "we don't even consider what is being done as treatment." Among the staff of the mental health institutions, it was mostly the psychiatrists who were opposed to the introduction of normalizing measures in the old and, in some instances, abominable institutions. Gratifyingly, the human services commissioner, whose department oversees the state mental health division, challenged the psychiatric profession to state "exactly what was so wonderful in the past that we ought to return to?" Also, she pointed out that the psychiatric association had not protested the earlier abuses and impossible situation of the institutions (*Trenton Sunday Times Advertiser,* August 2, 1977).

One phenomenon, which is evident in some of the critiques cited earlier, is the issuance of all sorts of warnings about the likely or impending failures of normalization and the implication that anything that can be perverted cannot be valid. I admit that I suspect perversion in many concerns with a refutation of the normalization principle when it has scarcely been implemented anywhere to any degree whatever and when devalued people are still massively and persistently the objects of rejection and destruction. To criticize normalization because somebody has committed some atrocity against a devalued group of persons and then labeled the atrocity normalization is no less an absurdity or atrocity.

SOME CLARIFICATIONS

Some further clarifications, at least as they pertain to the Wolfensberger formulation, are presented below. I hope that these clarifications, together with the foregoing material, will lay a few of the confusions or criticisms to rest.

Differentiating Process and Outcome

People have considerable difficulty in using the terms *normalization, normalizing,* and *normative* in a fashion that clearly distinguishes their process from their outcome implications and meanings. For instance, when the expression "normalized" is used in relation to outcome, such as "normalized appearance," one should then assume that it refers to appearance that falls within the culturally expected or valued range. In

contrast, when describing a measure that is part of the service process and methodology, one might refer to it as being highly normalizing even though this does not necessarily guarantee that it will be effective when applied to a specific individual or setting.

Differentiating Degrees of Normalization

It is often helpful to speak in terms of full or partial normalization, particularly since I have defined normalization as being both a process means as well as an outcome goal. A concept that is quite simple but with which people have considerable difficulty in practice is that of "stepwise incremental normalization" (first proposed by Fritz, Wolfensberger, & Knowlton, 1971). Actually, this concept is not unique to normalization, but is equally relevant to most developmental processes. It implies that in order to make any progress at all, it is often necessary to advance in very small and highly sequential stages. A child cannot progress from crawling to running without going through several intermediate stages, such as standing, taking one step, toddling a few steps, and walking. If any intermediate stage is not mastered, and perhaps even mastered *slowly,* the final stage may either never be reached, or may be attained imperfectly.

As obvious as such a phenomenon is, it is remarkable that in many of our human services we fail to provide all sorts of intermediate stages; and quite clearly, this is not always due to lack of resources, but due to lack of internalized recognition of the necessity for the existence of such intermediate stages and options. This reality is forcefully brought home when we consider such concepts as "*the* half-way house" which used to be prevalent in mental retardation, and still is very prevalent in fields such as mental health, corrections, and drug abuse. In practice, the developmental distance that the client has to bridge between a half-way house and independent living may be wider than that between the institution and a half-way house; and if additional intermediate residential options do not exist, the client may never achieve residential independence. In contrast, if a client can progress from institutional to independent residential living through small stages of perhaps three, four, or even five or more different residential settings that offer progressively more freedom and options, that client's movement through these developmental stages may be remarkably rapid. In fact, a client might move faster in a year by means of very small stages of progress than he/she would have in decades—if the giant steps were the only options available.

Analogous examples can be given for many other program areas. For instance, in the vocational area, we often speak of "the" sheltered workshop rather than of "vocational service systems," which provide a

