TOWARDS A SOCIAL THEORY
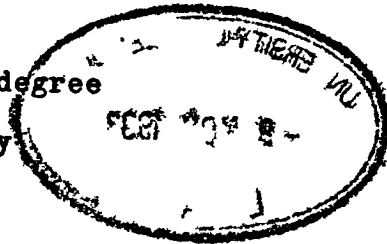
OF MENTAL HANDICAP

by

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SUMMARY

Traditionally, medicine and psychology have characterised
mental handicap as an objectively diagnosable condition of the
individual, in no way affected by society. Sociologists have
reacted against this dominant paradigm by developing labelling-
theory accounts of how individuals and state agencies can create
and maintain the category of handicap by stigmatization and
differential denial of social resources, and there have been
attempts to see the category as a functional one for indust-
rial societies. However, these ahistorical accounts do not add
up to an adequate sociology of retardation.

Tracing the history of the condition, as the core of this
thesis does, we find that it was not identified as a distinct
'social problem' in the West until the development of industrial
capitalism. The key event appears to be the introduction of
compulsory education, which .resented to a state committed to
universal education a group of 'ineducable' children. The
reactions to this 'discovery', however, must be construed as part
of a whole culture and ideology, and the thesis traces the
parallel development of scientific conceptualisations, popular
attitudes and treatment provisions in the light of economic
relations. (The historical analysis necessarily confounds
industrialisation with the growth of capitalism, but limited
cross-cultural material suggests the latter as the crucial
variable.) The main aim of the thesis is to illustrate the
importance of history for sociological theory.

The thesis also considers the necessary role of micro-
sociology and psychology in building a social theory of mental
handicap which accounts for the experience of individuals as
well as the structures of society, and Chapter 7 describes three
studies illustrative of what could be done. However, micro-
sociology cannot provide a sociological understanding without
a historically informed macro-sociology within which to locate
it.

CHAPTER 1

INTRODUCTION: SOCIETY AND MENTAL HANDICAP

The Mental Health Act 1959[1] defined mental subnormality
as a state of "arrested or incomplete development of mind".
Two sub-categories were identified:
(a) severe subnormality: "a state of arrested or incomplete
development of mind which includes subnormality of
intelligence and is of such a nature or degree that the
patient is incapable of living an independent life or of
guarding himself against serious exploitation, or will
be so incapable when of an age to do so".
(b) subnormality: "a state of arrested or incomplete
development of mind (not amounting to severe subnormality)
which includes subnormality of intelligence and is of
a nature or degree which requires or is susceptible to
medical treatment or other special care or training
of the patient".

This study is concerned with a single major question –
how can sociology contribute to our understanding of
mental subnormality?   (For a critical discussion of the
existing sociological literature see section 2 of
Chapter 2).   The main argument of the thesis is that
the dominant social-scientific model of mental handicap
is inadequate.   In order to understand the role and
status of mentally handicapped people in capitalist
society, and the role of social policy within the problem
of mental handicap, it is necessary to develop an
historical and macro-sociological perspective on these
questions. At the same time I argue that this must be
complemented by a micro-sociological examination of
attitudes towards mentally handicapped people, at the
individual and community level.   It is my intention to
demonstrate that the existing sociological literature does not
provide a theoretical framework that enables us to
understand mental subnormality as a social phenomenon.

Currently available studies are dominated by a medical
model which has been taken over by psychologists working
within the main-line tradition of clinical psychometry,
and this informs most current micro-sociological research
in the area - which is either epidemiological, examing
the problems encountered by families with a mentally
handicapped member, or looks at the 'labelling' consequences
of diagnosis but is static and uncritical.   (See Chapter 2
Section II; Chapter 8 offers a more critical discussion).
Separate from this is the study of changing provision
for the care of mentally handicapped people, which has
been mainly concerned with the effects of liberal pressure
groups on government and the growing awareness of the $p \cdot \cdot \cdot$
harm which incarceration in residential institutions
can cause.

