



A Quarter-Century of Normalization and Social Role Valorization: Evolution and Impact

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A contribution to the history of Normalization, with primary emphasis on the establishment of Normalization in North America between 1967-1975¹

WOLF WOLFENSBERGER

1 INTRODUCTION

In recent years, there have been many references in the literature to the early days of Normalization where the authors cited references that were not from the founding period, but secondary or retrospective ones from the 1980s. Among the reasons people cite post-1980 literature when discussing events that occurred up to 20 years earlier appear to be four: (a) they were not on the scene at the time; (b) they do not know the primary literature (perhaps the computer bases that were consulted did not go back far enough); (c) if they do know it, they do not have ready access to it; and (d) they prefer recent revisionist ideas to the historical truth, and therefore avoid the original literature.

So I went to my extensive personal archives and drew on these for this presentation. In fact, this was the first time that I methodically mined my relevant archives from the 1960s and 1970s for Normalization material. Historical revisionists may commence quaking in their boots because I can now cite genuine original sources and prove many of the points I will make.

The material will be presented in distinct sections, roughly chronologically, but with some overlap between time periods. In tracing the history of Normalization and Social Role Valorization (SRV), I

will try to minimize—as much as is practical—overlap with earlier writings on that topic and emphasize new material instead. Therefore, because this congress observes the 25th anniversary of the appearance of the monograph *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel & Wolfensberger, 1969), I decided to devote a disproportionate amount of material to it and treat several other historical elements in much more condensed fashion.

2 IDEAS AND SCHEMES THAT WERE WIDELY PROMOTED AS MAJOR ANSWERS IN HUMAN SERVICES, AND/OR FOR THE CONDITIONS ADDRESSED BY THESE, PRIOR TO THE ADVENT OF NORMALIZATION AND/OR SHORTLY AFTER IT, AND SOME IN COMPETITION WITH IT

In this section, I want to take a look at what the conceptual landscape in human services was like in the years or decades prior to the advent of Normalization, and to some degree overlapping with it, with selected emphasis on services close to the mental retardation field. More specifically, I will try to reconstruct the conceptual schemes that were viewed by many people as broad in scope, or as high-order foundations for

major sectors of human service, or for social change as it related to those human problems that human services addressed, at least somewhat comparable to the way some of us have viewed Normalization and SRV since their advent. Some of these schemes were very much alive around 1970 and were dangerous competitors with Normalization.

Of course, literally billions of people during the last century thought that Marxist arrangements would bring about something close to a paradise on earth, since a huge number of problems were seen to be no more than the fruits of economic and power inequalities, capitalism, and other ills for which Marxism claimed to have remedies. Today, materialistic social theories that assiduously try to avoid the idiom of Marxism but that are otherwise nearly identical to it have taken the place of Marxism in many intellectual and academic circles, and among people who formerly were professed Marxists but are now too embarrassed to admit it because of the recent ignominious downfall of communist regimes and economies worldwide.

For several decades, eugenic measures were seen as the most overarching package of solutions to social problems, and to many clinical and personal ones. This included a massive program of institutionalization, with specialized institutions erected for a large variety of afflicted people—those with leprosy, venereal diseases, TB, blindness, deafness, epilepsy, physical impairments, mental disorder, mental retardation; as well as for the inebriated, juvenile delinquents, orphans, elderly, and paupers—to say nothing of less numerous very esoteric institutions, such as the Home for Jewish Friendless and Working Girls in Chicago in the early 1900s (*Twentieth Biennial Report of the Board of State Commissioners of Public Charities of Illinois*, 1909) or the Home of the New York Society for the Relief of the Ruptured and Crippled.

The poverty of service conceptualization was such that even when the social alarm associated with eugenics had been heavily discredited by about 1930, institutionalism barreled right on for another 30 years in what I characterized in 1969 as “momentum without rationale” (Wolfensberger, 1969a). As I will emphasize repeatedly, there was also very little critique of institutionalism prior to about 1965. Almost everybody was willing to say that this or that could be better about institutions, but one will not be likely to find much in the *professional* literature—at least not

from the human service sector—that said (a) that institutions were awful places, or even (b) that there was anything intrinsically defective about the very idea of large institutions. If there were people who believed these things, they were not afforded a forum to voice such thoughts. What published critique there was of institutions came mostly from a few exposés, and mostly from outside the service system.

In response to both the terrible conditions in institutions of all sorts and to the fact that, nevertheless, waiting lists for them were normatively very large and long, a major reform concept for about 100 years was “more institutions” and “better institutions.” After circa 1930, the cry for more institutional space was not so much motivated by eugenic reasons as it had been before, but simply to reduce overcrowding in existing institutions and to service the huge institutional waiting lists. After all, some institutions had more people on their waiting list than they had inmates.

What did people mean by “better institutions”? Above all, they meant less crowding, and reducing it was widely considered to be the single biggest key to improving institutional conditions. They also meant things such as smaller dormitories², smaller wards, more cleanliness, less ugliness in the environment, less stench, a better toilet-to-resident ratio, better educated attendants and a few more of them, a few more professional staff members, and fewer who were very deviant themselves, and for most residents, a small cabinet for keeping some personal clothes and perhaps a few other items. An institution that had even some of these was considered a model institution to which observers streamed in envious admiration.

By the 1950s, 1960s, and 1970s, “better institutions” also began to mean two more things: (a) smaller institutions with only a few hundred to a low thousand or so residents; and (b) more equitable distribution of institutions across a state or province, both for humane reasons and reasons of local economy.

One of the “better institution” concepts that captivated many minds and was seen as a major reform idea was the “therapeutic community” concept originated by Maxwell Jones after World War II (e.g., Jones, 1953). This concept spread to many other kinds of institutions and seemed to experience occasional reincarnations through similar schemes, such as so-called “remotivation” schemes in the 1960s and 1970s.

Many people looked to therapeutic community schemes as at least a major foundation of “good institutions.” In one of my first published articles on Normalization, namely, the one for a psychiatric audience in 1970 (Wolfensberger, 1970b), I had to explain why and how Normalization was not the same as the “therapeutic community,” and that we should quit invoking images of the medical model with “therapy” language and instead think in terms of a “normalizing community” (p. 296). The article was promptly reprinted by the Pennsylvania Association for Retarded Children, together with a statement that “we must begin to practice the *Normalization PRINCIPLE*,” and widely disseminated over the state.

One idea that had many similarities to the “therapeutic community” but was inspired by different rationales was Project Re-Ed. Even though it was not of very broad scope or a high order, it is deserving of mention in this context because it had similarities with later Normalization developments. Project Re-Ed was launched in the US in 1961 with a \$2 million grant, on the initiative of Nicholas Hobbs, later president of the American Psychological Association. Hobbs and other visitors to Europe had been very impressed by the functioning of a professional identity called, in French, *éducateur*, which was like a combination of the German *Heilpädagog* (healing pedagogue) and traditional child governors and governesses, and they worked mostly with emotionally troubled children and in small residences. This model of service to such children had been developed in France after World War II in order to address a critical problem of child care created largely by the war. In Project Re-Ed, the equivalent of the *éducateurs* were to be young live-in teacher-counselors with training roughly corresponding to a master’s degree. But, unfortunately, the project had more of a personnel identity as its special focus rather than a concept of what was needed for certain children, other than that the approach was to be “ecological.” Also, it had a narrow focus on one particular class of children (i.e., those with mental problems) and mostly in a residential context. However, this model had enough parallels to Normalization that it is possible that Normalization would have been embraced as its overall service strategy if it had been available at the launching of the project. (See Hobbs [1966, 1983] and Linton [1969] for relevant literature.)

Even though Hobbs had been one of my professors, his work on Project Re-Ed had very little, if any, influence of which I am aware on the evolution of my thinking. One reason was that I was wrapped up in mental retardation, and, furthermore, I left Nashville, Tennessee—where Project Re-Ed was launched—just as it was being funded because my course work for my doctorate was completed. By the way, the Nashville Project Re-Ed was called Regional Intervention Project, hence RIP, which underlines how little consciousness people then had of image issues.

Vestiges of Project Re-Ed are still alive, but overall, the scheme did not catch on—in part undoubtedly because the mental field in the US is so clinically, ideologically, and morally bankrupt and has been intensely resistive to good things, and to anything resembling Normalization, in part probably because the things that work would delegitimize highly credentialed professional control over services and clients.

The antidehumanization and prodignity measures by David Vail, to be discussed later, were basically also a “better institution” scheme. Even among reformers in mental retardation, the “better institution” concept remained prominent until Normalization afforded an alternative vision, but the “better institution” concept has kept lingering, and still has many adherents. Vestiges of the idea of the “therapeutic community” still spook around in the mental field; and in aging specifically, the notion of “better institutions” (e.g., “better nursing homes”) is even one of the dominant ideas today.

One idea pursued ever since the great founding period of American services in the mid-1800s was “more public funding” for all sorts of services, and that was the cry one heard all the time everywhere. But proposals about how more money would be used were always tied to whatever the prevailing program concept was, which often was bigger or better institutions.

During the 1940s and 1950s, many people looked on psychotherapy and personal counseling—and some on psychoanalysis specifically—as a major answer to problems of living. Many people really thought that individual problems of a psychic nature would yield to this service modality if only (a) enough therapists or counselors could be trained, and (b) the people with the problems would come to them. Obviously, some people still cling to this notion, as is evident from the

extremely widely syndicated advice column of Ann Landers during recent decades, and to this day. The advent, and relatively sudden dissemination, of Rogerian counseling had much to do with this, because it was widely seen as both more readily learnable by more people than other forms of psychotherapy and as applicable to more situations and needs than the "heavy" psychotherapies, such as psychoanalytic ones.

A strategy that was perhaps the most broadly promoted one since World War II was a very vague construct of "attitude change." It probably had some of its roots in the social psychology developed in response to fascism, especially by refugee psychologists from Nazism. This body of theory and research had much to do with the so-called "authoritarian personality" and the development of mass prejudices. However, the ideas on how to overcome prejudices that we today would call social devaluations were very vague, and often outright naive. For instance, a major idea was that prejudice came out of ignorance, that ignorance gets dispelled by education, and that, therefore, prejudices by one collectivity about another are overcome by education. Out of this reasoning must have come the intense efforts to educate the public about mental disorder and mental retardation by means of tours of institutions, and such tours became very common in the 1950s and 1960s. Apparently totally unrecognized at that time was the fact that education by itself does not combat prejudice, and that contact with devalued persons or classes that is experienced as unpleasant is even apt to have an effect opposite to the desired one.

It was only in the 1970s that attitude change theories became more sophisticated, but we can still perceive vestiges of the old theories. In the public policy arena, one of the most prominent recent examples of false notions about attitude change has been the idea that racial barriers can be broken down by tedious cross-bussing of children in the school system, even though in many schools, the contact itself is largely negatively experienced, and the arrangement requires many children to get up hours earlier (often still in the dark) and spend hours on the bus every day—an imposition for which each group blames the other.

Before the advent of Normalization, and during its early days, behavior modification (which then was usually still known as operant conditioning) presented

itself as a quasi-savior for certain groups, including the mentally retarded. Many films were made that tried to show what behavior modification could do, and some of the accomplishments in individual instances were impressive—even amazing. However, so many of these films were made in institutions, and displayed little sense of awareness—or none whatever—either of the badness of the institutional arrangements or that the clinical methods of behavior modification were a very displaced response to institutionalism. For example, the 1967 film "Operation Behavior Modification" failed to bring out the limitations of institutional environments even though these were quite obvious in the film. The 1970 film "Operant Conditioning: Token Economy" brought this point out even more drastically without any apparent awareness of this by the filmmakers (Sandoz Pharmaceutical Co.). Also, almost all these films displayed an appalling unconsciousness of image issues and quite unnecessarily interpreted retarded people in all sorts of negative ways.

One of the most threatening major potential competitors of comprehensive normalized community services was the idea of (hard to believe these days) the "comprehensive community services facility" into which many people in the 1950s and 1960s put much hope. In essence, this was a single building in which, and to a lesser degree from which, it was believed all or most needed services could be rendered to a service region. Such a facility would have components such as a children's day service center, a sheltered workshop, some residential units, soft services (such as assessment and guidance) rendered to people coming in on an "ambulatory" basis, some specialized "ambulatory" medical services, and offices for people who might go out and render limited services in the community, probably mostly consulting other services, plus a very modest amount of home visiting. Obviously, this idea was rooted in the then-prevailing medical model, and the idea of Louis XIV's *hôpital général* and its later offspring, the *Allgemeine Krankenhaus* (Foucault, 1973; Thompson & Goldin, 1975).

Comprehensiveness was thought by some people to require service centers where each center constituted an agency, while other people thought that colocation of different agencies in the same building on the same campus would do the trick.

One version of the comprehensive service center concept was the so-called neighborhood center scheme. It was seen as more of a generic nature than "comprehensive" mental health or mental retardation centers. Many people had the idea that with many services colocated in neighborhood centers, citizens would rarely have to go outside their neighborhoods to be served. This just underlines how naive people were as to what constitutes comprehensiveness.

Unfortunately, it is this idea that ensouled the ill-fated community mental health centers, and the so-called "university-affiliated facilities" in mental retardation all over the US that became (a) financial milch cows for universities, and especially medical schools, (b) major consumers of mental retardation funds, and (c) only relatively minor contributors to the welfare of retarded people. That this idea would win out over community services that were normalized, diversified, dispersed, and citizen-controlled was for years a distinct possibility and a major fear among people like myself.

The single biggest service related to mental retardation that such centers, and other center-based units, rendered was the hugely expensive and stereotyped multidisciplinary assessment of retarded people—mostly children. These assessments tended to have a strong neuropsychiatric slant, and to be rather meaningless dead ends because there was hardly ever any meaningful follow-up and hardly any other or new services which the assessed person would receive as the result of the assessment. Conceptual poverty and program nihilism in mental retardation specifically were such that into the late 1960s, some people used the term "service" (in a community context) when they meant no more than a multidisciplinary assessment of a retarded person. This was perhaps not surprising, considering that in many locales in the US, this kind of assessment was often the first service established for retarded people and remained the only one for years. I wrote an exposé of this scandal (Wolfensberger, 1965a, 1965b) and had the hardest time getting a brief version of it published in the US, and only in something like an opinion column.

Many people argued around 1965-1975 that the biggest problem was not lack of services but lack of coordination, or what came widely to be called "services integration." These were mostly harebrained—but extremely popular—schemes on

which vast efforts were expended with hardly any payoff.

Aside from attitude change, all these schemes were either incredibly naive, or low-level, or both. Marxism was extremely high-level but also incredibly naive despite its vast number of adherents.

During the 1960s, one step ahead of Normalization, a movement gathered a great deal of momentum that was high-level and only medium naive, namely, a "rights" orientation. But there was always some fuzziness about whether people intended to invoke legal or transcendent rights, the latter often called "human rights" or "moral rights," and how the two should be linked. I remember promoting the idea in those days that *human* rights should be pursued, as being of a higher order and greater universality than legal rights.

The rights movement reflected at least some European influences, because the idea that certain services were a right rather than a privilege had long been established in the laws of several European countries, with additional such rights being defined in the mid-1960s, as exemplified by the Netherlands, Denmark, and West Germany (the latter in 1961).

In the US, Gunnar Dybwad played a very large role in this development, at least as far as the field of mental retardation was concerned. He promoted a rights orientation and judicial recourse for years, and all this work suddenly erupted into fruition with an avalanche of litigation in the late 1960s and early 1970s, most of it successful. In almost all the early cases, Dybwad was involved behind the scenes, exhorting and/or consulting.

The "rights" thinking first rested on two rationales. One was to finally achieve the old goal of "more money" by having certain services defined as a legal right. The second rationale was the removal of the social stigma that went with selective, arbitrary, or charitable funding. We now know that rightful funding does not necessarily accomplish this.

The early rights movement focused on one big goal, and several smaller ones. The big goal was *rightful* funding of schooling for handicapped children, but the movement might at first have settled for such funding for most rather than all children, and would certainly have settled for segregated education. Smaller goals included less compulsion in institutional settings, less compulsory drugging, and so forth.

In my opinion, the rights orientation would have had different, and less favorable, outcomes than it did if the lawyers had not begun to draw on the Normalization-related writings as soon as these came out. In fact, the lawyers often incorporated material from the Normalization-related literature within weeks or months after it appeared and used this material very well.

Altogether, if one had asked people active in mental retardation specifically during roughly the years of 1965-1968 what it is they wanted, one would generally have found a terrible impoverishment of concepts. For instance, most parents were so worn out battling the school system that they could hardly see around the corner of the next small step forward. Also, many had been brainwashed into holding extremely low expectations for retarded persons. Protection and kindness loomed much larger in their minds than anything else. And most professionals were very bankrupt in their visions, if not outright dehumanizing.

Just how pessimistic and outright nihilistic people tended to be about the mentally retarded in the 1950s, and to a large degree the 1960s, and how modest the aspirations of even most advocates for the retarded were, is difficult to imagine by people who were not there at that time.³

Because of the widely prevalent sense of futility about the retarded condition, expectations were low, and the more retarded a person was, the less was expected. The term "incurable" was also closely linked to mental retardation. Even people like Edgar Doll, one of the grand old men of mental retardation, who, as far as I know, was very kindly toward retarded people, insisted to me in 1961 or 1962 that "a mongoloid is a mongoloid" when I argued on behalf of the 1959 definition of mental retardation of the American Association on Mental Deficiency that left open the possibility that a retarded person might become unretarded.

The attitude of futility was also dominant, and exemplified, at the Plymouth State Home and Training School in Michigan where I assumed the position of director of research and training in 1963. There were only one teacher and one teacher's aide for the whole institution. From the rest of the staff, there was hardly any engagement with residents, even though a very large proportion of them were children and adolescents. The most dramatic incarnation of this

nonengagement was the following. Many of the dayrooms (perhaps even all of them) had gigantic picture windows, in my memory about 12 feet long, opening up to other areas, including spacious corridors. And yet it was normative to see as many as seven white-clad attendants sitting on chairs *outside* a dayroom, in front of the picture window, and looking *into* the dayroom in which there might be 50 children or youths milling about aimlessly without staff contact. Every once in a while, a staff member would dash into the dayroom to attend to somebody's toileting, break up a fight, and so forth. Otherwise, it was not considered important that the attendants be with residents and do anything with them.

This attitude of futility prevailed from the lowest to the highest echelons of the institution. In fact, the superintendent (though a pediatrician) once remarked in my hearing that it was a good idea to just wait for the infants to become 5 or 6 years old before doing anything with them, because at that age "programming will be much easier." Overall, the attitude was that the residents needed only custodial, nursing, and medical care. From among maybe 500 staff members, I could only identify at most five who had positive attitudes toward the residents, as well as significant developmental expectations for them. One result was that I constantly got into trouble, was terribly isolated, and only stayed one year.

And yet theoretically, this was the place where one might have expected a breakthrough, for five reasons: (a) the institution was new and therefore might have been unencumbered in many ways from breaking with all sorts of patterns and assumptions of the past; (b) it had one of the highest levels of funding for a public institution for the retarded in the US; (c) it had perhaps the highest ratio of staff to residents in any such institution; (d) it had a wide range of professional workers with solid credentials who, for the most part, were not dropouts from the mainstream of professional practice, as was so often the case in other institutions; and (e) the residents were very disproportionately children, and the superintendent was a pediatrician and a leader in the field.

An interesting hint on what parents envisioned and/or where the rights orientation was headed comes to us from a June 1967 symposium on "Legislative Aspects of Mental Retardation" held in Stockholm by the International League of Societies for the Mentally

Handicapped (the world association of national parent associations), with Bank-Mikkelsen, Nirje, and Grunewald among the 30 participants. It recommended that "accommodations" should "not exceed 15-20 persons" (ILSMH, 1967, p. 10).

As late as at the annual conference of the Canadian Association for the Mentally Retarded in October 1970 in Vancouver, I noted in my diary that the members were just arriving at the stage of what I described as "Isn't it wonderful that the mentally retarded can do anything!"

So the answers from even the most enlightened people to "what is the wildest reform idea you can think of" would generally have been—and at best—(a) rightful funding for segregated special education, and (b) more money for more smaller better institutions, more equitably distributed across one's respective state. And these are exactly the two directions into which post-World War II reform had been moving.

But, ironically, the new institutions that were constructed after World War II were usually vastly worse in design than the old ones, because the old ones actually came much closer to culturally normative features than the new ones. The new ones incorporated culture-alien features that—though interpreted as improvements—turned out to be primarily for management convenience, and very dehumanizing. This included tile walls and floors that were easier to clean or that could even be hosed down, hence more sound-reflective surfaces and noises; cold steel and plastic furniture that could be hosed; toilets and bathrooms that were open to visual inspection; and so on.

So, in my opinion, if Normalization had not come along when it did, and possibly even if it had come along but not been interpreted in a convincing fashion and on a massive scale, we would have seen mental retardation develop in the following directions:

1. There would have been massive investments into building new, smaller, regionalized institutions. This trend was already underway from the late 1950s on. For instance, Tennessee had one large central institution for the retarded, and built two more so that each third of the state would have its own, with the new ones intended for a number in the low thousand—which was low then.

Other states converted old TB sanatoria into mental retardation institutions, usually with several hundred residents.

Some states that had never had a public institution got themselves one in the 1950s, either by new construction or by conversion of other facilities.

Some states were in the process of simply rebuilding their old institutions. In the early 1970s, New York State pulled down every single residential building of its Syracuse institution and rebuilt from the ground up.

2. There would have been many more states pursuing the regional center model. Some states had already begun to make huge investments in it, which took many forms, depending on the respective states. Aside from Connecticut (a very small state), giant California committed itself to a regional center scheme, and many other states might have followed these leads if Normalization ideas of community-dispersed services had not become available as an alternative. The university-affiliated mental retardation centers, with their expensive clinical components that were beginning to bloom then, were playing right into the "center" concept.

Not surprisingly, the models for people from the late 1950s to the early 1970s were the Yakima Valley institution in Washington State, the Arkansas Children's Colony, Seaside Regional Center in Connecticut, and the Rolla Regional Center in Missouri. They were examples of "better institutions" that drew streams of visitors.

