Normality, Social Work and the Creation of Everyday Life Settings

Mosesson, Matts; Gildemeister, Regine; Jacobson, Tord; Sunesson, Sune; Sünker, Heinz; Söder, Mårten; Thomason, Corinne

1993

Document Version:
Publisher's PDF, also known as Version of record

Link to publication

Citation for published version (APA):
Mosesson, M. (Ed.), Gildemeister, R., Jacobson, T., Sunesson, S., Sünker, H., Söder, M., & Thomason, C. (1993). *Normality, Social Work and the Creation of Everyday Life Settings*. (Meddelanden från Socialhögskolan; Vol. 1993, No. 3), (Research Reports in Social Work; Vol. 1993, No. 3). Socialhögskolan, Lunds universitet.

Total number of authors:
7

MEDDELANDEN FRÅN SOCIALHÖGSKOLAN

Matts Mosesson (ed)

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1993:3

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GRÄVLINGEN

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Preface

by Matts Mosesson

This anthology has its origin in two different international seminars arranged by the research-group Grävlingen (The Badger) in October 1990 and 1991 in Lund. These seminars were part of an ongoing programme, made possible by support from the Swedish Council for Building Research, that are dealing with research problems in the areas of normalization, de-institutionalization and self-determination.

It must be noticed that this book shall be seen more as a documentation from the seminars, to show what is going on in the research-group Grävlingen, rather than a collection of well prepared scientific articles. Some of the articles are edited manuscripts, others are transcripts from audiotapes made with good help from Birgitta Borafia.

The four first articles in this book stem from the first seminar in october 1990 and the fifth and sixth stem from the seminar in october 1991. The two seminars were a bit different in their structure. In the first seminar the invited guests held lectures and discussions were held after each lecture.

In the second seminar much of the discussion was interweaved into the lectures, which were simultaneously changed as the seminar went on. Therefore the documentation of the second seminar has been difficult to arrange.

Invited speakers at the second seminar (not represented in this book) were Bengt Börjeson from School of Social Work, Stockholm University, who reflected over "Self-determination - an Antithesis to Powerlessness?"

From England and the Lewis Cohen Urban Studies Centre in London we had invited Peter Beresford and Suzy Croft who gave us interesting insight in "User-involvement, Citizenship and Social Policy."

In order to broaden the discussion we also had invited special persons to make introductory remarks. They were Finn Dam Rasmusen from the Institute for Community Medicine, Copenhagen University in Denmark, Elisabeth Lilja from the Nordic Institute for Studies in Urban and Regional Planning, Stockholm and Margareta Bertilsson from the Department of Sociology, Lund University.

To quote Sune Sunesson in his introduction to the second seminar, the Badger is a symbol of stubbornness, he is very good at digging and he has got a strong bite combined with an unwillingness to give up what he has got. These characteristics are needed in a time when changes for poor people, handicapped and other disabled are going on.

The problem of self-determination and self-organization is not just a theoretical problem. It is a problem of all kinds, political and ethical. Who is "self"? And what is "determination"? These two seminars were meant to shed some light over these questions, and hopefully make us a little bit wiser.

Contributors

Regine Gildemeister
Nürnberg University
GERMANY

Tord Jacobson
School of Social Work
Lund University
SWEDEN

Sune Sunesson
School of Social Work
Lund University
SWEDEN

Heinz Sünker
Faculty of Education
Bielefeld University
GERMANY

Mårten Söder
Department of Sociology
Uppsala University
SWEDEN

Corinne Thomason
Personal Social Services Research Unit
Kent University
United Kingdom

The Problematic Concept of Normalization

by Mårten Söder

Introduction

My background is that I have been doing a lot of work in the field of disability in general and my dissertation, ten years ago, was actually a summary of different kinds of evaluative studies that was done in relation to the services for mentally retarded persons. In later years I have been doing research on values and attitudes towards disability in general, not particularly to mentally retarded.

But, as I am going to discuss the concept of normalization, my reflections will relate to my experiences, first of all from the services for mentally retarded persons in this country. I also want to point out initially that what I am going to say is not a generalization made from some very high body of empirical research. It is rather what I would call reflections from a well informed observer. I have not been doing particular studies on the concept of normalization or the implementation of normalization. But as I have been doing other kinds of research in the field of disability, I have some informed knowledge of the debate that is going on regarding normalization.

The Principle of Normalization

The principle of normalization was first formulated in the field of services for mentally retarded. The person who probably was the first one to give a structured description of the principle of normalization was a Swede named Bengt Nirje, who back in the late sixties formulated it as a principle of organizing services for mentally retarded persons. Now there has been some studies in Sweden claiming that the concept was used already back in the forties in Sweden, but what happened in the late sixties was that Bengt Nirje gave it this particular definition and formulation, and that was a breakthrough for the principle of normalization.

The actual definition that Nirje formulated reads that normalization means "making available to the mentally retarded, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the main stream of the society." I think it is important to notice that he is talking about patterns and conditions of everyday life which are as close as possible to the norms in the society. In the short article that he wrote about this he makes it more concrete by talking about that "patterns of everyday life" means things like normal rhythm of the day, normal rhythm of the week and the right to live in a bisexual world for example. It is quite obvious when you read those concrete formulations that he formulated this principle as a reaction towards the conditions in traditional total institutions, because patterns of everyday life is kind of a negation of the things that was criticised in the total institution.

This little short six page article by Bengt Nirje made a tremendous success also internationally and it is almost remarkable that Bengt Nirje is nowadays travelling around the world still receiving honourable awards all over the world. Half a year ago he was in Australia to receive some award from the government and a few months ago he was in New York to receive a special award as being the father of the principle of normalization. Imagine yourself writing a six page article that twenty years after will give you awards from all over the world. So there must have been something special about it and I think that it had something to do with that in all those countries people had started realizing that - for a lot of different reasons - you could not go on building big institutions for mentally retarded. And there was at least in the United Stated and in Scandinavia a huge criticism of those institutions, and here comes a guy who very simplistic formulates what should be done in terms of "make it normal."

But of course this principle was adapted and transferred into different countries and changed a bit, and perhaps the most interesting re-formulation of the principle was done by the author of the book Normalization. Wolfensberger adapted the principle, as he said himself, to North American circumstances and in his definition it reads like this: "Utilizations of means which are as culturally normative as possible in order to establish and/or maintain personal behaviours and characteristics which are as culturally normative as possible." He is not talking about the normal patterns of everyday life as a goal, he is talking about normal means to reach the goal of normal behaviours and characteristics of the person, and this is very different from the basic idea of Bengt Nirje. This is very instrumentally adapted to the behaviouristic tradition in the United States, and this difference between Nirje and Wolfensberger has ever since been the focus for the ideological debate around normalization; whether you should, as Wolfensberger, put the emphasis on making the person normal, which Bengt Nirje has rejected and said it is not the person that should be normal it is the patterns of everyday life that should be made normal.

And this debate is still going on. The latest positions of those, Wolfensberger and Nirje, is very shortly something like what Wolfensberger said in a recent article, that he stopped using the word normalization because it has been so corrupted politically. Now he is talking about "social role valorization." The basic idea is that mentally retarded persons can only be accepted in this society if they can occupy roles that has high status or are socially valued in the society. So what we should do is start to make them occupy that kind of role and that can be done two ways, he says; either to change the values attached to different roles or you make the person fit to take on such roles. Basically I can not see any difference from the concept of "social role valorization" and the concept of normalization as it once was defined by Wolfensberger. He is still in for that instrumental interpretation with making the person normal in his behaviour and characteristics as the main goal. While Bengt Nirje today has drifted away to a position that could be summarized by; everything that is good is normalization. As he has been in a lot of debates where people are criticising the principle of normalization for the assumption that lies behind it, he has reformulated it in a way that basically says that a good life for deviant persons, that is normalization. I do not think that he today would say that patterns of everyday living is particularly important. It is rather that the person can choose himself. Would the deviant person choose to live in a traditional custodial total institution, that is OK for him.

That is roughly where the discussion, the internal ideological discussion in this field, has taken the concept of normalization. But I think it is important, as I said before, to realize that this discussion or this concept of normalization was initially a reaction towards the segregated traditional institutional system, and in motivating the principle of normalization there are two kinds of ideas. The criticism towards total institutions follows two lines that are close to the two different definitions from Nirje and Wolfensberger. One line is to consider segregation as a civil right where you basically say that disabled persons or deviant persons have a right to live in the main stream society, and as that, as a civil right it is just like equality or something like that.

The equality between the sexes - you don't have to motivate that, or at least generally you don't have to motivate everything, but women feel much better if they are equal to us men. But that is only one line of course. The other line is exactly looking at the effects on the persons and that idea says that institutions and segregation is bad because it has bad consequences for the development of the person. So normalization, integration, main streaming is good because it has good effects on the behaviour and the characteristics of the person. And these two lines can also be traced down in the studies done today in research.

Historical Changes

Trying to say something more specific about what I see as some of the problems with the concept of normalization, I will make use of some of the ideas that I had when I many years ago was doing a historical study about ideas and ideologies in the field of mental retardation in this country (that was part of my dissertation). I followed how the service system had developed and in particular what kind of ideas had been dominant in the contrivance. One of the things that struck me when I was going through that historical material was the sudden changes that occurs at certain points in time. It is just like you have a certain kind of perspective that is dominating through many decades and suddenly, in a fairly short time, changes rather suddenly and turns into something very different, and that different perspective becomes dominating for quite a while. What I was interested in was; why does those changes happen? In my dissertation I tried to relate that to a discussion about the material bases and the role of the surplus population in society. I don't think that was a very good explanation nowadays, the dissertation was accepted anyhow.

I like to think about it today in a slightly different way. At a certain point in time someone spots a problem, someone experiences a problem somewhere in society, and he starts to define the problem, trying to get hold of it, knowing what to do. And as he has done that his thought is developed in a more generalized way, we could call it principle of perspective. The initial problem gets generalized into a more coherent way of thinking in terms of a principle. And that principle is developed into what I in this complex will call an ideology.

Now this process means that from a concrete problem-definition will develop something much more general and something much more simplified in a way that becomes more and more distant from the social reality. And of course after a certain amount of time there has been a gap between that ideology and reality. That gap follows from two processes actually, one is the generalization, the transformation of a problem into an ideology, and the other process of course is that society changes. So the gap is created through the creation of an abstract ideology and through changes of society.

Taking Care of the Retarded

To give you a very rough example in the nineteenth century when they started to take care of mentally retarded persons in a systematic fashion in this country you might say that someone spotted a problem. There were some pioneers who saw a concrete problem. They saw small retarded children being mistreated in mental hospitals and in poor houses, so they wanted to do something to save them. That was the immediate response. What they saw were concrete particular children being ill treated and started to do something about it. While they were doing that they took care of more and more persons.

They developed a kind of principle or a perspective. The value bases for that perspective was basically philanthropic. You should help and save the poor souls in the society and at a more pragmatic level the principle was an educational one. You should train them by specially adapted methods and by doing that you should be able to transform them into decent citizens in the society. You should transform them from "needing to producing citizens of society." This principle then turned into an ideology. An ideology that was much more simplified, much more generalized. The nuances of the problem was kind of lost - ideologies are basically much more black and white. You are either for this principle or you are against it. Ideology said something like: take care of every retarded child in an institution and make them behave as none retarded when they are grown-ups, and make them earn their own living and so on.

After a period of about 40 years in this case, at the turn of the century, of course this ideology has moved to a reality that is quite different. This is a society that is going through a rather fast and rapid industrialization, people are becoming more rational, more modern in a way, in a lot of different areas. The basic problem, when it comes to mentally retarded at this point of time, becomes that they stop the process of rationalizing different sectors in society. Most obviously schools. When the school started at this point in time to make more emphasis on craving for a vocation than before, they started to use intelligence tests in schools in order to rationally organize the school system in order to have an output that they wanted.

Retarded persons stood out as an obstacle, a problem, because they were hindering the smooth functioning of a rational system and this was the complaints heard from many different areas. In mental hospitals for example where they now started to differentiate according to diagnosis, suddenly they discovered that there were some persons that did not really fit the traditional diagnostic system within the psychiatry at that time, they were mentally retarded. They did not know what to do with them, they wanted to get rid of them. So the new problem was basically mentally retarded persons as an obstacle.

That problem could not relate to that ideology at all, so someone started to make a new problem definition, and to develop a new perspective and a new ideology. In this case it turned out to be from seeing the retarded as some kind of embarrassment, a hinder in the smooth functioning in the different institutions. This turned out as an ideology, the sort of Darwinistic unique movement in the twenties and thirties. So this is the basic pattern.

Segregation and Institutionalization

I will try to say something about the normalization and put that in this kind of scheme. I think what has been happening is that in the late sixties the problem that was defined by the help of the principle of normalization or the ideology of normalization was, as I said before, segregation. The institutionalization and segregated measures came to stand out as a problem. Because this was a time when we in Sweden had a time of higher ambitions in terms of social policy than before. I think roughly you can say that up until the end of fifties or the beginning of the sixties we had developed the first phase in creating the welfare state, the one that we like to think about as creating a basic security system, creating "Folkhemmet", creating "the Peoples Home", as the image was at that time.

In the sixties we raised the ambition in a way so we started talking about the "Strong Society" instead of the "Peoples Home." The "Strong Society" was a society that not only took care and created a social security system for people but also were active in intervening and preventing problems. In that connection suddenly institutions (and the situation in segregated institutions, segregated schools and so on) stood out as something very negative.

It was in that particular context that segregation went to be seen as a problem. This normalization thinking then was turned into a principle with the basic values of equality. Mentally retarded should be treated as normal because they had the same value, they had equal rights, should have equal opportunities and basically they had the same equal value. They were first of all human beings and nothing else. That was the values that was proclaimed and in concrete terms its greatest important came to be as a principle of planning.

The normalization principle was most effective - well was effective if turned into a planning principle. It is obvious if you read the documents from the late sixties where people are discussing the principle of normalization. They are translating the abstract principle into a planning principle. It does not say anything of a method of how to deal with this people, but it says something about how big should the houses be, how big should the group be, what should the houses look like, how close should they be to ordinary housing areas and things like that. These are the things that are discussed. And the principle in turn, turns into an abstract ideology and that is in my mind what has happened to thinking in normalization terms in this country for example.

It means that the ideology looses it concrete contact. It becomes abstract in the sense that it is either/or all the time. Either it is normalization or it is something else. But when you ask: "What is Normalization?", you get a rather diffuse picture about it, and it also means that it sometimes becomes contra-productive to the goals that were proclaimed. Many parents to mentally retarded persons in Sweden for example can tell you stories about how they have been denied concrete services because the motivation has been the principle of normalization. Why should this county council pay for a vacation trip for your child? It does not do that for an average citizen. I mean basically that a lot of people are having experiences by this principle of normalization, as when it once was formulated was a way to articulate needs, it is now used to deny that kind of needs.

Concrete Problems

I think it is important to realize that what you see today is practical ideology and something very, very different from what it was back in the sixties. In the sixties it was a way of dealing with concrete problems. I remember somewhere in the middle of the seventies when I was participating in a panel debate. We were sitting on the scene and there was a lot of people in the room and the subject was about normalization. One of the participants in that panel was a Swedish author. She wrote a very famous hand-book on systematic indoctrination of children. She and I were discussing in that panel "what is normalization?", "what is normal?", "is it so good to be normal?" etc. We were asking those kinds of questions and she said: "well, I live in a house with 20 other persons, some of them are mentally retarded and we have only one water closet. Is that normal?"

Then Carl Grünewald, who was one of the very active people working for normalization, just said to us: "I am not interested in that kind of discussion. When we have been talking about normalization it meant going out to institutions where people were really 20 persons together. They were not getting dressed all day, they had to eat their food with their hands from tin-cans, and when you saw *that*, the reaction was - this is so terrible. We have to make it more normal, we have to cut down the size of the group, we have to get them dressed during the day, we have to help them to get a decent way to eat."

This was what the concrete problem was about. That is why I think it is very important to realize that the discussion at that time concerned something rather different from what we are discussing now when we are discussing the *principle* of normalization. And of course this gap also has been widened by changes that has gone along in society since the late sixties up until today. One basic thing that is changed is that back in the late sixties this country was still building the welfare state by the model of social engineering. The social engineer that was sitting at the central level in this society looking out on Sweden, systematically digging into the problems, systematically analyzing the data, finding *the* best solution. Part of it was that there was one best solution to every problem and everyone had the right to that best solution.

This model for social engineering is heavily criticised and even ridiculed today. But it is important to see that the principle of normalization grew out of that kind of thinking. We should have the best way to be normalized. The best way was making living patterns as normal as possible. That was the social engineering way of doing it. And the social engineer also used central means and he used the means that was close to him at the central level. He used legislation, he earmarked resources, creating special sector organizations from the top and down and so on. Now all this has changed because this led to heavy expansion of the public sector.

Ideology and the Changing Patterns of the Welfare State

Financial crises of the state and the answer to all those problems today could roughly be summarized as decentralization, and decentralization of course means that lower levels are getting more free to interpret what they are going to do. The means by which we could steer from the top nowadays has been steering by goals rather than by rules. So you could almost say that we have had a change of bureaucratic style in this country in this period. We don't have rule applying authorities any more. We have goal producing or authorities producing ideology because the idea is that in Stockholm they should give freedom to all the local municipalities in this country. The only way to steer and read the local level is by formulating goals and formulating ideology. And this is also important to understand what status formalization has today.