large number and wide variety of settings and options which afford small —in some instances even minuscule—steps forward (e.g., DuRand & Neufeldt, 1975 [chapter 12, this volume]), rather than demanding giant leaps that would be implied in a move from most sheltered workshop situations into most types of independent employment. Totally revealing of the lack of a sequential incremental normalization conceptualization in this area is the fact that to this very day, there are very few localities in which the agencies that operate sheltered workshops also have physically and/or socially integrated work stations in business and industry. Such work stations are places in ordinary normative open business or industrial settings in which handicapped workers may work under potentially still highly sheltered conditions—perhaps even under the supervision of sheltered workshop personnel (DuRand & DuRand, 1978). The clients might be integrated with regular workers, or segregated in a separate and sheltered part of the physical plant. In fact, such work stations typically would function under the federal wage and hour exemption certificate of a sheltered workshop. Such work stations are vastly—indeed, incredibly—more effective in normalizing the lives of handicapped workers than are sheltered workshops. Also, they are much less expensive and are relatively easy to set up. Thus, it seems that only the lack of relevant program concepts, rather than the lack of funds or the presence of other obstacles, can explain the scarcity of these options.

It cannot be emphasized enough that program managers need to conceptualize the process part of the normalization definition as consisting in most instances of a relatively large number of possibly small sequential measures that build successively upon each other. At the same time, it is also important to keep in mind that some developmental sequences are independent from each other and that progress in one of these sequences should not be made contingent upon progress in another. Thus, independence in residential living is often unrelated to independence in economic productivity and wage earning; therefore, a person who may not be able as yet, if ever, to work independently on the open market should not be held back from obtaining unsheltered residential living if he/she is capable thereof. Similarly, many other behavioral sequences are at least *partially* independent from each other, such as speech development and toilet training; children should not be kept out of school because they have not yet learned to walk, notwithstanding the common school regulations of the past; and similarly, children should not be excluded from educational programs because they are not toilet trained. A great deal of work can be expected from the human frontal lobes and the perceptual areas of the brain even when their input to the functioning of the anal sphincter is rather modest.

Differentiating Physical from Social Integration

One application of partial normalization is to differentiate between full or partial integration, particularly in the light of the confusion that prevails around the meaning of the concept of mainstreaming. Strictly speaking, pursuant to the structure of my definition of the normalization principle (Wolfensberger, 1972), a person could be said to be normalized or integrated when he/she has achieved the approximate limit of what normalizing measures can accomplish, or whatever degree of integration can be fruitfully attained. However, to paraphrase St. Paul, it is better to be redundant than to mislead; therefore, the phrases "partial normalization," or "partial integration," are preferable even where such partial normalization or integration is the maximum feasible or attainable one.

Additionally and relatedly, it is absolutely essential to differentiate between "physical integration" and "social integration." Too often, the term *mainstreaming* is utilized for what normalization parlance might merely call physical integration. Indeed, the concept of integration has so many components that it was necessary to devise 14 different "subscales" to assess it quantitatively within the context of the Program Analysis of Service Systems (PASS) (Wolfensberger & Glenn, 1973a, 1973b, 1975a, 1975b), which is an instrument that quantitatively measures the quality of human services, largely in relation to normalization criteria. These 14 components are grouped in Table 2.

Recognizing That Normalization Corollaries May Clash With Each Other

A major stumbling block to many people is the fact that different normalization implications may clash with each other, either in regard to a specific person or in regard to a group of persons or a service setting. One common example is that the service setting most valuable in terms of convenience of access to its population may also be located in an area (e.g., city core) that is already overloaded with services to devalued people, thus eliciting community rejection, and further devaluation (e.g., see Wolfensberger & Glenn, 1975b). Another example has already been mentioned: a devalued person may normalizingly choose a denormalizing measure, such as offensive grooming or garish clothing. Persons who adhere to the normalization principal are therefore confronted with demanding decisions as to what to do when they are relating to a person who chooses nonnormalizing options. Often, people flunk this test because of lack of understanding of the subtleties of normalization or simply because of lack of wise judgment needed in such a complex situation.

Table 2. Fourteen components of integration as defined in PASS

- 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*

Note: The 14 components are italicized.