3. A third thing that would have happened is that group residences would have developed, but they would have been very large and very abnormal. This is what was happening in Connecticut in the late 1960s and was considered a model. There were group homes with 20 residents, and they looked like institutions on the inside. In other states, facilities with scores of residents did spring up that were institutional in nature but enough tied to the community to be commonly referred to as community residences. Some states still have these to this day.

4. A fourth thing that would have happened would have been vastly more segregated education. Again, some states were well on their way toward segregated schools, and even segregated school districts, that is, school districts only for handicapped children.

In some states, it took decades to halt the above four developments, but others retreated from their previous plans along these lines almost right away, though often only after big local battles.

5. A fifth thing that would have happened is much slower expansion of the education of the more severely handicapped children.

Without Normalization, many of the positive things that have come about would have come about anyway, but many of them anywhere between 10-20 years later, and some of the more subtle corollaries of Normalization would not have come about to this day. In fact, some corollaries of at least the Wolfensberger formulation are still normatively rejected even on the conceptual level, to say nothing of the implementive one.

This brief sketch of selected ideas that constituted people's major "hopes" in regard to human services or major human service sectors, or in regard to social changes that would have a bearing on human problems and human services, reveals the poverty of truly high-order ideas, and especially ideas that were not outright utopian or divorced from practicality, as Marxism has always been.

In a later section, I will have more to say about where some of the early mentions of notions of a "normal life" fit in, because they played a very small role on the North American scene until *Changing Patterns* came out.

3 INFLUENCES ON SERVICE REFORMERS AND WOLFENSBERGER THAT PREPARED THEM FOR THE NORMALIZATION IDEA

In this section, I will review some of the major influences that predisposed me to be receptive to the Normalization principle. This coverage not only sheds light on why I embraced and promoted Normalization, but also why many other persons who had similar experiences became disposed in the same direction.

First of all, a new generation of people might easily forget that, at least in North America, the evolution and acceptance of the Normalization principle was deeply rooted in efforts at reforming institutions—mostly those for retarded people—as my subsequent account

will strongly bring out. After all, besides institutions, there was not much else to look at except the relatively few educational programs for children, and when one looked at institutions at the start of the post-World War II reform movement, all one could think of was "better institutions." Had institutions not been so awful, even people with a sense of justice and compassion would probably not have felt a great need for a radical alternative.

However, we also have to call to mind that until the late 1960s, there was only an occasional outcry about an institutional scandal or atrocity here and there, but very little protest about the normativeness of bad institutional conditions, and hardly any opposition at all to institutionalism *per se*. As I will recapitulate later, even if one wanted to cry out, one would probably not have found a forum controlled by the human service professions and structures in which to do so.

My own odyssey toward Normalization started in 1956, when my sense of justice was outraged by the conditions in the so-called "back wards" of a mental institution in which I was then working as a clinical psychology trainee (at the Norfolk State Hospital, Norfolk, Nebraska, 1956-1957). This outrage was fueled in subsequent years by additional tours of, and episodes of work in, several other institutions of different kinds.

Another thing that laid important groundwork for Normalization and SRV in my mind from my earliest days in human services in the 1950s was that I found it easy to evoke positive behavior from devalued people through my positive expectations of them and my expressions of trust in them. As early as 1956, while still working on my master's degree, I conveyed expectations and trust to inmates of the most violent and locked ward of a large state mental institution (the one mentioned above) in such a fashion that I was never attacked, though many other people were. Similarly, despite being present in all sorts of violent situations in human service contexts since, I have never been attacked myself, and have attributed this at least in part to the positive role expectations that I conveyed to potential attackers. (Strangely enough, while I found it relatively easy to convey positive expectations to wounded and devalued people, I have always found it very difficult to do the same to imperial people.)

People with experiences and sentiments similar to mine had their consciousness boosted by several related publications that started coming out after 1955, that drew attention to the process of degradation to which new members of institutions and totalitarian contexts are normatively subjected in order to bring them to conformity and submission (e.g., Garfinkel, 1956; Stone, 1961). Goffman (e.g., 1958, 1961) began to call this process "mortification." This concept helped reformers a great deal in formulating measures that were recognized later as being concordant with Normalization.

In 1958, Goffman had begun to publish on what he called "total institutions," culminating in his 1961 book *Asylums*. Under this construct of total institutions, Goffman subsumed not only human service institutions, but certain other social contexts that were highly separated from their societies, even in those instances where their members were societally valued people, as in the military, or on ships at sea. This analysis was very impactful on reformers, and on many people in North America who eventually ended up embracing Normalization.

In 1963, Goffman published *Stigma*, in which he addressed many issues that became very important in the later thinking on social imagery, social devaluation, Normalization, and Social Role Valorization. For instance, what Goffman called "courtesy stigma" (one of those awful terms without any readily identifiable meaning of which sociology abounds) referred to the fact that those who are closely associated with—or viewed as identified with—a devalued ("stigmatized") person acquire some of the same devaluation ("stigma") in the eyes of observers as the devalued person him/herself. Of course, this is the same as what the Wolfensberger version of Normalization theory and Social Role Valorization has called (in language that is much more descriptive and intelligible) "deviancy image juxtaposition" and "image transfer." However, the image juxtaposition and transfer realities have been dealt with in much broader and higher-level (more universal) fashion in Normalization and SRV theory than Goffman did, though both are indebted to him a great deal. Similarly, what Goffman called "spoiled identity" in 1963 I later subsumed (in my version of Normalization, and in Social Role Valorization) under (severe) image degradation, or incumbency in a distinctly devalued role of great "band-width" (role

band-width is explained in Wolfensberger, 1998). As I only noted consciously in 1994, he even used the terms "Normalization" and "normification" a few times in this book, but like everybody else in those days, in a very limited sense. He used "Normalization" to refer to the process through which nonstigmatized people treat stigmatized ones as if they were not stigmatized, and "normification" as the effort of stigmatized persons to present themselves as ordinary persons. Goffman attributed his idea of "Normalization" to a yet earlier writer (Schwartz, 1957) who, however, did not use that term but the phrases "strain toward a normalcy definition" and "behavior within a normality framework."

Thus, these publications prepared many minds for what was to come, and not only in North America. An example is the scale for measuring the nature and quality of residential care developed by Raynes and King in the mid-1960s, which was heavily based on Goffman, as the authors themselves stated (my diary notes of the September 1967 convention of the International Association for the Scientific Study of Mental Deficiency in Montpellier, France; the proceedings also included their presumably edited presentation [Raynes & King, 1968], and the book by King, Raynes, and Tizard [1971] reports on a whole series of related pieces of work).

Into a category similar to Goffman fell the work done by, or stimulated by, David J. Vail, who himself had been influenced by Goffman's works. In the early 1960s, Vail was the medical director of the Medical Service Division of the Minnesota Department of Public Welfare. Under his leadership, his division began (apparently in 1963) a drive to improve the living conditions in Minnesota's eight mental, and four mental retardation, institutions, via what he called an "attack on dehumanization" (Karlins, 1971-1972). The evolution of this project was apparently influenced by Vail's visits to services in Britain and Scandinavia on which he reported in 1965 and 1968 respectively (Vail, 1965, 1968).

Vail was one of those people who had been deeply influenced by Goffman's *Asylums*, and so he had a copy of that book distributed to each Minnesota institution as a basis for staff discussion ("Bronze Award," 1967) and scheduled a series of presentations and discussions on it. In 1966, Vail published his ideas and results (with many references to Goffman) in a

book entitled *Dehumanization and the Institutional Career* (Vail, 1966), which had a big impact on at least those people who could bring themselves to acknowledge that institutions were bad places. The book systematically brought to consciousness many of the institutional practices that workers in institutions had unconsciously adopted or copied and revealed their demeaning nature and debilitating impact in creating so-called "institutionalism" in inmates.

The book gave major emphasis to two concepts. The first construct was "dehumanization," by which Vail meant something that we would now subsume under the broader construct of social devaluation, and, more specifically, the casting of humans into the role of some kind of subhuman, that is, animal, plant life, or object. In a very systematic fashion, Vail delineated this construct as mostly encountered in institutions, and especially so in mental ones, with many compelling examples. As early as 1963, Vail also noted that when institutional staff dehumanized residents, they lost their own humanity.

While Vail had used the term "dehumanization" since at least 1963, he did not coin it. Dictionaries tell us that "dehumanize" was already used as a verb early in the 19th century and "dehumanization" as a noun was used in the late 19th century. However, Vail gave the term new nuances of meaning that it did not seem to possess previously, and contributed to the term becoming so well known that by the 1980s, educated people generally had begun to use it routinely.

Today we have available to us a much more sophisticated analysis of devalued roles and would no longer agree that all of the practices that Vail pilloried would put people into the roles of objects, insensate plants, or animals. However, this fact does not detract from Vail's insights.

Vail's second concept was "dignity" (which he also called "rehumanization"), and as earthshaking as it then was, it also revealed the poverty of ideas that prevailed then—as late as the mid- and late 1960s—as to what might constitute a desirable practical alternative to the prevailing patterns. In fact, while Vail's "dignity" measures were certainly concordant with the Normalization and SRV concepts yet to come, they suffered from the following deficiencies: (a) These measures consisted of little more than *not* doing the things that he called dehumanizing, though Vail also had much to say about what he called "the round

of life," by which he meant something close to Nirje's later routines and rhythms of a normal day. This section on "remedies" took up less than 13 out of 266 pages in his book. (b) Vail's dignity measures fell far short of what I have called the conservatism corollary implications of Normalization and SRV, because they merely involved abstention from "dehumanization." (c) Much of Vail's analysis and dignity measures were phrased in terms applicable first and foremost to *mental* institutions, though there were some efforts made by others later on to translate the relevance of all this to other settings and client classes—though still mostly in institutions. One reason Vail's dignity measures would have only modest relevance outside of institutional settings is that it would not occur to most people *not* to practice such measures most of the time anywhere else. (d) Finally, Vail was still an adherent of the concept of "better institutions." He made sure to clarify that he was not "against institutions," but trying to "soften" them and make them "more effective" (Vail, 1966, p. 206).

Vail's 1966 book was widely drawn on even by institutional in-service training programs, in part because it contained so many concrete examples and visual aids, which people widely copied. Also, for some years, the term "rehumanization" was a minor craze in intra-institutional improvement efforts. (Apparently, Charles Bernstein, superintendent of the Rome Custodial Asylum in New York State between circa 1902 and 1942, had already campaigned for a program of "humanization" of retarded people ["A Century on Ice," 1995].)

Vail's staff also developed other teaching aids, such as brochures that contrasted dehumanization with dignity. The National Association for Retarded Children (NARC) reprinted one such brochure entitled "Dehumanization vs. Dignity" in the late 1960s, and some local ARC chapters also reprinted Minnesota materials. One other teaching aid was a training film (Karlins, 1966) made in the 1960s in connection with Vail's book, called "Dehumanization and the Total Institution." It used animated cartoons with a Maxwell Smart-type of humor to teach the constructs of dehumanization and dignity, but largely prescribed "better institutions" rather than any alternatives to them. Also, based on the idea that retarded people should not be dehumanized, another film was made about the same time by the Association for Retarded

Children in Minnesota, entitled "In the Name of Humanity," which I first saw in March 1967 (at the North Central regional conference of the National Association for Retarded Children in Lincoln, Nebraska). Soon, in 1967, a better version of this film was made jointly by the Minnesota and the National Associations for Retarded Children, called "To Bridge the Gap." It contrasted Minnesota's programs and services with those in Sweden, Denmark, Norway, the Netherlands, and England, and featured Dr. Spejer from the Netherlands and Bengt Nirje from Sweden. The depiction of the Minnesota institutional snake pits was striking. Some of the scenes of severely deprived and retarded adults dancing and posturing in the back wards were almost incredible vignettes of man's inhumanity to man. One unforgettable scene showed a little child huddled in a corner for contact with the three convergent cold stone surfaces. Also, I heard Miriam Karlins, Vail's colleague, speak at the annual NARC convention in Detroit in October 1968.

Vail might have made other significant contributions to the reform movement had he not died in 1971 at the early age of 45 (Karlins, 1971-1972).

While Vail hardly went beyond "better institutions," his book was very important to Normalization developments because after reading it, I received the inspiration to interpret retarded people as needing to be accorded the three identities of human being, citizen, and developing person.

The most important one of these in the 1960s was the identity of human being, because it would negate all the dehumanizing that had been going on. The identity of "citizen" established the idea that a retarded person possessed rights, and that these rights could only be abridged by due process. This was a rather radical idea then. The image of citizen identity also suggested to people a participatory role in society for previously or otherwise devalued and excluded people.

Finally, the idea that a retarded person—even if profoundly impaired—was to be viewed as having growth potential was intended to counteract the widely prevalent nihilism about the prospects of retarded persons. I used to teach that I had never met a retarded person from whom I could not rather readily elicit a response that revealed unutilized—and usually also unrecognized—capacity for learning or growth. I prided myself in being able to demonstrate such responses rather quickly before students, parents, or

service workers, even from profoundly impaired persons whom I had never seen before. The expectations of such observers had normatively been so low that they were often quite astonished at my little demonstrations, which today would probably be considered elementary.

I certainly did not invent the notions that retarded people were human, citizens, and capable of further development. These were ideas whose time had come. For instance, in 1964, Bank-Mikkelsen gave a major presentation to the first international congress of the International Association for the Scientific Study of Mental Deficiency in Copenhagen. He interpreted this talk as an opportunity by the host country to present its work for the mentally retarded (Bank-Mikkelsen, 1964, p. 1). In this speech, he made a big point that the mentally retarded individual was "first of all a fellow-being" and therefore must have "full rights as a fellow-citizen" (p. 3). This led him to state that "the aim is to say the mentally retarded a normal existence, that is to say to assist with treatment of any kind and ensure living-quarters and work in the ordinary community for as many as possible" (p. 3). (By the way, this was the only use of the word root "normal" in his talk.) He also said that the mentally retarded "... do not need pity . . . they need to be respected as human-beings—with their particular handicaps" (pp. 6-7).

Thus, I merely collated notions that retarded people were human, citizens, and capable of further development, tied them together, and taught them in a way that caught people's attention—but I did not invent them. However, I cannot recall that anyone else had prepared a systematic presentation that contrasted the dehumanization of retarded people on the one hand with a precise and elaborated exposition of the three alternative interpretations on the other hand. In my speaking, I also heavily interpreted how the view of people as developing organisms implied a "developmental model," as I also briefly sketched in *Changing Patterns* (Kugel & Wolfensberger, 1969, p. 81). Later on, some people proposed that the term "developmental model" should be used in lieu of the term "principle of Normalization."

This, then, was the core of my service-reform teaching for about three years between 1966-1969, and what preceded Normalization in my mind. For instance, I can document from my archives that already in November 1967, I spoke on "Dehumanization and

Total Institutions” to the Greater Omaha Association for Retarded Children at a time when most parents looked with great and emotional favor on institutions. Relatedly, I also taught—as I put it in a 1969 article—“we are already 40 years behind what is known about the retarded” (Wolfensberger, 1969b, p. 53).

However, I rarely invoked the “dignity” notion in my change agency but instead emphasized the notion of respect, and especially so vis-à-vis people who meant well toward the mentally retarded but who operated on a pity or object-of-charity model. Toward them, I emphasized respect instead of pity, and services and inclusion on the basis of rightfulness rather than charity. However, unlike people who came after me, I never intended to abolish charity—in the sense of *caritas* and voluntary compassionate acts—as a major motive force in human interaction, nor would it have occurred to me then that other people would soon want to do this.

The impact of what I call the Vailish ideas can be noted in vignettes such as the following. When the National Association for Retarded Children (1968) issued a *Policy Statement on Residential Care* document in October 1968, the term “dehumanization” played a major role in it. While it was too early for the term “Normalization” to make an appearance in the document, it did emphasize humanization, rights, and “home-like environments.” (By the way, there were only the barest and vaguest hints in that report that “residential care” was thought of as anything but institutional care!)

Also, one visitor in 1968 to mental retardation services in Denmark and Sweden reported being impressed by the “dignity” being accorded to retarded individuals but did not mention Normalization (October 14, 1968, letter of three pages from Irving R. Stone to Rosemary and Gunnar Dybwad). When Grunewald (1971, 1972) translated and published portions of *Changing Patterns* into Swedish and Danish, he also included a long excerpt from Vail’s 1966 book. The impact of my teaching the three positive interpretations is exemplified by the Pennsylvania Association for Retarded Children already arguing (PARC flyer of December 8, 1969) that a retarded child was “a child...a human being and a citizen.”

One other development helped me understand and teach how those conditions came about against which Normalization measures were needed. This was that when the first publications on Normalization were being crafted, sociology had recently given prominence to the term “deviancy.” This construct came in extremely handy to Normalization discourse, although it had two big disadvantages: Most people outside of sociology had never heard of it, and even many people in human services had not. The second drawback was that in spelling and phonetics, the adjective “deviant” was uncomfortably close to the word “deviate,” which many people did know, and associated with sexual perversion. The terms “deviant” and “deviate” must have received a big boost when psychologists and others began to speak a lot in terms of normal distributions, and deviations from the mean, which happened mostly in the 1930s through 1950s. It is interesting that the entirely descriptive term “deviancy” would quickly acquire a pejorative meaning, and/or be used pejoratively, even though strictly speaking, both terms—deviant and deviate—are just as applicable to deviations into the positively desired side of a normal distribution as into the devalued side. However, I, for one, could simply not find a suitable alternative at that time for the term “deviancy” that had a sufficiently broad umbrella meaning, particularly since my later phrase “social devaluation” was simply inaccessible in those days.

Finally, more in the line of a relevant experience than an idea was what I learned during a year in Europe in 1962–1963. The doctoral program at George Peabody College in which I was enrolled from 1957 to 1962 had helped send two of its doctoral students (Gershon Berkson and James Moss) for a year to England to study under the illustrious Drs. Jack Tizard and Neil O’Connor at the Maudsley Hospital in London. By obtaining a U.S. Public Health postdoctoral research fellowship shortly after completing my doctoral work, I was able to follow not only in their footsteps, but also in the yet earlier tradition of human service study tours of Europe. I worked under the same two mentors for a year in 1962–1963, during which I undertook several minor and two major tours of human services—mostly to the mentally retarded—in England, Scotland, Northern Ireland, Eire, Germany, Belgium, and Switzerland. Later, I lectured extensively on my findings in the US and

Canada, reported on them in print (Wolfensberger, 1964a, 1964b, 1964c, 1965c), and drew on what I had learned in several other of my publications (e.g., Wolfensberger, 1965a [reprinted in Gunzburg, 1973, and Jones, 1971], 1965b [reprinted in Dempsey, 1975], 1967, 1979).

One of the research projects that Tizard assigned to me was to play an important role in my evolving service conceptualization, and that was to study and document the mental retardation service system of the county of Middlesex that was planned by rationally and systemically evolving a dispersed, centrally coordinated network of moderately diversified community services. This was cutting-edge stuff in those days, and taught me to think in terms of services that were (a) regional, (b) comprehensive, and (c) systemic, such as I was to help design later in Nebraska. Also, on the purely programmatic level, amazing achievements were attained, with even very severely retarded adults being taught to perform work at a very high level of skill and productivity. Their work performance was so impressive that Tizard, a medical officer, and I administered a homemade IQ test to all workers in one of the centers, and confirmed that they were indeed not misclassified as retarded: 32% could not tell their age, 67% could not write their name, and only 13% could combine two basic coins to make a sum of money. In one of my published reports on this, I called the Middlesex services "some of the most remarkable services to the retarded that I had ever seen" (Wolfensberger, 1965a, p. 62).

After my return to the US, I wrote Jack Tizard on November 20, 1963, that I had been speaking, and showing the slides I had taken in Europe, to an average of one parent group a week, and had also been talking to professional groups and showing them Tizard's film on the Brooklands project of more family-like living for retarded children. I reported that I had not been able to convince one single professional of the need for the kind of progressive things I had seen in England, but that the parents went wholeheartedly along with it.

Unfortunately, my monograph-length documentation of the Middlesex project (Wolfensberger & Tizard, 1964) could find no publisher, Middlesex County itself was abolished, and soon thereafter the service system in Britain lost not only its frontier status, but also its connection to cutting-edge developments elsewhere and slipped into

mediocrity. However, very relevant to my evolution of Normalization-related ideas was the recognition of what high expectations and adaptive environmental structures could accomplish, and that a community-based comprehensive service system simply had to be dispersed and diversified. Dispersal was concordant with smallness and integration, and diversification was concordant with what—in my version of the Normalization theory—became the construct of model coherency via the intermediate construct of "specialization," that is, that different services would provide different things to different people, according to their needs.

4 THE HISTORY OF INTERCONTINENTAL EXCHANGE IN HUMAN SERVICES THAT WAS THE CONTEXT FOR THE TRANSFER OF NORMALIZATION FROM SCANDINAVIA TO NORTH AMERICA

Next, I want to make a further contribution to an understanding of the sociohistorical context that facilitated the transfer of Normalization ideas from Denmark and Sweden to North America. This has not yet been done to any extent, as far as I know.

What laid the groundwork for this transfer was, first of all, the long tradition of people from North America visiting human services in Europe, and then telling and writing about it back home, and of outright importing new ideas and practices that they had learned abroad. Sometimes, they even recruited European practitioners of new developments and established them in North America.

This tradition goes back a long time. For instance, when a certain Dr. Mason Fitch Cogswell (1761-1830) learned in the early 1800s that his daughter Alice (1805-1830) was deaf, he recruited Thomas Hopkins Gallaudet (1787-1851) to go to Europe to learn ways of educating deaf children and to apply his learnings at the American Asylum for the Deaf, established in 1817 in Hartford, Connecticut. In Europe, Gallaudet also recruited a French teacher of the deaf, Laurent Clerc (1785-1869), to come back to Hartford with him.