It is a kind of an ideology that is used, not as back in the sixties when it was used as a kind of concrete thing for the social engineer. Today it is more used as a steering device for people who are at the central level and also at the local level it is producing this kind of ideology all the time. Actually it is not too long ago I was called up by some guy in the North of Sweden (I think he was working in a county council) and he said something like this: "Well, hello. You know, my politicians have told me that we have to make a new programme for the services to disabled in this county, so I am calling you to find out the latest views in terms of goals and aims for disabled people." Suddenly I found myself dragged into that ideology. But it was a rather strange feeling. The politicians there (did their civil servant say) came up with a proposal, and he calls the university of Uppsala and asks: "What is the latest news?"

I think this kind of concrete example illustrates how that ideology producing process is going on. And of course there is also another change in society at this time. I mean the obvious, applying normalization thinking has led to de-institutionalization and integration of disabled people, which means that the problems today are not so much the institution because they move the patients out. We have some new problems that is going on. I mean basically that we have changed the system during this period. And I think at a very basic level this means something for the future that I don't think politicians have reflected upon. To give you a rather simplified example.

Different Conceptions of Normality

I have recently been conducting interview studies with severely disabled, not mentally retarded everyone of them but severely disabled persons, in the North of Sweden. One of the first persons that I interviewed was a woman at about 60-65 years of age. She had a cerebral pares from her birth, she had epileptics, she could not move at all, she could only make some movements like wave with her hands and she had great speech difficulties so the interview took very long time. She was living in a very small farm house out in the country side under very poor living conditions together with her mother who was 20-25 years older, about 80 at this time. The mother told me that this woman never went to school. She was sent home when she first came to school because the teacher said that she was an idiot, no use for her to be in school. After that she was living on this small farm with her mother (the father was never mentioned and

I never asked about him). Basically they were living there and received no support what so ever from society until the *mother* became old and weak.

So the social services came to the farm-house to see what they could do to help the mother. Than they suddenly discovered the daughter, who had been going along living there with some simple aids that her mother and some neighbours had made for her. After the discovery about 10 or 15 years ago, there was a dramatic change in their life when the social services came in. The daughter got specially adapted wheel chairs and the social services rebuilt the house so that she could go with the wheel chair everywhere. Today they have something like six or seven hours a day of help in their home from the social services, and also from the health care system, and they are so happy. They kept telling me that this is the best time of their lives.

As one other theme in our interview study was: "What kind of influence can you say that people have on their own situation?", I started asking her about that and she just refused to listen to that. "You can't say anything to them, or try to influence them. If you start going like that they probably would not help you", she said. Their basic attitude was thankfulness and they would not dream of making any complaint about the services they received. One of the questions we asked in those interviews to figure out what ambitions and what goals people had in their lives was: "If you were to win 100 000 SEK what were you going to do then?" I asked that question to this woman and she laughed a bit and she said: "Well, half of it I would give away to someone who needed it but I would keep the other half to myself." And then I asked: "What would you do with that half you would keep to yourself?" She was silent for about five minutes, and then she said: "Well, I have everything I need, so I would give that part away too."

Now, compare this woman with another interview I did a couple of weeks later with a 20 year old woman with another kind of disease, an impediment with roughly the same kind of disability. She could not move at all, actually she had no hands, no arms, she was very dependent on help. But she was 20 years old and she had just given birth to a second child. She was married to a non-disabled man who was employed by the social services full time to help her, and on top of that they had 10 hours of help everyday in their home. She was constantly complaining about the quality of the help.

She did not like the persons who came to help. She had all her life, she was born with her disability, been integrated into school. She had been going to school, having peers like everybody else. The attitude from this young woman has nothing to do whatsoever with that from the 60 year old woman. This woman takes it for granted that she is entitled to a life pattern that is as normal as possible. She is not surprised that the social services employs her husband and sends help to help her to take care of her children. It is quite obvious to her that it should be that way. When I asked her about what she would do if she would win 100 000 SEK, the answer was: "Well, that is not very much money. Let's make it a million."

The Image of Disability

I think that in the politicians minds and even in the disability organizations minds and all the established institutions in Sweden in the field of disability, the picture, the image of disabled persons are still that of the old woman. The weak ones, in segregated or tragic environments that we are going to help and make their life more normal and make a decent living for them. But what we actually are meeting in this time is a kind of a new generation of severely disabled persons who would not take that attitude. Their reference is self-evident to them that their reference point is the normal life and they will make their demands according to them. And that, I think, is a great change in society that really helps creating that gap between ideology and society and of course this young disabled persons would never dream of formulating their situation in terms of normalization.

If I started talking to them about normalization or integration they would not know what I was talking about. So that illustrates the gap. Another way of seeing this gap has been in the mass media in this country, the discussion in Stockholm about parents with very, very severely disabled small children. Children that needs medical attention, constantly. Now there has been some young parents in Stockholm, 10 or 15 of them, who has given birth recently to this kind of children in the last years. They have tried, the philosophy of course has been normal environments, to stay at home. They have tried to keep their child at home but it is impossible. They can't sleep, they have to rush to different clinics to get help for different things all the time, so these young parents started saying: "Should it not be possible to build some kind of institution or home to take care of these children?"

And suddenly all the ideological pressure came on to these parents. From the highest authorities, from the community level and from the organizations of the parents for mentally retarded persons. These new parents knew nothing about old institutions, they knew nothing about what has been going on before, they just said it would be practical to have a small special home for them. And they got all the pressure from this ideology that said, institutions is something bad. This is just another way to illustrate that the concrete problems we face today are just not going to be dealt with within that kind of ideological frame.

I guess that is enough to illustrate the general pattern that I see here, and of course this debate today about normalization mirrors this kind of discussion. This internal debate that goes on, the ideological debate in terms of normalization questions like: "What is normal?", kind of keep coming back into this debate. Someone has formulated: "what is the difference between giving someone an opportunity by making his living arrangements normal, or by oppressing him by the tyranny of normality?" It is obvious when you think of Karl Grünewald going to the institutions of the sixties, when he saw those terrible institutions, that in most cases making normal was a way of liberating them from some kind of oppression. But it is not obvious today. How imposed normality on persons who are not living in institutions will work.

Last week we had an American ethno-methodologist, David Goode, at the department in Uppsala, and he talked about "the tyranny of normality". When he applied it to ethnomethodological studies of deaf/blind children with severe mental retardation (these are children who of course has no language, has no measurable IQ), he has been able through intense studies of a few of those children to show that there is a kind of a sociability among them. There is a way for them to interact with their environment as a subject and even communicate, without seeing, without hearing, without having a language. The training of those children is constantly trying to get closer to normality. They kind of have to make them normal.

They have to make them work and accept that they relate in ways that we do not understand from our kind of general knowledge. I also think that there is a way of applying the thinking of normalization in a way that makes you kind of forget about the problems that is created from the needs. The new type of well-meaning bureaucrats that I observed in many places in Sweden are basically doing that by producing an ideology that says - equal rights, equal opportunity, equal like everybody else, living as normal as possible. The ideology makes them forget that there is another problem involved, in this case mental retardation.

The Experts and Reality

I will tell another story. This kind of ignorance of the real problem was so striking to me when I visited, a couple of years ago, OECD seminar about "Identity formation for youth with disabilities." OECD seminars are usually populated by exactly those kinds of well meaning bureaucrats I am talking about. There are high level bureaucrats, some politicians, people with academic background, some researchers, some psychologists etc, and at this meeting there were two disabled persons too. Denmark let themselves be represented by one woman who was blind and one man that was sitting in a wheel chair.

The discussion that took place during this seminar was formed by the disabled people. They were in their early 20:ths, they were kind of providing examples about what they had thought were problems while they were teenagers, growing up, and they were not saying: "you should deal with the problem in this or that way." They defined the problem and put it on the table before the experts to be discussed, and the experts reaction was: "well, that is not really a problem."

I remember that at one point the blind woman told a little story. She had been home in her own apartment with a seeing friend and they had been drinking wine and sitting up until very, very late, joking and having a very good time. Then her seeing friend were leaving and she was following her out to the door. They were embracing each other and her friend said something like: "just imagine we are having such a good time and I love you so much that I even forget that you are blind." And the blind woman said: "that was so horrible to take. The indirect message was - it is like hell that you should be blind. But I can even forget that, because we are having such a good time." So she was crying when she went to bed and she told us all that.

Now, how did the experts in the session react to this. Someone said something like this: "Well, stupid remarks from our friends, that happens to everybody. I have had some stupid remarks from my friends too." Someone even suggested that: "if that friend was so prejudiced it was not really a good friend." At this point in time I asked for the word for the first time, because now I was a bit upset and I said something like: "it is hypocrisy to call that friend prejudiced. I mean she was just saying that it is bad to be blind, and that is so. I don't want to be blind myself. I want to hear, I want to be able to listen, I want to be able to think. I don't want to sit in a wheel chair." And of all the things I have listened to in different seminars during my years, this was the one that really provoked me.

Immediately, a member of the parliament in Luxembourg, of all places, rose and made about 10 minutes speech accusing me of being a fascist. He was serious, he was really accusing me of that. There were also people defending me. There was a British professor of education who said: "You know that Mårten Söder just said the most courageous thing I have ever heard in a seminar like this."

The problem to me of course after that is - what is going on in that kind of a seminar? If I were to come to you or to my neighbour and say "I don't want to be blind", they would look at me and say "so what?" But at this seminar, this was very, very provocative talk. And the people at the seminar were generally persons who are good intentioned and effective in promoting changes in the direction of normalization and individualization in their country, and they are not stupid. But I think that this is an illustration of what I mean with the well meaning bureaucrat and what is happening with the ideology of normalization.

They are thinking the disability away. They are persuading themselves that having a severe disability is just like if I am standing in Paris and I can't speak French, then I am disabled or handicapped too. I mean, they are constantly playing with these kind of comparisons. So, they are so into making environments normal and implicit in their thinking, in terms of the translation that Wolfensberger made, by making normal - make the person normal. But that relation obviously is not true in itself, we can't forget about the disability.

Research Free from Ideology

Let me finally say something about what this implies for the kind of research that is going on, and the kind of research that could or should be done. In the field of mental retardation research today is very much dominated by a kind of perspective that takes the present ideology as its starting-point. That can be done in two ways. One way is researchers who are very much linked to the US for example, to the rights movement, who look upon normalization as a kind of a civil right. The kind of research they are doing is usually very normative and pick out the good examples to prove that normalization is right.

There are some rather interesting qualitative studies for example, but the basis of those qualitative studies is all the time; "let's pick the good examples and show how normalization really can work." The Bogdan & Taylor project about the sociology of acceptance, that is a huge research programme, that is kind of interesting in a way, but it's ambition is basically to show that normalization was right. They pick out the examples of how mentally retarded persons has been integrated and fully accepted, and try to analyze the mechanism.

The other kind of research is more based on what I earlier called the effective perspective. I mean the investigating or the social science perspective as someone has called it. They are looking upon de-institutionalization and normalization as a gigantic social experiment, and the role of the distant researcher is to evaluate, to compare, but basically they are also taking their point of departure in the ideologies because they are evaluating how much has normalization been implemented and fulfilled. Now, the problem in my mind with this kind of research is that it is so tied up with an ideology that is based on the problems of the sixties.

The best research in the field and the kind of research I would like to see more of would be research and studying the problem of the nineties without being caught up in the ideological question, is this good or is it bad, where is the good example, where is the bad example. I am convinced there is a lot of interesting things going on right now in this society with people, who are living a so called normalized or integrated life, and in order to be able to define the new, the real problem of today, we have to do that in a kind of research that distances itself from this ideological debate.

And as I know most of the people with mental retardation, because I just half a year ago finished a review of social research going on in that field, it is quite obvious that research from an ideological point of view is so dominant. The social studies that has been done for example in the field of mental retardation has very much been evaluative studies that has taken point of departure in formulation of ideology, very normative kind of studies. And the kind of studies that I see that are studying realities today are basically qualitative studies. David Goode, the ethnomethodologist is one of them who is kind of really studying what is going on out there. There has been some ethnografic research in integrated schools too, that has been this rather close study of everyday life of persons who has been normalized or integrated.

An Account of Normalization and De-institutionalization in Practice

- drawn from the experiences of the "Care in the Community" Pilot Programme in England

by Corinne Thomason

Introduction

De-hospitalization has been a theme of British policy making for some time now, since the late 1950s in fact. However, progress towards good quality community care has been slow. Even as recently as ten years ago community care policies were bolstered by hope and buffeted by prejudice but rarely confronted with evidence. Although very few people - whether they be policy commentators, care practitioners, service clients or their relatives and friends - viewed permanent hospital residence as appropriate or optimal for people with long-term care needs. It was difficult to assemble convincing information on the comparative advantages of "Care in the Community" settings. Debate was based, at best, on tangentially relevant research, and more often seemed to be dominated by anecdote.

The Initiative

During the 80s, although policy direction did not change there was a slightly different emphasis in that there was a greater effort to make a reality of good quality Care in the Community. In order to promote this goal further the 1983 Care in the Community Circular, often known as the Care in the Community Initiative, offered new financial transfers and a demonstration programme. The circular altered the financial relationships between district health authorities, local authorities and voluntary bodies by allowing health authorities to make financial transfers and encourage community based services for people discharged from long-stay in-patient care. The payments were to be financed from hospital savings and were to be paid in perpetuity.

The circular also launched a demonstration programme with the express intention of shedding light on the scene. A comprehensive evaluation of the programme was commissioned from the Personal Social Services Research Unit, which is the body that I work for, with the express aim of accumulating and disseminating evidence about what does and doesn't work in order to leave us better placed to plan the development of community alternatives to hospitals in the future. At today's prices some £22 million pounds was top-sliced from DHSS[1] joint finance budget to fund the programme which

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[1] Department of Health and Social Services.

would assist long-stay hospital residents to move to community living settings. In the nature of things, it was expected that the projects would demonstrate both the good and the bad sides of community care. By supporting projects for a range of people with long-term needs in a variety of different settings, the DHSS thought to generate experience in a variety of circumstances and contexts. By commissioning a valuation of the programme it was anticipated that the problems and potential of Care in the Community would be comprehensively examined and widely disseminated.

The Projects

At today's prices some £22 million pounds was set aside for the Care in the Community demonstration programme, spread over four years. Applications for grant aid to support projects were invited from local authority social services departments, district health authorities and voluntary organisations. The programme was confined to England. The 28 projects eventually funded each received three years central government support and of the money provided *two thirds* went to support revenue expenditure and the remainder for capital.

Although applications for funding had to meet certain criteria, no single model of community care was laid down. Many styles emerged. Projects combined statutory and voluntary agencies in management in different ways, ranged in size from three clients to over one hundred, supplemented central grant aid with local resources to varying degrees, and selected contrasting styles of care delivery (as reflected in type of accommodation, approach to case management, strategic operation, and so on). Thus the de facto definition of community included almost any accommodation other than hospital residence - from independent living to residential nursing homes - combined with a range of support services and activities. Twentyeight different systems of community care were set in place.

The projects therefore succeeded in delivering community services in remarkably different ways. They started from different service foundations in their locales, and they inherited or developed different macro and micro organisational arrangements. They pursued different objectives. Some sought to include the most dependent long-stay hospital residents, some sought to return people to their area of origin, some built particular staff training programmes into their plans, some promoted the maximum independence for clients.

The strategists, managers and support workers in each project were particularly influential in determining the technologies of the new services. Client preferences were influential in some cases. Backgrounds in different organisational cultures, first hand experiences, insights, personal and ideological values and simply a desire to provide good quality care, all had effects.

Funding Criteria

Applications for support under the programme had to address a number of criteria laid down by the DHSS. They had to formulate plans for effective joint-working between health and social services authorities and for some form of case management for individual clients, they had to target their efforts on long-stay hospital residents but demonstrate at least an awareness of broader objectives, and they had to explain how they intended to finance the newly established services once the three year programme ended. Projects would also have to open their doors to regular monitoring, evaluation and publicity.

Schemes For People With a Learning Difficulty

The twenty eight schemes covered a number of client groups but eleven of them were for people with learning difficulties. The schemes moved a total of 367 people and varied in size from Bolton planning to move 80 people to Torbay moving only 10 people. 4 of the projects, Camden, Liverpool, Torbay and Warwick were managed by the voluntary sector. Schemes planned to offer a variety of housing, 2 were based on the core and cluster principle, 2 were using hostels (ten beds being the largest) and the larger schemes such as

Bolton, Derby and Maidstone tended to provide a range of housing through adapted housing with staff support through sheltered accommodation, family placements right through to independent accommodation. Projects were spread throughout England, 2 in the North East, 2 in the North West, 2 in the Midlands, 2 in the South West, 1 in the South East and 2 in London.

Rationales and Objectives

When the Care in the Community circular was launched there were about half a dozen board policy objectives identifiable in documents at the time.

1. To promote agency pluralism and mix
2. To encourage efficiency in the use of available resources, where efficiency is defined to include the promotion of client well-being
3. To promote joint-working
4. To involve the consumers or users of services in planning and decision making
5. To provide community care for a range of client groups and characteristics, not confining the move to the most facile hospital residents
6. To explore a variety of service arrangements and philosophies of care

These broad objectives had their local counterparts and therefore when we came to the analysis stage we did an interesting exercise with the service objectives identified by the 28 projects at the outset of their funding period. There were more than 50 identifiable objectives which were organized into manageable groups under the following 7 headings:

1. client group objectives
2. philosophy of care
3. consumerism
4. joint working and agency mix
5. service provision
6. efficiency and service outcomes
7. client related outcomes

The majority of projects had a multiplicity of objectives. In over half the projects, anything between 10 to 19 different objectives were traced, and 20 projects had 15 objectives or more. When we looked at the frequency of classification of different objectives across the programme philosophy of care type objectives were the most frequently cited.