It is my contention that we can better understand
both how the mentally handicapped 'achieved' their
current status and why governments have adopted different
policies at different times if we adopt a historical
perspective which centres on changing socio-economic
circumstances.   Thus the development of a sociological
perspective will initially involve a historical and
comparative study of individuals whose mental capacities
mark them as 'outsiders' unable adequately to fulfil
societal expectations of 'normal' behaviour.
Consequently the role/status of mentally handicapped
people will be examined in the light of historical changes
in attitudes towards and social policy provision for
the mentally handicapped.   Following Scull, I intend to:-

> "... develop an historically informed macro-
> sociological perspective on the interrelationship
> between deviance, control, structure, and the
> nature of the wider social system of which they
> are both a part and an essential support"

and to   .

> "... demonstrate the superiority of explanations
> which focus directly on the complex dialectical
> interplay between transformations in the social
> control apparatus (and thus in the shapes and
> forms of deviance) and change in the wider
> social system." [2]

Thus a major objective of the study will be to examine
the relationship between different socio-economic
conditions, attitudes towards mentally handicapped
people and social policy in this area.   This will
enable us to understand the relationship between societal
and individual attitudes towards the mentally handi-
capped, social policy priorities and the dominant
ideology of a society.

A subsidiary purpose and complementary aspect of
the thesis is a micro-sociological examination of
attitudes towards mentally handicapped people.
Here I contend that the 'problem' of the mentally
handicapped, at least in Western industrial societies,
is in fact two different problems:-
(a) There is the mainly macro-sociological problem of
the treatment, care or placement of the mentally handi-
capped individual by and in a welfare-state society which
has decreed that every 'normal' citizen shall be
educated to a certain minimum standard and be expected
to maintain himself or herself at a certain level of
health and well-being by obtaining paid employment,
at a certain minimum standard of competence, and which
therefore finds itself with the responsibility for those
who fall short of this level in any respect.
(b) Secondly there is the mainly micro-sociological
problem of the attitudes of individuals and local
communities to mentally handicapped people - to some
extent a problem for themselves, particularly in areas
where hostels are to be set up, but in many ways even
more a problem for their families, who suffer not only
from actual prejudice, but also from an expectation of
prejudice fostered in them by cultural attitudes to
mentally handicapped people, which they themselves
frequently share.

An interactionist perspective at the micro-level
is more or less adequate for understanding the individual
and family problem, though macro-level historical processes

shape our shared attitudes. However, in order to
understand social policy towards and public provision made
for the mentally handicapped, only a historically based
sociological perspective can fully cast light on how the
problems arise, though micro-level sociological analysis
is still of relevance because the attitudes and
experiences of individuals are shaped by and do feed
back into their culture. In any case we have not fully
understood a phenomenon, as sociologists, unless we can
tackle it at both levels.

> "What social science is properly about is the
> human variety, which consists of all the social
> worlds in which men have lived, are living, and
> might live ... this requires that our work
> be continuously and closely related to the
> level of historical reality - and to the meanings
> of this reality for individual men and women". [3]

In the next two chapters I look at currently
available sociological research and at the medical and
psychological models of mental subnormality which inform it,
and point out what I see as shortcomings. The following
three chapters demonstrate what can be gained from the
historical approach to the understanding of mental
handicap as a social phenomenon. Chapter 4 covers its
sketchy treatment in pre-industrial society. In Chapter 5
I discuss the changes that occurred in the nineteenth
century with the growth of compulsory schooling and
devleopments in the twentieth century leading up
(in Chapter 6) to an evaluation of what are currently
regarded as priorities in the area of mental handicap
care and provision. Chapter 7 is a complementary micro-
analysis, examining attitudes towards the mentally handi-
capped at an individual and community level; it contains
a report of three small and illustrative ethnographic
(qualitative) studies undertaken by the author, as well
as a review of the research literature. Finally,
Chapter 8 attempts to synthesise the various strands of
the earlier discussion into a viable sociology of mental
handicap.