In the 1830s and 1840s, Samuel Gridley Howe and other American human service leaders visited human services in Europe and wrote about it after they came

back home. Howe had seen the work of Édouard Séguin with the mentally retarded in France, and helped him to become established as a leading mental retardation pedagogue in the US, to which Séguin came in 1848. (There are some disputes about the exact year, but I believe 1848 is correct.)

Of course, the information flow was not all one-way. At a certain point, it became more reciprocal. For instance, many eugenic ideas that had originated in Britain, and then had been taken up and implemented in the US, began to be carried back to Europe as Europeans began to take intense note of these developments and to cite them in support of the promotion of parallels in Europe—and, in the case of the Nazis, surpass them (e.g., Kevles, 1985; Proctor, 1988).

During the 1950s and 1960s, there had been a slow but influential trickle of American visitors (many from the mental health field) to Europe that included—perhaps for the first time—Scandinavia as a major source of noteworthy innovations. Coverage of mental retardation services was often a secondary aspect of their visits because, in those days, mental retardation services were generally administered by mental health services and professionals. However, what did intrigue visitors was that starting around 1960, a good number of institutions were built in Sweden that were not only “better institutions,” but came close to being “best institutions.” They were small and anticipated later Normalization formulations by having small sleeping spaces (instead of dormitories), small and diversified social spaces (instead of “day rooms”), a culturally normative internal decor (in fact, they were often breathtakingly beautiful), being well-staffed, and increasingly locally administered. (See also Grunewald, 1969a.)

When North Americans planned to go abroad to learn from human services there, some of them at least tried to prepare themselves by first reading English-language accounts about services in the countries they planned to visit. I will now give a sketch of the publications that were available to visitors during the period of about 1960-1975, since this time span included both the years that laid the groundwork for the Normalization transfer and the years that constituted the actual transfer period itself. This review has no pretense to being exhaustive but is probably more extensive than readers are apt to find elsewhere.

Within different categories of publications, I will list the items in sequence of date rather than alphabetically by author.

A number of publications dealt with *services in many countries, or even the world*. Taylor and Taylor (1960) wrote about the evolution and organization of special education for the handicapped in various countries of Western Europe. This would have been very useful to visitors, but the publication was not well known and, hence, not much used.

A British booklet (Robinson, 1961) reviewed “patterns of care for the mentally disordered” in the US, the Netherlands, and the European part of the USSR. Also in 1961, Linn (1961) surveyed the state of general hospital psychiatry in many countries around the world, including Austria, Germany, Switzerland, Italy, and Scotland. In 1965, Furman (1965) wrote a description of community mental health services in Great Britain, the Netherlands, Denmark, and Sweden. Since this was published by the U.S. Government Printing Office, it was easily available and well disseminated. Kiev (1968) and Masserman (1968) reviewed psychiatric services in the Communist countries of Eastern Europe.

Of course, in 1969, *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel & Wolfensberger, 1969) came out, and it had chapters describing model services in Denmark, Sweden, Britain, and the US, but more will be said about this later.

Perin (1970) wrote on the design of environments, with special emphasis on Britain and Scandinavia, but only tangentially concerned with human services or handicapped people.

In 1969, Dybwad (1969) reviewed patterns of organizing services for the mentally retarded in different countries around the world, and in 1970, Dybwad and Dybwad (1970) wrote a chapter on community services for the mentally retarded in selected countries all over the world.

Programs we would call “social security” for the handicapped in the Netherlands, Sweden, Britain, and the Soviet Union were sketched by the (US) Secretary’s Committee on Mental Retardation (1971) in 1971.

Lancaster-Gaye (1972) reviewed the services for the handicapped in the same countries as Furman (1965) had (Britain, Netherlands, Denmark, Sweden), but

promoted residential services as the bulwark of long-term security for handicapped persons.

On behalf of the Joint Commission on Mental Health of Children in the US, David (1972) wrote a book with a wide range of program vignettes, and descriptions of services and personnel training structures, in Europe. This included much of relevance to mental retardation, although some of this was already outdated when published.

Holowinsky (1973) reviewed the status of special education and defectology research in Communist Eastern Europe, namely, the USSR, Poland, Hungary, Czechoslovakia, Yugoslavia, Bulgaria, and Romania.

Various European human services, especially for the elderly, were reviewed, and to some degree compared to American services, by Kahn and Kamerman (1975), with special emphasis on Denmark and Sweden.

Thursz and Vigilante (1975, 1976) wrote a two-volume work on social services in 19 countries, including Britain and Sweden in the 1975 volume, and Denmark and Finland in the 1976 volume.

One class of publications about multiple countries consisted of reports by visitors from North America who were reporting back home what they had seen and learned abroad.

Among these were two 1961 monographs on European services to the mentally disordered (and to a lesser degree, the retarded) in Belgium, Britain, Denmark, France, and the Netherlands. One was by Barton, Farrell, Lenehan, and McLaughlin (1961) and the other by a team of visitors on behalf of the then influential Southern Regional Education Board (1961)—a southern multistate quasi-public consortium headquartered in Atlanta, Georgia. Bank-Mikkelsen was already mentioned in it as the major Danish contact person. But, strangely enough, while the six visitors were very influential people in the professions and state government, including from Tennessee (my own state at that time), I could never detect any evidence that they tried vigorously or successfully to apply what they had learned. Perhaps they had only seen but not learned.

Among the travel reports of North Americans in the 1960s was a whole series of papers that I produced between 1963 and 1965, pointing out features of services and the professional scene—mostly in mental retardation—that I had observed during my 1962-1963

study tour in England, Scotland, Northern Ireland, Eire, Germany, Belgium, and Switzerland. First, I wrote a long report to the National Association for Retarded Children (NARC) that had given me a small supplemental grant.⁴ NARC—mostly Rosemary and Gunnar Dybwad—drew on this report to advise other travelers. I built on this report to produce an entire series of publications (Wolfensberger, 1964a, 1964b, 1964c, 1965c), three of which (Wolfensberger, 1964a, 1964b, 1964c) were reprinted later in Henry David's (1972) book on *Child Mental Health in International Perspective*. Several of my later publications (Wolfensberger, 1965a, 1965b, 1967) also drew on what I had learned on these travels. As mentioned earlier, I also wrote a monograph (Wolfensberger & Tizard, 1964) reporting my extensive study of one of the most significant regional mental retardation service programs in Britain, namely, the one run by the since defunct county of Middlesex. This was never published but was privately widely circulated, and what I learned from this study was very instrumental in paving the way for my being so receptive later to the Normalization concept. Thus, in contrast to the travelers of the Southern Regional Education Board, I was deeply impressed and shaped by my experiences in Europe and vigorously tried to put my learnings into action.

Vail (1965) described the British mental health system. Faber (1968) wrote on services to retarded children in 12 countries around the world, including England and Denmark. Kelley (Staff, 1970a) reported on what he thought were the relative strengths and weaknesses of services to the retarded in six European nations (Denmark, England, France, Germany, the Netherlands, and Sweden). (Kelley was then superintendent of a very bad institution, Mansfield in Connecticut, and his comparison seemed to be rather unrevealing.) The President's Committee on Mental Retardation sent a subcommittee to Britain, Denmark, Sweden, and France in 1967, and it reported on its findings in 1968 (Humphrey, Jones, & Kugel, 1968). Gregor (1972), then president of the Canadian Association for the Mentally Retarded, reported on his 1971 visit to Norway, Sweden, Denmark, Germany, France, and the Netherlands.

Until the mid- to late 1960s, many people thought that the Netherlands was the model country in Europe as far as human services were concerned, and there

was much visiting there by North Americans. (In fact, in the late 1950s, the Swedish association of parents of the mentally retarded [the acronym of which was FUB] sent Nirje to the Netherlands to study sheltered workshops [Nirje, 1992b].) In addition to reportage in multicountry publications cited previously, a President's Panel on Mental Retardation (1963b) study mission reported on the Netherlands in 1963, Dolnick (1971) reported on Dutch sheltered workshops for the handicapped, and Jonson (1971-1972) reported on his visits to many Dutch services for the retarded. The Dutch National Association for the Care of the Mentally Retarded, together with the Bishop Bekkers Institute (1973), described the structure of Dutch services for the mentally retarded in a monograph—very like one of those produced in Scandinavia in English to orient the hordes of foreign visitors to Scandinavia. However, this publication seemed a bit late because by then the gaze of North American visitors had shifted heavily to Denmark and Sweden.

Indeed, as Nirje put it in a memorial to Bank-Mikkelsen (see Nirje, 1991, and the Nirje, 1992a version), the President's Panel on Mental Retardation had "discovered" Denmark and Sweden in 1962. By the late 1960s and early 1970s, something like Scandimania broke out, with Denmark and Sweden especially being overrun by North American visitors. Sweden facilitated this process by establishing (ca. 1970, through the Swedish Medical Council) a postdoctoral fellowship for U.S. biomedical scientists.

Most of the material published in English during the 1960s and 1970s on Scandinavian services seems to have been on Sweden, followed by Denmark, with Norway a poor third, and material on Iceland and Greenland (which belongs to Denmark) being next to nonexistent.

This material falls into several broad groups: items written as high-level broad descriptions, reports by visitors to their peers back home, and Scandinavians themselves explaining their services to each other and the anglophone world. The latter included items written at first for domestic consumption in the respective Scandinavian tongue and then translated into English, apparently in large part in order to be used by the many visitors to the Scandinavian countries. These latter items included a category describing specific service agencies or sites.

Publications on two or more Scandinavian countries that were written at least in part (in some cases, entirely) as reports by returning visitors (in all such cases, visitors from the US) included ones by the President's Panel on Mental Retardation (1963a), the Scandinavian Study Group (1966) on health services, Vail (1968) on "mental health systems" but also covering mental retardation, Smith (1968) on mental retardation, Lippman (1969) on the handicapped, Clark and Clark (1970) on the mentally retarded, Graf (1972) on advocacy on behalf of the handicapped, and Scheiner (1975) on mental retardation.

Further, because the demand for information from Denmark and Sweden had become ravenous by circa 1970, in these countries a great many unpublished human service-related documents were developed in English, to be used mostly as handouts to visitors. (I have a fair number of these in my archives.) For instance, in January 1968, Nirje prepared a summary in English of the 1967 Swedish "Law About Provisions and Services for the Mentally Retarded" as an unpublished handout. Some of these documents were very sizable, such as a two-volume Danish curriculum for retarded pupils. Some of these documents were so much in demand by foreigners that they were eventually published.

Other descriptions of only Swedish services, specifically written or coauthored by Swedish writers themselves in English, included Nilsson (1967) on special education, Myrdal (1969) on Swedish society in general, Fors (1969) on Swedish social policy, Tidman, von Sydow, and Thiberg (1969) on the elderly, Sterner (1969) on services for the handicapped, Grunewald (1969b) on the mentally retarded, Lundstrom (1969) on special education, Wester (1970) on children and child services in Sweden, Grunewald (1970) on economic opportunities for the mentally retarded, Montan (1972) on the Swedish Institute for the Handicapped, and Berfenstam and William-Olson (1973) on early child care.

Reports on Sweden exclusively by visitors to it included Engel (1968) on the health system, Perske (1969a) on services to the handicapped (mostly retarded), Woolf (1970) on services to the retarded, Elliot (1971) on the handicapped, and Kimberly (1972) on sheltered workshops.

On Denmark specifically, Rowe (1964), a visitor, reported on attendant training in mental retardation. In

1966, the Minnesota Association for Retarded Children (*Lillemosegard*, 1966) printed a bilingual brochure on the flagship of Danish mental retardation institutions, *Lillemosegard*, obviously intended as a model of what a "better institution" would be. Muriel Humphrey, the U.S. vice-president's wife, had visited Denmark in 1967 and briefly reported on it in 1968 (Humphrey, 1968). Bank-Mikkelsen (1968) wrote on services to retarded children, and Melchior (1968) described the segregated regional day schools ("center-schools") for pupils with all kinds of handicaps. The Danish National Service for the Mentally Retarded (1969) reported on the work of its previous 10 years. (This was a *Festschrift* for Bank-Mikkelsen's 50th birthday.) Perske (1969b) wrote up the observations of his study tour of services to the handicapped and retarded. Moise (1972), mother of a retarded young woman, Barbara, and later author of *As Up We Grew With Barbara* (Moise, 1980), reported on her visit to Denmark (accompanied by Barbara) in a monograph studded with pictures.

We can see that more was written about Sweden than Denmark, both by the natives and by visitors. I never encountered a good explanation of why Norway was either trailing behind Denmark and Sweden, or was so much less popular for study tours than the other two countries, especially considering that knowledge of English may have been even more widely prevalent in Norway than in the other two countries. Perhaps some other writers will be able to give us a good explanation.

Among miscellaneous other single-country reports was the one of the study commission sent by the President's Panel on Mental Retardation (1964a) to the USSR. The panel also sent a mission to England, but it never wrote a report (Gunnar Dybwad, private communication, April 19, 1994).

By the early 1970s, a vast informal guidance and referral network had sprung up, with people who wanted to visit European services asking those who had already been there for advice on where to go, and for names and addresses of contact persons. (I have many such inquiry letters in my archives.)

After 1971, the visits of North Americans to European mental retardation services were mightily facilitated by the *International Directory of Mental Retardation Resources*, edited by Rosemary Dybwad (1971, 1977-1978, 1989). The 1971 edition was

followed by 1972 and 1973 supplements, and by revisions in 1978 and 1989. (There had been a forerunner of this work in 1960 [International Bureau of Education, UNESCO, 1960], covering mental retardation services in 71 countries, but, as far as I know, this work was hardly known or used in North America.)

Sterner (1976) wrote a voluminous work on *Social and Economic Conditions of the Mentally Retarded in Selected Countries* around the world, based on an earlier (1973) informally circulated mimeographed draft entitled "Some Data and View-points on the Social and Economic Conditions of the Mentally Retarded in Countries at Various Stages of Economic Development."

After my 1963 return from a year in Europe, I began to receive so many requests for information from other prospective travelers that I began to write, and periodically update, an unpublished guideline for such persons. It did not so much advise where to visit as (a) where to get further information, and (b) *how* to visit.

This concludes my review of the kind of background of publications in English about European and Scandinavian services—based heavily on study tours—that constituted the fertile soil for a transfer of Normalization concepts to North America. Not covered in this sketch are the reverse kinds of visits and reporting by Scandinavians in their own countries and tongues. Of course, only a few of the people going on study tours abroad wrote up or published their observations. For instance, between 1968 and 1972, I mediated extended work-study stays (up to one year) for four students from Nebraska in Denmark, Germany, and Sweden respectively, but they never published about the things they learned.

However, there are four points I want to add before going to the next topic.

1. When I toured services on the European mainland in 1963, one thing that struck me was that the leaders I met were rather smug about what they were doing. They felt that they had a good angle on their field and had little to learn from what was going on elsewhere—even elsewhere in Europe. The United Kingdom and Eire were different, with much orientation to the US. Especially in Eire, many service leaders in the early 1960s had been in the US, or were planning to go, as I discovered on my 1963 study tour

there. The innumerable family ties of the Irish to relatives in the US may also have been a factor.

2. One remarkable thing about so many American visitors to other countries is how little they perceived of what they saw that was good or even exemplary (at least for its time), and how often they interpreted as old hat good things that they had probably never seen. By the time I went to Scandinavia in 1969, I was already on the leading edge of reform thinking in North America and well prepared by my earlier exposure to Normalization and the editing of *Changing Patterns*. Nonetheless, where so many other visitors came away with an "isn't it nice" response or "we are already doing this or that," I came away with my mind blown, as they say these days. But then, we had the same experience with visitors to our Nebraska services between 1969 and the mid-1970s who could look at things they had never seen and go away without a conversion experience, perhaps allowing that "this is nice" or even muttering "this is old hat."

3. There was one kind of reverse visiting that is relevant to the transfer process, and that is the one that consisted of several trips each by Niels Erik Bank-Mikkelsen, Karl Grunewald, and Bengt Nirje to the US between 1967 and 1971. At that time, Bank-Mikkelsen was head of the Danish mental retardation service, Grunewald was his counterpart in Sweden, and Nirje was executive director of the Swedish parents' association in mental retardation. They toured and spoke widely, a lot of what they spoke on reflecting Normalization thinking, and they received a great deal of press when they expressed their disgust at what they saw in U.S. institutions. In Massachusetts, after Dybwad (1969) took him through an institution, Grunewald told him, "Don't you ever do this to me again!" When Grunewald shortly after came to Nebraska, he only wanted to see some of the best wards of Nebraska's only state institution for the retarded (the Beatrice State Home), because he said he could not stand to see any more bad places. Even in some of the least-worst children's units there, Grunewald said that where he saw two staff members, he would see 35 in Sweden. In late 1967, Bank-Mikkelsen made national news in the US when he said that in Denmark, cattle were better kept than retarded people in U.S. institutions such as Sonoma State Hospital in California.

All three visitors got so burned by the negative reactions of institution defenders to their comments that they became very reticent to use strong language (as I can document from my correspondence files). These visits and the press they got also contributed part of the background for the transfer of Normalization to North America. Other people from Europe who were doing remarkable things also were visiting in North America during those years, but none that I know of made the same impact as regards the transfer of Normalization.

4. It is my impression that until the early or mid-1970s, the Americans were indeed primarily the learners in this travel exchange, but that then the balance began to tip the other way, with Europeans beginning to fall all over themselves to visit North America—mainly the US—and transfer developments from there to Europe. This was partly just one element of the Americanization of the developed world, but part of it had to do with the explosion of human service ideas and practices in the US, including those in response to *Changing Patterns*, the Nebraska mental retardation service system model, the Normalization principle, and the legal rights victories. To this day, many European countries eat up as fast as they can every service craze cooked up in the United States, and the less meritorious ones perhaps even more enthusiastically than the meritorious ones.

The next section will address the actual Normalization transfer itself.

5 THE PRODUCTION OF *CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED*

What follows next is both the story of how I came to understand and embrace Normalization, and at least part of the story of how it achieved massive dissemination in relatively short order. This section of the story is difficult to organize because two parallel developments are involved: the mental retardation service revolution in Nebraska that started in 1967 and the production of the book *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel & Wolfensberger, 1969), which contained the first systematic written exposition of Normalization, namely, in the chapter by Nirje (1969). Because this

congress celebrates the 25th anniversary of *Changing Patterns*, and because the Nebraska story has been told in more detail than the *Changing Patterns* story, I will now focus on the latter. However, I want to emphasize that without the experiences of the Nebraska reform group to which I belonged, *Changing Patterns* would neither have become what it did, nor have had the impact that it did.

From fall 1964 to fall 1971, I was a "mental retardation research scientist" at the Nebraska Psychiatric Institute, with an academic appointment (first as assistant, then as associate, professor) in the department of psychiatry at the University of Nebraska College of Medicine in Omaha, and, in the years toward the end of my stay there, with a joint appointment in the department of pediatrics.

Nirje made several speaking trips across the US during the later 1960s and early 1970s. According to my diary, I met him first when on one of these trips, he spoke about Normalization at the North Central Regional Convention of the National Association for Retarded Children in March (10-11) 1967 in Lincoln, Nebraska. What made Nirje's presentations so impactful were two things: (a) While he had stage fright before presentations, once the curtain went up—so to speak—he was a charismatic, electrifying speaker with great rapport with his audience. He later reported that he got his first standing ovation in the US in Nebraska in 1967. (b) He had more and better illustrative slides than anyone else and interpreted them very well. I found a note in my diary that I should recommend to Dr. Kugel, my dean, to spring the expenses to invite him to give a seminar in Omaha sometime.

According to my diary, I met Nirje again at the September 1967 conference of the International Association for the Scientific Study of Mental Deficiency in Montpellier, France. There, he introduced me to Karl Grunewald, head of the Swedish mental retardation services. I also met Bank-Mikkelsen there, Grunewald's counterpart in Denmark, who invited me to Denmark—an offer I was to take up less than two years later.

Dr. Robert Kugel joined the faculty as head of pediatrics soon after I arrived in Omaha, and became dean of the medical school not long after that. He had an established history of involvements and publications in mental retardation, and had been appointed by

President Johnson to the President's Committee on Mental Retardation (PCMR). The PCMR was the successor to President Kennedy's extremely influential President's Panel on Mental Retardation that had produced an epochal report in 1962 (President's Panel on Mental Retardation, 1962, with several subcommittee reports: 1963a, 1963b, 1963c, 1963d, 1963e, 1963f, 1964a, 1964b).⁵

In September 1967, the PCMR sent a subcommittee, including Kugel, to Denmark, Sweden, Britain, and France (Humphrey, Jones, & Kugel, 1968). Later that year, the PCMR commissioned Kugel to compile a resource package on residential services for the mentally retarded in the US so that the committee could draw on it for formulating recommendations, and gave him a grant to cover expenses. In turn, Kugel enlisted me to do the bulk of the hands-on work of the project. Somewhere along the line, the decision was made that the compendium should not merely be an in-house resource, but a book, and about halfway through the project, when it became clear how much editing I had to do, I requested to be a coeditor instead of only the major staff worker on the book.

Our basic plan for the book was to first document compellingly just how awful institutions were, then to sketch some alternatives and positive models, and then come up with an integrative chapter that would point to the necessary action measures.

The significance of that part of the book that documented the bankruptcy of the institution system can hardly be appreciated any more these days, because until then, hardly any criticisms of institutions—or even institutionalism—had appeared in the *professional* literature, in part because it would simply not be permitted by those in power and in part because critics who were professionals figured that they could kiss their careers good-bye. As far as I know, all the other exposés had been by journalists, politicians, lawyers, former institution inmates, and some of the conscientious objectors to military service who had been assigned to alternative service as attendants in 65 public institutions all over the US between 1942 and 1946, including at least 16 mental retardation institutions (Sareyan, 1994). To the best of my knowledge, Blatt's *Christmas in Purgatory* (Blatt & Kaplan, 1966) was the first book-length institutional exposé by a leading professional. I suspect that the publication of this book facilitated the appearance of

subsequent critiques of the mental retardation institutions. Prior to Blatt, I barely managed to get away with a few critical comments in my three 1964 and 1965 articles (Wolfensberger, 1964a, 1964b, 1965c; reprinted in David, 1972) that reported on my more noteworthy observations of mental retardation programs in Europe. Even these criticisms were almost unique then.