Philosophy of Care

A philosophy of care is a combination of beliefs, values and attitudes which is translated into a practice model - it cannot therefore be simply defined. It is attractive for ease of analysis to first look at *normalization* in order to gauge the extent to which objectives within this important category have been achieved. This second group of project objectives may, therefore, be loosely termed statements or broad value positions regarding the style of care, service management or even the system or attitudinal changes projects wish to effect. Thus the specification of a flexible approach to community care, emphasis on appropriately trained staff, changing attitudes among the general public and attempting to provide for as near normal a lifestyle as possible, are all examples of philosophy of care objectives.

Most project plans were underpinned by a strong set of service values concerned with the orientation and quality of care. Normalization and ordinary life models were influential across 19 projects. Within this sub-set of 19, however, the particular normalization stance taken both initially in project plans and in practice with the organisation and management of services varied quite distinctly. When reflecting on their achievements over the full DHSS-funding period, several projects noted difficulty in interpreting normalization, having become bogged down putting the concept into practice. Some staff interpreted it wrongly as meaning they should behave simply as friends, rather than professionals. In one project the result was a conflict between ensuring service monitoring and abandoning individual programme planning meetings because the latter were not seen as 'normal'.

Generally, philosophy of care objectives have been reactive. They were largely specified in contrast to the dominant sets of attitudes prevailing within host agencies or hospital systems, and were intended to challenge the preconceptions of service providers themselves in some cases.

Some projects now feel that this fundamental starting point, i.e. "hospital bad - community good", has made it very difficult to objectively criticise some of the less palatable aspects of community living. The very heavy philosophical commitment can be quite hard to retract although most projects have been forced to re-think principles at some stage. Although noted on fewer occasions than anticipated, philosophy of care objectives were also linked to the aim of replicating successful models of care.

Most projects now believe that they have been catalysts for related service developments in their areas, but this has not been easy to achieve. One project offered a generally applicable note of caution. Challenging preconceptions about who should be discharged (and, as a corollary, about the ways people should be assessed for discharge) and about the preferred style of community setting, may be seen as threatening to the established order. Negative responses may take projects one step back before they (hopefully) move two or three steps forward. For example, with hindsight the Greenwich project opined that it has been over-ambitious to assume that a new service could fill a major gap in service provision. Yet the gap was partially filled, with the consequence that the project demonstrated the feasibility of the service model, providing a basis for replication in a rolling programme and challenging the views and attitudes of many service providers. This type of effect is, of course, precisely what the DHSS intended for projects when launching the demonstration programme.

Some projects set the long-term aim of changing societal attitudes towards people with particular long-term needs by involving communities, volunteers and local helpers. A quarter of people questioned in a recent DoH-funded survey were 'strongly opposed' to integrating people with learning difficulties into the community, suggesting a pressing need for major attitudinal change.

The responses to the EOPQ illustrate that the majority of projects reported success on this front. Projects for people with learning difficulty, in particular, noted a shift from paternalistic attitudes towards an acceptance of people as adult citizens. These changes are usually slow, but GPs and dentists, bus drivers, shop assistants, acquaintances in pubs and others have been noted to adopt more normal modes of interaction. Successful community integration is not the same as general attitudinal change and a lot still remains to be achieved in some projects or for some individual clients, but the essential first step has been taken in many cases.

The projects themselves did not find it easy to decide whether they had met their philosophy of care objectives, or to what degree, yet most were adamant that such broad and often quite unspecific aims were important. Even when projects realised they were over-optimistic at the outset, they reaffirmed their commitment to the same ideals and, in similar circumstances, would adopt similar aims.

Given the gender-specific language nobody quoted Browning - "Ah, but a man's reach should exceed his grasp, or what's a heaven for?" - yet the message is surely correct. In the face of resistance from professionals, managers, purse-holders, relatives and communities, a clear set of ideals may seem like the only sustaining force behind a policy to establish high quality community care services. As the West Cumbria project commented: "There has been a feeling that our criteria were too optimistic, but we have achieved a lot. Perhaps if expectations had been lower we might have achieved less."

Client-related Outcomes

The last of the categories employed to describe the original objectives of pilot projects is arguably the most critical. It is therefore surprising to find only occasional explicit reference to client outcomes. Thirteen projects aimed to bring about improvements in general client welfare, and eight to work on client independence and self-determination, with a similar number setting out to improve life satisfaction or quality of life. Other, more specific objectives, were also cited. Nine made no explicit reference to objectives concerning client outcomes, but consumerism, normalization, and many other process aims, usually only justifiable because of the assumed favourable client-related effects, could be directly included in this group of aims. (Such assumptions need to be tested in evaluative studies).

Generally, client-related outcome objectives imply that projects deemed success as improving health, skills, self-image and appearance, social interaction, integration and engagement. Other criteria included increases in life expectancy, improvements in morale or life satisfaction, greater independence from staff and enhanced opportunities to make decisions.

How do projects themselves view their achievements in this area? Two types of information relevant to client-related outcomes was gathered. First, the EOPQ gathered narrative descriptions of the effects of projects on the lives of clients. Second, seven client-related outcomes were listed. Projects were asked to rank these in order of achievement, after consultation with key actors in their area or agency, the first ranked dimension being the one with which projects felt they had made most progress.

For the programme as a whole, projects' perceptions of achievements resulted in the following ranking of client outcomes:

1. improvements in life satisfaction
2. greater degree of personal freedom
3. appropriate personal presentation
4. use of community facilities and meeting people
5. greater engagement in activities
6. improved living skills
7. fewer behaviour problems

Interestingly, whilst nine projects ranked improvements in life satisfaction as their greatest achievement, eleven ranked personal freedom as most important, although the latter appears lower down the ranking for the programme as a whole. (It was ranked seventh by three projects, serving to emphasise the difficulties of reaching an overall consensus). However, only for the elderly mentally impaired and young adult client groups did improved life satisfaction and greater personal freedom fall below second rank order. Improvements in living skills were ranked as the greatest achievement only in Brent and the second most important in Waltham Forest.

Indeed, only for the mental illness client group was this dimension not among the lower of the ranked achievements. In Greenwich, also a project for people with a mental illness, the retrospective view from 1988 was that it is important for clients to gain self-esteem and satisfaction with their quality of life (in some cases resulting in improved skills). Developing this point, it was noted by more than one project that clients appeared to have *lost* some skills since moving to the community because of the relatively high emphasis placed on other aspects of lifestyle. (There is some quantitative confirmation of this, although changes do not reach statistical significance). For the programme as a whole the lowest ranking was ascribed to reducing problems associated with behaviour. We should bear in mind that the rankings relate to achievements and not to intentions or priorities.

The narrative accounts of changes in client well-being contained in the EOPQ, combined with discussions conducted with project staff as part of regular monitoring, amplify these rankings, but more importantly also begin to tell the story of Care in the Community. Some clients rated as immobile or wheelchair bound in hospital are now walking, others have acquired speech after many years without, and many have shown a rekindled interest in events going on around them, with an enthusiasm for making choices and a greater willingness to express opinions. One woman went on her own to visit friends in America after many years of hospitalization. One client in Islington is now living in her local area and regained contact with her family after many years in locked hospital wards and prison.

In *relative* terms, projects expressed the general view that they helped achieve improvements in client well-being. "From the rise in client self-esteem and quality of life we believe we have demonstrated convincingly that community services are more appropriate for those who have moved out" (Winchester project). In *absolute* terms, however, they also expressed dissatisfaction with the levels of, for example, independence, life satisfaction or personal freedom attained to date. They opine that they have been able to give clients more control over their lives, but are now finding it difficult to offer yet more freedom because of service and environmental constraints. Thus, whilst at the end of 1988 relatively few Care in the Community clients lead completely independent lives, most were more independent than before. Staff are frequently pessimistic about the general life satisfaction of clients even though most believe that there have been improvements compared with hospital. Because the most tangible indication of success within the broader framework of this Initiative is the movement of clients from hospital to supported community settings, there is the danger that later periods of in-patient treatment are somehow regarded as 'failures' or placement breakdowns. For some people with a mental health problem, readmission to hospital is likely to be a recurring event but one which heightens the need for a supportive community placement to which they may return.

One of the most telling messages to surface from the retrospective assessments by projects is that it takes a long time to combat the many years of hospitalization and institutionalization. The Torbay project commented that behaviour or dependency which has taken over 30 years to acquire will not disappear overnight. Yet there is still room for improvement in client welfare (broadly defined) and we see no good reason why most projects should not continue to achieve this in years to come. There is an obvious need for long-term client outcome research in this respect.

Reassessing Local Objectives

If the various client objectives, achievements and experiences are combined it is possible to gain an overview of project perspectives of the Care in the Community demonstration programme. We asked:

a. To what extent have project objectives been achieved, looking at them as a group?
b. With hindsight, were these objectives realistic?
c. With the benefit of experience, would projects choose different objectives were they to embark on a similar venture in the future?

General Achievements

The specific question asked of projects on the extent to which their original success criteria had been met, elicited the following responses:

* Twelve projects felt they had *achieved their overall objectives*. The response was qualified in some cases - 'though it is an ongoing process', 'substantially achieved them all', 'though not fully self-financing', 'against the odds' and 'despite poor resources'.

* Ten projects felt they had *partially achieved* their objectives. Four noted that they had not reached their target numbers of transfers, two felt they had not maximized satisfaction for all clients, and another two had not replicated 'ordinary' lifestyles. Five other areas of partial achievement were mentioned once each: inadequate staffing resources

not involving family and friends, not achieving agency integration, not offering clients enough independence and not establishing the planned core and cluster facility. Yet among the partial achievers were projects which had registered success along these very same dimensions. For example, four had moved their target numbers, three had improved clients' quality of life and one had given clients more independence. From the projects' vantage points no pervasive patterns of success or failure seem to emerge.

* Two projects were of the opinion that, overall, they had *not achieved* their objectives. In one case there was no further comment, in the other the 'isolation problem' was seen not to have been resolved and being perceived as crucial to overall success.

* Two projects were *not able to say* what they had achieved; it was either 'too early to say' or the original criteria 'were not well enough defined to be sure'.

* Finally, one project did not offer an answer to this question.

Given the small number of either completely negative or uncommitted responses, the overall impression gained is favourable. Resource and time constraints were cited most often as explaining an inability to fully meet all the original success criteria, although their impact was felt in very diverse ways. There is no doubt that the relatively limited experience held in most agencies of planning and operating de-hospitalization policies, a lack of experience also shared by the DHSS at that time, was responsible for the near universal delays experienced in acquiring and subsequently using community facilities. The causes of these delays - planning permission, fire and other regulations, builders, staff recruitment difficulties, resistance among hospital staff, confusion in social security offices as to entitlements, public relations difficulties and so on - were common to very many projects. Some delaying factors can be avoided if they are anticipated early enough, but in 1984 there was little experience to guide service managers. The upshot was that some projects effectively had only two years in which they were actively engaged in community care which was funded partly or wholly by the DHSS.

As part of this general overview of achievements, projects were given a list of twelve broad objectives commonly specified for community care services for people with long-term support needs. Projects were asked to reflect on their general achievements in the period of central government funding and to tell us which were the most important outcomes. (1 indicating the most important outcome or achievement, and ranking 12 the least important. These are not priority rankings of intentions, rather orderings of successes).

-adequate housing provision
-development of suitable rehabilitation or training facilities/techniques
-provision of appropriate day support services
-successful operational development of project staff team
-application of appropriate assessment/review arrangements
-mainstreaming of project with other services
-demonstrating innovative service models
-adherence to project principles/philosophies

-successfully moving target clients into the community
-providing more cost-effective services than hospitals
-achieving successful joint working
-changing attitudes in the wider community

This was a very complex exercise which demanded a broad overview of a project, asking staff to make comparisons of different aspects of care in the community which would not ordinarily be compared.

The three most important achievements across the full range of objectives specified (for the 25 projects answering) were:

1. successfully moving target clients into the community
2. adherence to principles and philosophy
3. adequate housing provision.

The least important achievements related to cost-effectiveness, integrating services into the mainstream and changing attitudes in the wider community. Marked differences can be seen between client groups. The development of suitable rehabilitation techniques or facilities was not deemed to be a particularly important outcome for projects for elderly people but was ranked fourth by the projects for people with a mental illness. The provision of adequate housing was the most important achievement for projects directed to people with a mental illness and was ranked second by projects for people with learning difficulty. With the exception of Winchester, housing was seen to be relatively unimportant in projects for elderly people. By contrast, achieving cost-effectiveness and 'mainstreaming' were seen to be more important by projects for elderly people. In fact, there are many marked contrasts between the elderly projects and others, differences which are also mirrored in the broader evaluation. Adherence to principles and philosophy was seen to be most important for project for people with a learning difficulty.

How Realistic Were Objectives?

The second general question asked projects if their original objectives now looked realistic. Their responses can be grouped as follows:

* Fifteen of the 28 projects believed their original objectives <u>were</u> realistic. Of these three felt that resources had been inadequate and three that they had not had enough development time. Two projects noted that it was important to have ideals.

* Nine projects viewed their objectives as unrealistic. Time-scales were too short (two projects) with a variety of service and resource constraints only becoming apparent after projects had been launched.

* The other six projects either gave no specific response, or did not know if the original project objectives were realistic.

Repeating the Project

Finally projects were asked whether they would choose the same objectives if they embarked on a similar venture.

* Eighteen felt they would not alter their objectives at all or very little, if any. Five of these projects said they would keep the same objectives but approach them differently.

* Seven projects felt they would make substantial alterations to their objectives, such as taking more notice of resource restrictions, or changing the emphasis of client-related objectives by being either more specific or less specific (one project each).

* Three projects either gave no response or did not know whether they would choose the same objectives if able to embark on a similar venture.

From Interpretation to Implementation

Local objectives, not surprisingly, were much influenced by the national agenda and by some of the specific guidelines contained in the 1983 Circular. Nevertheless, local flavour was not lost. The programme is characterised by a wide span of objectives, some like philosophy of care featuring strongly throughout the programme, others relating purely to an individual project. What is clear is that projects interpreted the circular in quite different ways. The result has been models of practice which are diverse and gives priority to similar aspects of service delivery in different ways.

Projects also give quite different and contrasting stories about achievement in relation to clients, services, philosophies and costs when asked to take a reflective look at services.

Whilst some projects have failed on some counts, most appear to remain optimistic about both their own services and clients and about care in the community policies generally. The tremendous enthusiasm, energy and commitment which characterised the early days of "the Initiative" may not be so obvious or widespread today, but very few projects have lost sight of their original ideals or philosophies of care, and many have commented on just how valuable those broad principles have been in keeping the momentum going and securing ultimate success. A strong sense of achievement emerges from the programme, and whilst one could argue that project perspectives are basically impressionistic, it would be quite wrong to ignore such important and informed impressions.

What is Normalization?

As we can see from the myriad of project objectives and the emphasis on ideology, strong philosophies of care have been the cornerstone of these projects. The most powerful and widely known philosophy based on these foundations is that of normalization which originated in Scandinavia in the late 1960s and which has since most often been associated with an American, Wolf Wolfensberger. Back in 1972 his version of normalization was:

> Where a person lives in a *culturally normative community setting* in ordinary community housing, can move and communicate in ways typical for his age and is able to utilise, *in typical ways*, typical community resources, developmental, social, recreational, and religious facilities; hospital and clinics; post office; stores and restaurants; job placements.
>
> Essentially, normalization concerns the *value that society places* on stigmatized groups of people, such as those with a learning difficulty, such as they are *not treated as less worthy* than ordinary citizens.

More recent interpretations of the normalization principle tend to emphasise positive discrimination and favour people with a learning difficulty and consequently the provision of better than average services, in order to compensate for their position of disadvantage. Normalization places particular emphasis on the need for opportunities to develop and maintain a broad range of skills in ones personal life. It also strongly favours development of individual service packages, suited to the need of the particular person. These features appear to be more important than the question of whether environments and settings are normal or ordinary.

Normalization was a specific objective of many projects which makes this an important springboard for the evaluation. The original normalization argument has influenced new conceptualizations of the term, for example the thrust of the Jay Report, and has spawned a number of closely related philosophies of care and support such as the ordinary life approach conflated by the Kings Fund.

> When we use the word ordinary we do not mean dull or exactly like everyone else, or standard or even average. Ordinary, simply means having the opportunities and the options which most people have. We live in a world where it is ordinary to have variety and opportunity and choice. It is ordinary to be special, at least to someone. It is ordinary to have opportunities for parts of our lives to be special and also to be different in ways which other people value very highly (Kings Fund Centre 1988 p.2).

The normalization philosophy is perhaps best conceptualized today in terms of the five accomplishments framework which was developed by John O'Brien (1987) and others. The accomplishments - community presence, choice, competence, respect, and community participation - are positive life experiences which it makes sense for a person to seek more of; "together they indicate a balance of valued day to day experiences that constitute a good quality life" (O'Brien 1987, p.177). The accomplishments have used to define effectiveness by Bolton CHC 1987 and London 1988, among others.

Community Presence

"The sharing of the ordinary places, that define community life" (O'Brien 1987 p.177).

The most important place is the home, which is the centre of our lives. Integration in ordinary residential, work, education, and leisure settings is a right and a need shared by all of us. Such settings are concrete representations of peoples' place within society; they are powerful mediums of personal identity and value (Robertson 1987, Tower 1985, Branston 1980).

Choice

"The experience of autonomy both in small, everyday matters (e.g. what to eat or what to wear) and in large life-defining matters (e.g. with whom to live, or what sort of work to do" (O'Brien 1987, p.177).

"Each choice we make is an expression of our personal autonomy - our freedom to define who we are and what we value. Making choices provides us with the power to determine to a greater extent what happens to us on a moment to moment basis as well as over a span of time" (North East CMH and Carl 1986 p.1).