The utilization of the term *normalization* either as a legitimizing slogan or in a fashion that lacks awareness of the fact that some normalization corollaries may be in conflict with each other was displayed in an article entitled "Surgical Contraception: A Key to Normalization and Prevention" (Bass, 1978). The article was written by a long-time advocate of the sterilization of the retarded who had published earlier articles in journals such as *Eugenics Quarterly*. Despite 56 references, not one of them was a major normalization reference, the title of the article notwithstanding. While it is certainly reasonable to expect that many retarded people will lead more valued lives without bearing, or having to rear, children, there are also some normalizing benefits in parenthood. Also, many instances of sterilization would have to involve nonnormative, devalued, and undignified coercion, court orders, etc. Thus, if we assume that no sloganeering was involved in the article, a more appropriate title would have been "Normalization Issues Involved in the Surgical Sterilization of Retarded People."

A series of considerations and choices are presented below that should be reviewed by the person who is confronted by the dilemma of a

client pursuing a denormalizing option. Underlying this sequence are three related principles: first, one pursues the line of persuasion, pedagogy, modeling, and other forms of culturally normative social influence to steer a person toward a course of action one desires. Second, one imposes coercion only where one would do so legally in the larger societal context, i.e., where one would do so with other (valued) citizens of the same age. Third, one chooses the least restrictive alternative if one does coerce. Thus, one proceeds as follows:

1. As a precondition to almost any course of action, it is often necessary (especially with adults) to determine whether a person understands the problem that is at stake, the specific aspect of his/her own functioning and identity, the likely (or even quasi-certain) consequences of his/her own behavior, and the nature of a proposed measure.
2. In order to raise a person's level of understanding, or to move him/her toward a desired course of action, the utilization of *culturally normative informal* avenues or social influence should be explored and applied to the point of grossly diminished returns. Many people who choose nonnormalizing options have had little or no relevant education or training, perhaps have never had the opportunity to interact in a positive fashion with a valued and adaptive age peer, and/or have never had the nature and consequences of their choices interpreted to them. Thus, numerous options are typically available for noncoercive change, including systematic and long-term reinforcement for emitting the desired responses. Except in emergency situations, coercion should not even be considered until social influence options have been exhausted—and only too often these have never even been tried in a valid fashion.
3. Particularly where adults of legal age are involved, it is often essential to ascertain a person's level of competency for making important decisions.
4. In instances in which a person does not appear to be competent, it must be determined who is formally responsible for the person under law and/or informally in fact and practice. Here, one must not merely be oriented to the formalities of the law, but also to the realities of special social relationships, and an individual who has carried de facto responsibilities for the person in question should be accorded extensive respect and participation in the decision-making process.
5. If a person is a minor without a competent guardian or an adult who is significantly impaired in competence, a guardian should be appointed. This guardian should be a minimal guardian, i.e., the

guardianship role should be specified by the court to be no more extensive than the person's impairment warrants.

6. In instances in which shortcomings in competency to understand or act do exist, it then becomes important to determine what has been and can be done to increase competency; whether the measures that have been employed have been adequate; and if they have not been adequate, whether there is a reasonable likelihood that additional measures may increase the person's potential for comprehension and competency.
7. In the case of children, coercive methods applied normatively to valued children (exacting obedience, being under the physical and largely also the social control of parents or parent surrogates, etc.) may be applied, although social influence methods should generally be given priority over coercive ones.
8. Before applying coercion to an adult, it should be determined whether the issue at stake is so important as to warrant the coercion. The issue should be carefully examined not only in its own right, but also in relation to other issues that involve the person, and that may very well have a higher urgency. An issue that may be important, if it is the only one at stake, may recede into insignificance when it coexists with half a dozen other and even more important ones.
9. It is important that, to the highest degree possible, the person understand not merely the demands made upon him/her by an interventive measure, but also the likely benefits if the measure is successful, or the potentially unpleasant consequences if it should fail.
10. The people in power who are involved should develop a clear picture in their minds just what is at stake in the proposed intervention, what infringement of the person's rights might be entailed, and what the upper and lower limits of the likely outcomes are apt to be.
11. If proper legal and moral means are used to override a client's wishes and rights, the duration of this state of affairs is to be considered. Other things being equal, short-term structures are more defensible than long-term ones.
12. Legalities, lack of resources, the person's condition, etc., may be such as to render effective intervention an impossibility, at least in terms of making a significant difference in a person's life. In some cases, all one can do is to share suffering and walk with a suffering person without effecting more than a moral victory.