One issue that became totally clear to us right away—in good part because of my concurrent involvement in the reform of the Nebraska mental retardation services—was that it would be impossible to come up with a meaningful proposal for residential services outside the context of the total service system. But since our mandate was focused on residential services, we did what I have always done: “Give them not what they say they want, but what they really need,” and we used the reference to residential services in the book title as a cover for addressing the total service system.

Kugel and I came up with a list of chapters we wanted and their potential authors, which included some authors whose work we already knew to be relevant. One problem was that the PCMR wanted to get the work done in very short order because it had been charged by the President to come up with concrete recommendations within a year. Nonetheless, when we contacted the potential contributors, almost all agreed right away, which was amazing considering how prominent some were and how busy they all were.

Grunewald was the only invitee who at first declined but eventually yielded to some arm-twisting by Nirje and I. Also, once most contributors were aboard, the National Association for Retarded Children chipped in a small but crucial amount of money to help a few of the contributors with their expenses.

Who and why some contributors were solicited is almost self-evident. The reason for others I can only imperfectly reconstruct, but “political” considerations played a part in one or two cases. Because the rationale for inclusion of the British service model may now be less obvious than the others, I will briefly comment on its history in Appendix A.

By the end of January 1968, we not only had all contributors aboard (see Appendix B for a table of contents of *Changing Patterns* as actually published), but one, Michael Klaber, had already sent in a first

draft of his description of the mental retardation system in Connecticut, which was then considered a model.

However, what later turned out to be the biggest conceptual contribution of the book—namely, the Normalization principle—was hard and late to come by; in fact, it was a heart-stopping cliff-hanger.

To begin with, we had not even asked Nirje to write on Normalization, but an evaluation of the U.S. institutions for the retarded that he had visited in 1967 (Faribault in Minnesota, Central Colony in Wisconsin, and Woodbridge in New Jersey), and we planned to put this in the section entitled “As Others See Us.” Nirje indicated that he would evaluate these institutions in light of “what we mean here by Normalization.” As late as January 24, 1968, I wrote to Nirje that “the presentation and elaboration of the concept of Normalization strikes me as particularly appropriate,” showing that I perceived it as a good idea to include, but not as yet as the centerpiece of the book, let alone as the cornerstone of the reform movement.

Furthermore, whether we would ever actually get a manuscript from Nirje was very iffy. Believe it or not, our deadline was the end of February 1968. In March, Grunewald wrote us that Nirje was stressed, had not yet begun to write, but had said that he knew very well what to write. In turn, I conveyed to Nirje that I knew he was stressed and hoped he would stay stressed until he was done, since he was legendary for performing best when under stress. By late May, we not only had many final chapter drafts in hand, but preliminary drafts from all the remaining authors—except Nirje. But while he had difficulty writing the paper, he had no difficulty writing us long, literate letters, apparently meant to be reassuring, with messages such as the following:

I am still alive and aware of the fact that you are waiting for my paper. . . I realize that you are pressed for time, and I am writing this to confirm that I am aware of the lack of time now. . . I am now taking out a week vacation to be able mentally to concentrate on the paper. To be on the safe side I will leave the country for a week.

Nirje may well have been stressed, but my own stress level was astronomical, and I found his reassurances not very reassuring. On June 8, 1968, he wrote, “My paper is still not written, and I feel very

bad about it. I can too well imagine your disappointment and irritation."

However, that month, he also came on another trip to the US, and so we arranged for him to be virtually taken prisoner in Washington and locked up with some secretaries at the President's Committee office for three days—and this worked! He dictated to them at a furious pace, and, by June 20, he had his first draft completed there and sent it to us. We recognized quickly that a section of his chapter had something that we had come to realize that the book lacked. Namely, despite the presence of several chapters on services that were exemplary for their time, the monograph did not contain a clearly stated unifying idea for an alternative to the prevailing institutional scene. In fact, until we got Nirje's chapter, we considered the chapters by Tizard and Dunn to be the pivotal ones.

So we divided Nirje's chapter into two: one chapter early in the book on how bad U.S. institutions were, and another one late in the book sketching Normalization as one of the major alternatives. Within days after Nirje got back home to Sweden in late June, he had our proposed revisions in hand, and he was actually quite ecstatic about how well they read.

Amazingly, Nirje's (1969) Normalization chapter consisted of less than eight pages of text, plus an appendix of less than seven pages summarizing the Swedish law on "provisions and services for the mentally retarded" of 1967 that reflected Normalization thinking, though at least the English translation did not actually mention "the Normalization principle," much as the Danish mental retardation "care" law of 1959 reflected the idea without giving it a name.

Anticipating skepticism and resistance from opponents to reform, Nirje made two observations in a July 1968 letter. Namely, even in his few visits to U.S. institutions, he (a) had already seen worse things than those shown in Blatt and Kaplan's (1966) *Christmas in Purgatory*, and (b) he underlined something that Grunewald had said earlier, which was that the services in Sweden "are not dreams in the blue but actual accomplishments of 'hard-headed' and penny-pinching appropriation committees of the county councils."

The last chapter on action implications was to be authored by Gunnar Dybwad, who was given much less time to work on it because he had to see everybody else's work first.

According to my correspondence, I proposed to Dybwad on June 21, 1968, that the

cardinal features of future trends in mental retardation residential services [be] four basic and highly interrelated components:

1. *Integration* of the retarded with the non-retarded, which implies location of services in population centers.

2. *Dispersement*, implying smaller units and achieving closeness to family and community.

3. *Specialization*, which also implies smaller units and individualization, but which calls for reduction in closeness between resident and family in some cases. [As mentioned, this was the seed of the later construct of "model coherency," elaborated in Wolfensberger and Glenn, 1975b.]

4. *Continuity* between residential and other services, resulting in less fragmentation, more individualization, and economy.

Of course, this concept of continuity was not at all the one against which the postNormalizationists these days have been railing.

The reason I suggested to Dybwad to work these concepts into his chapter, which he did, was that they had already been evolved in connection with, and written into, two sets of Nebraska's mental retardation reform plans (a state-level and a local county-level one) that were published in July 1968 by groups of people to which I belonged (Governor's Citizens' Committee on Mental Retardation, 1968a, 1968b, 1968c; Menolascino, Clark, & Wolfensberger, 1968a, 1968b).

However, before this chapter came about, it became clear that Dybwad had a Nirje problem in brimming with insights but having difficulty staying put in front of paper and pen. By late June, we had finals of many chapters and advanced drafts of all the others except Dybwad's, and by early August all the advanced drafts had been finalized and distributed to all the PCMR members for review, but we still had no draft from Dybwad.

Then Dybwad did another Nirje on us. With everyone on pins and needles to get his chapter, and us not even having a draft, Dybwad took off on a world tour, leaving a string of forwarding addresses where he generally could *not* be reached by our mail. And then in early August, Kugel received a sorrowful letter from Dybwad dated August 1: "I am now in my 60th year..., all alone here in my sickroom in Adelaide"

(Australia!), “weak. . .weary. . .with plenty of time to think and worry”—especially about what he called me later in the letter, “an editorial aggressopath.” “. . .That’s why I am writing to *you*, Bob,” expecting Kugel to protect him from me. But Kugel also took off on vacation, so I had to write Dybwad a long letter.

With time running out on us, and having learned a lesson from Nirje, we did to Dybwad as we had done to Nirje, except more so. After his recovery and return, we got him to fly to Omaha on several weekends in a row and locked him up in my office suite with secretaries or myself by his side virtually around the clock for days to write or type everything he thought, said, dictated, or wrote by hand, with mountains of food always close at hand. When he was not in my office, he was in our home sleeping, but he also often slept in my office.⁶ This also worked very well, and he produced a great chapter that recapitulated, elaborated, and extrapolated certain Normalization issues, also incorporating some of the ideas already developed in Nebraska at that time, such as elements of the above-mentioned construct of “specialization” of services.

All chapter drafts underwent at least one editing by me, and a critique by Kugel, and some underwent very extensive editing and revising. Also, all chapters were reviewed and commented on (sometimes with implications for yet further revision) by several members of the PCMR, and also by several of the expert consultants of the PCMR (Gerard Bensberg, Curtis Krishef, E. L. Johnstone). On February 16-17, 1968, the PCMR had also held a national conference in the Washington area for 25 or so selected leaders and consultants to take a preview at the direction of the monograph, with Kugel, Gunnar Dybwad, and myself as major presenters.

Actually, the final decision whether the PCMR would officially sponsor the publication of the book was not made until all the members had reviewed the manuscript in its totality later in 1968.

Around early December 1968, the final version of the monograph went to the U.S. Government Printing Office and appeared in print within weeks in January 1969. (Nirje [1992b] recalled January 10 as the publication date. In a 1997 personal communication, he also claimed that the PCMR hurried *Changing Patterns* into print before Richard Nixon was inaugurated in February, lest his administration interdict the printing.) Both in its mode of coming into

being and in the reaction to it, one could characterize the book as having had a caesarean birth. It soon became known as “the blue book,” and sometimes as the Kugelberger book, as a lot of people began to refer to either Kugel or myself as Kugelberger, some in jest and some from temporary disorientation.

Of the first printing run of 5,000 copies, 2,160 were immediately distributed, free of charge, with a cover letter, to all state governors, all members of the U.S. Congress, all state mental retardation coordinators, all 450 superintendents of public institutions for the mentally retarded and “mentally ill,” 550 directors or operators of private residences for the mentally retarded, all leaders of the National Association for Retarded Children (NARC) and of the American Association on Mental Deficiency, all leading figures of all the state units of the NARC, and miscellaneous others.

There were at least two more printings, for a total of over 20,000 copies, and when these ran out (sometime between 1972 and 1974), the Pennsylvania State Office of Mental Retardation paid to have facsimile reprintings done, again with very wide distribution, especially all over Pennsylvania because it was then in the forefront of reform.⁷ One reason for this was that this office had recruited one of the senior staff members of the community service system around Omaha, Mel Knowlton, who was still working in that office as of 1998.

In his 1983 text on the history of mental retardation, Scheerenberger (1983) called *Changing Patterns* “one of the most consequential and successful publications of the reform era” (p. 227) and of a quarter-century. Among the likely reasons for this, we can point to five.

1. Unbeknownst to most people today, the book contained the first published explicit formulation and description, of any length in any language, of the Normalization principle. This is the reason why portions of it got so quickly translated back into Swedish (Grunewald, 1971) and Danish (Grunewald, 1972), and soon after into German (Kugel & Wolfensberger, 1974).

2. However, not only was Normalization presented in its clearest form to date, but it was presented in stark contrast to the devastating institutional realities and their history. It is well known that a change agency effort is vastly more likely to succeed if the inadequacies of a prevailing pattern are exposed

simultaneously with the presentation of an appealing and plausible alternative.

3. A great many of the recommendations incorporated into *Changing Patterns* had begun to be implemented in Nebraska, even before the book was published, via a virtual service revolution. This implementation took place both on the level of systems organizing, and on the programmatic and clinical level. The principle of specialization was demonstrated by the initiation of a wide variety of services. Also, all this began to be sketched in various publications (e.g., Wolfensberger & Menolascino, 1970a, 1970b), and was otherwise widely disseminated. People came from all over the world to see for themselves, and many experienced a mental paradigm shift. This lent credence and power to *Changing Patterns*.

4. By a fortuitous coincidence, three of the contributors to the book (Cooke, Bank-Mikkelsen, and Tizard) were announced in spring 1968 as winners of the Kennedy Foundation International Award—at that time, the closest thing to a Nobel prize in mental retardation—for achievements prior to their contributions to the book. (Gunnar and Rosemary Dybwad were to receive the award belatedly in 1986.)

5. The strategy of massive distribution of the book by the PCMR must also have played a big role.

Editing *Changing Patterns* was one of the greatest balancing acts of my career, with the 14 contributors having been born in eight different countries, working in four different countries, several being very temperamental, and time being so short. In July 1968, Norris, who wrote up the Essex model, complained that the pace I demanded of him was “ungentlemanly.” Often, we talked past each other because people did not understand each other’s terminology, even when they spoke or used the same tongue. The terms used by the Scandinavians would often not be understood by Americans, and when I told Norris that we wanted data on client movement, he threw us behind by asking through the mail what that was, perhaps wondering if we were asking about toilet-behavior statistics, which was a common preoccupation then on the American service scene.

In retrospect, I have marveled that as extensive a work as *Changing Patterns* could attract so many senior and competent people as authors on such a rapid schedule of production. The prestige of the President’s Committee on Mental Retardation probably had much

to do with it, plus the attraction of being part of an extensive reassessment of the field. One reason that motivated many invited contributors to participate was well expressed in Lloyd Dunn’s acceptance letter of December 15, 1967: “All I need is another assignment as I attempt to get my affairs in order for my leave of absence from the United States. However, the business of residential facilities in this country is such an important matter that I cannot refuse your kind invitation. . . .” Another reason was a recognition that the prestige of the PCMR made it very likely that the product would have an impact. Also, it is my impression that people actually had more time in those days prior to the introduction of so many timesaving devices, and to the increasing formalization, bureaucratization, and complexification of everything. People today might also not have the leeway to devote so much time to a project without receiving funding for it. Further, modernistic values have made people more prideful, and I doubt that authors of the same calibre as those in 1968 would today be as accepting of extensive editing by a person much less senior to most of them. All in all, I thus doubt that the same feat could be duplicated today.

By the way, no one received any royalties for working on *Changing Patterns*; however, Kugel, who collected antique pewter artifacts, gave each contributor a reproduction of such an item, in my case a candle sconce. On my part, my wife and I sent the Dybwads a gigantic box of Omaha steaks which arrived just in time to replenish Gunnar’s protein for writing a chapter (Dybwad & Dybwad, 1970) for a book by Joseph Wortis that was, as Gunnar put it, “about as overdue as my chapter was for your book, and that is hard on Rosemary’s nerves not to mention those of Dr. Wortis” (letter, February 5, 1969).

I do not want to leave readers with the impression that all the contributors to *Changing Patterns* agreed with its major conclusions. Far from it: Some have continued to champion institutions to this day; I believe that some never came to understand systemic diversified community-dispersed services; some never did anything to promote Normalization; even some who liked Normalization understood it incompletely and/or did not embrace some of its implications, as documented later on in Appendix C. Some contributors dropped off the cutting edge of reform into the human service woodwork; some, though they eventually

approved of the work, engaged themselves in other pursuits and were for all practical purposes no longer involved in the reform struggle. But then—as I will show later—the PCMR itself never endorsed the book either. The contributors most prominent in continuing the war joined by *Changing Patterns* in North America on an ongoing basis were—in my opinion—Nirje, Blatt, Dybwad, and I, and even we either continued to have differences on some important issues, and/or developed such as time went on. Also, all of us who did embrace Normalization still had incomplete and still-evolving notions of it, as I will also elaborate in a later section.

Interestingly, in 1970, Rothman published *Changing Patterns in Psychiatric Care*. One cannot help but wonder whether it was trying to capitalize on, or compete with, *Changing Patterns in Residential Services for the Mentally Retarded*, but it did not cite the latter, nor any of its authors, nor even carry any term that would suggest “mental retardation” in its index.

In the mid-1970s, and as part of the U.S. bicentennial of the 1776 revolution, Kugel undertook a revision of *Changing Patterns* on behalf of PCMR and invited me to co-edit it again, but I felt that such a revision was—so to speak—overtaken, and I wanted to do things I considered more important for that moment in time. So he recruited Ann Shearer to do the kind of nitty-gritty work I had done on the first edition, and the work was published—again by the PCMR—in 1976 (Kugel & Shearer). However, as I had anticipated, it received relatively little attention.

6 THE ELEMENTS OF NORMALIZATION THAT INITIALLY WERE NOVEL OR HIGHLY CONTROVERTED

A later section of this chapter will be devoted to the impact of Normalization, but in order to lay the groundwork for that topic against the historical background, I will briefly sketch some of the elements that were part of either Nirje’s or my Normalization formulation, or of both, that were either new to the service scene of their time or that were intensely controverted. In order to do this, it can be very helpful to contrast some of these Normalization elements or corollaries with the ideas that prevailed previously or

concurrently about what constituted high-order promising concepts of service and/or human relationships, as covered in an earlier section.

Few of the people who came upon the human service scene after circa 1975 can even imagine how bleak things were in many human service domains, and especially in mental retardation. Rather than recapitulating the history of horror stories prior to that era—a lot of which I have done elsewhere (e.g., Wolfensberger, 1969a [reprinted 1974b, 1975a], 1991b; and in our Training Institute workshop entitled *Developments in the Field of Handicap and Mental Retardation From Prior to the Reforms of the 1950s-70s Up to the Present, With Implications for the Future: What Is Better, What Is Still the Same, What Is Getting Worse, and What Lies Ahead*)—I want to list here some of the positive measures that blew people’s minds when they encountered them in real life.

For over 100 years, people had never seen a public institution get smaller, and hardly ever a private one that did. In fact, most had never seen a small institution, period. That is why so many people were bowled over by seeing some of the new small institutions that sprang up in the 1950s and 1960s, such as a small number of newly founded private ones, and others interpreted as “regional centers.”

In early 1968, most of the 12 leaders of the mental retardation reform movement in Nebraska toured a small Lutheran institution for people with many kinds of handicaps in the small town of Axtell, Nebraska, and could not get over the fact that residents were called “guests,” and that those who were bedridden were nonetheless dressed in normative clothes every morning. To this day, ambulatory residents of U.S. Veterans’ Administration hospitals still commonly go about in bedclothes and housecoats all day.

On a visit to Germany in 1967, I learned that mentally retarded residents of an institution went integrally to public swimming pools. This was worth writing home about!

In 1969, people’s minds were blown when they saw retarded residents of group homes having free access to telephones, and conducting uncensored telephone conversations with family and friends.

My mind was blown in 1971 by witnessing retarded and nonretarded people living together on a close-to-equal basis in North America’s first l’Arche community in Toronto.

People who visited the ENCOR service system in the Greater Omaha area of Nebraska in 1972 were struck by the fact that in its various service settings, there were many pictures displayed of the retarded clients.

The realistic but dignified depiction of retarded people in normative relationships and contexts in high-quality art work by Marthe Perske, starting in 1970, "gob-smacked" many people, and was a profound new kind of mental boost to many parents.

Against the background of the "bad old days" conditions, the poverty of higher-order ideas for proper services, and the little things that blew people's minds as revolutionary, we can now appreciate much better certain concepts or implications that were associated with either Nirje's and/or my Normalization formulation. I will only briefly sketch those that one would not have encountered as popular at the time, either because these things were novel, or because they had not been widely disseminated previously, or because they had been forgotten or outright rejected. It seems to me that 11 things can be put into this category.

1. The idea of applying normative conditions to deviant people. By the way, before people learned to think and talk of normalized residential settings, they sometimes did talk of "homelike" ones, but the term was almost always applied to institutional settings since the vast majority of people had never seen other kinds of residences and could not even conceive of them. Also, "homelike" largely meant "less institutional" rather than normalized. After all, such settings were literally thought of as similar to a home, but not truly like an ordinary home.

2. Striving beyond normativeness toward the societal ideal for vulnerable persons, i.e., what I later called the conservatism corollary. (See Wolfensberger, 1998, for a recent elaboration of this construct.)

3. The notion that a single theory or principle could be applied not only to all retarded people, and not only to all handicapped ones, but to all deviant ones.

4. The delineation of major historic deviancy roles and their impact on "models" of (a) social interactions, and (b) human services.

5. The power of role circularities.

6. The concept of a "developmental model."

7. The concept of (deviancy) image juxtaposition, its components, and its importance.

8. The concept of age-appropriateness, and the distinction between age-appropriate and culture-appropriate phenomena. (From my diary, I could recover that I already spoke about age-appropriateness at the October 1970 conference of the National Association for Retarded Children in Minneapolis, and possibly earlier.) The term "age-appropriate" is now encountered in generic public discourse.

9. The separation of certain service and life functions from each other; "specialization," later "model coherency."

10. The dispersal of services, in order to achieve the five desiderata of (a) avoidance of negative dynamics within larger groupings of deviant people, (b) "specialization," (c) not overloading social assimilation potentials, (d) avoidance of deviant-person and deviant-group juxtapositions, and (e) easier access by users and the public.

11. The distinction between physical and social integration, already greatly elaborated in Wolfensberger and Glenn (1973b).

In regard to numbers 7 and 10(d), the phrase "juxtaposition of deviancies" is already found in my work-related diary as early as October 1970, but its most systematic formulation came in the 1975 edition of PASS (Wolfensberger & Glenn, 1975b). The person who gave me the most decisive help in spelling out this construct was Dr. Bill Bronston, who had been sentenced by the New York State Department of Mental Hygiene to a year of penal servitude under Burton Blatt and me at Syracuse University for his role in bringing about the Willowbrook exposé.

The concept of "service specialization," which eventually became model coherency, evolved from an idea apparently first presented in 1959 by Lloyd M. Dunn, chair of the Department of Special Education at George Peabody College for Teachers (since become part of Vanderbilt University) in Nashville, Tennessee, in an advanced graduate course on social and educational aspects of mental retardation which I attended. He proposed that "omnibus" institutions for the mentally retarded be replaced by smaller, more dispersed specialized institutions for specific subgroups of different identities and needs. He also

proposed this concept in a keynote address to the Southeast Region conference of the American Association on Mental Deficiency on November 9, 1961, in Nashville, Tennessee, and then later that month wrote it up into an unpublished manuscript, which he also distributed to his students. Although it was a keynote address, apparently nothing came of it, and no one apparently acted on it until I drew on his ideas to sketch a wide range of different types of residences for the mentally retarded during the 1968 crafting of the Nebraska state plan for reforming mental retardation services (Governor's Citizens' Committee on Mental Retardation, 1968a, 1968b, 1968c). Some elements of the concept of "specialization" have now become so self-evident that one has to tell horror stories in order to get people to appreciate their importance. For instance, when I visited the Elwyn Institute in Media, Pennsylvania, in April 1970, despite the fact that it was considered one of the better publicly supported institutions for the mentally retarded in the US—particularly since it also accepted residents on the basis of private payment—a living unit for females (called "Hope") had in it residents all the way from children of age 8 to adults in their 40s. However, "specialization" was not conceptualized only for residences, but as a way of designing any kind of service for what I—starting in 1974 or 1975—called "model coherency."