Competence

Choice, particularly informed choice, is closely related to the third accomplishment competence, which is:
"The opportunity to perform functional and meaningful activities with whatever level or type of assistance required" (O'Brien 1987, p.178).

Closely related to the choice and competence accomplishments are the concepts of independence and self-determination. In western culture, the most highly valued aspects of peoples lives - such as identity, dignity, respect, participation, and their own life satisfaction - stem from the ability to be largely independent and self-determining in most of the core activities of daily living, particularly those related to personal care and other everyday needs.

Independence and self-determination are associated with ownership of one's own life (i.e. an internal locus of control) and, subsequently, with positive self-identity. In contrast, an external locus of control tends to be associated with dependence, powerlessness and dependent control over a stigmatized identity. Cevers (1980, p.42) refers to "indecent dependency with its resulting degradation of the human spirit." A related concept is that of risk taking, which is a normal, indeed essential, part of the learning process. There are many risks associated with developing greater independence and self-determination and a more valued lifestyle generally (Cambridge

1987). Successful choices leads to the person being perceived as competent and able to participate in valued ways.

Respect and Community Participation

The fourth and fifth accomplishments, respect and community participation, are both central to the ultimate goal of full and valued participation in community life. Respect is "having a valued place among a network of people and valued roles in community life", while community participation is the experience of being part of a network of personal relationships with other people, family, friends, neighbours and colleagues (O'Brien 1987, p.178). Both accomplishments reflect the deep needs shared by us all, to love and to be loved; to give, receive and share. Horizontal relationships of the gift relationship and life sharing kind are more valuable than traditional, more vertical and directive helper - client relationships because they are based on mutual consent, reciprocity and fellowship; the horizontal gift relationship means that individuals want to give of themselves rather than simply give as a response to a pay cheque (Sumara 1987, p.166). This is perhaps the ultimate reflection of the perceived value and dignity of any person, particularly someone with disabilities as O'Brien (1987, p.176) notes "benefits of friendship with a sibling or a neighbour cannot be purchased at any price."

Evaluation

Our evaluation was guided by three broad questions concerning Care in the Community:

1. Does it improve client well-being?
2. What does it cost?
3. How does it work?

These state, in general terms, the outcomes, costs and process tasks of the evaluation. We determined to ask these questions of each project in order to address our central research task which was to discover in what circumstances could cost-effective community services be provided to meet the needs of particular groups of long-stay hospital patients.

The broad framework for the research can be sub-divided into four topics; outcomes, costs, process and services and practice. These general topics are derived from the production of a welfare model which is an analogy to the economic theory of production which has been developed by the unit which I work for. It takes into account all aspects of the process of dividing welfare services and their consequences. In other words it describes its inputs, both resources such as buildings and staff, and as non-resources such as regime of staffing procedures, and characteristics of clients. Both intermediate and final outputs result from the production process. These final outputs are the ultimate goals for welfare provision such as the quality of life of clients. Within this framework we used a variety of research instruments, but as I will focus specifically on how we set out to monitor normalization in practice, we need to talk specifically about two research indicators: environment level indicators and client level indicators.

We have seen that the normalization perspective helpfully suggests looking at the services and lifestyles of people with a disability or illness to determine whether they conform to the style and standard we would expect for ourselves and would value. But normalization itself is a process objective, which rightly places most emphasis on rights and views of individual people with a learning difficulty or mental illness or other long-term need. Therefore it is important for an evaluation to extend beyond the checklist of normal or ordinary patterns of living and hence we look at 9 dimensions of outcome.

1. Type of accommodation provided
2. Integration and opportunities
3. Social contacts
4. Choice and empowerment
5. Activities and engagement
6. Skills
7. Symptoms and behavioral problems
8. Morale and life satisfaction
9. Personal presentation

Normalization in Practice

It is not surprising that in a pilot programme many project initiators elected to deliver services in innovative ways, often informed by philosophies of care such as normalization which were both new and controversial within their local areas or host agencies. However, translating a philosophy into practice has not been straightforward. The process that engendered considerable debate over the philosophy may require many compromises to make it workable. The difficulty has been that, in an effort to transform service provision, strict adherence to philosophy has often become an end in itself and has led to inflexible service solutions, which in a perverse way can actually compromise the original principle. This has noticeably been the case for normalization.

Normalization has been frequently misunderstood. Many people believe that normalization was just common sense, treating people as if they had no handicaps or making people normal, when in fact the philosophy is about good quality care in valued settings. Projects have found themselves arguing over assumptions that such as more than three people in a living unit is not normalization - which were incorrect in the first place. The result is that the provision in larger units is not valued even though the people who live there are progressing well and like living there. Other examples cropped up in group interviews with staff:

Example 1. Gerald doesn't need to wash unless he chooses to do so, because self-determination is part and parcel of normalization. Never mind the fact that his personal appearance is alienating him from his peers.

Example 2. Even though John's prize possession is his toy car, and he gains so much pleasure and security from having it with him, one must not allow him to have it because it's not normal for a 75 year old man to have a toy car.

Example 3. Not enough money for coffee.

Reported in this way, misunderstandings of this kind may seem petty, but in a dispersed setting where a staff member is responsible for implementing a new philosophy of care, choosing the correct course of action can frequently prove difficult. In practice, projects would appear to have moved closer to taking cognisance of what people need and want as well as what can be provided within available resources and ability levels, even though this might compromise some philosophical or ideological intents. This is not a problem, nor is it particularly novel, but it can prove painful to have to abandon some carefully chosen and laudable aims.

"Kevin holding up his buttonless trousers with one hand whilst trying to hold and scrape his place simultaneously."
"Janet being helped to choose exactly the right dress to go out for the evening."
"Peter buying and cooking baked beans for tea."
"The same amount of the same cereal placed in each bowl before people were called to breakfast."
"Suzy standing naked beside an open window waiting her turn for the bath."
"Jane giggling delightedly as she luxuriates in bubbles and refuses to get out."
"Jim and Julie, at different times and in different places both so obviously enjoying the simple tasks they have been given."
"Walter, putting up determined physical resistance to going to work and, having been made to go, sitting glowering at nuts and bolts and doing nothing all day."
"There were times when I sat shivering in thick woollies, surrounded by residents wearing much less, some with hands blue with cold."
"At other times it would have been difficult to envisage a more cosy setting, lounging by a warm fire, watching television and nibbling biscuits."

"On hearing these paragraphs you may think that you can pick out examples of the bad old hospital ways and the bright new happy community existence. I can assure you that the examples come from both settings. I have indeed seen many things that made me ashamed not to have the courage to speak out, but none of these was confined to one setting or the other. I have learned, if nothing else, that institutional ways do not necessarily disappear if people are moved to a three bedroom semi, and that a comfortable ordinary lifestyle can be created in the most unpromising of residential surroundings."

From these very powerful statements I think that it is fairly obvious what the dangers are of focusing too heavily on one element of creating an ordinary life. And yet this is what has happened in many projects where community care seems to have been much more about buildings than about people. So investment has gone into creating a homely environment, and client needs have come quite low in the list of priorities. Once clients have moved in, not enough resources for adequate staffing levels are left for example.

The programme encompasses a range of living options of all different sizes, and the important thing to say is that people can grow dramatically in positive environments at both ends of the size spectrum and vice versa. From a practice point of view people working in larger units on the whole feel that even where clients have improved they could achieve more in a smaller setting. But size is not the crucial determinant of a successful service, (there are other important factors such as adequate staffing ratios, support systems, education and training, philosophy of care, provision of a good service that meets peoples needs) but it can act as a guide.

One difficulty in providing valued care is to decide *valued by whom*? Some schemes have focused on buying very desirable residences in up-market areas and finishing them with colour co-ordinated accessories, on the assumption that if someone is evalued because of an illness or handicap then it doesn't help them to move to a devalued environment. There is another equally powerful argument. If you are more familiar with the life in a back to back in the centre of town, then a detached residence in the suburbs will seem alien and uncomfortable. Project managers have found themselves doing a fair amount of soul searching in selecting the right settings for clients, endeavouring to suppress their own personal preferences (e.g. architects, e.g Skelmersdale - Consumerism).

The underlying goal of planners of residential facilities within the community is to achieve a form and degree of domesticity which maximises a clients ability to exercise the independence necessary for well being broadly defined. This is not the same as a policy of ordinary housing at all costs, the dilemma between the enforcement of rules to ensure safety and the need not to limit client choice nor exclude elements of proper everyday risk from peoples lives has therefore had to be resolved locally. A decision has to be made in best interests of clients to place some bounds on the lengths to which normalization or ordinary living can be allowed.

Many projects have offered accommodation which goes a long way towards achieving ordinary living arrangements but there is still a need for other settings - all valued by projects and by clients - for people who are not yet ready for independence. On every criteria of normalization examined here the projects have done better than hospitals. Differences between accommodation types suggest that smaller independent settings score better with people with a learning difficulty but generally not significantly so for people with a mental illness. Importantly all clients express high level of satisfaction with their community based accommodation. The problem with normalization is that it is often interpreted too narrowly. If the pilot programme has taught us anything it is that people can benefit from a whole spectrum of facilities. *Size* is not the crucial determinant of a successful service, there are other important factors:

* adequate staffing ratios
* support systems
* education and training
* philosophy of care
* individual care planning
* self-determination.

Institutionalized practices most frequently arise where there are inadequate staffing ratios. Time and again, carefully thought out projects who have spent so much time and money getting it right in terms of environment, philosophy, induction training, flounder because staff are too thin on the ground to implement programmes.

For example, it takes a lot longer to help Jane to get her own breakfast, than to do it for her. Jane will probably prefer you to get it for her anyway. So the path of least resistance is easier and faster especially when you are the only member on duty, and you have all the beds to change before you take Jane to the doctors at 11 00, and prepare lunch for six by 12.30. This leaves little time to spend with Jane on an individual basis, trapped at home 4 days a week because there is no appropriate day care for her - but more of this later.

On the positive side, I could recall as many examples of 10 bedded hostels which regardless of size, manage to promote a feeling of individuality as well as a strong sense of stability and security. There is no doubt, that when you enter the particular hostel I have in mind, that 10 very different people live there, they have their own lives and the hostel has offered the base and support from which to achieve personal goals. Numerous tenancies with 24 hour support where people have regained domestic skills, long forgotten, and staff support provides the means to further social horizons.

Last, but not least, adult fostering placements. It is here that I have seen the most *dramatic* changes in people. Perhaps because some have been of high dependency and improvements have been more apparent. It is essentially the *quality* of care which has struck me so markedly.

I have been amazed at the commitment of the people who are caring for people as part of their families, and more amazed at peoples development in this environment. A prime example is Mark, 25 years old, and disabled after Hydrocephalus at the age of four. In hospital he was curled into a ball in a wheelchair when I saw him, he couldn't do anything for himself and would respond to nothing, not even touch. Two years after moving in with Joyce and Stan, he can walk, make himself understood, is only occasionally incontinent, feeds himself, helps with the housework. For Mark, the 24 hour care given by two very committed people has opened up his life. It is hard to imagine that he could receive this level of support in any other environment.

Equally for George in his late fifties with much milder symptoms, but now part of a young family and a local community who all take an interest in what happens to George, even the local teenage boys have apparently been supportive rather than hostile or resort to ridicule perhaps informed by the example of the two very forceful teenage girls who belong to George's host family. In an interview with Linda who is their mother, she expressed the view that in her opinion this is the (best) form of Community care, a plan which allows the community to participate in the provision of care.

If making a reality of good community care, is care *by* the community in an integrated and coordinated way, then Linda, her family and George seem to be getting there. Many would argue it is about changing the way people with learning difficulties are perceived that also certainly seems to be happening in this case and flags the next issue I wanted to discuss, project philosophy.

In practice, what projects have found is that constructing a package of care must take cognisance of what people need and want, as well as what can be provided within available resources and ability levels. It is naive and impracticable to believe that adherence to philosophy will provide a good quality service that meets peoples' needs and yet many projects initially fell into this trap.

For example, including elements of normalization into everyday care is not always easy within services which have traditionally been delivered to people rather than in conjunction with them. Incorporating self-determination and choice into services requires an element of risktaking by both staff and clients. For instance staff must allow some scope for clients to make 'wrong choices' and must accommodate conflicts between the wishes and needs of the user and professional requirements. The growth of an articulate consumer movement and self advocacy is forcing user interests into the debate. Kidderminster, Somerset and most of the London projects encourage and work with citizens advocacy schemes.

It is not simply ideas about asylum and community services which will decide whether a client receives integrated or segregated day care or employment. Decisions must also be affected by the availability of services in the community and the wishes of the client. In Warrington, for example, some residents preferred to return to the industrial Therapy Unit at the hospital for employment, even though alternatives were offered. Their decisions were based on valued contact, familiarity and friendships, which were more important to them than work in the community. Many users choose to break such links in the longer term. Day services have simply not been available in some areas, which has constrained flexibility. When they are available, their regimes may well conflict with the goals projects have set for clients. In such circumstances, mainstream services may be deemed inappropriate.

Assessment has proved controversial. Some projects have found the traditional medically-orientated and hospital-based assessment of skills to be inaccurate or inappropriate for assessing needs in the community. It may focus too negatively on limitations rather than capabilities. Many projects employ 'getting-to-know-you' programmes taking clients from the hospital environment for lunch, shopping trips or holidays, so that project personnel can make better assessments of their abilities and behaviour, ungoverned by familiar surroundings. In the process, project staff have uncovered clients' brothers, sisters, sons, daughters, skills and interests long forgotten because no one had ever asked about them. In essence what I am stressing is there is no uniquely 'best' philosophy of care. The philosophies and the care-packages which have emerged within the demonstration programme have been as much a result of choice and availability as an attempt to adhere to ideals.

Implementing a philosophy is a good way to bring out peoples prejudices. Some projects have found that although induction programmes have included sentence on normalization the principle remains widely misinterpreted and may benefit from constant review. What is normal to one person may be completely off the wall to another. Age, background and geographical location may also alter perceptions of what is normal behaviour. Retraining and continued training can address these issues. The messengers of the normalization creed advise that it should not be written as a set of rules.

Rather it should be used as a value base from which certain general principles emerge. The fundamental notion is for full appreciation and valuation of all people as essentially human, instead of labelling and separation, by virtue of handicap or age. From this premise follows the right of all people to human dignity, choice, privacy where desired and respect. Moreover, services which are designed to fit individual configurations of needs are required.

Normalization related issues seem to be much clearer in the field of learning difficulty than in mental health. I don't know whether any of you feel this way but certainly within the programme there was much more of an ideological battle about ways of caring for people amongst the mental health projects than within the programme as a whole. On a personal level this is one area that I still feel very uncomfortable about after visiting projects. And although the evidence from our research provides additional empirical support in favour of normalization-based principles and approaches, it seems to me that there is still scope for much more debate about implementing an ordinary life model for people who may be quite disabled when they are ill. For this client group I think it is really difficult to arrive at a balance between an enabling and a restrictive environment. What is interesting is that within the programme individual project leaders who were the furthest apart in terms of what their philosophy of service development have come much closer together in their approaches through their experiences.

One example from our findings concerns one of the dimensions we use to measure how normal a service was and what is personal presentation. At the end of the day we decided not to report the personal presentation results in detail because of our concerns about interpretability and because such reporting could encourage inappropriate comparisons between projects. The problems with the interpretation of the results is illustrated by the residents of one semi-independent setting in one of the mental illness projects. Clients dress in smarter clothes than they did in hospital, are usually tidier and there are few if any problems with personal cleanliness, posture changed little from in hospital but generally personal presentation per se is better, the problem is that the clients general appearance does not conform to what is rated as usual within the community, the client's appearance is in some respects inappropriate. In other words it appeared clients present themselves rather better than in hospital but their clothing, posture, traits and general appearance are sometimes inappropriate for community settings, this is particularly true for people with a mental illness.

Smoking is another case in point. Most of the homes have had to have some regulation about not smoking in bedrooms because of the fire hazard. Similarly with medication, there is a dilemma over whether to allow some in control of their own medication and there will always be examples of people who don't take their medication when they are feeling well. There is also a problem of de-skilling if people live in environments where things are done for them. Walthamsburger argues that the development of skills and abilities that is environmental normalization and client normalization are reciprocally reinforcing people who have scored quite highly on daily living tasks in rehabilitation in hospital, have sometimes not fared as well in the community if they have been living in facilities where things are being done for them.

Ordinary living can of course mean neglect and low quality of life if services are not coordinated around a persons needs. The National Federation of Housing Associations and MIND in their 1987 document argue that people with mental health problems or a mental handicap should be able to live in ordinary housing which is both inconspicuous and not segregated with support services provided to maintain them in that accommodation.

However a common problem amongst projects is where clients have not received assistance with domestic chores. The professional support worker perhaps feeling that it is not his or her job to encourage or assist domestic cleanliness and order. One has only to see some clients living in facilities where there has been lack of support in this area and where the clients themselves are not motivated to carry out these tasks to realise that there is a very fine dividing line between a service which promotes self-determination and a service which could be accused of neglect.

Reference List

Abbott, P. and Sapsford, R. (1988) Community Care for Mentally handicapped Children, Milton Keynes, Open University Press.

Audit Commission (1986), Making a Reality of Community Care, HMSO, London.

Barry, N. (1986) Lennox Castle, While the talking goes on, lives are being wasted, Social Work Today, 23 June, 12-13.

Bayley, M (1973), Mental Handicap and Community Care, Routledge and Kegan Paul, London.

Blatt, B (1970) Exodus from Pandemonium. Human Abuse and a Reformation of Public Policy, Boston, Massachusetts, Allyn and Bacon.