The above discussion could continue at considerable length, and many other considerations could be listed. No claim is made that the

issue is treated exhaustively; only some of the more common and illustrative points have been listed.

A related consideration here is whether one has to invoke a trade-off or a compromise. Briefly, a trade-off occurs in a situation in which it is impossible to optimize both horns of a dilemma. In contrast, a compromize implies that both horns can be optimized, but that present conditions are such that one must or does sacrifice something that, in theory, is quite obtainable.

CONCLUSION

In another paper, I plan to discuss the limits of the normalization principle (Wolfensberger, in preparation, b). Like most thought systems or scientific theories, such limits exist, but do not thereby render a concept worthless or even of low value. Indeed, there is little within the implications of the Wolfensberger definition of normalization that is not empirically supportable, and one would almost have to go to metaphysical systems for more broadly applicable concepts. One such system might be radical Christianity, which would subsume much of normalization, but which would also reject some (not many) of its implications. Another competitor might be the "idealistic agrarianism" of various fringe groups; or even idealized socialism, although its implications to some devalued social groups would be unclear, or even catastrophic (e.g., in the case of former landowners or capitalists).

REFERENCES

Aanes, D., & Haagenson, L. Normalization: Attention to a conceptual disaster. *Mental Retardation,* 1978, *16*(1), 55–56.

Anderson, R. M., Greer, J. G., & Dietrich, W. L. Overview and perspectives. In R. M. Anderson & J. G. Greer (Eds.), *Educating the severely and profoundly retarded.* Baltimore: University Park Press, 1976.

Bank-Mikkelsen, N. E. A metropolitan area in Denmark: Copenhagen. In R. Kugel & W. Wolfensberger (Eds.), *Changing patterns in residential services for the mentally retarded.* Washington, D.C.: President's Committee on Mental Retardation, 1969.

Bank-Mikkelsen, N. E. Denmark. In R. B. Kugel & A. Shearer (Eds.), *Changing patterns in residential services for the mentally retarded* (Rev. ed.). (DHEW No. (OHD) 76-21015.) Washington, D.C.: President's Committee on Mental Retardation, 1976.

Bass, M. S. Surgical contraception: A key to normalization and prevention. *Mental Retardation,* 1978, *16,* 399–404.

Beckman-Brindley, S., & Tavormina, J. B. Normalization: A new look. *Education and Training of the Mentally Retarded,* 1978, *13*(1), 66–68.

Burton, T. *The trainable mentally retarded.* Columbus, Oh.: Charles E. Merrill, 1976.

Cochran, W., Sran, P., & Varano, G. The relocation syndrome in mentally retarded individuals. *Mental Retardation,* 1977, *15*(2), 10–12.

Conolly, J. [The construction and government of lunatic asylums and hospitals for the insane] (R. Hunter & I. Macalpine, Introduction). London: Dawsons of Pall Mall, 1968. (Originally published, 1847.)

Crnic, K. A., & Pym, H. A. Training mentally retarded adults in independent living skills. *Mental Retardation,* 1979, *17*(1), 13–16.

Daniels, J. Y. On words. *Mental Retardation,* 1974, *12*(1), 52.

Department of National Health & Welfare. *Mental retardation in Canada: Report, Federal-Provincial Conference, Ottawa, Ontario, October 19–22, 1964.* Ottawa (Canada): Author, 1965.

DuRand, L., & DuRand, J. *The affirmative industry.* St. Paul: Minnesota Diversified Industries, 1978.

DuRand, J., & Neufeldt, A. H. *Comprehensive vocational service systems* (Monograph No. 4). Toronto: National Institute on Mental Retardation, 1975.

Fritz, M., Wolfensberger, W., & Knowlton, M. *An apartment living plan to promote integration and normalization of mentally retarded adults.* Toronto: Canadian Association for the Mentally Retarded (National Institute on Mental Retardation), 1971.

Grunewald, K. (Ed.). *Människohantering på totala vårdinstitutioner: Från dehumanisering till normalisering.* Stockholm: Natur Och Kultur, 1971.