Among the reasons that Normalization was so powerful were three interrelated ones. (a) It enabled people to put together, into one unified mental scheme, so many things that they had seen here or there, that had positively impressed them, and that previously they had not known how to connect to each other. (b) It often told them something that they had known "inside," and to which they could now explicitly assent. (c) It gave them an idiom that enabled them to discourse explicitly and effectively on these things.

So, for instance, if they had seen persons with severe behavior problems occupy spaces that contained many breakable items and had ordinary glass windows, and own some personal possessions, who were not being unnecessarily locked up, who had some beauty in the environment, and so forth, people could now subsume all this under the "aha" idea "why, yes, these are normal things, and these are human beings, and if one treats people more normally, that will get them to act more normally."

7 THE PERIOD BETWEEN *CHANGING PATTERNS* AND THE TEXT ON THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES

We will next look at certain events between 1969 and circa 1973 that had to do with people's response to *Changing Patterns*, the evolution of Normalization thinking, and how it came about that the 1972 book *The Principle of Normalization in Human Services* (Wolfensberger, 1972c) got written. Some of the items that will be covered in this and other sections of this chapter will overlap a bit, but that is unavoidable.

As it turned out, *Changing Patterns* broke the back of the institutional movement. However, it is hard to describe how, in the next few years after *Changing Patterns*, there coexisted both a wave of enthusiastic and epidemic acceptance of Normalization and the idea of community services across the US, as well as the most bitter opposition to these. Whenever I describe either one or the other, I am afraid that an audience will get the wrong impression.

Because of the bitterly divided response to *Changing Patterns*, the *American Journal of Mental Deficiency* (March 1971, 75[5], 645-649) took the extraordinary step of publishing reviews of it by three different parties. One of these reviews called reading it "an adventure." Another (by Cleland & Shafter, 1971) said that "If the authors . . . intended to employ social-psychological principles to evoke 'in-group' attitudes on the part of their reading audience, they appear to have achieved a breakthrough . . ." adding that the work outlined "a plethora of scapegoating, vitriolic and strident censure . . ." and "much 'sizzle' and a little 'steak' . . ." "If these are the attitudes of the future, institutions are in for dark times—and with them, the residents . . ."

In turn, an institution superintendent in Virginia wrote (May 12, 1971) to Cleland and Shafter,

May I congratulate you both on your restraint and detached review of "Changing Patterns in Residential Services for the Mentally Retarded" which probably has the distinction of being, next to "Christmas in Purgatory," the worst publication in the field of mental retardation. Since I am more straight forward [sic] and call "a spade a spade," I would not have been so benign in my evaluation of this pamphlet. The only disagreement I have is with

your evaluation of Wolfensberger's chapter which although somewhat better than some of the other writing, is too long and probably intended for those who are completely ignorant in this field. It intrigues me to note that the executive leadership of the NARC concurs in the views expressed in that publication. I am not too surprised.

The reason I have a copy of this letter in my files is that copies were sent all over the country by the writer.

Ironically, in 1978, Cleland wrote a textbook on mental retardation which a reviewer (Newberger, 1979) said "consistently (applied) principles of Normalization."

Another reader described the *Changing Patterns* book as "vituperative and sensationalistic."

Strangely enough, not one of these reviews, and only one of the seven others in my files, mentions the Normalization principle or Nirje's chapter (1969) on it. The one reviewer who did (Hallahan, 1970) only mentioned that the editors considered Normalization to be the single most important concept in the book. The most lauded chapter by virtually all reviewers (even those who did not like the book) was the one I wrote on "The Origin and Nature of Our Institutional Models."⁸ However, while it indicted the institutional model and called for alternatives, it gave no prescriptions for such. In other words, the reviewers were so gob-smacked by the book's thorough indictment of the institutional model that their minds reeled and could hardly register the prescriptive elements, and least of all the radical nature of the Normalization principle.

Even though the PCMR had sponsored and published *Changing Patterns*, and lavishly disseminated it, the PCMR never formally endorsed it and maintained an ambivalent—sometimes even undermining—stance toward it. To begin with, the PCMR had made clear by a statement on the inside front cover of *Changing Patterns* that "the Committee has taken no position on these works. The Committee's views are presented in two reports made to the President," namely, its 1967 and 1968 annual reports.

In its own newsletter, *PCMR Message*, the PCMR announced *Changing Patterns* only in a brief neutral blurb in the February 1969 issue. It carried a brief laudatory response to it by Elsie Helsel (at that time, a major actor in the Cerebral Palsy Association of America, as well as in mental retardation) in its May

1969 issue—and that was it as far as coverage in its own very widely disseminated periodical was concerned.

Although the PCMR members had seen prepublication drafts of *Changing Patterns*, the PCMR's September 1968 second annual report to the president, *MR 68: The Edge of Change* (PCMR, 1968) did not mention it, and gave very little emphasis to proposals consistent with its reform thrust. However, it did have many proposals for making institutions better institutions!

The PCMR's third annual report (PCMR, 1969) did a bit better. While it did not mention Normalization and referred to *Changing Patterns* only by including it in a list of the PCMR's nine previous publications, it did have a sprinkling of both Vailish and Normalization-type passages.

One passage contained the Vailish formulation of "The retarded as fellow human beings having individuality, dignity and a personal stake in daily life and work" (p. 22). Normalization-inspired passages said that "we must make as great as possible integration of the retarded into normal community living" (p. 26), and "the total integration of the retarded into normal community living, working and service patterns is a long-range objective" (p. 26). A rights orientation was called for (p. 26) and institutional warehousing was condemned, but not institutions themselves (p. 26).

Worst of all, even with *Changing Patterns* in hand, the PCMR authorized a subcommittee, entitled "PCMR Work Group on Residential and Family Living" and chaired by an arch-institutionalist, to work on a separate monograph entitled *Residential Services for the Mentally Retarded: An Action Policy Proposal* (PCMR, 1970). I was given a rough draft of it to critique, and I did. It was plain awful, promoting a thinly disguised pro-regional-center-with-regional-institution model that reflected the concept of "the comprehensive residential facility" "close to the community" for "serving a region or community" that would be "participating in all phases of comprehensive planning." Residents in this center would "be helped to live as normal a life as possible in safety." In the draft of this document, the director of this kind of facility was still referred to as a "superintendent," which was changed to "administrator" in the published version. Parents and citizens were interpreted as

volunteer workers "to the mentally retarded and the staff," not in governing board positions. *Changing Patterns* was listed among its references but as authored by the President's Committee, probably in order to avoid the distasteful word "Wolfensberger." Nirje was quoted—but only a 1967 paper of his, not his 1969 Normalization chapter. Two papers by Dybwad were also quoted—but again, vastly less trenchant ones than his 1969 chapter in *Changing Patterns*.

All this underlined what I had said in a previous section on the prevailing bankruptcy of vision.

After getting the prepublication copy of this document, I wrote the following:

To my surprise I find again and again that even leading professionals in the field have neither fully conceptualized or internalized the notion of the comprehensive service system of the future of which residential components are an integral part, but merely a part. This confusion is often symptomized by proposals to diffuse institutions, by attempts to place community services under institution administration, by attempts to interpret institutions as regional resource centers, etc. Also, many individuals confuse the concept of local services with the concept of local service centers, and fail to distinguish between local or regional offices and local or regional service systems which may be administered by but usually should not be located in a regional office. This confusion is all the more remarkable because everybody pays lip service to the concept of continuous and comprehensive services.

Confusion is particularly marked in the current standards for residential services by the American Association on Mental Deficiency (AAMD)—a set of standards which only applies to institutions and not at all to the new conceptualization of local, special-purpose, dispersed services which are part of a regional service system. These standards can be cited as an example of lack of commitment to the principles of Normalization. Even the most recent statement of the President's Committee on residential services, as well as that of NARC itself, is primarily relevant to institutions, rather than to residential services in the new sense of the term. This confusion must be overcome! We may have to go back to the President's Panel report of 1963, if need be, and begin all over to explain the concept which we erroneously had assumed was understood.

One of the reasons why I referred to the AAMD standards was that they were favorably mentioned in the PCMR's June 1970 monograph. I gave feedback along the above lines to Fred Krause, a senior staff officer of PCMR (later its executive officer) with whom I was on friendly terms.

When the PCMR published the document in mid-1970, there were only two minor changes from the draft I had critiqued, and the document was published as an official document of the full PCMR, rather than only one of its committees, and without the kind of disclaimer put on *Changing Patterns*. This made it appear that even though the PCMR had published *Changing Patterns*, the PCMR did not agree with it, but did agree with what was in the 1970 document.

The low profile of the PCMR in regard to *Changing Patterns* and Normalization probably had multiple reasons. (a) The committee was divided, having several very strong pro-institution members. (b) Many of its members were oriented to center approaches and medical and/or university dominance of services, and were not very favorable to the idea of community-controlled diversified and dispersed services. (c) Some committee members were probably afraid of appearing too radical, especially with the election of Richard Nixon to the U.S. presidency in late 1968.

We therefore have to conclude that as a committee, the PCMR never realized, or wanted to acknowledge, that it had godfathered the crucial service reform document in mental retardation. The closest it came to such an acknowledgment occurred seven safe years later in its 1976 report *MR 76: Mental Retardation: Past and Present* (PCMR, 1977), which was published as a substantial book interpreted in a cover letter as "a concise and accurate history of mental retardation in America." Among other things, it gave considerable coverage to its own past activities and products, and, in this connection, devoted one brief paragraph to *Changing Patterns*, mentioning the principle of Normalization in connection with it and calling *Changing Patterns* one of the committee's "most influential documents"—but in the area of "institutional living" (p. 130). In its otherwise extensive index, Normalization was not even listed.

In early September 1969, the International League of Societies for the Mentally Handicapped (ILSMH), the international confederation of parent-founded national organizations, held a *Symposium on*

applied for state funding. It turned out that when the agencies that we were afraid of saw the instrument, they decided not to even apply for funds because they could not hope to compete in terms of the instrument's criteria. Those that did apply and fell short, but not too short, were funded with the requirement that they would bring their practices into closer conformity with the instrument. The same process was repeated the next year, and there were significant improvements in PASS scores.

About 1½ years after *Changing Patterns* appeared, some of the giants started blinking.

Dybwad and I had been involved up to our eyeballs in change agency activities in or with Pennsylvania. In May 1970, Dr. Donald Jolly of the mental retardation office of Pennsylvania convened a small invitational get-together in Hershey, between several top people in the state's mental retardation system, potential new commercial service providers from all over the US, two key people from the Pennsylvania ARC (Pat Clapp and Hannah Geisel), and I, which was a little like a struggle of the latter three against the devil—and we won. A superintendent of one of the state's worst hellholes made one of the most explicit public confessions of an evil commitment to enmity toward the retarded that I have ever witnessed, and I chastised him grimly for it, after which he had nothing more to say.

Among others, one of the things that happened there was, unbeknownst to most people, the most crucial turning point in mental retardation in Pennsylvania, a key state. Only two days after this meeting, the governor of Pennsylvania announced that he would seek a break with the past and endorsed a community services approach much along the lines pioneered in Nebraska and recommended in *Changing Patterns*. In July 1970, the Pennsylvania Senate approved a bill that included a provision for "normalizing accommodations." After Nebraska, Pennsylvania was one of the first states, and the first large state, to commit itself to normalized community services, which made this event so important. The reason I am not mentioning Connecticut along the same lines is that it remained stuck stubbornly on its regional center model for many years to come—a model that would have been impressive if it had not been overtaken almost as soon as it was being implemented to any extent.

In October 1970, the annual convention of the U.S. National Association for Retarded Children (now called The Arc) passed a resolution endorsing "Normalization of the retarded and their assimilation into society as persons and citizens," and expressing its "appreciation and gratitude to Dr. Wolf Wolfensberger for his untiring commitment of time, energy and thought" on behalf of retarded people and the Normalization principle.

On December 10, 1948, the UN adopted a universal declaration of human rights.⁹ In June 1967, a symposium on *Legislative Aspects of Mental Retardation* of the International League of Societies for the Mentally Handicapped, held in Stockholm, spelled out various proposed rights of retarded people. In October 1968, the league adopted a "Declaration of General and Specific Rights of the Mentally Retarded" that was modeled on the UN declaration. (It had been drafted largely by Elizabeth Boggs, one of the parent founders of NARC.) In turn, on December 20, 1971, the UN General Assembly passed a "Declaration on the Rights of Mentally Retarded Persons," which differed only in minor ways from the League's statement. It incorporated two references to "normal life," which probably would not have happened if Nirje's 1969 chapter on Normalization had not been produced. One of these passages referred to "the necessity of assisting mentally retarded persons to develop their abilities in various fields of activities and of promoting their integration as far as possible in normal life . . ." The second one said that "if care in an institution becomes necessary, it should be provided in surroundings and other circumstances as close as possible to those of normal life." Unfortunately, this phrase still resonated with the idea of the "better normalized institution."

Obviously, Normalization, service reform, and community service ideas were gathering an avalanche of momentum. It was largely in response to the threat posed by these ideas that the superintendents of U.S. institutions for the mentally retarded got together in 1971 and formed an organization named the National Association of Superintendents of Public Residential Facilities. It held its first annual meeting in conjunction with the annual convention of the American Association on Mental Deficiency in 1971. Of course, it is very likely that association members and others would have denied then, and may still deny today, that

the organization was founded as a defensive measure against the new community services avalanche. However, that this was a real concern is apparent in an editorial article in the fourth issue of the organization's newsletter in March 1972 by its chairman, entitled, "The Need for Accountability in Community Mental Retardation Programs," which preposterously implied that institutions had been and were accountable but community services were not. In order to buttress that idea, and in support of the "better institutions" concept, a major concern of the new organization in its early years was the development of institutional accreditation standards.

The appearance of *Changing Patterns* also gave yet another big spin to European study visits by North Americans, and in fact launched something I earlier called "Scandinavia." Among other things, several universities—above all the University of Wisconsin—and some private entrepreneurs organized annual tours of human services in Europe, especially, Scandinavia. Some of the tours specialized in taking parents of retarded children.

In 1971, Sweden held what appears to have been the first European conference on special education, and much of it, and the material about it, was in English. At first flattered by their status as models, services in Denmark and Sweden soon felt overrun by overseas visitors.

8 AN INTERPOLATIVE NOTE ON THE ONGOING EVOLUTION OF NORMALIZATION IDEAS INTO THE EARLY 1970S

Before going on to the description of how the writing of *The Principle of Normalization in Human Services* (Wolfensberger, 1972c) came about, I want to interpolate a section that documents the fact that during the late 1960s and early 1970s, there was still much evolution going on in the thinking about Normalization, including by Nirje himself. I believe that it is failure to parse the history of the idea of Normalization into its proper phases, and to recognize the different steps in the evolution of Normalization, that has led to much confusion about whom to credit for what.

Many people have claimed that this or that speaker or writer had invented Normalization prior to its Scandinavian formulation of the 1959-1972 era. One thing that is true is that the moral treatment scheme had been very concordant with Normalization, though the British version of William Tuke (1732-1822) much more so than the French version of Philippe Pinel (1745-1826). In the US, moral treatment ideas were particularly strongly—but futilely—promoted by Samuel Gridley Howe (1802-1876) over a period of decades during the mid- and late 19th century. The reason this turned out to be futile was that moral treatment was resoundingly rejected between circa 1860-1885 in favor of a new materialized and medicalized way of thinking about human beings and human services, and by the mid-20th century, few people in human services who were not also historians would have known what moral treatment was, or even have heard of it. In fact, the systematized Normalization from 1969 onward can be considered to be almost a reinvention of moral treatment from a different perspective.

However, all the claims that Normalization had been formulated in a recognizable form in the 20th century prior to the 1959-1972 era I have so far found to be false. It is true that the verb "to normalize" had been used in English since at least 1865 to mean making something abnormal normal, and the noun "Normalization" had been used in the same sense since at least 1882. One can even find the verb "to normalize" in an English-German dictionary of 1906, if not earlier. But mere uses of these words outside a more systematic context of explicated meaning cannot be taken to signify the same thing as Normalization did once it was defined by Nirje (1969).

Prior to 1969, there had been a few instances of the term "Normalization" in reference to human service, a rare outcry to let people be normal, and a fair number of calls for specific isolated measures that we can interpret as having been consistent with parts of the Normalization theory yet to come. Beatrice Wright—a prominent leader in the field of physical impairment—even used the term "anormalization" (1960, 1966). However, the only way one could interpret any of these instances to be equivalent to what Normalization became in 1969 is if one did not understand Normalization, or wanted to depreciate the achievement of Nirje's, and later Wolfensberger's, systematization.

According to Ericsson (1986), the "Normalization of life conditions," and even the term "Normalization principle," were used with a limited meaning as early as 1943 by a Swedish government commission, but he does not provide a reference to any such commission document. Ericsson also credits Bank-Mikkelsen with having spoken in the 1950s of the enablement of "a normal existence" for retarded people, but he cites a 1964 statement by Bank-Mikkelsen, rather than a 1950s document. In light of the many erroneous retrospective claims and historical revisionisms that I have been able to identify in regard to Normalization history, with people often being said to have spoken about Normalization when they never actually used Normalization terms, a verbatim citation of original documents is essential in order to buttress a claim.

What I mean by this is illustrated by the fact that Normalization is never mentioned in at least the English translations of the two major pieces of Scandinavian legislation that are often said to be major milestones in the legal encoding of the Normalization principle.

The 1959 Danish "Act Concerning the Care of the Mentally Retarded and Other Exceptionally Retarded Persons" (Bank-Mikkelsen, 1969)¹⁰ certainly does not mention Normalization in its English translation, and even the terms "normal" or "normally" appear only once each in respect to compulsory education being normal, as well as its termination at age 21 (p. 248). However, according to Nirje (1992b), the preamble of the law also contained the phrase "to let the mentally retarded obtain an existence as close to normal as possible" (the phrase is not included in what Bank-Mikkelsen [1969] called a "copy" of the law in English in *Changing Patterns*), but as Nirje said, "none of us were yet ready to talk about 'Normalization' and even less about a 'principle.'"

The English translation of the 1967 Swedish "Law About Provisions and Services for the Mentally Retarded" (e.g., Nirje, 1969) also does not seem to mention "Normalization," nor does it even seem to use the phrases "normal" or "normally." Even to the degree that elements of a Normalization idiom had been used early on, this cannot be automatically assumed to mean that it referred to an idea that came close to Nirje's 1969 formulation. I therefore offer the following proposal.

While Nirje (1992a, 1992b) credits Bank-Mikkelsen with the idea, I would put it differently. I would say that Nirje was the first publicly prominent person who stated, in 1969, a systematized formulation of the Normalization principle, *and* in conjunction with a highly developed Normalization idiom, such as the terms "the principle of Normalization" and "the Normalization principle."

As for Bank-Mikkelsen, I would say that he had the vision of a direction into which things should move and was the person in an executive capacity to be able to actually implement measures in this direction earlier, on a higher level, and more systematically than others, but his thinking was not evolving as rapidly as Nirje's during the late 1960s and early 1970s. Instead, he was more of a "pathbeater," a *Vorgänger*. I also suspect that even on the administrative-implementive plane, he may have been overtaken by Grunewald and Swedish developments around 1970, because Danish developments were by then going too much according to an earlier plan that was already being overtaken by new ideas, much as happened in Connecticut at the same time, while Sweden was still unfreezing its earlier patterns and showing more flexibility with new ideas.

Evidence that Bank-Mikkelsen was still evolving his thinking includes that, in 1969, he praised the use of convicts as ward aides in a Massachusetts facility (Staff, 1970b, p. 7)—something that my own formulation of Normalization interpreted, as early as the same year, as denormalizing (e.g., in Wolfensberger & Glenn, 1969) because of what we later called "deviant staff juxtaposition."

Evidence that Nirje's own Normalization ideas were still very much evolving between 1967 and 1971 includes the fact that his March 1967 presentation on it in Nebraska was not nearly as well developed as one he gave there in January 1971. Also, I have in my archives a six-page memo Nirje wrote, dated June 12, 1968, entitled "Outline for a Plan to Attack Inhuman Conditions in the United States' Institutions for the Mentally Retarded" [see appendix to chapter 2]. From the dating, it is clear that Nirje wrote these recommendations at the headquarters of the National Association for Retarded Children in New York, and probably at least in part in preparation for his trip to the Washington office of the President's Committee, and only about a week before writing the first draft of

his contribution to *Changing Patterns*. The document was full of new ideas and proposals, many of which have since been accepted and implemented—but strangely enough, the principle of Normalization was not mentioned once. Instead, the language revolved around combatting “dehumanization,” and “dignity” was mentioned—that is, the two key concepts of Vail. Also, better, smaller, and less remote institutions with wards of up to 20 residents continued to be promoted in this document as a major remedy for some types of retarded persons.

When I visited Bank-Mikkelsen in Denmark in April 1969, and *Changing Patterns* had already been out several months, one expression he used, which meant as much as Normalization to him, was that the mentally retarded “need the same living conditions as the population in general.” How underdeveloped the concept of image juxtaposition then still was in Bank-Mikkelsen’s mind was brought out by the fact that he was rather gleeful about the Danish mental retardation services being funded to a very large extent by a tax on alcohol and tobacco (called a “vice tax” in the United States), which he said was also a practice in Iceland at that time. Further, neither in Denmark nor in Sweden did I hear it stated in 1969 that even the most lavish institutional or segregated educational provisions fell short of full Normalization. In 1964, Bank-Mikkelsen (1964) had spoken of “day institutions” for people living at home (p. 3), of “non-residential institutions” (p. 5), and of “regional centers.” Indeed, in Denmark, several large old institutions served in this capacity for some time into the 1970s, at least.