It is important for me to point out that social
policy issues are not a major focus of this thesis.
I do not see it as the role of the sociologist to engage
in social engineering. However, I think I succeed in
demonstrating that much current discussion and research
by sociologists, and indeed psychologists, in the field
of mental handicap, start from ill-theorised premises
and is therefore doomed to produce unsatisfactory solutions.

REFERENCE NOTES, CHAPTER ONE

1: Since the 1959 Mental Health Act alternative 'official'
   definitions of mental handicap have been put forward
   which suggest that severe mental handicap and mild
   mental handicap should be regarded as different points
   along the same continuum and that behavioural as well
   as intellectual factors should be stressed. The extent
   to which this has resulted in changes in the way they
   are handled is discussed in Chapters 5 and 6. The most
   recent definition is the one contained in the Mental
      Health (Amendment) Bill 1982, introduced in the House
   of Lords in November 1981:

> To subnormality or severe subnormality there shall
> be substituted references to mental impairment or
> severe mental impairment....
> 'Severe mental impairment' means a state of arrested
> or incomplete development of mind which includes
> severe impairment of intelligence and social function-
> ing and is associated with abnormally aggressive or
> seriously irresponsible conduct on the part of the
> person concerned....
> 'Mental impairment' means a state of arrested or
> incomplete development of mind (not amounting to
> severe mental impairment) which includes significant
> impairment of intelligence and social functioning
> and is associated with abnormally aggressive or
> seriously irresponsible conduct on the part of
> the person concerned.

2: Scull, 1977 P11

3: Mills, 1959 P146 (Penguin Ed. 1970)

CHAPTER 2

SOCIOLOGICAL WORK ON MENTAL HANDICAP:
A REVIEW OF LITERATURE

1. Introduction

This chapter reviews briefly a selection of the
rather scanty work undertaken by sociologists in the
area of mental handicap. The next chapter critically
discusses the dominant clinical and psychometric models
which have not only provided the framework for most
psychological and sociological research in the area, but
also the underpinning to social welfare provisions for
the mentally handicapped in Britain and other Western
industrial societies. Together these two evaluations
demonstrate the lack of an adequate sociological framework
within which we can understand the role and status of
mentally handicapped people - an essential preliminary
to empirical research in the field.

One of the initial puzzles in studying mental handicap
is the widely varying terminology, historically and presently,
between Britain and the United States. It is usual, now
to distinguish between two classes - 'severe' subnormality
and a 'mild' or 'high-grade' variety.' Consequently, as
a preliminary to disucssing the sociological contribution
to date it will be necessary to clarify the terminology
used (see section 1.1 below). Thereafter I look at the
growth of concern with mental handicap among sociologists
stimulated by: (i) the results of epidemiological studies
which demonstrated a markedly unequal distribution of
mild mental handicap among the social classes, (ii) the
growing dissatisfaction with biological and psychological
models of deviance, and (iii) the development of dynamic,
interpretive perspectives in sociology. Section 3 of the
chapter evaluates theoretical formulations of the problem
of the mentally handicapped and empirical research deriving
from these. Finally section 4 reviews sociological

research into social policy towards the mentally handicapped, which demonstrates the inadequacies of current provision for care and re-education but lacks the theoretical framework to offer much in the way of a sociological understanding of the phenomenon itself.

1.1 A Note on Terminology

It is necessary to stress at the outset that the terminology used in the field of mental handicap is very confused. There is no agreed international terminology, and words no longer used officially are commonly retained in everyday speech.