Blatt, B. with Mangel, C. (1967) The Tragedy and Hope of Retarded Children. Look [Magazine,USA] 31 October 1967, pp 96-103.

Blunden, R. and Allen, D. (eds.) (1987), Facing the Challenge - An Ordinary Life for People with Learning Difficulties and Challenging Behaviour, Project Paper No. 74, King's Fund, London.

Cambridge, P. and Knapp, M. (eds.) (1988), Demonstrating Successful Care in the Community, PSSRU, University of Kent at Canterbury.

Cmnd 3975 (1969) Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and other Irregularities at the Ely Hospital, Cardiff, (Ely Report), HMSO, London.

Cmnd 4683 (1971), Better Services for the Mentally Handicapped, HMSO, London.

Cmnd 7468 (1979), Report of the Committee of Enquiry into Mental Handicap Nursing and Care Jay Report, HMSO, London.

Cmnd 849 (1989), Caring for People: Community Care in the Next Decade and Beyond,
HMSO, London.

Department of Health and Social Security (1980), Mental Handicap: Progress, Problems and Priorities, HMSO, London.

Department of Health and Social Security (1983), Care in the Community, HC (83)6, LAC (83)5, HMSO, London.

Donges, G. S. (1982) Policymaking for the Mentally Handicapped, Aldershot, Gower.

Griffiths, Sir R. (1988), Community Care: agenda for action. A Report to the Secretary of State for Social Services by Sir Roy Griffiths, HMSO, London.

Jones, K. (1984), Ideas on Institutions: Analysing the Literature on Long-term Care and Custody, Routledge and Kegan Paul, London.

Jones, K. with Brown, J., Cunningham, W.J., Roberts, J. and Williams, P. (1975) Opening the Door. A Study of New Policies for the Mentally Handicapped, London, Routledge and Kegan Paul.

Knapp, M., Cambridge, P. and Thomason, C. et al (1990), Care in the Community: Evaluating a Demonstration Programme, Gower.

Morris, P (1969), Put Away: a sociological study of institutions for the mentally retarded, Routledge and Kegan Paul, London.

O'Brien, J (1986), A Guide to Personal Futures Planning, mimeograph.

O'Brien, J. (1987), A guide to life-style planning: using The Activities Catalog to integrate services and natural support systems. In Wilcox, B. and Thomas Bellamy, G. (1987), A Comprehensive Guide to the Activities Catalog. An Alternative Curriculum for Youth and Adults with Severe Disabilities, Paul H. Brookes, Baltimore.

O'Brien, J. and Tyne, A. (1981), The Principle of Normalization: a foundation for effective services, CMH, London.

Oswin, M. (1978) Children Living in Long Stay Hospitals, London, Spastics International Medical Publications/Heinemann Medical.

Renshaw, J., Hamson, R. and Thomason, C. et al (1988), Care in the Community: The First Steps, Gower.

Rivera, G (1972) Willowbrook. A Report on How it is and Why it Doesn't Have to be That Way, New York, Random House.

Ryan, J. with Thomas, F. (1980) The Politics of Mental Handicap, Harmondsworth, Penguin.

Scull, A. (1977), Decarceration: Community Treatment and the Deviant - A Radical View, Prentice Hall, Englewood Cliffs, NJ.

Shearer, A. (1986), Building Community with People with Mental Handicaps, their Families and Friends, London, CMH and King's Fund.

Towell, D. (ed.) An Ordinary Life in Practice: developing comprehensive community-based services for people with learning disabilities, King's Fund, London.

D. (1988) Managing Strategic Change, in Towell, D. (ed.) An Ordinary Life in Practice: developing comprehensive community-based services for people with learning disabilities, London, King Edward's Hospital Fund for London.
Wagner (1988) Residential Care - the research reviewed, HMSO, London.

Wolfensberger, W. (1972), The Principle of Normalization in Human Services, National Institute on Mental Retardation, Toronto.

Wolfensberger, W. (1983), Social role valorization: a proposed new term for the principle of normalization, Mental Retardation, 21, 6, 234-239.

Creating Normalization? On the Methodizing of Everyday Life

by Regine Gildemeister

In trying to create normalcy for patients in institutions, it is very essential in what way the institution functions. I will try to show that by give you examples from two different institutions and how the patients are treated there.

The In-door Reality

The first example is from an institution where the illness is in focus and the patients are very passive and anonymous. They tend to behave as if they are going to be spoon-fed during the day. They don't do anything. They just sit down and stare like sheep at the therapist, with such big eyes. Expectations from the co-patients are related to active participation and hence communication. They are supposed to talk and prove themselves to be proper or good patients. Partial inadequacies are accepted as long as they are the result of an illness related to a torpid state of mind. In the group discussions with patients, the behaviour of the others is generally seen and judged according to this lower profile.

The requirements set up by the lower profile prove to be those that the majority of the patients always seem to deviate from. It is then, when feelings of annoyance arise, that this deviation is interpreted as "not wanting to." One is deprived of his rights as a patient and restricted by the co-patients during the process of doing therapy. This requirement profile for patients is hence realized to many different degrees. Whoever deviates from it is deficient.

Criticism of this normative orientation is hardly ever expressed. The experience of ones own deficiencies in regard to the norms is not interpreted as not wanting to, but rather then as a part of the illness. One must keep in mind that illness itself remains diffuse, that no common concept has been developed for this. The focus of the therapeutic method is, however, not seen in the patients as a group but rather in individual therapy. This too proves under closer inspection to be the result of the socialization in the institution. Particularly the new ones in the institution don't know what to do with the individual sessions. "They are so incredibly understanding, they let you talk about everything." This is what one patient said about the individual sessions.

Individual therapy has enormous importance for those socialized parts of the patients role and immense hope is attached to it. "You are a totally different person as the end product of therapy", is a quotation from another patient. One acquires the idea of how to systematically work through and realize ones own life story, which is seen as a source of ones own suffering. The patients concentration on individual therapy, that in the therapy reveals a structural contradiction in the institutional field of interaction because this concentration contrasts with the core of everyday behaviour in the institution, the struggle for social relationship, for social reference.

This is not in the interest of the professionals. They keep on trying to encourage the group members to bring up topics openly in the group but find themselves in conflict with the control of information by the patients. Information is almost systematically reserved for individual therapy with the result that the presence in the groups is often limited only to physical presence. Particularly when no other topic has been defined, such as occupational therapy, theatre, art and so on. The groups become going slow. They become silent, and this silence is feared to a high degree.

The type of active patient, or the type of active patient role, is sustained by some about one third of the patients. But those who not only fulfil their roles, but also overdo it, they do a great deal of the work towards making the everyday life of the institution function. They are extremely important for the specific structure of this clinic. By relating to the basic principle definitions of the treatment of illness, they also create a context of action for the others. Hence the pre-selection of clients for the day clinic becomes one, or even the only central tool for the professionals in this process of creating norms. What develops here is a structure of everyday life, in this kind of institution, and can be described as institutionalization of a balance therapy, between relating to ones own problems and reflecting society reality. This balance is always very plain.

Decisions for the context of this institution is, from the point of view of the analyst, the institutionalization of spheres which must be kept in balance. A balance between the everydayand the particular, the mystification of illness and therapy and their interlinking to the everyday forms of living, routinizing. A positive revaluation of the personnel as well as of those they are training. These are spheres which almost must be interlinked. The dynamics of this institution life, from simultaneously integrating and separating the particular or the particularized, and the usual everyday life where so little happens.

Getting used to this discrepancy of the particular what is really important and everyday life where nothing is happening, can itself be seen as a kind of a hidden curriculum. On the one hand there is this sphere of deep inward experience, which is built out of individual session where communication is completely geared to the individual person. On the other hand there is this sphere of heteronomy in which the individual is essentially controlled by outer world events and must fit in with the given procedures and structures, where people sit together and don't know what to say to each other. Both of these are bound together in one and the same everyday life in the institution, and yet at the same time they are different from each other.

Being able to tolerate the two poles of role and person in a patient, in the ideal case being able to integrate them, is probably the latent effect of the life in the institution. Especially because a special sphere, the individual therapy is created (nobody knows what it is) everyday life becomes less burdened with meaning. For this reason, often fragile, it can nonetheless function as such. The collective boredom of hanging around is not noticed because something else will be happening, and this something else has been given a greater value. This means that the fragile level of the society basis of daily life works, because at least one thing is given a meaning. Even if, and just because it takes place in the form of a mystification.

A Possibility to Communicate

I have another example, very short, from another type of clinic. They create a kind of other everyday life. It is a psycho-somatic clinic that is an in-patient institution far from the centre of the city. First impressions comparable with the day-room-scene we first described convey rather a family atmosphere. It is indicated through using first-names and "you", although the clinic is larger. I will briefly relate the following example from the work of everyday life of the clinic as a contrast. Let's begin here with the definition of the problems. It is a scene from a therapy group.

Patient Anette describes a problem with a boyfriend, with whom she is living. During the course of the session the therapist asks her why she is here.

Annette: "Because of the medical authorities. Diagnoses is neurotic disturbances in development and all that shit."

The therapist asks what she herself thinks about it.

Annette: "States of panic and depression and not being able to cope with life."

The therapist then says to her that he does not see any reason for talking about it any further. The girl, Annette, begins to cry. She is afraid that she will have to go back to the psychiatry clinic.

The therapist: "Fantasies, fantasies."

Annette: "But that is the reality for me in the condition I am in right now."

This dialogue is continued for a few more sequences and led to a new question.

The therapist: "What is reality now?"

Annette: "Here and now on the chair?"

The therapist: "Yes!"

Annette: "Reality is now where I feel so shitty."

The patient is requested to describe the feelings of this condition in more detail. And this continues for a few more sequences in which Annette again begins to cry. She is requested to make eye contact with the members of the group. A co-patient has taken her hand and another patient has placed her hand on her back. All of them are looking directly at her. Annette stops crying then: "It is better now than when I first came in," she says.

What does all this mean for the question of how everyday life and normality are created in this institutional context? The patient, Annette, describes her problem. The therapist asks her why she thinks she is in the clinic, from her own point of view. Annette resorts to the former criteria of admitting authorities. The therapist again tries to come back to her own definition. She says: "I can't cope with my life." Precisely as this proves to be insufficient, the therapist obviously sees no basis for working with her. The problem is not defined, and only within defined boundaries can the problem be worked on. The entire sequence is aimed at creating this workable problem, and this must obviously have certain properties.

The result of the intervention aims at establishing inter-personal contact, a level of reality which can be seen here as a way of solving problems. A workable problem is essential for beginning the process of putting things into a relationship. Reality is defined here as what is happening here and now in the group, or what is happening in the emotional relationship to the other patients. This little scene makes clear the basic understanding of the problem to be worked on. The implementation of systematic focusing, feelings, and the corresponding setting of practical norms. The formal shaping of communication is the decisive basis for collective reality in this context.

Creating a relationship with others is only possible on the basis of revealing sensibilities and feelings. The essentially institutionalized focus on communication in this institution, is in revealing feelings and thus positively revaluing the emotional state which are not normally expressed in this form. The reality at which the socialization is aimed, is not limited to the micro cosmos in the group, the therapy group, but is rather the larger community of the whole institution. This also occurs at the level of the weekly general assembly. There the admission of new patients and the departure of older patients takes place.

The Use of the Group

Let me take a second example, as the last example, from the event. The assembly is led by two patients from a small platform which is decorated with glossy paper, flowers and candles. Behind it is an oversized picture painted by the patients, with the motto of the week which they have selected. LIFE IS A PARTY AND WE ARE ALL INVITED! The beginning is accompanied by the sound of a bird, when the two patients gets up in front of the platform. The first patient Irmgardt who is a compulsive eater, addicted to pills, depressive and thinks that "I am the sun of my life", utter the opening: "We are adults and insanities."

After the opening by the patients, the cast of the inner circle introduce themselves. First professionals. "I am Bernhard, and I am a medical doctor." Then the patients: "I am Conrad, and I am an alcoholic with depressions." The naming of symptoms is followed by questioning from the therapists. Thus public introduction in the general assembly is very emotional for all the new patients, practically every one of them break down in tears during the course of the introduction. Every single introduction is ended by a sentence from the head of the clinic: "You are very welcome here," and then the first name is used. "You are very welcome here Hans," etc. This is followed by applause from the entire assembly, about 100 people.

The weekly formal procedure of the general assembly is equivalent to a ritual. The general assembly is called The Emotional Hearth of the Clinic by the therapists and the patients, and the spirit of the community is continuously: "We can get on!" The commitment to formalize self help prevention, i.e. "I am Irmgardt. I have eating problems and I am addicted to pills," does not contrast with this. By naming the symptoms of their psychic suffering the illness becomes ever present, and this is an enchant banishment.

The fact that everyone does it, must do it, suspends the tendency to stigmatization. In this context it provides the release of the person from the necessity of keeping up a facade in the public life, a facade of normalcy. On one hand it must be accepted that one has not achieved normalcy in the sense of existing society ideas. On the other hand this is indeed the pre-requisite for a new normalcy. One of the results of all this is that deviations defined here as a psychic disturbance, can be translated into the normalcy of everyday life and the fundament to the normalized inner-institutional reality.

It is important to note that illness, outside the formalized self-representation, is practically never focused on - it is no longer problematical. As the result of the release brought about by publicly naming the illness, freedom is created for working on the real illness, which is no longer an illness but rather an inadequate relationship to life. However, life is here in a very fundamental sense community life, and this is also the formula of the clinic. The purpose is "turn on to live life", not a model of illness like in the other clinic, but rather as a model of treating the practise of life itself. Illness is only a message, a deficiency syndrome above all of social emotional need-satisfaction. Learning to live life means being embedded and accurate in a dense personal emotional life web of relationships.

The focus of the everyday institutional structure lies here in the artificial product of community, Gemeinschaft. It is the creation of a form of social integration which is supposed to be completely natural, but which has itself as a main goal. It is hence not surprising that life in the clinic becomes in fact a normative model for life in the world, for life itself. "If everyone has done such a therapy then the world would be a lot nicer place", one patient said.

Investigating Institutional Everyday Life

This analysis of institutions follows the ethnographic tradition, which researches the elements of everyday life in which the agents interpret the environment and act on it. Institutions of psycho-social-work were investigated with the purpose of trying to discover the every-day routines, events, typical situations and conflicting occurring problems. In brief everyday life, the logic within it by way of which that order is created, is accepted as natural and is reproduced daily. Nothing is being said about the rightness of this so identified everyday institutional life. Reconstructions do not have the aim of identifying what is covering mistakes, or determine whether or not therapy taken place here is correct or not correct. Instead the central question for the quality of psycho-social work are returned to the institution itself, such as: "Are you doing what you really intended to do?" In that the material is related to the surface of the institution and the analytical description of the institution is trying to discover the patterns, rules, principles and various norms-oriented situations documented here.

The study is orientated to the obvious, which is in principle accessible to everybody. This obviousness is, however, obvious in such a way that not one of those actually participating in the institutional reality really recognize it. This demonstrates an entirely general movement of institutionalization, namely the invisibility of the obvious becomes invisible, nobody will see it. The invisible obviousness is, however, anything but unimportant. At the beginning I pointed out the paradoxical institutionalization in this field. The core of the paradox is the tempt to deal with psychic disturbances by reverting to the qualities of everyday life, the loss of witch however is a point of departure for the problematic situation. In creating the specific forms of organizing the everyday life and normalcy, the institutions produce social bonds as a basis. They simulate social anchorage. They develop themselves as a centre for interpreting the meanings of living together, representing a basis for the work on and with the persons living there.

Such institutionalization of normalcy in deviation, however, has its limitations. It is fundamental dependent on not transforming itself into the real practise of the life. If they went over to real social forms, they would give up the therapeutic character from which the dynamics of the institution, the institutional life, is produced and reproduced every day. But precisely here lies a problem. Every institutionalization contributes precisely to the normalization of lifeforms, and then its own structure becomes invisible. Motives also resites from this. Society attempts to deal with uprooting, disorientation and loss of convention. Special kinds of social laboratories arise in which social integration problems are worked on, which express themselves in and through the individuals. In the end, however, they remain social problems themselves, from which the processes of social change are denied. In a certain sense, experiments are being done as to which type of person and social form is wanted.

My hypothesis is that this is only the beginning of the development of creating models of life. What develops here then, are artificially produced forms for a compensatory creation of normalcy and social anchoring. Both opportunities and danger are involved here, which I would like to take into my concluding remarks.

First, the instrumentalization of the social dimension, and the development of a potential redefined cultural feeling, showes consequences for the individual as a systemic technical view of himself. It is a kind of engineering the state of ones own soul.

Second, the danger of permanent dependence on the artificial production of the world of the clinic in the form of a loop. Particularly the discrepancy between normal everyday life and the model of normalcy of the artificially produced formes becomes an ever new problem to be worked upon.

Third, the danger of taking steps in the direction of ones own creating of meaning by compensating for social deficiencies. Such steps, however, are found particularly when they are believed to be anchored in a practical anthropology of mankind, that means assumptions on the nature of man. They are not immune to distortion, and even these terms are very sensible to fascist features. Nonetheless, I am not pleading against artificial production of normalcy in which precisely this normalcy becomes in fact reflective, opening up freedom to act and shape ones own world. But my plead states for systematic awareness and monitoring by public bodies and research institutes, i.e. in the manner of reconstruction as just described here.

An Introduction to Research on Normalization and Everyday Life Intervention

by Sune Sunesson

Introduction

I will take this opportunity to tell you something about what our research group Grävlingen (The Badger) has been doing and what we are planning to do, and I will try to utilize the papers by Regine, Corinne and Mårten just to show how we can use the knowledge that they have shared with us.