Altogether, it is not surprising that some people who had been to Scandinavia during the late 1960s picked up some Normalization ideas and language, but also the idea that institutions could be normalized. For instance, in October 1967, after coming back from her tour of Denmark and Sweden as part of the PCMR subcommittee mentioned earlier, Muriel Humphrey (1968), the vice-president’s wife, a member of PCMR, and a grandmother of a child with Down’s syndrome, called for “[creating] in institutions as normal a living pattern . . . as possible,” and to “encourage normal living . . .” Her remarks were published in the March 1968 issue of the PCMR newsletter, *PCMR Messenger*. Note that while she had gotten the phrasing “as normal as possible” from her visit to Denmark, she was also still thinking of normalized institutions, just

as continued to be pursued in Scandinavia for years to come.

Also, Nirje saw it apparently as no big problem to work for a branch of the Ontario government between 1971-1978, that was concerned mostly with institutions for the retarded. This is, in fact, when tension between us developed because I also worked in Canada during 1971-1973. (We moved there within two months of each other, both having been extruded from our jobs, as further told in the next section.) My main role there was to dismantle the institution system in favor of community service systems that were run by community bodies rather than the provincial government, and I saw Nirje’s boss as being largely on the other side.

I also observed—and got the data to prove it—that in 1969, residential placement outside the home of retarded children in Denmark and Sweden was not strongly discouraged and that for retarded adults, it was actually encouraged. In fact, Nirje’s (1969) statement that it is normal for adults to move out of the parental home was often translated to mean that the person should move into a group home or agency apartment. This accounted in good part for the fact that these countries had higher residential placement rates than the US *despite* lower rates of prevalence of mental retardation (e.g., Wolfensberger, 1980).

Now let me say something about the evolution of my own thinking on Normalization. My first exposure to Normalization—namely, to Nirje’s 1967 presentation in Lincoln, Nebraska—did impress me, but it did not produce a breakthrough in my mind. I can only hope that this was Nirje’s fault and not my own, but I doubt that we will ever know. Four more things had to happen before my “aha” experience was completed.

The first was to—finally—see Nirje’s writing for *Changing Patterns*, upon which Kugel and I agreed, and stated so in *Changing Patterns*, that Normalization was “perhaps the single most important concept that emerged in this compendium” (p. 10), as was also reiterated in Dybwad’s chapter (p. 385).

The second thing was Grunewald’s visit to Nebraska on his spring 1969 tour of the US. We scheduled his visits wall-to-wall, starting with a TV news conference at the airport when he arrived, parties late into the night, early-morning working breakfasts, meetings with the governor, and speeches. At one

public presentation in Omaha (March 18, 1969), Grunewald explained the Swedish service situation and elements of the Normalization principle and showed a number of very persuasive slides. He emphasized that we should be using Normalization-relevant terminology, citing as an example the phrase “preschool” for a child center as being normalizing, but not the expressions “prevocational” or “day developmental child center.” After Grunewald came down sick from exhaustion and we had evidently used him up, we put him on an airplane to his next host. But then getting sick was partly his own fault because I had written him beforehand to “come well-steeled and well-rested—as we are planning a rich experience for you.”

The third contribution to my “aha” experience was touring services in Denmark and Sweden in spring 1969. Because of a providential accident of history, I received a subsidy from the American Baptist Home Mission Societies to visit services in Denmark and Sweden for two weeks in spring 1969. (This organization had recruited me to lead a group study tour, but when the group idea fell through, they gave me the funds to do it on my own.) These two weeks were scheduled so hectically that I hardly got any sleep. In Sweden, the wall-to-wall scheduling by Karl Grunewald and Bengt Nirje was a bit of an act of gleeful revenge for my having done the same thing to them earlier in Nebraska. Soon, I came down with a throat infection, which Karl Grunewald cured with penicillin.

There were days when I visited as many as five different services, but the brevity of visits did not prevent me from prodigious learning. The range of services visited was very wide, from integrated athletic after-school programs to segregated institutions. The area in which I learned the most, and where I felt North America was furthest behind, was what the Scandinavians called “activation,” that is, keeping severely handicapped people from becoming, or remaining, nonambulatory and mentally dulled. My notes say that second most important to my learning was Normalization and humanization with respect to even the most profoundly retarded people.

Prior to my trip, I anticipated that I would be taking a great many photos for teaching purposes back home, but I had no idea how many things worth photographing I would encounter. Already on the first

or second day, I had to send someone out to replenish my supply of film and flashbulbs. Those were the days when one had to set one’s camera’s focus and exposure by hand, and I had no light meter because it was a very expensive item then, but to my great relief several weeks later, virtually all my pictures came out good—a staggering 300 of them, which became the foundation of years of my teaching on Normalization and activation. Surprisingly, many of these pictures are as valid today in what they could teach as they were then.

One of the things that I found aesthetically almost overwhelming was the consistent tasteful beautification of indoor environments in Scandinavia, in people’s homes, public places, and service settings, with much use of color, plants, and candles.

When, promptly upon my return, I wrote a letter of gratitude to the Baptist Home Mission Societies, I mentioned naively that I might write one or two papers on what I had learned. To Nirje I wrote—admittedly in an awkward style—that “The single profoundest learning experience I had was in regard to the virtual abolition of the bedfast person and how this is to be abolished.” However, I added three criticisms. (a) I said that “I did not see a single institution that I really found to be necessary, not even if it was small.” (b) I felt that resources, though lavish, were not efficiently used. (c) People in Scandinavia had very little interchange with each other and were therefore woefully ignorant of what was going on in locales other than their own, and I proposed that something be done about this. I sent almost identical feedback to Grunewald.

The idea that nonambulation could be almost 100% prevented or reversed, and that, at any rate, no one needed to be bedridden, was so unimaginable in North America that people simply did not believe it. For instance, when I lectured with my Scandinavian slides, people would often claim that the Scandinavians were simply hiding their nonambulatory people from visitors. One line of argument was that in Sweden, the profoundly retarded and multiply handicapped were classified as “chronically ill” and put into facilities other than mental retardation institutions. I wrote to Grunewald about this in late 1969, and we discussed in several letters the idea of making comparative surveys of the prevalence of nonambulation among retarded people in Nebraska and Sweden.

In Appendix E, I have noted some of my experiences on this trip on which I have either never reported in print, or which are worth recapitulating.

The fourth event that nailed down my “aha” experience was Nirje’s aforementioned return trip to Nebraska in January 1971. He spoke on several occasions, one of these being in Lincoln on January 9, 1971, at a workshop for training the new workers in the new community services in Nebraska. Even at this late date, I learned a great deal and made many notes in my diary. Here are some of his statements that I recorded.

“If need be, education must be brought to the bedside.”

“Mentally retarded people are normal persons with a specific handicap.”

“The larger the place, the shorter should be a person’s stay there,” which referred to residences for the retarded.

“When I see faces in the window, I know something is wrong,” referring again to residences for the retarded.

“Don’t speak of a person as mentally retarded in his presence unless he does it first.”

In my diary, I organized my notes of response to Nirje’s talk. I told the audience that there were so many new ideas and concepts in the presentation that, like with Nirje’s 1967 presentation, it was almost too much to digest. But as we had told all the Scandinavians, I promised that “we will not merely apply Normalization, but outnormalize the Scandinavians,” which, at least in many respects, did in fact happen. I said that I had seen the best institutions in Denmark and Sweden, and still believed that these were not needed if only we were to “specialize.” I said that, as in Sweden, we must begin to include retarded persons on service-related committees, and that they would often function as “hidden teachers” to other committee members even if their contribution was not of a problem-solving nature. I also issued a warning to the directors of the new community services who were there: “Brace yourselves! We will put our demands into a little red book”—an allusion to Mao’s little red book in China—but, as it turned out, my 1972 text on Normalization had a big red circle on its covers.

A few days later, Nirje gave a similar presentation in Omaha, where I also continued my line of remarks that retarded persons must not only be trained for

committee work, but must also be oriented to represent others, not just their own person. I pointed out that the apartment-living projects Nirje had helped start in Uppsala, Sweden, were the “parents” of the apartment projects that had just been launched in Nebraska. A retarded man with limited sight and hearing was in the audience, and someone told him, “Because of this man [i.e., Nirje], you can live in your apartment like any of us.”

Even as I was still learning Normalization, my own ideas began to diverge with what I consider to be three kinds of contributions to the theory in the early 1970s: (a) teasing out some of the rules implied by specific stated Normalization implications, (b) generalizing them to all (what I then called) deviancies, and (c) relating these rules to the larger body of sociopsychological science.

I saw it as a waste of my time to undertake the writing of the detailed reviews of the relevant research in the sociopsychological literature that people of academia love, and thought that others would gladly jump on the opportunity to do so. In this hope I was somewhat disappointed, but I was satisfied with stating what I considered to be empirically well-established facts that were proof of the validity of Normalization, and later SRV, as a high-level and consistent theory for addressing social devaluation.

There is much else to say about the evolution of Normalization thinking, such as via the three editions of PASS (Wolfensberger & Glenn, 1969, 1973a, 1973b, 1975a, 1975b), the construct of model coherency, the various editions of PASSING (Wolfensberger & Thomas, 1980, 1983, 1988), and the Social Role Valorization monograph (Wolfensberger, 1991a, 1992, 1998), but here, I only wanted to cover the topic enough (a) to convince readers that Normalization was very much an evolving concept all along, and to some degree still is, considering the steady progress being made in SRV theory by the members of the North American SRV Development, Training and Safeguarding Council (Thomas, 1994), and (b) to make clear what the relative roles were of the early key actors in Normalization during the crucial founding era.

One reason that everyone with previous human service involvement had to do a lot of evolving and working through was that we were all caught up by old mental bonds that needed to be broken. Our

reorientation to new ideas simply could not occur all at once, but just one step at a time—though many of us took many steps in very rapid succession. The only people around 1969-1971 who took to Normalization like fish to water were lawyers and ordinary citizens of goodwill who were given a good explanation of it. Many of them responded in a way one could summarize as “Of course, why not?”

9 THE PRODUCTION OF THE NORMALIZATION TEXT

The next topic I will cover interlaces the story of how the *Normalization* text (Wolfensberger, 1972c; partially reprinted in Blatt, Biklen, & Bogdan, 1977, and Romot, 1979) came about, how I universalized Normalization applicability to deviancy in general,¹¹ and how my reform work got me into trouble in my job and got me driven out of the country.

Even before *Changing Patterns* was sent to the printer, I had begun to incorporate Normalization into my teaching and speaking. While attending the annual conference of the National Association for Retarded Children in Detroit in October 1968, I noted in my diary that the Normalization coverage contained in *Changing Patterns* would not be enough and that some other “paper” on it would be needed, and soon began to write some position papers and articles on it, the first one being on its applicability to “mental health” services.

One reason for this was that my primary academic appointment at the University of Nebraska was in the Department of Psychiatry, which in turn was located in a building that was both part of the university as well as one of the state’s mental institutions, though its smallest one. It was called the Nebraska Psychiatric Institute. It had several clinical service units, of which several were residential units that deeply scandalized me, partly because of their dehumanizing features and partly because of their otherwise low quality and irrational nature.

There never was any interest among the vast majority of the 300-plus staff members at the institute in the mental retardation reform work in which I was a major actor on the national, state, and local levels, not even when the developments in Nebraska became

a world model. In fact, to the director of the institute, who was also the chairperson of the psychiatry department, the more local our successes were, the more threatening they were because they made local psychiatric practices look very bad. He also had the idea that since I was a psychologist, I should be “doing real clinical work,” by which he meant testing and psychotherapizing people.

My job started down the skids when, in May 1968, I wrote a memo to the institute director protesting the violation of citizenship rights of our “patients,” including their confinement in locked units, and warned that this might lead to lawsuits against the institute. In July 1968, I pointed out the irony of the institute releasing a public relations film about itself that was entitled “Opening Doors” while it put people behind locked doors “for their own good.”

In October 1968, I wrote three position papers on what I now call “shrink” services (a term I later began to use in order to avoid the term “mental health,” which might convey a legitimizing message) in Nebraska and at the institute, and also sent the director prepublication copies of Nirje’s two *Changing Patterns* chapters, spelling out how Normalization could be applied in the field of mental disorder. This development had great significance for Normalization because it established—as far as I know, for the first time—that Normalization was readily generalizable to fields other than mental retardation. I also spelled out the profound conflict of interest created by a university department being paid to run a state institution and other clinical services, and how this was a major obstacle to staff becoming community-oriented.

One of the psychiatrists who was asked to critique one of these position papers wrote an apoplectic response to it, among other things characterizing it as “autistic reductionism,” and Normalization was greeted with “what else is new”—and all that in a setting that was just short of being a snake pit for its inpatients.

Undaunted by these onslaughts, I took parts of my in-house position papers and drafted a manuscript, which, in August 1969, I submitted boldly to the *American Journal of Psychiatry*, the flagship publication of American shrinkery. Within weeks, the editor advised me to reduce it by half, throw out a section on the contemporary context of psychiatry in society and on the service-model crisis in psychiatry, and to resubmit it. This I did, with a heavy heart, in

October, and the resultant paper that was very narrowly focused on Normalization was then accepted in January 1970 and—to the fury of my psychiatric colleagues and superiors—published in the September issue (Wolfensberger, 1970b; reprinted in Smrtic, 1979). One of the points the article made was that “obviously, a community mental health center attempting to offer ‘comprehensive’ services under one roof is likely to violate the Normalization principle” (p. 294), which probably crazified the minds of most readers, because these centers were then widely seen as the best new hope in mental care, as mentioned before.

Soon after the article came out, several people who had been victims of the mental field and/or its institutions wrote to me in gratitude. Also, *Time* magazine got wind of the article and wrote a piece on it in the October 12, 1970, issue, entitled “Is Basket Weaving Harmful?”, that just about sealed my doom at the Nebraska Psychiatric Institute.

It also certainly did not help that in 1970, I published a chapter in a major psychiatry text (Wolfensberger, 1970a) that described the tension between the status quo defensiveness in psychiatric agencies and services, and the culture and functions of change and research. Since this description also applied to the service function of the institute, it was yet another nail in my coffin, together with the point I made that most of the functions performed by psychiatrists in mental retardation could be—and commonly were—performed by other professions.

Starting soon after these events, both personnel support and physical space began to be taken away from me, my position was “reorganized,” and my situation there became untenable to me in a number of ways. All my other achievements at that time were not of relevance or interest to my psychiatric colleagues and superiors, including my work on *Changing Patterns*, which probably few even knew about. So, mournfully, I began looking for another job. My dean, Kugel, was not pleased to see me leave but apparently thought that protecting me would incur too high a political cost to his position. Unlike other professors who perished when they did not publish, I perished in good part because of *what* I published.

Interestingly, the impact of the offending article on the mental field, for all I can tell, has been nil, as had been the distribution of *Changing Patterns* to all mental institution directors and other mental health

leaders. Among other things, the mental field in the US has assimilated relatively few Normalization ideas, including the importance of keeping residential congregations of its clients small.

Before I left the institute, I also rewrote the part of my manuscript that the *American Journal of Psychiatry* had made me throw out, and submitted this in February 1970 as a separate article to the *American Journal of Psychiatry*, by which it was rejected in April with the advice to submit it to a social or community psychiatry journal. So within days, I submitted it to the *Community Mental Health Journal*, by which it was also promptly rejected in June 1970. I then submitted it in September 1970 to *Psychiatry*, after revising it to fit its different manuscript style. In November, I was told that even though the referees were divided in their opinions, it would not be published because it covered nothing “strikingly new to those who are already conversant with the issues.” After that, I gave up trying to get shrink journals to publish it, but I mention all this here because the manuscript eventually played a part in bringing about the 1972 *Normalization* text.

Overlapping with these developments, but limping somewhat behind them, was the production of some articles for the mental retardation field. Some of these were not specific to Normalization, but featured it in significant ways. For instance, already in 1970, two colleagues from Omaha (a student under my supervision, and the residential director of the newly created ENCOR service system described by Lensink [1976]) and I wrote a monograph that was the first systematic statement on Normalization-based apartment living. This was published in 1971 (Fritz, Wolfensberger, & Knowlton, 1971) by the Canadian Association for the Mentally Retarded, to whose National Institute on Mental Retardation I was about to move for two years as a visiting scholar.

Also, in the October 1971 issue of *Mental Retardation* (Wolfensberger, 1971a; reprinted in Rosen, Clark, & Kivitz, 1976), I wrote about four phenomena of high concern to Normalization that are major corollaries of deindividualization such as one typically finds in institutions: (a) congregation of clients in numbers larger than one typically finds in the community; (b) an environment that is geared to the least functional member(s) of a grouping; (c) reduction of autonomy and increase in regimentation, including moving people about in groups; and (d) the conflation

into a single setting of life functions that ordinary citizens tend to carry out in different settings (i.e., the opposite of “specialization”). In a continuation article in the December 1971 issue of the same journal (Wolfensberger, 1971b; reprinted in Rosen, Clark, & Kivitz, 1976), I sketched the normalizing opposite, namely, residences of family size that were highly specialized in their mission and manpower structure, with “separation of functions such as sleeping . . . working, treatment and playing,” physically and socially integrated into the community so they could be “individualized and individualizing,” convey “high expectancy for normalized behavior,” and afford greater autonomy (Wolfensberger, 1971b, p. 31). However, I also predicted that the need for group homes could be reduced by two measures: individual placements and family subsidy (pp. 32-33), for which I pleaded. This idea had been presented in chapters by Cooke (1969) and me (Wolfensberger, 1969c) in *Changing Patterns*, but had been totally ignored. Spelling out the economic benefits, I characterized such subsidizing as “one of the most efficient service options” and predicted that it “will become an accepted provision that will contribute to the lowered demand for removal of a child from his home” (p. 34). (Today, this is hailed as a postnormalization era invention under various new names, which may include the words “individual,” “supported,” “planning,” “brokerage,” or “direct funding.”) I even predicted that “the need for any type of group residence will decline, except perhaps for the aged retarded . . .” (p. 37).

However, entirely specific to Normalization was a series of four articles on which Robert Perske and I had begun to collaborate (three by me, one by him, but each critiqued by the other author) that incorporated what we had learned in Scandinavia. In March 1970, we submitted these four articles as a single package to *Mental Retardation*, one of the two major journals of the American Association on Mental Deficiency. Usually, manuscripts got reviewed in about four months, but parts of these manuscripts—believe it or not—got misplaced by the editor, and it took several letters of inquiry and complaint, and a full seven months, to get the reply (in October 1970) that the papers had all been rejected, allegedly because they had nothing new or substantive to say. A reviewer of one of the papers said “. . . so much of this paper has been said elsewhere and—in recent years—has been

said so many times . . . for example, the question of integrated and segregated special class education and the principle of Normalization both have been covered many times in our literature.” The claim that Normalization had been covered many times in the literature prior to 1970 was, of course, totally false. After all, even the very term “Normalization” had been almost completely alien to human services before 1969.

All this made me angry, so in late October or early November 1970, I decided to bypass the article review process of my field by taking all four rejected manuscripts, plus the one rejected by the psychiatric journals, plus the psychiatric one that got published, enlarging all these, adding yet other chapters, and working it all into a book, to be entitled *The Principle of Normalization in Human Services*. I asked Nirje to write two chapters, one on “Normalization in Law: An Example from Sweden” and the other on “The Right to Self-Determination,” which was to include a description of the beginnings of what is now called self-advocacy, and the integrated social clubs that I had seen in Sweden that formed the training ground for retarded young people to participate in public affairs, but only the latter chapter came to be—and it turned out to be another cliff-hanger.

According to my notes, I had Nirje start writing on his chapter as early as during his January 1971 visit to Nebraska, entailing more sleepless nights on many people’s parts. However, once again, the chapter was not finished until late 1972, when the rest of the book was virtually in hand. I had to lure Nirje once more into a trap and lock him up around the clock at the National Institute on Mental Retardation in Toronto, with 24-hour coverage by secretaries and me, which once more worked.

Braving a snowstorm, I attended the 1971 convention of the North Central Association for Retarded Children in Des Moines, Iowa, and there heard Gunnar Dybwad speak (on February 5) on the role of the law. So I asked him to write a chapter on legal aspects of Normalization, drawing on the legal developments in Pennsylvania, and also a chapter on “The Role of the Consumer Movement in the Implementation of Normalization Principles.” Because he was too busy (among other things being acting dean at Brandeis University), I asked Perske to write the latter, but he could not do it either, so both chapters

remained unwritten. But Dybwad (1973) did produce a chapter similar to the one I wanted on the "consumer" movement for the book on *Citizen Advocacy and Protective Services for the Impaired and Handicapped* (Wolfensberger & Zauha, 1973) on which I was working at about the same time.

At first, I tried to get a major commercial publisher for both the *Normalization* text and for what was to become the 1973 edition of PASS (Wolfensberger & Glenn, 1973a, 1973b). Starting in April 1971, I submitted the manuscript of *Normalization* in turn to Allyn & Bacon, Brunner/Mazel, Basic Books, Harcourt Brace Jovanovich, and Academic Press, but without success. A senior person with one of these publishers even acknowledged that he considered the book "seminal"—but that it did not fit in with their plans. So eventually, after I had moved in September 1971 to the Canadian National Institute on Mental Retardation in Toronto as a visiting scholar, its director, G. Allan Roeher, came to the rescue.¹² The institute was a part of the Canadian Association for the Mentally Retarded (founded by parents of retarded persons and the Canadian equivalent of the National Association for Retarded Children in the US) in Toronto. The institute and its sponsoring body were very much in the publishing business and decided to publish the book, which might never have come about if *Mental Retardation* had not rejected all four of our manuscripts on the topic!

Though copyrighted in 1972, the book did not actually appear until early 1973. By then, almost 4 years had lapsed since *Changing Patterns*, and more than 3 whole years had been lost and wasted in getting to the relevant public something substantial beyond it on *Normalization*!