The origins of the words commonly used to refer to mentally handicapped people, at least until recently (see Table 2), are in the languages of ancient Greece and Rome. The word 'idiot' is of Greek origin and 'imbecile' of Roman, but it is more recently that they became terms specifically referring to mentally handicapped people. Idiot originally meant a private person, or one without a public office. It suggested a person set apart from society with the connotation of a non- or extra-social individual, a person who lived in a world of his own, more or less outside society. In English law, from the Middle Ages until the end of the nineteenth century, 'idiot' referred to a person of unsound mind, of whatever description: a person incapable of caring for himself or his property or of fulfilling the ordinary duties required of him by the state. (See chapters 4 and 5 for a more detailed historical analysis). Imbecile, in Ancient Rome, was used to describe a person with any form of disability. It was only much later that it came to have a more restricted meaning - referring to severely subnormal people. Words now commonly translated as 'Fool' were used in Ancient Greece and Rome. 'Fool' was used to describe people we would now refer to as mentally handicapped as well as those who were mentally ill. A 'fool' was frequently 'kept' by the wealthy for the amusement and entertainment of the household.

Table 1: Simplified Chart of the Classificatory terms
in use or recommended for use in England and
Wales, 1913-1971[1a]

			FEEBLE-	MORAL
1913 Mental Deficiency Acts	IDIOT	IMBECILE	MINDED	DEFECTIVE
(Hospital terminology for grading wards)	(Low Grade)	(Medium Grade)	(High Grade)	(Sometimes refractory
World Health Organisation I.Q.	0-19	20-49	50-60	
(1957 Royal Commission		Severely subnormal		(Sometimes Psychopath
1959 Mental Health Act	Severely subnormal		Subnormal	
1971 White Paper	Severely mentally handicapped		Mildly mentally handicapped	
				(& others
1971 Education Act	E.S.N.(S)		E.S.N.(M)	

Table 2: Equivalent English Language terms used in
Mental Handicap[2]

General Terms	Categories	I:Q. Equivalent
Mentally handicapped Mentally retarded Mentally defective Mentally subnormal	High Grade Subnormal Feebleminded Moron Mildly retarded E.S.N.(M)	50-70
	Medium Grade Moderately retarded Imbecile E.S.N.(S)	25-49
	Low Grade Severely retarded Idiot Ineducable	0-24

Two more recently coined terms that have been used
for certain mentally handicapped people are 'feeble-
minded', and 'moron', a term invented by Goddard in the
early part of this century to refer to the mildly
subnormal.

In England and Wales prior to the 1959 Mental
Health Act the terms 'idiot', 'imbecile' and 'feeble-
minded' were used to refer to degrees of handicap - the
severely, the moderately and the mildly subnormal respect-
ively.   The official terminology since 1959 has been
'mental handicap', as a generic term, with 'subnormal'
and 'severely subnormal' being the sub-categories.
Since the 1972 Education Act children (under 16 yrs)
have been referred to as 'Educationally subnormal (mild)'
and 'Educationally subnormal (severe)' - the latter being
those previously referred to as 'trainable' with the
connotation. that they were ineducable.   (See Table 1).

In the United States, prior to the acceptance of
the terminology recommended by the American Association
on Mental Deficiency, the term 'moron' was used as an
equivalent for the term 'feeble-minded', and 'feeble-
minded' itself was used to refer to all mentally handi-
capped people.   Now the term 'mentally retarded' is in
general use, having replaced 'mentally deficient'.
(Table 2 summarises the main terms that have been and
are used to refer to mentally handicapped people.)

In this thesis I intend, in general, to use the
English terminology - 'mental handicap' and 'mental sub-
normality' and 'mild' and 'severe' to distinguish between
what is usually regarded as the two major categories.

The important point to stress, and a significant fact,
is that none of this terminology is neutral.   Indeed,
it is only within the last ten years that it has become
normal practice when referring to mentally handicapped
people to recognise that they are indeed 'people' - part

of the human race.[24] Furthermore, all the words in common use convey a notion of diminished status and of stigmatization and imply that the labelled person is less than 'normal', not fully human. They provide stereotypical images - ones that carry with them the notion of certain undesirable characteristics and the lack of other more desirable ones. (See section 3 below). This is reflected in and reinforced by the way in which words like 'moron', 'idiot' and 'fool' are used as terms of abuse and derision. Indeed, there is no available neutral terminology in the field, as is the case with the terminology used to discuss other deviant and minority groups.