Our group and its research work has been increasingly directed towards the area of institutionalization and normalization, and especially interventions to create and mimic everyday life conditions - either by educational or by other devices. Sweden has been the scene of rather deep-going anti-psychiatric discussions, and a great debate about psychiatry started already 20 years ago. At the same time, inmates of all kinds of total institutions started to organize. There were prisoners' liberation groups, organized groups of psychiatric patients, and above all there was a very successful movement that was directed to reforms for the institutions of the mentally handicapped. This went along with a reformist welfare state development. Thus, some of the de-institutionalization efforts were seen not immediately as a way of saving money, but rather as a way of making services much better, and that was the background of reform for the mentally handicapped people and those with learning difficulties.

So the background of the downfall of the great institutions is not only a cynical one, to save money. On the other hand, the fact that it may save money is sometimes seen as an argument against it. However, that argument has not been effective here - it has not blocked the discussion as it has, for instance in Denmark, where everything that saves money has been seen as automatically detrimental by most professionals of the health and social services.

After De-institutionalization

The interesting thing then, is what actually goes on, what is being done underneath the ideologies, and what options that are given to the de-institutionalized people themselves, or their families. What type of influences work in those new or unknown institutional contexts, and what are the conditions of development of different types of organizations within that area? It has been very important for us to attack this with a view upon the organization as dependent upon the environment.

But the theoretical background of organization studies and the studies of the history of locking-up-people has not encouraged environmental approaches. One approach goes like this: We have inherited organizations like the psychiatric hospitals, that are indeed materializations of theories applied to a raw material, on the one hand, that is, patients and illnesses, and on the other hand different interventions and applications of medical psychiatric instruments or tools, to these patients and illnesses. These two sets of kindred theories, the theories of the categories of interventions and the theories of patients and their conditions are materialized in the institutions.

We can call this picture *the hardboiled structuralist* view. This type of theory has great advantages, it is in fact the classical critical theory of anti-psychiatry, but, of course, it is also a rationalist theory that puts the doctor in the centre of world. This type of theory, accordingly, tends to over-rationalize psychiatry.

To understand what actually happens when you break up mental hospitals you may have to add approaches to be able think in other terms, because then what would happen would not be predictable from the same set of presuppositions as those which explains the hospital's functions in the steady state. The same logic of development will probably not continue to dominate all the institutional slivers and splinters that emerge when the hospital is torn apart.

The tearing to pieces of hospitals is one of the processes you can watch now. Mostly it seems to entail that some pieces are broken, scattered and minced, but some other pieces, probably harder ones or more durable ones, continue to exist almost like they were before. A lot of functions like those of keeping people locked up in hospital wards and the old techniques of surveillance and custody have less importance now, but still, some central psychiatric functions continue to exist and even develop further in the new situation. That goes for medication techniques, for instance. So what we often find is a situation where one of the slivers grows into a new organization - that may take the form of out-patients de-centralized services where medication is the most important thing.

Normalization and Care

When you break up the hospital structure, the most important tasks of the services that come to the fore seem to be on the one hand normalization and on the other hand care and protection. The care part of it seems still mostly to be a medical responsibility, but the normalization part is very often taken care of by someone else. Sometimes it's the social services, sometimes it's the looser or less hard nosed part of the hospital structure, or charity and consumer organizations etc. This part has to do with giving the ex-patients somewhere to live outside the hospital. Of course, this is not only a housing problem, a problem of where to sleep when you are released from hospital, it is just as much a problem of how these ex-inmates are to spend their lives, where they are to stay in the day time and what to do. The question then is, what preconditions, what social frames does the environment provide to the organizations which are initiated to normalize or create everyday life for those who have none?

The environment of an organization can be seen as all the other organizations that influence it, by restricting its leeway or telling it what can be done. The influences of the environment work in a number of ways. The control over funding, job opportunities, staff, delivery of patients or ex-patients into the services, and a number of other very material things are heavily influenced by environment control. But there is also another set of problems influenced by the environment. I mean conditions that have to do with the right to speak, the right to say yes or no and to launch claims, the legitimacy of the claims-making. The claims that the organization makes for its turf, its domain, and the way it acts on behalf of its professional interests or the interests of the ex-patients or patients, are also a very important part of its relations with the environment.

The problem of normalization as such, as Mårten Söder points out in his contribution to this seminar, is context-dependent. It has to do with a cultural setting. Sweden and several other countries seem to have a generalized, let us say *modern* view of the disabled. That means adherence to the idea that some of the most important problems that face disabled persons are prejudice, stupidity, and old ways of looking at things. It is not modern or *rational* to have prejudice against the blind, it is stupid and old-fashioned. *Modern* people know that a blind person can be just as good in most jobs as a seeing one, as a company executive, as a cabinet member in Government - doing all right.

When I went to high school, the area where the students came from was very close to a part of Stockholm where many hospitals were and are situated. In school we had pupils both from the so called blind institute, a training institute for young blind people, and from an orthopaedic training hospital. This new rational attitude - "the modern way of doing it" was pointed out to us already when we were children and high school students. Gunilla here has no legs, Sven can't see, but never mind, they are going to be in your French and Latin classes and they will do well. And that was the way we were taught to see it - these people are all-right, it is just that they lack some little detail. That was, of course normalizing, we were a normalizing setting for these students.

The concept of normalization thus has very much to do with political reform and the idea of a modern society that eradicates prejudice and stupidity. That modern view of things produced the expansion of normalizing settings. It started with high schools like mine, but after a while the expansion of settings where normalization could be achieved was a fact and so we came into what Mårten Söder called a "normalizing society" in his paper.

Normalizing the Individual

What these discussions led up to, is that on the one hand we can identify normalizing *settings*, and on the other hand we find methods of normalizing the *individual*. Of course this may create a new problem. Some of the creations by the modern politics of normalization which have to do with normalizing settings are not supposed to be methodizing life, but offer space for development of life. Some of the settings for development in Mårten's examples from institutions and programmes for the mentally handicapped were supposed to show that, and so were several of Corinne's examples in her paper. But on the other hand we have normalized or normal settings that also are combined with very, very deliberate methods of upbringing and discipline.

Home (Normal, educative)	Normalizing context (Normal, non-educative)
Normalizing treatment institution (Non-normal, educative)	Madhouse Lock up, throw away key (Non-normal, non-educative)

Let's make a two-by two table and write "home" in the upper left cell. That is a place where you bring up children, isn't it? Socialization, upbringing, is something that takes place in a normal setting but it still normalizes the individual. Ideologically, the way that you look upon normal socialization has an effect on how you try to create a home life environment, like the one Corinne has told us about, the three bedroom semi, a beautiful metaphor for English normalcy. That is normalizing by taking some of the outer features of normality and create a space for those who hope to become "normal." That is what I have out in the upper right corner of the table.

The non-normal setting where you try to bring up people is the next type, in the lower left corner, as described in several of the examples that Regine has told us about. Education, socialization, like what a parent does with his child, but in a non-normal setting. And of course, the fourth type is the place where no ambitions what so ever are to be found, this is "lock-them-up-and-throw-away-the-key", the extreme form in the lower right cell of the table. This is the Schreckbild, the terror image, that has to do with pre-modern social engineering.

What is Left and What is New?

This is, I think, a way of understanding the institutions that do normalizing work. What separate these types of organizations are not details or mere shades, but substantially important differences.

On the one hand, the two modern forms of education and socialization (non-normal/upbringing and normalizing contexts) are demanded in a situation where the old ways of handling this things are all looked upon as something that has to do with the terror image of madhouses, or the negligence of "home" - as a place where handicapped children were buried and forgotten through the dark ages. The problem then is that these new inventions are, in a way, working with a momentum of their own, and you cannot just understand them as something that happens as a *reaction*, they are not just logical consequences of the development or materialization of theories. But what, then, governs the conditions under which patients are allotted to the different programmes? The three bed-room semi and Anette's new home (in the case Regine Gildemeister's paper mentions), have a relation to what is left of psychiatry, and especially what is left of the old apparatus. These ties may be much more important for the conditions of the inmates than we can believe if we make an abstract analysis. These are empirical questions and I think that they have to do with the different conditions that the environments produce in organizations. It is a very difficult task then, just to orient yourself, to find a sensible way to investigate those things.

Claes Levin of our group made a study that was very interesting in this respect. What he did was to compare an institution that worked according to the AA ideology, that is a very production-oriented treatment-centre for alcoholics. It puts it's focus on the production of sobriety and the production of conscious alcoholics or, maybe, conscientious alcoholics. Claes compared it with an environmental organization, the office of the social services in the town where this little AA-institution was located. The office and the AA-clinic were supposed to cooperate.

He found that he could use some very fundamental ideas from organization theory to understand why the fundamental pre-conditions of these two organizations were so different that the prospect of working together, doing things together, was absolutely utopian. There were fundamental differences, like in the very definition of work - what "work" is. That was something they could not understand over the organizational frontier - one guy was doing something, that is, he "worked", and the other said "you are not even working." They could not find any point of reference that they had in common.

Of course that kind of thing happens very often between all those institutions that take care of what is left after the downfall of the great institutions. A Babylon has been created, normatively and also conceptually.

In accordance with that spirit of Babylon revisited, Ove Mallander is working on what happened after the closing-down of some nursing-homes for severely mentally handicapped and Tord Jacobson works on the alternatives to institutional care for the elderly. Another of the ideas for research that we work on is a comparison between alternative programmes to create or compensate for every-day-life for the so called mentally ill. In that area it is very difficult to understand, just with a quick glance, what is going on, the panorama is so wide.

There are not just two, three or five types of options to these people that are current, instead maybe 25 different types of solutions are in circulation, according to my very limited knowledge. I guess that we would get a very complicated picture if we tried to describe all the different programmes in this sector. That would have to do with the mix of bits and pieces from the old hospital that has been inherited by the new structures. If you smash something and several people try to pick up some of the pieces and build something new of it, of course, these new buildings are going to be very different, and that is in a way what has happened with the bits and pieces of the mental hospital.

The Rights and Needs of the Patient

The only research strategy you could adopt then, is to try to cling to some general problems or concepts. One way that some people have done that is in the immediate tradition of the Italian psychiatry and European anti-psychiatry, that is to look at patient's *rights* and *needs*, just as David Cooper had been doing for the years before he died. He was in fact working on a critical theory of "needs." How are "needs" understood and problematized, how do people formulate needs, how do they define needs for themselves, as compared to social engineering concepts of what people and especially "patients" need?

The problem of "rights" is another one. How do we know what "rights" are, to protection, care, whatever, and how do people themselves seem to define rights when it comes to these things? This of course, is a way of working that has an anthropological leaning. It is not just observing what people do, but trying to understand what elements in their ways of constructing their lives that give us clues to these questions, and then to compare different forms and different solutions when it comes to these fundamental elements in health policy.

Another way would be to go more into what Regine has been doing, as referred to in her paper here, to look upon the ways images of normality and everyday life are constructed. So how do people construct the images of everyday life? Why are some people normalizing lives according to a swimming pool/cafeteria type of everyday life conception and why do some adhere to a work-oriented picture and some to a dish washing/housework conception of normal everyday life? Let's look upon the ways these things are conditioned by the *environment*, by founding agencies, by patient referring agencies and so on. And then we could go on to look upon a number of different ways of solving what seems to be the same problem, and try to understand them in their very complicated context.

This could be done in several ways. We have had a number of discussions about how to find ways of entering the field and how to understand the ways that people are treated in those organizations. An important research question would be to explain and why people want to be treated in so different programmes. Some people seem to prefer what the Germans call "the psycho-social ghetto" (free space, little intervention) to anything else, and even fight for their right to be there, or to engage in movements to develop such solutions. Others fight for their right to be "changed" by treatment and intervention, like psychotherapy.

Some people point to the very interesting result that the recovery rate from what you may call the "ghettos" may be just as good as the recovery rate from some of those very sophisticated programmes. This may be seen as embarrassing for those who have worked there and designed those programmes, and also as a fact supporting a certain "treatment nihilism." This, however, leads us into evaluation problems and comparisons. We rather hope that we can develop the environmental analysis, to find a conceptual basis for understanding the restrictions of actual treatment and care organizations.

Now let's hope that in a year from now our group has made some progress, and that we have something more substantial to tell on the matters of de-institutionalization, normalizing of everyday life and self-determination. Your contributions are a very important source of new ideas.

Self-determination and Self-organization

by Tord Jacobson

About the Concepts

The object for the seminar is to discuss self-determination and self-organization. One reason to choose these concepts as objects for a seminar is that they are important in completed, ongoing and planned research within the Badger group. Another reason is the ongoing academic and politic discussion about these and related topics in Sweden, which I will touch upon later.

A third but not least important reason is the fact that there is still too little written about them, at least outside (moral) philosophy. I have not found the concepts in encyclopedias for social sciences.

Within moral philosophy however, the discourse about self-determination is very long and extensive; names like Thucydides, Wilhelm von Humboldt, John Stuart Mill, John Rawls and Iris Young are well known. For those of us who conducts empirical based research, there are however limitations connected to these theories in the sense that all of them takes constructions of thoughts, like Rawls original position, as points of departure. So, this philosophical discourse is maybe necessary but certainly not sufficient for our purposes.

At the same time every one of us has some kind of more or less intuitive everyday understandings about the content and meaning not only of self-determination but also of concepts and phenomenons like power and powerlessness. But these understandings are all too often incongruent and useless for analytical purposes. Attempts to find a path through this misty field guided with help from everyday understandings could be misleading and dangerous.

What is Self-determination?

We can of course turn to the dictionaries again. Self-determination means autonomy which in turn originates from autos (self) and logos (law) - that is self-regulation. But that translation does not make us much wiser.

One possibly better way to penetrate self-determination is to relate it to concepts, phenomenons and facts of power and powerlessness. We could regard them as components in a continuum with power at one end, powerlessness at the other and self-determination somewhere in between. All of them interrelated to one another but not in a predetermined fixed way and not as a zero-sum game. Not only does the continuum alters size and place but also shape over time and space.

One could argue with reference to Michel Foucault that power is not an object or permanent state of art and can consequently neither be given, delegated nor conquered nor dispossessed, lost or robbed. Probably the same goes for powerlessness and self-determination. Therefore, all of us (not at least researchers) simultaneously are executing power and self-determination and experiencing powerlessness.

Consequently self-determination, power and powerlessness should not be regarded as attributes/characteristics or as specific relations but as parts of all kinds of relations between people and between people and the socio-material structure surrounding them. If that is true, it is a discouraging conclusion because it makes the concepts even more diffuse and hard to get into the core of. This transparency is probably one of the signs of self-determination, power and powerlessness.

John Stuart-Mill identified three provinces for self-determination; first, our inner realm of conscience, for instance freedom of speech and press. Second, our freedom to develop our life-plans, provided that we do not harm others and third, the freedom to make common course.

To Iris Young self-determination means that "all organizations and social institutions shall be organized in order to secure that every participant participates equally and in accordance with democratic rules in all basic decisions regarding the activity." As participants she means persons whose actions directly contribute to the activity and those who we expect to obey the rules and instructions of the institution.

Where do those definitions lead us? The first and third criteria of Mills seem to exist in our societies in varying degrees but certainly not the criteria of Iris Young. Mills´ second criteria of self-determination, the freedom for people to develop their life-plans is I think the most interesting and relevant one for us.

One way to explore that criteria of self-determination could be to ask: What are the limits and possibilities for us to fulfil our life projects? Do self-determination and self-organization occur despite, thanks to or in line with the total societal development? When people give up or hand over self-determination - do they do it voluntary or not? When people tries to increase their self-determination - do they do it for egoistic or altruistic reasons? Is self-determination in praxis dependent of the individuals *in*dependence or some degree of dependency to others? In the latter case - how "much" dependency, and of what kind of dependency?

Obviously empirical investigations can be carried out on different levels and fields; on a psychological, on a social and on a theoretical level in the fields of economy, politics and ideology for individuals, for informal and formal groups/associations or in private, semi-public and public provinces. These examples shows us that demarcations against other more usual concepts in this field are necessary; for example concepts like democracy, responsibility, obligation, compulsion, users' involvement etc.

We also have to consider how the principle of self-determination and autonomy correlates to principles of caring for the weakest and of justice. Self-determination could mean different things within different juridical systems such as compulsion, discipline, and within formal, material and reflexive systems of justice.

The Badger research-group are for normative reasons mostly interested in the conditions for a transition from the existing forms of subordination and superior order to democracy and public life, from liberation to self-determination. We should therefore be aware of the fact that liberation could also bring new forms of subordination and a new superior order into the daylight. Adam Michnik, the Polish author and journalist, reminds us that only the free man can choose what is good - to fight the evilness with power is not only ineffective but also immoral.

Compulsion and control, arms-power, are said to be the most effective form of power. But that is as Sune Sunesson has pointed out only partially true - it is an effective power *over*.. (to do what You already can control). Effective power *over* creates discipline (in forms of whips and panoptic structures) and powerlessness but also resistance, i.e. in situations when people are *unwilling* to obey.

Effective power to achieve something (You not yet have control over) presupposes *either* self-determination, influence and initiatives from the citizens *or* what Foucault called pastoral power or another kind of discipline which offers candy, certificates or salvation, i.e. in situations when people, to some degree, are *willing* to obey - which coincides with, in Weber's terms, legitimacy and authority (Herrschaft) grounded on rationality, tradition or charisma or a combination of them.

Why We are Talking About Self-determination Now?

In Sweden, which is said to be the most extensive and most regulated welfare state in the world, a huge power-investigation is just completed. In 1985 the social-democratic government assigned about five million dollars to the research community and asked for an investigation of power in Sweden. Some of us were very disappointed with the outcome of the investigation: Contrary to their task the investigators, mostly political scientists, did not consider to what extent the citizens could execute influence over their own situation.