Soon after the book's appearance, some people started to call it "the big red dot," because that is what the designer had put on the front and back cover in order to draw attention. Interestingly, the publisher felt so uncertain about how the book would be received that only 3,000 copies were printed. And indeed, there were some people who were very unhappy with it. Some thought that the price of \$8.50 in U.S. funds and \$9.50 in Canadian for a "paperback" book was exorbitant. Some readers said that the first chapter on "The Role of Ideology in Shaping Human Management Models" was the best in the book, while others said it was the worst.

Roeher sent the book out to several Canadian leaders in human services and asked them for their critique. One of the most prominent figures in the province of Manitoba wrote back a letter dated September 1973, advising that the text not be used with people involved in community college programs for entry-level human service positions, citing a long list of reasons:

1. The writing is wordy and inclined to be repetitious . . .
2. The writing style is too emotionally charged. At times the writer is almost evangelical in his style. This is clearly evident in Chapter 9 (Normalizing Activation for the Profoundly Retarded . . .). Mental retardation has, for too long, been a field in which emotionalism has been used to sway public opinion, often at the expense of veracity.
3. The writing style is too subjective to be acceptable. Dr. Wolfensberger has, I believe, fallen into the trap of 'riding his own hobbyhorse' to such a degree that it would seem he is concerned more with persuading his readers toward his own biases rather than them making their own decisions based upon an objective presentation.
4. This being a Canadian publication, it is regrettable that the writer had done such little research in the field in Canada. It is quite evident that he has been influenced almost entirely by his experiences in the United States, and a brief tour of Scandinavian facilities. This does not for a moment suggest that the principles could not be the same, but there is shown a lack of knowledge, or concern for the field in Canada.

5. Dr. Wolfensberger has frequently made inferences, some of which are untenable, and then later has used his own inference as fact to support an hypothesis.

The above factors lead me to believe that this publication should not be used as a text for NIMR Levels I and II, and only judiciously as reference material. I feel that a much more objective approach should be presented to students in this vitally important area.

However, even with hardly any publicity, 700 copies of the book sold within a month, with the Pennsylvania Office of Mental Retardation alone buying up 300 for mass distribution. By now, close to 100,000 copies must have been sold, and the book qualified for the ranking of a best-seller in the non-fiction category on the Canadian market. Two chapters were reprinted in a book by Blatt, Biklen, and Bogdan

(1977), and portions were reprinted in Israel (Romot, 1979). Also, in 1982, a Japanese translation was published (Wolfensberger, 1982).

In 1991, a Delphi panel of 178 leaders in mental retardation identified this book as the single most impactful one on mental retardation in the last 50 years, including from among over 11,000 publications since 1966 (Heller, Spooner, Enright, Haney, & Schilit, 1991). Ironically, I had never intended the book to be specific to mental retardation, but it was never widely received outside of it.

In connection with the production of the 1972 text on *The Principle of Normalization in Human Services*, it also seems appropriate to say something about the difference between Nirje's Normalization formulation, my own, and for that matter, anybody else's. That there are differences, and what these are, has already been discussed at some length in the literature (e.g., Perrin & Nirje, 1985; Wolfensberger, 1980), though one party's characterization of another party's formulation must not be taken as necessarily correct.

In order to have a rational and productive discussion about the definition of Normalization (and later SRV), it is essential to keep in mind four tenets of the philosophy of science: (a) all definitions are arbitrary, (b) they should have clarity so that people can discourse on a defined entity without projecting conflicting meanings into it because of a definition's lack of clarity, (c) a definition should have utility, and (d) much like classification schemes, a definition that conforms to Occam's razor (i.e., "one should not multiply entities without necessity") and has parsimony is generally to be preferred. It is doubtful whether any definition other than a parsimonious one will earn the accolade of being called elegant, which is a term used for theories that economically and harmoniously have a lot of explanatory power.

We can now see that there could be many definitions of Normalization that meet the first three criteria, in being clear and useful despite their arbitrariness. However, different definitions relating to a topic are extremely unlikely to have the same degree of parsimony, and, most likely, no more than one—if any—will be deemed elegant.

Thus, when it comes to definitions of Normalization, one should ask which—if any—meet the criteria of clarity, utility, and parsimony, and which does it best, and it is these aspirations that led me to

depart in some very significant ways from the definitions formulated by Bank-Mikkelsen and Nirje. These departures took a number of incremental steps over 14 years (see the chapter by Yates, and also Wolfensberger, 1986), and I want to point to three ways in which my Normalization formulation, even from its primitive divergence from Nirje's starting in 1968, accumulated parsimony credits.

1. If one combs the writings of Bank-Mikkelsen and Nirje prior to 1973, one will note that they had only or primarily mental retardation applications on their minds. Even Nirje's (1992b) revised 1992 definition of Normalization only expanded it to other handicaps. In contrast, I felt as early as 1968 that Normalization could and should be generalized to all conditions considered to be deviant by society, that is, to people who are rejected and devalued by their societies for other reasons, such as appearance, nationality, race, age, or whatever; or who are in devalued states (such as that of sickness) or devalued roles (including that of hospital patient).

2. In human services, goals and means are very intertwined. My formulation not only speaks to both means and goals, but also has things to say about which of multiple competing means are preferable.

3. The more other meritorious pre-existing or later arriving lower-order concepts, theories, or service means can be subsumed by a theory, the more parsimonious it is, and my Normalization formulation—and SRV even more so—subsumes a zillion ideas and measures on many levels that have been, and will be, promoted in human service and human relationships. For instance, my formulation subsumed actions on all levels of social organization: from the societal all the way to the single individual, and it allowed both for actions on a group or individual, and/or on the environment of such parties, including actions that change the perception and valuation of a person by others so that they no longer view the person in a devaluing fashion.

Parsimony is one of the great attractions of Normalization, as Lakin and Bruininks (1985) noted in reference to Wolfensberger's formulation: "Normalization as a concept has endured primarily because it is elegant in its simplicity, yet it provides both a utilitarian and an equalitarian guide against which to measure the coherence of programs and services for handicapped citizens" (p. 12).

The only other thing that I want to say here on this topic is that a constant bone of contention in Normalization circles, and outside them too, has been whether Normalization ever means making people normal. Nirje has strongly asserted that it should not, and that Normalization should only refer to life conditions, whereas the Wolfensberger formulation of Normalization allowed for that possibility from the first, but with the proviso that one is clear about different meanings of the phrase "making normal."

Of the many meanings of normality, two are particularly relevant to this discussion. One is that something is concordant with its proper nature, for example, cows have four legs, and cows with more or fewer legs are abnormal; humans are meant to see and hear, and therefore, being blind or deaf is abnormal; and so forth. Another meaning is in terms of statistical norms prevailing in a society.

The Wolfensberger formulation does not say that one absolutely must change a person or class, or even make a person or class normal in one of the above meanings, but rather that this is often possible; *nor* does it say that *only* changing the environment, or society, is permissible, but it does delineate means that are known to be relevantly efficacious in modifying societal and personal perceptions and evaluations, and therefore also devaluation. In fact, people could exercise knowledge of these very same lawful rules to achieve the opposite end of making people devalued. If one applies the Wolfensberger formulation pretty much across the board, one *will* end up "making normal" all sorts of people, whether one wanted to or not, as is implied in the last sentence of number 3 above.¹³

However, since I have abandoned a Normalization formulation in favor of a Social Role Valorization construct, the question of "making normal" recedes into the background in favor of the question of whether someone's social roles can be valorized, and of course we know from social science what the overarching strategies are through which this can be accomplished *if* that is what one wants to pursue. However, *whether* one wants to pursue this or not is a value issue above the level of social science.

But, in my opinion, even within Nirje's formulation it is not really possible to interpret Normalization as involving only action on the environment. Waking someone up at six o'clock in the morning so that the

person can get to work on time and thereby live in a normal rhythm of day and week, and earn a normative income, certainly acts plentifully upon that person. And are all the things that one does on behalf of a sick or injured person that act directly on that person rather than only on that person's environment to be defined as outside the realm of Nirje's formulation? Would all medical and health measures be excluded that restore a sick person to health, or a bodily impaired person to normative functionality? Where would personal counseling fall? After all, some forms of psychotherapy are aimed very much at what one can call "person Normalization," leaving aside for the moment the question of the validity and effectiveness of such measures. Would Nirje's formulation imply that anything whatever that acts on the person is not Normalization? Then what about environmental actions that are known to be extremely likely to control the person? Where would they fall?

Nirje himself (1969, p. 187) spoke of "a basic requirement for helping [the retarded adult's] life development come as close to the normal as possible," which most people would have read to mean that retarded persons might grow less retarded—hence more normal—via the rearrangement of life conditions.

Therefore, as long as one grants that abnormalization abnormalizes a person, and not just the person's environment, as Vail brought out so powerfully, one cannot say that Normalization only normalizes life conditions. Obviously, we must apply the same interpretive framework both to normalizing and abnormalizing measures and outcomes.

In short, I cannot see how Nirje's formulation allows an exclusion of actions on a person. Even the very distinction of action on persons versus on their environments is a largely artificial and verbal one, since environments exert vast—sometimes total—control over people.

People who state that Normalization *never* means making a person normal are usually not only mentally fixated on applications to mental retardation, but also view mental retardation as a static condition. This was highlighted by some correspondence I had in 1973-1974 with Dr. Richard Sterner from Sweden, whom I had met on my visit there in 1969. Dr. Sterner was a person of international renown who had been president of the Swedish association of parents of the mentally retarded. He questioned my Normalization formulation

because it would allow retarded persons to become nonretarded, and I assured him that this was deliberate on my part and not a mistake, in that intellectual functioning was not necessarily fixed for life, and that retarded identity might be reversed especially in younger and less retarded people, and in those of these who receive intensive programming.

Before going to the next topic, I want to mention that the *Normalization* text contained an entire chapter on “direct subsidy” to persons or families as “a powerful adjunct to the armamentarium of tools useful in implementing Normalization” (p. 234), recapitulating an idea already presented in *Changing Patterns*. Again, this was one of the most ignored chapters of the book. The time for this idea was yet to come, and when it finally came, its early presentations had been completely forgotten.

10 WHAT WOULD HAVE HAPPENED IF NORMALIZATION HAD NOT APPEARED ON THE NORTH AMERICAN SCENE WHEN IT DID, OR IF IT HAD NOT FOUND VIGOROUS CHAMPIONS

Other contributors to this book are presenting material on the impact of Normalization, but one thing I want to say on this issue is what would have happened if Normalization had *not* come onto the scene when it did, and even if it had come but had not found vigorous, articulate, and creative interpreters and promoters. There are a lot of people who simply assume that the community service movement *had* to evolve the way it did, but they are very, very wrong.

While the deinstitutionalization of the mentally disordered was a de facto process starting in the mid-1950s, it is important to recall that for a number of years, the reality of this process was hardly recognized, in part because it was not the result of a conscious plan based on a high-order concept. Nor was it given a conscious and explicit direction by national leaders even as it became clear that it was happening, nor was it adequately interpreted for some years to come. One can liken it more to a drift that occurred without much planning, intent, or consciousness, and that was described on a somewhat low level of awareness and

meaningfulness by only a modest number of people. Further, virtually all the early interpreters of this drift pointed to the new psychoactive drugs as its cause, which, as research has since revealed, was at least in part an erroneous assumption. Finally, this deinstitutionalization was not accompanied by a strong, clear, and practical conceptualization of community alternatives. The community mental health centers were promoted as being that, but never were.

Deinstitutionalization in mental retardation was entirely different. Here, explicit, highly ideologized ideas and ideological leadership came first. Largely as a result thereof, there occurred a dramatic increase in community services, both of the residential and non-residential kind. As soon as deinstitutionalization became a statistically ascertainable fact as reflected in national institutional movement statistics (which occurred about 1970), these statistics were interpreted (mostly in oral rather than written forums) for what they were by the leaders of the scene, such as myself.

It was only after the early successes of deinstitutionalization in mental retardation that mental health began its notorious and unconscionable systematic dumping policy, and it was only after mental health began to do this that similar dumping also became normative in mental retardation, roughly in the mid-1970s.

So altogether, I believe that the following things would have happened instead. (This is somewhat along the lines of “predicting the past.”)

1. Without the thinking generated by the Normalization culture, the impact of the civil rights thrust would probably have been not only less, but also very different.

2. The major reform emphasis in education would have been (a) on rightful funding, (b) for most but not necessarily all retarded children, and (c) without any major controversy over integration. In other words, rightful segregated education would have been the major thrust for a long time.

3. There would have been a larger number of smaller institutions, more equitably distributed over a state or province.

4. There would have been a very slow rise in mini-institutions for several score to perhaps 200 residents. These might have been interpreted as “community residences,” as several small institutions in the 1970s and even into the 1980s were.

5. Institutions of all types would have been "better," for example, with less crowding, better staff ratios, less ugliness, and so forth.

6. There would have been a much larger number of "regional centers," that is, multipurpose facilities with both residential and non-residential components.

7. Even more money would have gone to rather worthless university-affiliated service centers than eventually did anyway.

8. Group homes would have developed, but these would have been large, with 12 to 20 residents, and would have developed much, much more slowly than they did.

9. Because the rights movement would have gathered further strength, there might very well have been even more "dumping" of people out of mental retardation institutions in the name of "rights" than took place anyway.

10. Finally, Normalization-related ideas would have penetrated, though not necessarily under that name. By the time they would have gathered sufficient theoretical formulation and social strength, they would have been confronted by such a massive capital investment in smaller regionalized institutions and non-normalized, large community residences, plus yet other economic interests, that a transition to small normalized community residences and integrated education would have been a long, drawn-out process that might have taken at least 10, more likely 20, and possibly even more years longer to get to where we are now.

As mentioned before, among the powerful reasons to project this kind of "alternative present" is that these were the *very* directions into which things were moving already in the late 1960s and early 1970s. It was exemplars of these very things that were held up as models. The regional center concept was then considered the forefront of reform, with different versions thereof being developed in California, Connecticut, and Missouri. Another cutting-edge idea was to move toward a larger number of smaller and presumably better institutions, either by using already existing facilities—predominantly former TB sanatoria—or by fancy new construction, as in Illinois (i.e., the Ludemann Center).

Of course, these models, and some others as well, were outright atrocious when evaluated from a Normalization perspective. One example of this is that

the Rolla Regional Center in Missouri was depicted in the 1967 training film *To Bridge the Gap* (Walsh, 1967) as a model, whereas people versed in Normalization/SRV would see it as an abomination.

Also, these were some of the very directions into which even Denmark and Sweden were moving in 1969. For instance, as mentioned, there was a much greater emphasis there than in North America on agency residences versus independent or family living. Until the Americanized version of Normalization began to find its way back to Denmark, emphasis there had been on lavishly designed, furnished, and staffed new small institutions and schools, the latter not only segregated but—for day schools—also so far outside the population centers that they were even called "green schools," that is, schools out in the greens.

In Sweden, it was only with a 1986 law that more extensive provision was made for community residential living for severely retarded persons outside of institutions (Pedlar, 1990). Also, Pedlar reported that retarded people in community residences were not very well integrated, for which she was able to identify at least three reasons. One was that these residences had been so lavishly staffed that personnel ended up doing everything for residents, and this became a disincentive for integrative undertakings. Second, a relatively high proportion of the staff had once worked in institutions and had been transferred to community residences as institutions were being downsized. Third, there prevailed such a strong faith in Sweden in the public operation of whatever services were needed that volunteerism suffered from not being encouraged, and from even being discouraged. Even so-called "contact" persons, called for by the 1986 law and supposed to be ordinary citizens who provide some personal involvement with retarded residents, received some payment. (This is one of the perverse fruits of socialist ideology.) Thus, we get a peculiar situation in Sweden where there is much of what one might now call "integration" with paid people and relatively little contact with ordinary citizens. While we have the same problem of poor integration of people in community residences in America, it is largely for different reasons.

It took a superhuman effort to avert a non-Normalization reform concept in Nebraska, and it is quite possible that if Nebraska had also gone to the regional center and smaller institutional model (as most

of the reformers even there had initially envisioned), we might have seen very few community residences and apartment projects in North America even decades later. After all, even Burton Blatt continued to exalt the "good small institution" until just a few years prior to his death in 1985 (e.g., Blatt, Ozolins, & McNally, 1979).

11 CONCLUSION

Unfortunately, I have unfinished drafts for several more sections on the history of Normalization and the evolution of Social Role Valorization, a lot of it as yet unpublished, but my writing time simply ran out, and these materials will—I hope—be published later in some other context. Fortunately, the contributions of several other speakers at the Ottawa conference further add to the history of Normalization and SRV, and my concluding presentation also covers a few more historical points.

Somewhat arbitrarily, I decided to end with two reflections.

The first one is on the five different ways people during the late 1960s and early 1970s tended to react to presentations on Normalization.

1. Benevolent and polite rejection, derived from the conviction of the listeners that the speakers simply did not know the relevant realities about the lives of handicapped (mostly retarded) persons, because if they did, they certainly would not be making such outlandish claims and proposals. This kind of response was particularly apt to be forthcoming from parents of retarded persons, who were pleased that someone was well-intentioned toward people such as their children, even though ignorant or misguided.

2. The grossest kind of hostile rejection, which came almost entirely from service professionals. In the early years of teaching Normalization, the teachers would often get into the nastiest arguments with hostile listeners or entire audiences, and sometimes even the smallest and most obvious elements of Normalization were vehemently contested.

3. Noncomprehension, in that what was presented was simply not grasped because it was so remote from what people knew and were able to conceptualize. However, in that case, the response did not tend to be hostile but bland, often of the nature of "What else is new?"

4. An "aha" response, when what we were teaching made profound sense to people but they had never heard it stated before, or never in a way in which they could understand it. This latter response most likely was emitted by ordinary citizens who were neither human service workers nor parents of handicapped persons.

5. Finally, there were people who were open to learning about Normalization but who did not agree with at least portions of it because they held high-order beliefs, perhaps of a religious, political, or socioeconomic nature, that clashed—or seemed to them to clash—with Normalization. Many persons in this group found that the more they understood our Normalization formulation, the less conflict there would be in implementive measures. However, there often was also agreement on many implementive measures—but not for the same reasons. For instance, it was not unusual for services of Christian bodies to get higher scores on the PASS instrument than most other services, but not necessarily for reasons that would have derived from Normalization.

This pattern of five kinds of response continued pretty much the same throughout the 1970s, except that in the early 1970s, several additional ones gained greater ascendancy.

1. One came almost exclusively from human service workers. Some concluded that Normalization was the craze of the moment and they did not want to be left behind or appear outdated, but they really had no commitment to it. They figured that they had better learn the Normalization idiom and its superficial notions lest they be viewed as archaic, or lose prestige or positions, especially if they worked in settings where Normalization had been mandated from the top. Some people went on doing whatever they had been doing or wanted to do and simply called it "Normalization." These people of empty minds and often weak service souls almost all jumped off soon and onto whatever other popular and "safe" crazes came into vogue.

2. There were people who had opposed Normalization from day one but were embarrassed to admit it once so many Normalization corollaries became everyday conventional wisdom. Instead, they continued their opposition by calling for going "beyond Normalization." For instance, Rosen, Clark, and Kivitz (1977) issued a "beyond Normalization"

call as early as 1977, and one has heard that phrase ever since, and often from people who never were “in Normalization” enough to go beyond it.

3. Another group also consisted largely of the same old enemies of Normalization who now began to shift their arguments into the form that Normalization lacked research evidence. These people are still with us, and probably always will be, since they continue to stutter the same argument despite mountainous supportive evidence from both formal research and other forms of empiricism—and this group of largely social science academicians can generally not relate to the latter.

4. As the years passed by, we also had to begin increasingly to combat not merely opposition to Normalization, but also all the misconceptions or wrong teachings about it. That became increasingly a problem until SRV began to be formulated in 1983 (Wolfensberger, 1983). Relatedly, there were the well-intentioned people who either (a) thought they had understood Normalization but had not, and therefore applied the term “Normalization” to non-normalizing practices, or (b) subscribed to one of several competing formulations of Normalization. With the latter group, one might be in very extensive agreement—perhaps on 80% of the relevant measures, but even then not always for the same reason.

It was only around 1980 that a distinct change set in, apparently for four reasons. (a) Many ideas that had been taught in connection with Normalization became more widely known and accepted. (b) Particularly with the evolution of SRV, striking improvements took place in our teaching. (c) Certain ideas arising from other sources, such as the civil-rights movement, were sufficiently concordant or overlapping with Normalization or SRV to make these latter appear reasonable. (d) More and more, people began to actually see instances of implementation of what had been taught, and saw that it either worked or was better than what went before.

After that, new problems set in that I will address in my chapter at the end because they have implications for the future.

My second concluding reflection is that one of the best favors that I could have rendered to Normalization would have been to die after finishing the PASS 3 manuscript in 1975 (Wolfensberger & Glenn, 1975a, 1975b).

During the early 1970s, I began to be widely considered one of the foremost leaders and teachers on issues related to Normalization, residential services, comprehensive service-system planning and implementation, and Citizen Advocacy. But about that time, I also began to speak on several new controversial issues.

One was that dynamics of social decadence were beginning to dominate Western society, which nobody then believed or wanted to hear.

A second was the growing danger of “deathmaking” of devalued people, and, because of that, just about everybody concluded I must be insane.

A third was that before ARC audiences, and during my year (1976-1977) on the NARC board, I began to warn not only that the ARC movement had to get ready to start fighting deathmaking, but also that the parent movement was in the gravest danger of decline. Between 1968 and about 1976, I had been very popular and influential in ARC circles, being invited endlessly to talk at their national, state, regional, and local conventions, and to serve on national committees—but all that changed almost overnight.

Fourth, I began to teach that paid service without life-sharing is bankrupt. For instance, in a speech before a shrink audience in 1974 (later published [Wolfensberger, 1975b] as a chapter in a psychiatric text), I pointed out how people in the mental services were deeply devaluing and socially distancing of their clients. I believe that this was the last time I was invited to speak to such an audience. For making a similar point at the 1979 national convention of the American Association on Mental Deficiency in Miami—namely, that we were doing very well, financially and socially, off retarded people—a woman in the audience wrote to me that never in her life had she ever disliked anyone so much as me. This was of course very revealing, considering how large is (a) the variety and number of reasons for not liking someone, and (b) the number of people one might dislike.