2. The Growth of Sociological Concern

As I have already stressed, research in the field of mental handicap has been dominated by biological and psychological models. This is because, at least until recently, the 'cause' of the handicap has been seen as inherent in the individual and therefore of little interest to sociologists as such, except for the evaluation of social policy objectives and alternative forms of care within a clinical perspective. (Chapters 3 and 8 develop these points more comprehensively). This evaluative research, which has only developed in the last thirty years, has in general concentrated on studying one stage or another in a mentally handicapped person's life-cycle, pointing to the problems experienced by them, by their parents, and by the community in 'coping' with them and their handicap, and pointing also to the inadequacies and 'failings' of the public welfare services which process and provide care for them.

However, in the same period, a few sociologists have attempted to step outside the clinical model and. develop sociological perspectives. This growth in interest has been stimulated by three separate but related developments. Firstly, epidemiological research has discovered that cases of mild mental subnormality are almost exclusively

found within the manual working class.   Secondly,
biological models of human development have been challenged
with the development of theories that stress the importance
of environmental factors in the development of intelligence.
Thirdly, there have also been theoretical developments in
sociology and especially in the area of deviancy theory.
Before briefly reviewing these developments I will clarify
the important distinctions made between biological and
social (genetically inherited and environmental) causes
of mental handicap.

2.1   The Biological and the Social

The categorization of the mentally handicapped into
sub-categories is usually based on psychometric tests,
although social competence - that is, the ability to
cope adequately in the community as judged by 'experts' -
is also a relevant factor.   Categorization of this type
is mainly for administrative convenience, for determining
the placement of the   people ascertained as mentally
handicapped.

A different method of classifying mentally handicapped
people, and one that has especially stimulated sociological
interest, is one based on assumed aetiology.   It has become
an axiomatic (but not totally unquestioned) fact that
there are two main types of mentally handicapped people:
those whose mental subnormality is the result of specific
biological factors (even if these cannot be detected)
and those whose mental subnormality results from
the inheritance of 'inferior' genes and/or environmental
influences - frequently referred to as 'subcultural type'.
Indeed, Sarason and Gladwin[3] have suggested that we should
use different terminology when referring to these two
groups - the former should be called the mentally defective
and the latter the mentally retarded.   .

The argument for distinguishing between the two
groups is reinforced by the widely accepted assumption
that while all societies recognise and react to the

severely mentally handicapped, it is only with
industrialization that the mildly mentally handicapped
are seen as different and managed as deviants.
This development appears to be closely related to the
introduction of mass schooling - the majority of the
mildly handicapped are labelled as educationally sub-
normal while at school, but once the period of formal
education is completed they apparently merge with the
rest of the population. (This offers the possibility
for sociological anlysis of labelling and this is
developed in section 3.2 below).

However, the argument that mild subnormality is
socially and historically relative has not gone unchallenged.
Edgerton[4], in a review of the limited anthropological
research, argues that 'stupidity' as opposed to more
severe mental handicap is recognised in the vast majority
of societies - non-industrial as well as industrial.
As Ryan[5] has pointed out:

> "Although there is scope for much greater
> cultural relativity than is usually appreciated,
> especially as regards how the stupid are treated,
> this does not mean that there will be no stupid
> people in an ideal society, nor that differences
> in competence will cease to be socially
> meaningful. Every society for which there
> is information has its inept, however variously
> that is defined. Societies vary, however, in
> what skills are required and what social support
> there is for those who, for whatever reason, cannot
> acquire any such skills. Trying to understand
> how our society has produced the ones it has,
> both as regards the number defined as subnormal,
> and the stigma, and the actual conditions of
> existence of so many people ..."