They did not come any closer to the citizens than a questionary to about 2000 persons asking them about their *attitudes*, not actual behaviour, to six "roles of citizenship"; as parents, residents, consumers of health care etc. They found very little self-determination but much of what they called "silent powerlessness." But they did not try to *investigate* this powerlessness, which is why some of us present at this seminar, are planning to start such an investigation. The need for it is obvious.

What the power-investigators did do was to argue that we are now (once again) facing the dominance of an individualistic view of democracy. Collective action and decision-making are not on the agenda any more. Now is the time they say, for exactly - self-determination. The state shall intervene as little as possible. The extensive welfare state is neither affordable nor desirable. Our new conservative prime minister cheered, not surprisingly, their conclusions when he learned about the "results".

Is it reasonable to argue that the welfare state has become a prisoner of its own success? That a pessimism concerning the ability of the state to govern is well grounded? Or are those pleadings for self-determination and self-organization just shrewd tactics, a way of organizing bad intentions?

Where Shall We Look for Self-determination and Self-organization?

In what contexts are the possibilities for freedom/self-determination most favourable? Is it in the minimal or withdrawing liberal state where very little is decided upon on the macro level - like Thatcher´s England? Is it in a corporative state where there are a lot of different sometimes competing forums for decisionmaking as in Germany? Or is it a (social-democratic) welfare state where the material problems are few - as in Sweden? "Freedom" could obviously be minimal and maximal at the same time, and concern both freedom-to and freedom-from.

In Sweden nowadays official state goals of prominence are such as ,de-centralization, de-institutionalization, de-regulation etc. Most of the measures begin, as You can see with de- ... One of the preconditions for this policy to become successful in the eyes of the clients is the capability of these well-established institutions to break their "bureaucratic shells" and contribute to a more democratic planning and management of welfare state issues. One possibility is of course that what we are witnessing is a centralization through decentralization.

Another trend which could counter the first one is that different occupations within the welfare state, like social workers, are striving to professionalize their work, to close it from outside influence in order to present only completed, expert-based solutions like physicians do.

One example of welfare state arrangements in Sweden that are subject to reconstruction and where tensions are created, is within the elderly care system. It has despite of recurrent complaints and increasing demands been one of the most successful sectors of the Swedish welfare state, in terms of popular support and confidence. The demands concerns "more" and "better", not self-determination. But as the welfare state are going to withdraw from this sector, arguing that the withdrawal will not only save money but also improve the system, self-organization increases out of necessity. But does that mean that we will also face deterioration? Are bad outcomes automatically the consequence of "bad" plans and vice versa?

Other examples of empirical fields undergoing interesting changes are the caring systems for disabled people, physically and mentally.

Our main focus is self-determination and self-organization within welfare state arrangements and measures, not within the material production or on the labour market. That means that the so called "civil society" will be in focus for our attention. The notion of a desirable civil society has, at least in Sweden, during the last years been opposed to the oppressive social order, planned and realized by politicians and the state. This re-introduced civil society will be strengthened by, nota bene, political measures.

The discussion about civil society has not been so extensive in Sweden as on the Continent. That has changed though, after the downfalls of the old regimes in Eastern Europe. This is understandable as the normative part of the concept has always been connected to a criticism of state regulations and because it has its roots in liberal political values.

That has not however always been the case. In the Latin use, as societas civilis in Ciceros De re publica, it meant state and politics. "Civil society" in English and "sociéte civile" in French are directly connected with the Latin understanding of it. The present Swedish understanding however can be traced to German philosophy and sociology of the last century. It is more similar to the German term "Bürgerliche Gesellschaft" and to Danish "borgerskap". The difference is wether the individual action has priority to the collective one or not, wether freedom and politics are incompatible or not.

But the great transformation and modernization changed these societies. The civil communities (Gemeinschaft) were eroded by the division of labour and lost their importance as focus for identity and safety for the inhabitants. In Sweden self-organized institutions confidently were handed over to the state. In that sense the modern welfare stat is the opposite to the former civil society. People are today totally dependent on the state. On the other hand that dependency has become a too heavy burden to the state. Today the same state which earlier strove to grow is appealing to the individual for relief and despite the fact that, simultaneously tries to keep its exclusive position and dominance. As the political scientist in Roskilde, Denmark, Lennart Berndtsson, says: Only a fool can be surprised over that.

Those who advocates reforms have correctly always pointed out the importance of an effective public sector as a prerequisite for prosperity of the market. Now when the welfare states are facing financial crises they will be even more dependent on a dynamic and expansive market. So welfare states are even more dependent on the economic-technical rationality that is so widely criticised.

An alternative is of course to promote new civil communities, self-determination and self-organization in order to avoid the erosion of the welfare state and the social destruction that seems to follow in the path of individualization. Berndtsson indicates a fundamental issue; whether the antagonism between the progressiveness of individualism within economy and its regressiveness in social society can be resolved. Homo economicus is hard to imagine without homo sociologicus.

The Discourse of Social Work: Normalization Versus the Autonomy of Life Praxis

by Heinz Sünker

Social Work and Normalcy

Social work, taken here as a general definition of that which has long been separately called social work and social pedagogics in the German tradition, must be aware of its social embedment in a particular way. As the logic of its constitution reflects - without merely being a reflex - on relationships that Max Horkheimer in his sociophilosophical and sociopolitical study "Zur Kritik der instrumentellen Vernunft" sees as being characterized by the fact that there are no safety zones on society´s thoroughfares (Horkheimer p. 158).

If the issue of the origins and validity of social work is to be located in social contexts and relationships in this way, this leads to sociohistorically changing problem definitions, problem processing strategies and self-assessments that addresses the problem of societalization and thereby the social nature of the existence of the individual members of a specific society. Unlike the other social sciences or even educational science, this simultaneously reveals a problem of social work that transcends the issues of origins and validity: Socially constituted, the consequence of a societalization pattern permitting the transition from charity to social work, is that social work involves society and the individual.

Thus we have to investigate how social work is localized in the conflict between society and the individual addressed here, or how far social work, since its origins - and to a large extent up to the present - proves to be societally or sociopolitically functionalized in its reference to social normalcy. This reference to normalcy is inherent in the perspective of social existence since the beginning of bourgoise society, although it may evoke the appearance of generelizability from which deviancy can be defined as an individual problem. From a historical perspective, seeds of the approaches toward individuality, which are frequently considered as being new, can already be detected in early bourgeois society. As Dreßen observes:

> In all his papers and experiments, Jeremy Bentham was concerned with this correct behaviour. Domestic peace should no longer only be defended externally through the power of a sovereign but by each individual in opposition to him or herself as well. This required that the leader´s claim to power should be replaced by legitimacy, by legality, that no longer depended on the arbitrary will of an individual but on the ritual of order. Power can no longer be localized in an individual person or in one location, power lies in the system itself, in the normalcy that each person has to obey. Thereby, during the course of industrialization, the resistance of external and internal nature becomes levelled out in mechanized reality, at most, only still exploited as raw material and energy... After the secularization of society, the only standard of happiness or truth that still holds is smooth functioning (Dreßen 1982:104, translated).

We also have to view the point with which Klaus Mollenhauer concluded his study on the origins of social pedagogics in industrialized societies against this background. It is:

> ...the contrast between educational and social scientific, sociopolitical perspectives that are mostly presented as a complementary juxtaposition in the discussion, that is already superseded into the particular structure of social-pedagogic thought. As our historical study has shown, it is namely this thinking that is characterized by the advance of the distinct situation of the individual, over recourse to the causes, to the situation of the entire society. Assistance to the individual in distress was always linked to thoughts on the reform of the preconditions, of the society. In the social pedagogic institutions, the contrast was joined in the form of new constellations of social order, filled with educational meaning and designed according to social purpose and need (Mollenhauer 1959:132, translated).

He saw this as being linked to the need for a positive justification of social work whose theory would be "given with pedagogics in the specific form of a social pedagogics" (Mollenhauer 1959:130).

In recent times, Michael Winkler has both extended and radicalized the issues raised by Mollenhauer in his study on a theory of social pedagogics by assuming that, theoretically, the origins of social pedagogics can only be viewed as a contingent event that has nothing to do with any logic of education that general pedagogics tries to unfold systematically. The difference between general pedagogics and social pedagogics then leads to the realization of the pedagogic problem in specific historical contexts that have shaped the way in which the problem appeared and the activities in response to it.

Between these papers from Mollenhauer and Winkler, which essentially follow the pedagogic discourse, several articles have appeared on the self-image of social work/social pedagogics that have further accentuated the integration of social science, social policy and social work proposed by Mollenhauer from the direction of a theory of professionalization. These are the volumes "Sozialarbeit als Beruf" from Hans-Uwe Otto and Kurt Utermann (1971) and "Gesellschaftliche Perspektiven der Sozialarbeit" from Hans-Uwe Otto and Siegfried Schneider (1973). At the same time the volume "Sozialarbeit unter kapitalistischen Produktionsbedingungen" from Walter Hollstein and Marianne Meinhold (1973) presented articles linking issues from the functional analysis of social work to ideological criticism and generally drawn against a background that assumes that, in present-day society, the social worker is assigned the role of being the agent and representative of the ruling state. This makes the social worker´s task to be responsible for both the material and ideological reproduction of the existing system through the support of its clientele.

Twenty-five years after Mollenhauer´s study, Hans Thiersch and Thomas Rauschenbach considered the fundamental, "intrinsic" difficulties with the object in a textbook article on the theory and development of social pedagogics/social work, and linked this to the conclusion that the state of the theoretical discussion in itself is still unsatisfactory, "split into numerous, scarcely related issues, incomprehensible, and preoccupied with not always productive priorities" (Thiersch & Rauschenbach 1984:985, translated). The question on the "thing itself", the constitution of the object of social pedagogics, which we repeatedly encounter, is not just linked in disciplinary reference to the issue of "disciplinary identity" but simultaneously also to the search for a "guiding science." Thus Thiersch and Rauschenbach call for a theory of social work/social pedagogics "as a theory within educational science, although an educational science that, in turn, is oriented toward the social sciences and is conceived in terms of social theory as well as action theory" (Thiersch & Rauschenbach 1984:1009, translated).

In summary, this line of discussion still contain problems on its agenda that should be analyzed as questions on the relation between theoretical discussion and disciplinary identity, theoretical discussion and the heterogeneity of "praxis", on guiding science and the observable changes in educational science and their consequences for social pedagogics/social work.

At the same time, when regarding theoretical conceptions and the answers they contain to the question of self-image, it is necessary to clarify a broad contradiction, as Franz Hamburger has formulated it:

> How, namely, a discipline and its profession expanded in a basic mood that can be called euophoric and simultaneously drew its underlying knowledge from theories that demonstrated their lack of function, their repressive character, their contribution to stigmatization, and their own need for assistance. Thus, we are dealing with the paradox that a thorough criticism of professional social work is the foundation for an optimistic generation of students and college teachers who are open to change and motivated to act (Hamburger 1986:20, translated).

In his "Philosophy of Right", Hegel presents an analysis of bourgeois society that deals with the consequences of the pattern of societalization for the existence and constitution of the members of bourgoise society. This includes the form and content of the interrelationships of the members of this society that finds a specific expression in their autonomy - only to be related to self-determination in an abstract way - as individuals. The external relationship of autonomous individuals to one another that is simultaneously expressed here (see Hegel 1955, §§ 182, 183) leads to both structural and behaviorally relevant contradictions because of these preconditions:

> In these contradictions and their intervening, the bourgeois society offers the drama just as much as the exes of the misery, and the physical and moral ruin that they both have in common (Hegel 1955, § 185).

In this 1959 study, Mollehauer pointed out that, originally, social pedagogics defined its own roots and perspectives by interpreting the situation of bourgeois society as "cultural decline" and seeing its task as a "comprehensive social regeneration" that would make "all the people the object of education" (Mollenhauer 1959:121-122, translated).

Social pedagogics/social work thus mislaid its object from its very beginnings by referring to supposed promodern forms of community and the "renewal of the people´s life" (Mollenhauer 1959:122, translated), while - as Hegel´s analyses shows - bourgoise society produces its own contradictions. In my opinion, this mistake has led to social pedagogics´ individualizing approach toward that which as "generality" (allgemein) - and thereby as reason - cannot unfold concretely (and comprehensively) in the individual existence in the bourgeois society, in turn, needing to find its professional and profession-justifying perspective in work on the establishment of normalcy and adjustment - if necessary, this is given a philanthropic foundation as in the case of enlightenment pedagogics and its followers.

Complementary to the above-mentioned pedagogical discourses, we find the systematic location of a second line of discussion that addresses the constitution of the object of social work, and whose contributions can be compiled under the label of social work and social policy. In this context, social work is defined as a politically inherent form of social practice (Müller & Otto 1980:8-10); whereby this political intrinsicalness is innate to social work. If it is correct that the most functional reference of state social policy is the reproduction of the capitalist formation of society determined by private realization of capital and free labour, then social policy is "the state processing of the problem of the continuous transformation of non-wage earners into wage earners" (Lenhardt & Offe 1977:101, translated). Each specific form of politicalization or de-politicalization of social work must be explained within the context of the specific historically restricted conflictual or critical solution (or nonsolution) of this problem.

If social policy is thus the "active design of the process of proleterianization" (Müller & Otto 1980:8, translated), then social work is "a specific strategy by which the state secures the existence of wage labour" (Müller & Otto 1980:9, translated). Because the existence of wage labour is an extremely improbable form of human existence, its retention requires highly complex and differentiated structures, and it requires extreme preconditions in cultural, social and personal terms; it must be "normalized as duty" and "installed as obligation" in complex processes (Offe 1983:51, translated). The existence of wage labour is thus full of risk and prone to malfunctioning and greatly threatened by frictions and crisis. As social policy is concerned with designing the process of proletarianization so that it runs as smoothly as possible, limited means must be organized so that the real social effects remain supportable or are accepted and/or adopted by those concerned.

Social policy - and its extension, social work policy - therefore has to find answers to crises of motivation and meaning, of rationality and finance, to the crisis of legitimation.Securing the loyalty of the masses through the support of the welfare state represents one of the possible system-intrinsic answers in this context (see Narr & Offe 1975).

The current problematic situation of social work can be interpreted as an interface of complementary and contradictory critical trends. Social work faces the twin pressure of the state´s financial crisis and the sociocultural crisis of meaning and motivation. The dramatic escalation of legitimation problems that this has caused leads to an increasing pressure regarding legitimation in the praxis of social work. The current debates on "alternative professionalization", "utility-value-oriented social work policy" and "de-professionalization" can be viewed against this background.

These recent discussions appear to find their object in the current conflict in a criticism of the regulations of the welfare state in diverse political and scientific publications that is expressed in terms of "bureaucratization", "economization" and "legalization" - though with decisive semantic differences. Social pedagogics/social work is insofar particularly affected by this way of discussing the "crisis of the welfare state" because, as a discipline, it has greatly exploited the expanded institutionalization of social assistance in its expansion from a marginal discipline to a central and systematically organized element in the welfare state (see Clarke 1979, Wolin 1987, Blau 1989, Lynn 1990, van Krieken 1990).

For this reason, Max Horkheimer and Theodor W Adorno (1947) have argued in the "Dialektik der Aufklärung" in the chapter "Kulturindustrie" that we are now seeing the establishment of a type of welfare state on a higher level:

> However, the culture industry reflected the positive and negative care for those administered as the immediate solidarity of persons in the world of achievers. Nobody will forget, everywhere there are neighbours, social workers, Dr Gillespies, and naive philosophers with their hearts in the right place who will make healable single cases from the socially perpetuated misery through good-willed intervention from person to person, so long as the personal depravity of those concerned does not stand in the way (p 179).

Against the background of such a discussion directed toward social theory and social policy, new contributions have since arisen that base their considerations on current social dynamics and developmental trends in the societalization type that are directed toward using social policy to overcome the instrumentalization of social work linked to the "proletarianization premise."

This focuses attention on the possibilities of relativizing the instrumentalization of social work through a regulative social policy in order to achieve a new definition of the reciprocal relationship. Decisive in this context is the goal of a change of perspective in which "social policy" is contrasted with an alternative of "politics of the social." Instead of focusing on regulation and accumulation as defined in capitalist theory (see Kotz 1990), this uses structuring and forming approaches to individuals to set the task of conceptualizing a reproduction-oriented social work from subjectivity (see Diemer 1989, Redaktion "Wiedersprüche" 1989).

In a social situation that can be interpreted as a transitional phase between Fordism and post-Fordism, it is necessary to find the "starting point of a nonvoluntary, subject-oriented social policy as well as a social work/social pedagogics" (Schaarschuch 1990:133, see Sünker 1989) with the concept of reproduction, that is, of the reproduction context of the entire society in its concrete historical expressions.

The Separation Between Social Pedagogics and Social Work

Issues to be localized in this context that focus on the question of the constitution of the object of social work and its perspective of "focusing more on the subject" are thereby not viewed as an extension of those previously performed on the "people´s life." This is also shown by a further look at the history of the discipline in which the earlier separation between social pedagogics and social work is seen to be conspicuous and requiring explanation.

The traditional understanding of social pedagogics as social education, that is, as education to community or sociability in contrast to individual education proposed by Karl Mager (1844) contrasts with the position of Adolf Diesterweg (1850) for whom the link between pedagogics and welfare becomes a problem and need through involvement in the "social question" (see Kronen 1986, Roeßler 1986).