Fifth, in the field of special education, I was first disfavored for opposing the prevailing practice of low expectations, the watered-down curriculum, exclusion, and segregation. But when the field flip-flopped and converted Normalization into one simpleminded term—namely, “mainstreaming”—I tried what little I could to stem this tide of stupidity and simple-mindedness (e.g., Wolfensberger, 1974a), trying to

emphasize the many components and degrees of integration, but to no avail. The mainstream of education in America has always been unintelligent and simpleminded. At any rate, because I did not endorse what went under "mainstreaming," nor even the very term itself, the education field bulldozed right past me and left me isolated once again. By 1994, "inclusion" was just as mindlessly mouthed as only about three years earlier "mainstreaming" had been, with no one who talks inclusion admitting having been a mainstreamer.

Finally, in response to my contact with l'Arche, I began to try to bring my religious faith and my work into closer harmony, which resulted in my being interpreted as having had a conversion to religious fanaticism.

Altogether, these things quickly isolated me, because people no longer wanted to be perceived as having anything to do with whatever my name was associated with. Even while people claimed to be

trying to implement Normalization and residential services, they quit coming to my workshops on these topics, and the Normalization-related workshops did not experience a second upswing until less "tainted" people began to teach them. Also, some of my innovations began to be attributed to other people, which sometimes was rather funny.

Although time proved me to be right on deathmaking and the decline in the ARC movement, this changed nothing with most people who had started either shunning me or scaring others away from me. After all, as Burton Blatt had warned me, the one thing people will never forgive one for is having been proven right.

At any rate, if I had done Normalization the favor of dying when I was at the peak of my reputation and effectiveness, it probably would have been more explicitly embraced and more systematically studied. But I certainly have no regrets for God's gift of more years.

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NOTES

1. An advanced draft of the material in this chapter had been prepared for the Ottawa congress, but only portions of it were selectively presented.
2. During the 1950s, the Southbury Training School of the State of Connecticut was considered a model because of its so-called "cottage system" with its smaller living units.
3. Gunnar Dybwad (private communication, April 19, 1994) disagrees with this interpretation and believes that the President's Panel on Mental Retardation (1962) report is evidence of a community services vision, and that many parents had a good community services vision. I believe that the more ambitious visions were held by a very small minority of people, though some of them were in leadership positions. I also believe that my assertions are supported by much evidence later in this chapter.
4. By the way, NARC's subsidy of my trip evolved into the NARC's Rosemary Dybwad Award for study travel abroad, which was formally launched in 1964.
5. Some of the President's Panel on Mental Retardation Reports have a different date on their face page than the date given on another page by the U.S. Government Printing Office. The discrepancy was never more than one year, and I have used the U.S. Government Printing Office dates in my references here.
6. It was with a combination of flattery, bribery and threats that I got Dybwad to agree to this arrangement, writing to him as follows:

Your participation in this book is of the utmost importance. We do not know anyone who has your stature in the field or who would be capable of writing that chapter the way it should be written. . . . we suggest that you come to Omaha to be waited upon hand and foot by legions of . . . research assistants and secretaries . . . We would set you up in comfort and style, and provide you with dictating machines, secretaries that take dictation, etc. Also, if you so desire, you could do much of your work at a nice quiet sunny swimming pool or any other leisurely setting that facilitates a creative flow of your apperceptive masses. As you create, these creations would be transcribed and edited on the spot and sent back to you for further consideration. This leisurely creative pace would be punctuated by sumptuous meals, including exotic components such as the finest Sauerbraten, Pakistan curry, Beef Bourguignon, etc. You might wish to have your honored spouse by your side (to amuse, assist, or support you), which also can be arranged. The idea is that after a week or two of this, you would have had both an enjoyable rest as well as a productive period, at the end of which your chapter would essentially be done . . . At this point, we have finalized all chapters except yours. If worse came to worst, we would do the chapter ourselves, but we don't want this to happen. Burning incense daily for your recovery, we remain worshipfully but nevertheless editorially yours . . .
7. Thus, for archival reasons, it is important to note that there are three versions of the first edition of *Changing Patterns*: (a) the original printing(s), (b) a reprinting acknowledged on the inside title page as having been made possible by NICHD, and (c) a 1974 reprinting by the Pennsylvania Department of Public Welfare (Harrisburg, PA), acknowledged on the inside cover. The reprints all look like the original in color and size, and are facsimiles in nature.

8. In 1974, the chapter was also published as a separate monograph by the Center on Human Policy at Syracuse University, and again in a more lavish format in 1975, and was long one of its best sellers.
9. The 1948 UN statement had been preceded by a long-forgotten "Declaration of the Rights of Children," written in 1921 by Eglantyne Jebb, which was later adopted by the League of Nations but forgotten upon its collapse in the 1930s (Meyers, 1979). Beginning in 1956, the U.S. Department of Health, Education and Welfare (since reorganized) published a widely-disseminated poster of a "Creed for Exceptional Children." Leonard Mayo had been instrumental in drawing it up in 1954 at a conference he chaired that had been sponsored by the US Office of Education, and while he was director of the Association for the Aid of Crippled Children (since become the Easter Seal Society). While not framed in rights terms, this creed did call for "equality of opportunity" and an "ideal of a full and useful life for every exceptional child." This creed probably helped pave the way for later proclamations of the rights of handicapped people.
10. Even prior to the 1959 law, a law had been passed on June 18, 1958 that governed education and special education. While it mandated access to public education for all handicapped children (Lambert, 1970) 15 years before this happened in the US, a huge number of handicapped children began to be put into special segregated public schools that were called "center-schools," in part because they were regional schools (hence, in a certain sense, "central" even though they were usually not centrally located for the population), but in part probably also because of the then prominent concept of service centers, mentioned earlier.
11. This generalization of Normalization was already evident in my first Normalization publication in early 1970 (Wolfensberger, 1970b), in which I had not only generalized certain specific Normalization implications into general rules, but also had already framed them as applicable to deviant persons in general. For instance, I proposed that services should "employ culturally typical means" generally to
 shape, enhance, and maintain behavior that is as much as possible also culturally typical. . . The use of culturally normative rather than esoteric means is intended to minimize the appearance of separateness of deviant individuals. The attitudes and values of society should be shaped so as to be more accepting and tolerant of harmless types of differentness, such as differentness in appearance, demeanor, intelligence, speech and language, nationality, education, race, skin color, ethnic background, dress, etc. (p. 4).
12. Roeher had approached me to come to Canada at least as early as March 1971, at the Annual Conference of the Canadian Association for the Mentally Retarded in Winnipeg. He said it could be for a "sabbatical." On his invitation, I then visited the National Institute on Mental Retardation in Toronto in late March 1971 but did not decide until later that year to move there for a year or two, upon which we agreed that my appellation would be "visiting scholar."
13. Quite aside from how I did formulate Normalization, the fact is that one could say that the North American Normalization movement had three major thrusts.
 - a. A sociopedagogic approach that emphasized what one could do in contact with devalued people to enhance *either* their competencies or their social image, on *either* the individual or group level, and *either* within or outside of formal services. Examples would be addressing people's personal appearance, providing groupings with other people that contributed to devalued persons' competency development and image enhancement, engaging devalued persons in activities that were challenging and age-appropriate, presenting devalued persons to others in physical settings that were image-enhancing, and emphasizing positive interactions of any parties with devalued persons, to name just a few.
 - b. Social-systemic measures in support of competency or image enhancement even outside of contexts in which devalued people were present, for example, in the language that one used about them even when they were not present, in the names and logos that one gave to their services, in the funding efforts (such as fund-raising appeals) for services that would benefit devalued people, in the image juxtapositions created about them by and in art, the media and advertising, etc.
 - c. A thrust that is perhaps best described as a rights orientation. Within this thrust, one could in turn identify two distinct emphases: a legal orientation (e.g., trying to define all sorts of things as rights in law) and

a human/transcendent rights orientation (e.g., emphasizing people's human rights even apart from whatever the law may say).

In respect to the third thrust, it is interesting that the rights orientation that developed both out of, as well as independent from, the Normalization movement first of all increasingly focused on legal rights that were largely decontextualized from the broader context of human rights; and that secondly, it sought to resolve almost all problems of a sociopedagogic and social-systemic nature via the medium of legal rights. I believe that the latter was and is a very unwise strategy, in part because it cannot possibly succeed.

Appendix A

**A BRIEF SKETCH OF THE SELECTION
OF THE ESSEX SERVICE SYSTEM AS A SERVICE-MODEL CHAPTER**

While at the 1967 International Association for the Scientific Study of Mental Deficiency congress in Montpellier, France, I also met David Norris from Chelmsford in Essex, England, northeast of London. I was so impressed by him and what he told me that I took up his invitation to visit him in Essex on my way home. He toured me through a most impressive community service system there—one that was truly systemic—and a few nonsystemic pubs as well. This service system seemed to have taken up about where Middlesex had left off. It demonstrated how important it was for dispersed and diversified community services to be carefully planned years in advance, and very sequentially implemented, which contributed greatly to my concepts for U.S. services, especially in Nebraska. On returning home, I wrote Norris—an Irishman—with apologies to Swinburne,

Let us praise while we can
The wild Irish man
Though they may honor none
But the tamed one.

When it came time to write *Changing Patterns*, we decided to ask Norris to write up the Essex model, especially since we did want one from Britain. It was not easy to get him to do it, and, among other things, we had to write letters to his bosses to let him do it. When he delivered his first draft, he did it, in his words, "to our mutual surprise and relief." But actually, his chapter was one of the more literate and even poetic ones.

Appendix B

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Appendix C

DOCUMENTATION OF RESERVATIONS ABOUT NORMALIZATION IMPLICATIONS
BY CONTRIBUTORS TO CHANGING PATTERNS

Although Lloyd Dunn had been the first to conceptualize a diversified range of residential settings for retarded people, he was thinking mostly of facilities for between 10 to 200 people, most of them between 10 to 50 people. As early as March 6, 1968, after seeing his chapter draft, I wrote him the following:

I am not too sure about the continued role of the large institution that you suggest might still be needed even if special-purpose facilities are developed. . . . It may well be timely to call for a planned phasing away of these institutions to go hand in hand with any long-range regionalization and specialization plan, since otherwise we will be confronted with an unplanned but foreseeable catastrophe similar to the one confronting communities where large VA hospitals were closed down overnight. What I am asking myself lately is whether we have been belaboring a rationale for continuation of the traditional institution not because we really see much of a role for it in the future, but because the implications of not seeing a role for it are so drastic or charged that we can't face them, or we are afraid others can't face them.

In regard to the issue of whether to replace the traditional institution with small special-purpose facilities, Tizard once told me he would advocate going ahead even if we still do lack evidence of the type that you call for, because, as he put it, we couldn't possibly do worse than we have in the past.

Even Burton Blatt still held up large facilities, such as the Seaside Regional Center in Connecticut, as models as late as 1979 (Blatt, Ozolins, & McNally, 1979).

As regards educational integration, Dunn asked me in a January 1973 letter what some of us meant by "...normalizing education for the trainable mentally retarded. I assume you do not mean that most mongoloid children can be educated in the educational mainstream . . ." To this I replied (February 7, 1973) as follows:

To me, school does not mean the three R's, but preparation for life. As such, I can see no viable rationale for having separate structures for severely handicapped children.

. . . To me it is merely a question when and how all children will be served, and how fast we can extend the age limit downward. Here, tremendous opportunities for physical and social integration are opened up, and I do firmly believe, and have actually seen it done with great success, that the younger handicapped child is the one that can be socially integrated quite readily. Thus, I mean indeed that mongoloid and epileptic and hydrocephalic children can be educated in the same room with non-handicapped children, and that from such arrangements, no one will suffer, while many will gain.

However, I am strongly opposed to what I have come to call "dumping," which is the mere placement in the mainstream, without the necessary support. Integration is meaningless if it is only physical, and in order to be social, all sorts of supports are needed. Among these might be an intensive program of making the handicapped children physically and socially more attractive prior to physical integration; attitudinal preparation of parents, staff, and children; overstaffing the integrated group; provision of high-level consultancy; the presence of an adequate range of teaching materials, etc.

At present, a transfer of the severely retarded from special MR agencies to public schools usually means a drop in quality. However, I am willing to live with this temporarily in order to establish the clear mandate, and to set up the necessary administrative and service structures. In the long run, I see it as absolutely essential that monitoring and program evaluation mechanisms be instituted as never before.

I have just come back from Pennsylvania where now, since there is no other alternative left, the educational establishment in the state has made a 100% turn-around and has embraced the profoundly retarded, running noses and all. Because all loopholes have been closed, teachers are suddenly totally and for the first time re-orienting themselves, and are developing a willingness to become child developmentalists, change diapers, etc. This was a most heartening experience, because it opens teachers' attitudes now to being trained as to what to do with the more severely, profoundly and multiply handicapped.

Appendix D

NORMALIZATION
Bengt Nirje

Normalization means . . . A normal rhythm of the day.

You get out of bed in the morning, even if you are
Profoundly retarded and physically handicapped;
You get dressed,
And leave the house for school or work,
You don't stay home;
In the morning you anticipate events,
In the evening you think back on what you have accomplished;
The day is not a monotonous 24 hours with every minute endless.

You eat at normal times of the day and in a normal fashion;
Not just with a spoon, unless you are an infant;
Not in bed, but at a table;
Not early in the afternoon for the convenience of the staff.

Normalization means . . . A normal rhythm of the week.

You live in one place,
Go to work in another,
And participate in leisure activities in yet another.
You anticipate leisure activities on weekends,
And look forward to getting back to school
Or work on Monday.

Normalization means . . . A normal rhythm of the year.

A vacation to break routines of the year.
Seasonal changes bring with them a variety
Of types of food, work, cultural events, sports,
Leisure activities.
Just think . . . We thrive on these seasonal changes!

Normalization means . . . Normal developmental experiences
Of the life cycle:

In childhood, children, but not adults, go to summer camps.
In adolescence one is interested in grooming, hairstyles,
Music, boy friends and girl friends.
In adulthood, life is filled with work and responsibilities.
In old age, one has memories to look back on, and can
Enjoy the wisdom of experience.

Normalization means . . . Having a range of choices,
Wishes, and desires respected and considered.
Adults have the freedom to decide
Where they would like to live,
What kind of job they would like to have, and can best perform.
Whether they would prefer to go bowling with a group,
Instead of staying home to watch television.

Normalization means . . . Living in a world made of two sexes.
Children and adults both develop relationships with
Members of the opposite sex.
Teenagers become interested in having
Boy friends and girl friends.
Adults may fall in love, and decide to marry.

Normalization means . . . The right to normal economic standards.
All of us have basic financial privileges, and responsibilities,
Are able to take advantage of
Compensatory economic security means,
Such as child allowances, old age pensions, and
Minimum wage regulations.
We should have money to decide how to spend;
On personal luxuries, or necessities.

Normalization means . . . Living in normal housing
In a normal neighbourhood.
Not in a large facility with 20, 50, or 100 other people
Because you are retarded,
And not isolated from the rest of the community.
Normal locations and normal size homes will give residents
Better opportunities for successful integration
With their communities.

Appendix E

**OBSERVATIONS FROM MY STUDY TOUR TO MENTAL RETARDATION SERVICES
IN DENMARK AND SWEDEN IN APRIL 1969**

The observations reported below are drawn from my travel diary and my correspondence shortly after returning from my trip, and are meant to supplement those reported in the body of the chapter or elsewhere.

One of the things I learned in Scandinavia was the incredible power of attractive and normative environments to elicit normative behavior even from very impaired, disturbed, and self-abusive persons. While people might still be engaging in very stereotypical behavior, they could be seen doing so in the midst of beautifully normative environments without doing harm to them, something which apparently nobody I knew of in North America thought would be possible.

Perhaps one of the most crucial aspects of Normalization in Denmark and Sweden was that handicapped people received either rather large pensions, or good payment for work, or both, and this enabled them to lead a more normalized lifestyle in all sorts of ways, both in institutions and in the community.

Already by 1969, it had become quite common for retarded people in both Denmark and Sweden to spend their vacations all over Europe, particularly its southern parts. This had many normalizing effects and was only possible because of the lavish personal subsidies mentioned above.

About Denmark specifically, one thing that was so remarkable was not only the normalizing features of so many services, but the sheer magnitude of the service system, in that during the 10-year period of 1959-1969, 150 new service settings had been created, all but about 10 of these of a nonresidential nature, and all that in a country that had fewer than 5 million inhabitants.

Bank-Mikkelsen said that reform in Denmark would not have been possible if it had not been for the "new attitude" of parents of retarded people, which, he said, "changed the whole thing." But while Bank-Mikkelsen saw parents as the motive force behind the reforms, I found that people lower down in the mental retardation services almost uniformly saw parents as the enemy. At one place, I was even asked whether the parent group where I was from gave us any trouble, to which I replied that "I am part of such a parents group, and I do."

Visiting the Karens Minde institution for the mentally retarded in Copenhagen, I met a man with Down's syndrome who kept a picture of President Kennedy on his wall. I happened to have an American half-dollar with me with Kennedy's head on one side and tried to make it a present to him, but he rejected it and said, "It won't work."

In one of the workshops of that institution, I wanted to buy a plate hanger that was being made there, but instead my host insisted that I take it free, with the comment, "Remember the Marshall Plan."

Bank-Mikkelsen told me that even though Norway was wealthier than Denmark, its service development was much slower, and parents were sending their retarded children from Norway to Denmark to be served there, with the Norwegian state paying only part of the cost. The net effect was that the Danish taxpayers were thereby subsidizing the rich Norwegians.

After visiting the Danish school for mental retardation workers, I wrote the following comments, which, I believe, I shared with Bank-Mikkelsen.:

June 17, 1969

A. Some observations which impress me.

1. The large number (1,200) of students in training at any one time, considering the small size of the country.
2. The length of training (3 years and more).

3. The breadth and depth of training which not merely includes content directly relating to mental retardation, but also aims at self-actualization and general upgrading of the trainee's personality and academic and civic skills.
 4. The balance between practical and theoretical training.
 5. The great amount of monies the Danish Mental Retardation System is willing to invest in the training program.
 6. The industrial and business-like setting of the industrial school.
 7. The youth of the trainees.
 8. The advanced training for houseparent work.
- B. Points which bear further exploration and discussion or which might be definite weaknesses.
1. The theoretical training has certain unreal qualities as exemplified in the following aspects:
 - a. Teachers have little practical experience in general, and even less in mental retardation.
 - b. Some content appears to have been decided upon very arbitrarily and by college-oriented academicians.
 - c. Some texts appear to be college texts, and some content appears to be somewhat irrelevant, much too advanced, or both.
 - d. In some areas, there appears to be little evaluation of either the student's grasp of material or its relevance to them.
 - e. There appears to be limited feedback from advanced or graduated students to the training program or its content.
 2. A relatively rigid European status system appears to impose considerable limitations to the rapid advancement of competent young personnel.
 3. I understand that there is a high turnover among graduates, due to a significant degree to low salaries. This sounds like poor economy to me, considering the high cost of training.
 4. I am not sure on this point, but I suspect that personnel statistics and follow-up data are scanty. Suggestions for possible changes are an inherent part of some of the above comments. An additional point would be to intensify and accelerate the training of training personnel, especially in practical experience, and have students evaluate the performance of the teachers.

During my visit to Sweden, Grunewald enunciated what we have since called the "grouping-up" principle, that is, a small group should not have more than one or two severely impaired members because this way, these can be "pulled up" and do not, what he called, "dominate" the group.

I also learned that for years already, there had been a group home on the very street on which Grunewald lived.

The fact was also amazing that so many retarded people in Sweden—even some very retarded ones—could speak some English, considering the low expectations that American special education teachers generally held of their pupils.

One thing that was almost too good to be believed was that there were over 900 Swedish "circles" for retarded adults that were analogous to similar ones for nonretarded people that had been started long ago by labor unions and political parties in order to promote adult education of workers. These circles were called something that would roughly translate as "study groups."

One peculiar thing about word usage in Sweden was that the term "research" was commonly applied to doing "diagnostic work-ups."

Despite the fact that I saw an enormous amount and variety of impressive things in Denmark and Sweden, at the same time, my diary also recorded many shortcomings, which underlines what had been a red thread in my teaching ever since, namely, that no service will ever practice or bring together everything that is already known as being good.

One weakness in both countries was in the domain of the work ethic, which was weak both on the part of service personnel and handicapped people. Workers had relatively few demands made upon them, and they in turn made relatively light demands on their retarded charges, though surprisingly, the normativeness of the surroundings and the expectations for normative behavior—even if not for productive behavior—worked very well in eliciting

normative behavior. In other words, the environment was one in which people acted relatively normally even if they did not necessarily have to work hard.

Also, many other visitors may not have noted how many of the workers below the top level held a great many attitudes inconsistent with Normalization and were quite ignorant about the good things that were going on in the services other than their very own, or in other Scandinavian countries. Relatedly, retarded adults doing rather high-level work in workshops were often still called "patients."

One big obstacle to integration in Denmark was that some services were run by the localities and others by the state, and the latter included special education for retarded children. This observation underlined the importance of the concept of "continuity" among provisions, and the importance of a single administrative or controlling umbrella.

One interesting feature that I elaborated on elsewhere (Wolfensberger, 1971a, 1971b) was that in Sweden, group homes and apartments built specifically for retarded people had an institutional flavor, while such residences in generic buildings did not.

Not included in my feedback to Nirje and Grunewald, but published in one of my articles as early as December 1969 (Wolfensberger, 1969b), was the conclusion that failure to specialize residential service types was one of the main reasons why even progressive countries such as Denmark and Sweden still relied so heavily on traditional institutions. Unfortunately, this is one of the points that I have preached consistently all these years that has been least understood and least implemented, exemplified most clearly today by the near-total failure to provide a highly specialized type of small residential service for people who display very severe social problems but who are not mean of spirit.

Despite these shortcomings in Denmark and Sweden, the overall achievements were so dramatic that I noted in my diary that I experienced a feeling of "acute envy."