Grunewald, K. (Ed.). *Menneskemanipulering på totalinstitutioner: Fra dehumanisering til normalisering.* Copenhagen: Thaning & Appels, 1972.

Grunewald, K. Sweden: Services and developments. In J. Wortis (Ed.), *Mental retardation and developmental disabilities: An annual review* (Vol. 7). New York: Brunner/Mazel, 1975.

Grunewald, K. Sweden. In R. B. Kugel & A. Shearer (Eds.), *Changing patterns in residential services for the mentally retarded* (Rev. ed.). (DHEW No. (OHD) 76-21015). Washington, D.C.: President's Committee on Mental Retardation, 1976.

Grunewald, K. Community living for mentally retarded adults in Sweden. *Current Sweden,* 1977, *159,* 1–10.

Holbrook, R. C. & Mulhern, T. J. Alternative to walls. *Mental Retardation,* 1976, *14*(2), 28–29.

Howell, S. C. Adapting environments for the developmentally disabled. In D. Bergsma & A. E. Pulver (Eds.), *Developmental disabilities: Psychologic and social implications.* New York: Liss, 1976.

Humphreys, E. J. The President's address: The elephant's child. *American Journal of Mental Deficiency,* 1949, *54,* 14–25.

International League of Societies for the Mentally Handicapped. *Improving the quality of life: A symposium on normalization and integration.* Arlington, Tex.: National Association for Retarded Citizens, 1977.

Knight, R. C., Zimring, C. M., & Kent, M. J. *Normalization as a social-physical system* (Technical Report No. 3). Amherst: University of Massachusetts, 1976.

Knight, R. C., Zimring, C. M., & Kent, M. J. Normalization as a social-physical system. In M. J. Bednar (Ed.), *Barrier-free environments.* Stroudsburg, Pa.: Dowden, Hutchinson & Ross, 1977.

Knight, R. C., Zimring, C. M., Weitzer, W. H., & Wheeler, H. C. (Eds.). *Social development and normalized institutional settings: A preliminary research report.* Amherst: University of Massachusetts, Environment & Behavior Research Center, 1977.

Kugel, R., & Wolfensberger, W. (Eds.). *Changing patterns in residential services for the mentally retarded.* Washington, D.C.: President's Committee on Mental Retardation, 1969.

McDowell, F. Correction. *Education and Training of the Mentally Retarded,* 1977, *12,* 73.

Mesibov, G. B. Alternatives to the principle of normalization. *Mental Retardation,* 1976, *14*(5), 30–32. (a)

Mesibov, G. B. (respondents—J. P. Chapman, D. G. Hansen, B. Pieper, R. C. Sullivan, R. M. Smucker, & A. P. Scheiner). Implications of the normalization principle for psychotic children. *Journal of Autism & Childhood Schizophrenia,* 1976, *6*(4), 360–378. (b)

Montessori, M. *Il segreto dell'infanzia.* Milano: Garzanti, 1950.

Montessori, M. *The secret of childhood.* Notre Dame, Ind.: Fides, 1966. (Dome paperback edition, 1970.)

Nirje, B. The normalization principle and its human management implications. In R. Kugel & W. Wolfensberger (Eds.), *Changing patterns in residential services for the mentally retarded.* Washington, D.C.: President's Committee on Mental Retardation, 1969.

Nirje, B. The normalization principle. In R. Kugel & A. Shearer (Eds.), *Changing patterns in residential services for the mentally retarded* (Rev. ed.). (DHEW No. (OHD) 76-21015.) Washington, D.C.: President's Committee on Mental Retardation, 1976.

Olshansky, S. Passing: Road to normalization for ex-mental patients. *Mental Hygiene,* 1966, *50,* 86–88.

Raynes, N. V., Pratt, M. W., & Roses, S. Aides' involvement in decision-making and the quality of care in institutional settings. *American Journal of Mental Deficiency,* 1977, *81,* 570–577.

Rhoades, C., & Browning, P. Normalization at what price? *Mental Retardation,* 1977, *15*(2), 24.