Picking up on this tradition, there have been occasional attempts to integrate pedagogics and welfare, whereby frequently the ontologization of social assistance to existential "care" and "welfare" should serve as a foundation. This can be illustrated through the application of the "help concept" in Alas Fischer:

> For the first requirement of moral and spiritual help is that the one in need of help wants to be helped, and in conjunction with this, is convinced that he or she can trust that the helper is able and prepared to give that help unselfishly and sincerely (Fisher 1954:319, translated).

This approach shows that the contradiction in the institutionalized process of social assistance as an institutionalized process is inherent and characterizes the entire professionalization process of social work. The socialization of "assistance" - to describe it as a consequence of the dissolution of traditional milieus and communities and of social differentiation processes in modern society (see e.g. Luhmann 1973) - leads, on the one hand, to a doubling of assistance and control and, on the other hand, to professionalization. Fischer´s idea has recourse to an understanding of assistance that is replete with references to "community", "proximity" and anthropological constants, and must therefore, in turn, systematically miss its object as a consequence of not understanding social processes of differentiation.

On the basis of the historical-systematic form of the institutionalization process of social assistance that focuses on processes of inclusion and exclusion, pedagogics, which had played a decisive role in the helping concept - above all, conveyed through the concept of maieutics - played hardly any further role in the discussion on social work. The institutionalization process of social assistance in its forms, contents, and consequences primarily becomes the object of problems that are dealt with within the theory of professionalization (see Otto & Utermann 1973, Otto 1973, Dewe & Otto 1984). This leads to a split in social work:

> On the one side were the mainstream social workers who pursued their traditional goal of professionalization. They....followed an individual-change, therapeutic model of practice;....On the other hand were social workers whose careers were generally a direct result of the country´s economic problems....(They) were more interested in effectively implementing public welfare programmes than in doing therapy with

> clients,....The latter group was sharply critical of the former group´s professional aspirations (Popple 1985:565, see also Gilbert & Specht 1976:288).

The one modern differentiated society of complementary self-autonomy of efforts at professionalization that, in a reductionalist way, focuses on a profession and not on comprehensive problems of the constitution of the object and its processing, has in the meantime led to a general criticism - which is not just related to social pedagogics/social work - of expert knowledge and expert actions.

This criticism focuses on the thesis of the expertocratic and therefore expropriating and interdicting mantle of the professional-client relationship. One result of this analysis and criticism is the demand to take the behavioral autonomy of the client seriously or to utilize its constitutive significance for the processing of problems.

J Rosenfeld has representatively expressed a widely held position on this in his work "The Domain and Expertise of Social Work":

> In social work there is a clear hierarchy of solutions. The most desirable solution is to help people in need deploy their own resources: for example, they become self-sufficient through employment or become protective of their children by gaining understanding that they had not previously had. The next most desirable solution is to make resources available to people in need through their existing social networks,....A final solution in this hierarchy is to be used when these kinds of provider systems are not available. Then social workers strive to mobilize societal resources (Rosenfeld 1983:187).

In a general social theoretical and more far-reaching reading of the problem, the autonomy of life praxis to be supported is contrasted with the risk of a colonization of the life world (see Sünker 1989b:83-132); this discusses the treatment of the individual.

Habermas has drawn the conclusion from this situation that professional activity should give itself the task of being an:

> ....interpretative mediation between expert knowledge and the everyday practice in need of orientation. It is left with the illuminating demand that it must support the comprehensive self-understanding process of a life world that simultaneously must be protected from the objectifying, moralizing and aestheticizing assaults of the culture of experts (Habermas 1987:434, translated).

With regard to the question of the perspectives of social work, my thesis is that more precise level of explanation of a solution could be introduced into the discussion on behavioral autonomy, the autonomy of the life praxis, just as in the problems represented by colonialization from the context of professionalization theory against the background of the above-mentioned reconstruction of the facettes and segmentations of the disciplinary discourse.

For the mediation between subject theory and professionalization theory needed here can lead to the view within this social-theoretical and sociopolitical context that the concept of the autonomy of life praxis, that is, subjectivity, which is diametrically opposed to that of colonialization and social control, is linked to the fact that the hopes for rational potentials contained in this idea of the communicative rationality of the life world and the educability and rational potential of all can thereby also be released with the help of professional activity. This could also lead to a relativization of the thesis found in Habermas that talks about an everyday praxis in need of orientation, in that this is rightly posited against or as a supplement to expert cultures.

Furthermore, reference should be made here to the Anglo-Saxon debate on "self-determination", whose origins lie in casework concepts (see e.g. the papers in McDermott 1975) and discussions on professional ethics (see Holland & Kilpatrick 1991). It should be pointed out here that very different interests are involved and very different conclusions are reached in this debate. Major differences are named by McDermott:

> But whether the obligation to refrain from coercing or manipulating the client should be regarded as stemming from a fundamental right or technical principle for achieving certain social work goals is the point at which controversy breaks out. And the issue is further complicated by the fact that those who acknowledge that the client has a right to self-determination tend to disagree on whether it is a right to self-determination in the ordinary sense of the word or some idealized version of the concept (McDermott 1975a:7).

This confrontation between proponents and critics of the self-determination approach continues until the present day. Vehement advocates of this approach - alongside the classic casework - such as Gilbert and Specht, who justify their position on criticism of the "advocacy approach", proceed from the assumption that:

> Instead, the old-fashioned, ethical social worker perceived that his clients, although perhaps social victims, were nevertheless self-determing people who, given appropriate respect, support and opportunities, could decide what was in their best short-term and long-term interests (Gilbert & Specht 1976:292).

And they reached the conclusion that:

> ...there is a broad area of social work practice in which clients are capable of making choices but are not always knowledgeable about opportunities available for exercising a choice. Professionals can facilitate client self-determination by maximizing these opportunities (Gilbert & Specht 1976:292).

Rothman (1989:598) begins his text on the concept discussion with a sharp criticism: "Client self-determination may be the most confounding and professionally debilitating concept of all the intellectual principles undergirding social work." Correspondingly, he considers it to be urgently necessary to overcome what he calls "this befuddlement in regard to a fundamental practice concept of social work" (Rothman 1989:608).

He also sees a clear solution: Because intervention "is guided by a professional who is charged by society to produce beneficial outcomes that are based on objective, knowledge-driven analyses and judgements", the responsibility for action is in the hands of the professionals. To put it even more strongly: "But the centre of gravity, from the standpoint of structuring practice, lies with the professional rather than with the client" (Rothman 1989:208-209).

McDermott takes an intermediate position between these extremes that discusses the problems and perspectives in dealing with the concept. On the bases of an analysis of the breadth of the meaning of self-determination, he reconstructs the use of the term - however, without basing it on social theory - in order to conclude that in social work this is related to "social functioning" or to being "socially acceptable" (McDermott 1975b:124). Analog to the use of "normalization", "community" or "integration" found in the German discussion, this international approach to social work theory also concerns the idea that "a self-determinated life is a virtuous one" (ibid:125). He sees the principle challenge of self-determination to be to accept the legitimacy of a behaviour that goes against the expectations of society. McDermott therefore considers that:

> The function of the principle is to remind the social worker that he is not morally free to compel or manoeuvre another human being into acting against his own wishes without strong countervailing grounds for doing so (McDermott 1975b:131).

Several tasks result in the light of these considerations: First, this concerns a social scientific and educationally based (Bildungstheorie) reformulation of the old "help concept" that seriously considers the element of dialogue in helping and educational action and simultaneously defines its location in the social objectification process. Second, links have to be made to considerations on the relation between free will and determination, between self-determination and dependency, that discuss this issue in social-theoretical and sociopolitical contexts.

The Individual and Society

If the reconstruction of elements of the - internally divided - discourse on social work has made it clear that the segment known as "social pedagogics" should be criticized because of the erroneous relations to society that have entered it, and the segment known as "social work and social policy" because of the functionalization it contains, and both together because of being directed toward "normalization", then the perspective of a subject-oriented social work, which should overcome the relationship between professionals and clients and extend a "politics of the social", is faced with the task of relating this approach to contributions to the theory of bourgeois society - above all, in the shape of a materialist everyday theory - and a critical educational theory (Bildungstheorie) (see Sünker 1989a, 1989b, 1989c).

In this, subject orientation specifically does not mean centring on the individual - in the sense of an extension of the atomistic existence of the individual in the bourgeois society - but focusing on the mediation between individual and society. This considerations is based on the interest in regarding persons - with full consideration of their varying potentials - as actors within and in conflict with structures/social relationships. This means that the relation between self-determination and agency should be considered. The approach can be compared to the views expressed by Giroux in his article "Theories of reproduction and resistance":

> Whereas reproduction theorists focus almost exclusively on power and how the dominant culture ensures the consent and defeat of subordinate classes and groups, theories of resistance restore a degree of agency and innovation to the cultures of these groups (Giroux 1983:260).

Supplemented by the presentation of the contradictions of bourgeois society found in Hegel, this becomes particularly controversial today. On the one side of the individual, this essentially concerns that which was always inherent to bourgeois capitalistic society: the process of individualization - which once more makes it clear that autonomy and self-determination do not have to merge. Also if the history of the bourgeois society and the history of capitalist relations do not merge, nonetheless - as mentioned by Horkheimer (pp 128-161) - the rise and decline of the individual is included in the history of the relationship between the two. The atomistic and atomized existence of the individual is a consequence of the capitalistic societalization pattern that can be compared to the alternative idea of the "association of free individuals" that was already sketched by Marx.

In the course of sociohistorical process, the individuation of the individual is increasingly driven forward in bourgeois society. This tends to replace the perspective of real individuality, which is conscious of being socially and intersubjectively conveyed, with an individualism that is not to be equated with the realization of the individual but ends in privatism, egoism and consumerism. This also explains why Lefebvre (1972) calls the present formation of society a "bureaucratic society of directed consumption."

For issues of autonomy, self-determination, or dependency, Lefebvre´s conclusion remains essential in this context: "Autonomous activities have since been replaced by attitudes" (Lefebvre 1975:243, see Sünker 1992).

Against this background and in this situation, it is necessary to ask which possibilities for professional activity remain or open up in the field in social work (see Brunkhorst & Sünker 1985). The perspective of a subject-oriented social work presented here is therefore bound not only because, from the professionals´ perspective, this would call for an awareness of the socially transmitted constitutive conditions of its object but also of their subjectivity and agency in any case. A specific change of profession theory consequently includes the conceptualization of "action competence" (see Müller et al 1982, 1984).

The professional who is characterized by action competence understands his or her task in the field of social work as a maieutic one, in other words, as a release of that which is suggested in the discussion on the life praxis, which goes beyond self-determination and agency, but is not yet realized. If this idea of the autonomy of the life praxis of all who have to be supported by professionally instigated educational processes and interfaced through the orientation toward social justice - thereby transcending the level of interaction - is taken seriously, then the task of formulating the political productivity of social work is once again on the agenda.

Reference list

Blau, J (1989) Theories of the Welfare State, in Social Service Review.

Brunkhorst, H, Sünker, H (1985) Strategische Alternativen kommunaler Sozialarbeitspolitik, in Neue Praxis 15.

Clarke, J (1979) Critical sociology and radical social work: problems of theory practise, in Parry et al (eds) Social Work, Welfare and the State, London.

Dewe, B, Otto, H-U (1984) Professionalisierung, in Eyferth et al.

Diemer, N (1989) Für eine "Politik des Sozialen", in Wiedersprüche 9 (H 31).

Dreßen, W (1982) Die pädagogische Maschine. Zur Geschichte des industrialisierten Bewußtseins in Preußen/Deutschland, Frankfurt.

Eyferth, H, Otto, H-U, Thiersch, H (Hg) (1984) Handbuch der Sozialarbeit/Sozialpädagogik, Neuwied.

Fischer, A (1954) Die Problematik des Sozialbeamtentums, in Leben und Werk, Bd 3/4 "Gesammelte Abhandlungen zur Soziologie, Sozialpädagogik und Sozialpsychologie", hg von K Kreitmaier, München.

Gilbert & Specht (1976) Advocacy and professional ethics, in Social Work 21.

Giroux, H (1983) Theories of Reproduction and Resistance in the New Sociology of Education, in Harvard Educational Review 53.

Habermas, J (1987) Metaphysik nach Kant, in Cramer, K et al, Theorie der Subjektivität, Frankfurt.

Hamburger, F (1986) Schwerpunkte der neueren sozialpädagogischen Theoriediskussion. Bd 4 der Schriftenreihe des Pädagogischen Instituts der Universität Mainz, Mainz.

Hartwich, H (1977) Sozialstaatspostulat und gesellschaftlicher Status quo, 2, Aufl., Opladen.

Hegel, GWF (1955) Grundlinien der Philosophie des Rechts, Hamburg.

Heller, A (1984) Everyday Life, London.

Hollstein, W, Meinhold, M (1973) Sozialarbeit unter kapitalistischen Produktionsbedingungen, Frankfurt.

Horkheimer, M o J (   ) Eclipse of Reason, New York.

Kanz, H (1986) Bildungsgeschichte als Sozialgeschichte, Frankfurt.

Kilian, H (1971) Das enteignete Bewußtsein. Zur dialektischen Sozialpsychologie, Neuwied.

Kotz, D M (1990) A Compperative Analysis of the Theory of Regulation and the Social Structure of Accumulation Theory, in Science and Society 54.

Krieken van, R (1990) Soziale Kontrolle im Abseits: Zur Erklärungskraft der historischen Soziologie des Wohlfahrtsstaates, in Sozialwissenschaftliche Literatur Rundschau 13 (H 21).

Kronen, H (1986) Das Auftauchen des Terminus 'Sozialpädagigik', in Kanz.

Lefebvre, H (1972) Das Alltagsleben in der modernen Welt, Frankfurt.

Lefebvre, H (1975) Metaphilosophie, Frankfurt.

Lenhardt, G, Offe, C (1977) Staatstheorie und Sozialpolitik, in KZfSS: Sonderheft.

Luhman, N (1973) Formen des Helfens im Wandel gesellschaftlicher Bedingungen, in Otto & Schneider.

Lynn, L E (1990) The Rhetoric of Welfare Reform, in Social Service Review.

McDermott, F E, ed (1975) Self-determination in social work, London.

McDermott, F E, ed (1975a) Introduction.

McDermott, F E, ed (1975b) Against the persuasive definition of self-determinaton.

Mollenhauer, K (1959) Die Ursprünge der Sozialpedagogik in der industriellen Gesellschaft, Weinheim.

Müller, S, Otto, H-U (1980) Gesellschaftliche Bedingungen und Funktionsprobleme der Organisation sozialer Arbeit im Kontext staatlichen Handelns, in Sozialarbeit als Sozialbürokratie? Zur Neuorganisation sozialer Dienste. Neue Praxis: Sonderheft 5.

Müller, S, Otto, H-U, Peter, H, Sünker, H (1982) Handlungskompetenz in der Sozialarbeit/Sozialpädagogik I, Interventionsmuster und Praxisanalysen, Bielefeld.

Müller, S, Otto, H-U, Peter, H, Sünker, H (1984) Handlungskompetenz in der Sozialarbeit/Sozialpädagogik II, Theoretische Konzepte und gesellschaftliche Strukturen, Bielefeld.

Narr, W D, Offe, C (1975) Wohlfahrtsstaat und Massenloyalität, Köln.

Offe, C (1983) Arbeit als soziologische Schlüsselkategorie, in Matthes, J Krise der Arbeitsgesellschaft, Frankfurt.

Otto, H-U (1973) Professionalisierung und gesellschaftliche Neuorientierung. Zur Transformation des beruflichen Handelns in der Sozialarbeit, in Otto & Schneider.

Otto, H-U, Utermann, K (1971) Sozialarbeit als Beruf. Auf dem Weg zur Professionalisierung? München.

Otto, H-U, Schneider, S (1973) Gesellschaftliche Perspektiven der Sozialarbeit, 2 Bde, Neuwied.

Otto, H-U, Sünker, H (1991) Volksgemeinschaft als Formierungsideologie des Nationalsozialismus. Zu Genesis und Geltung von "Volkspflege", in Politische Formierung und soziale Erziehung im Nationalsozialismus, Frankfurt.

Popple, Ph R (1985) The Social Work Profession: A Reconceptualization, in Social Service Review 59.

Redaktion "Wiedersprüche" (1989) Sozialpolitik oder Politik des Sozialen. Anmerkungen zum analytischen Zugang zu einem Politikfeld, in Wiedersprüche 9 (H 32).

Roeßler, W (1986) Zur Geschichte des Befriffes 'Sozialpädagogik', in Kanz.

Rothman, J (1989) Client Self-Determination: Untangling the Knot, in Social Service Review.

Rosenfeld, J (1983) The Domain and Expertise of Social Work: A Conceptualization, in Social Work 28.

Schaarschuch, A (1990) Zwischen Regulation und Reproduktion. Gesellschaftliche Modernisierung und die Perspektiven Sozialer Arbeit, Bielefeld.

Sünker, H (1989) Subjectivity and Social Work, in Education 40.

Sünker, H (1989a) Bildung, Alltag und Subjektivität. Elemente zu einer Theorie der Sozialpädagogik, Weinheim.

Sünker, H (1989b) Heinz-Joachim Heydorn: Bildungstheorie als Gesellschaftskritik, in Hansmann & Marotzki, Diskurs Bildungstheorie II, Weinheim.

Sünker, H (1992) Everyday life, in Szell (ed), Concise Encyclopedia of Participation and Co-Management, Berlin/New York, forthcoming.

Thiersch, H, Rauschenbach, Th (1984) Sozialpädagogik/Sozialarbeit: Theorie und Entwicklung, in Eyferth et al.

Winkler, M (1988) Eine Theorie der Sozialpädagogik, Stuttgart.

Wolin, S (1987) Democracy and the Welfare State, in Political Theory 15.

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Socialhögskolan
Box 23
221 00 Lund
046-10 70 00