Robinson, H., & Robinson, N. *The mentally retarded child: A psychological approach.* New York: McGraw-Hill, 1976.

Rosen, M., Clark, G. R., & Kivitz, M. S. *Habilitation of the handicapped: New dimensions in programs for the developmentally disabled.* Baltimore: University Park Press, 1977.

Schwartz, C. Normalization and idealism. *Mental Retardation,* 1977, *15*(6), 38–39.

Shakow, D. Normalisierungstendenzen bei chronisch Schizophrenen: Konsequenzen für die Theorie der Schizophrenie. ["Normalization" trends in chronic schizophrenic patients: Some implications for schizophrenia theory.] *Schweizerische Zeitschrift für Psychologie & ihre Anwendungen,* 1958, *17,* 285–299.

Simmons, J. Q., & Tymchuk, A. S. Therapies of mental retardation. In J. M. Massermen (Ed.), *Current psychiatric therapies* (Vol. 16). New York: Grune & Stratton, 1976.

Sloan, W., & Stevens, H. *A century of concern: A history of the American Association on Mental Deficiency 1876–1976.* Washington, D.C.: American Association on Mental Deficiency, 1976.

Soeffing, M. Y. Normalization of services for the mentally retarded: A conversation with Dr. Wolf Wolfensberger. *Education and Training of the Mentally Retarded,* 1974, *9,* 202–208.

Tennant, L., Hattersley, J., & Cullen, C. Some comments on the punishment relationship and its relevance to normalization for developmentally retarded people. *Mental Retardation,* 1978, *16*(1), 42–44.

Throne, J. M. Normalization through the normalization principle: Right ends, wrong means. *Mental Retardation,* 1975, *13*(5), 23–25.

Throne, J. Unified programming procedures for the mentally retarded. *Mental Retardation,* 1977, *15*(1), 14–17.

Vitello, S. J. Cautions on the road to normalization. *Mental Retardation,* 1974, *12*(5), 39–40.

Wolfensberger, W. The principle of normalization and its implications to psychiatric services. *American Journal of Psychiatry,* 1970, *127,* 291–297.

Wolfensberger, W. *The principle of normalization in human services.* Toronto: National Institute on Mental Retardation, 1972.

Wolfensberger, W. A brief overview of the principle of normalization. In S. A. Grand (Ed.), *Severe disability and rehabilitation counselor training.* Albany, N.Y.: National Council on Rehabilitation Education (State University of New York at Albany), 1977. (a)

Wolfensberger, W. The normalization principle and some major implications to architectural-environmental design. In M. J. Bednar (Ed.), *Barrier-free environments.* Stroudsburg, Pa.: Dowden, Hutchinson & Ross, 1977. (b)

Wolfensberger, W. *Judeo-Christian perspectives on human services.* In preparation. (a)

Wolfensberger, W. The limitations of the normalization principle. In preparation. (b)

Wolfensberger, W., & Glenn, L. *Program analysis of service systems: A method for the quantitative evaluation of human services* (2nd ed.). Vol. I: *Handbook.* Toronto: National Institute on Mental Retardation, 1973. (a)

Wolfensberger, W., & Glenn, L. *Program analysis of service systems: A method for the quantitative evaluation of human services* (2nd ed.). Vol. II: *Field manual.* Toronto: National Institute on Mental Retardation, 1973. (b)

Wolfensberger, W., & Glenn, L. *Program analysis of service systems: A method for the quantitative evaluation of human services* (3rd ed.). Vol. I: *Handbook.* Toronto: National Institute on Mental Retardation, 1975. (a)

Wolfensberger, W., & Glenn, L. *Program analysis of service systems: A method for the quantitative evaluation of human services* (3rd ed.). Vol. II: *Field manual.* Toronto: National Institute on Mental Retardation, 1975. (b)

Zigler, E. Twenty years of mental retardation research. *Mental Retardation,* 1977, *15*(3), 51–53.

Zipperlen, H. R. Normalization. In J. Wortis (Ed.), *Mental retardation and developmental disabilities: An annual review* (Vol. 7). New York: Brunner/Mazel, 1975.