It would seem to me that the important consideration
is not that 'stupidity' (mild mental handicap) is
'discovered' or at least comes to be regarded as a
social problem at the time when a society industrializes,
but that what is regarded as 'incompetence' is to some
extent culturally relative. *'Subnormality'* is a
social category, and in fundamentally important ways
the social problem of mental handicap is created by

a society as a consequence of the demands and expectations placed on individuals. While it is probably correct to say that a considerable number of those labelled as mentally handicapped in Western industrial societies could function quite adequately in less complex and demanding social systems, this does not mean that in some ways they are not 'really' differentially equipped.

2.2 Epidemiological studies of Mental Handicap

Epidemiological studies provide information on the determinants and distribution of mental subnormality in the population. Although, as Morris[6] has pointed out, epidemiological research itself does not require the specialised skills of the sociologist, the starting point for much sociological research in mental handicap has been epidemiological.

Sociologists have become interested in the epidemiological finding that, while organically caused mental handicap is fairly normally distributed throughout all social classes, mild non-organic subnormality is concentrated in the manual working class.[7]

> "... in an industrial society, parents of severely subnormal children are evenly distributed among all the social strata in the society, while those of mild subnormal subjects come predominantly from the lower social classes ... mild subnormality ... is virtually confined to people in lower social categories."[8]

This social class bias has been shown to exist by a number of studies in both Britain and the United States.[8a] In addition to this 'discovery', epidemiological studies have revealed a number of other interesting factors for sociologists: for example, that minority and working class children are over-represented in the mildly mentally handicapped category; children who come from disrupted homes and exhibit problem behaviour are more likely to be labelled than those from normal homes or with 'normal' behaviour; the school is the main labelling agency for the mildly subnormal - diagnosed subnormality is highest in

the school years, and lower amongst the pre-school and
adult populations.

These findings, as well as reinforcing the arguments
for distinguishing between biological and social categories
of mental handicap, have provided an impetus and starting
point for sociological research.   The sociological
input has been in attempting to explain the 'causes'
of these statistical differences, and to a limited extent
in questioning the validity and reliability of the
findings.   However, the only major empirical sociological
research which has attempted to account for and explain
the epidemiological findings on the racial and social
class distribution of mild mental subnormality in Western
industrial society is a small study by Mercer in the
United States.   (This study is briefly reviewed in section
3.3 below).

2.3   The Challenge to the Biological Model
A further factor which encouraged the development of
sociological interest was a questioning of the assumption
that mental handicap was caused *solely by biological/
genetic factors* and was inherent in the individual.
In the late nineteenth and early twentieth century
degeneracy and eugenic theories had become dominant and
it was accepted that mental handicap (when there was no
obvious cause) was the result of the inheritance of 'low
intelligence' genes.   However, by the 1950's environmental,
cultural and social factors began to be regarded as
increasingly important in 'causing' mental handicap,
especially mild subnormality.

An important theoretical statement of this development
is to be found in a review article by Sarason and Gladwin[9]
published in 1958 – one of the first systematic attempts
to establish the social aspects of mental handicap. [9a]
The article critically reviews and evaluates the existing,
mainly psychological research, as well as suggesting
possible directions for future investigation.

They argue that mental handicap is a social and cultural problem in addition to being a biological and psychological one. Attitudes towards mentally handicapped people, they suggest, are culturally determined and are based on criteria of what is and what is not socially acceptable behaviour. This is demonstrated, they argue, by the fact that in Western society mental subnormality is a large social problem, statistically and emotionally, while in most non-European societies it is inconsequential and confined to cases of severe pathological defect.

As a result of their analysis of the literature they conclude: (i) that mental handicap is culturally relative; (ii) that intelligence tests are culturally biased, testing only the ability to deal with the types of problem solving tasks set in schools, and (iii) that a low I.Q. does not reflect the future intellectual or social potential of children. They therefore suggest that future research must be concerned with at least two distinct but related areas: the aetiology of subnormality - both individual and environmental - and the ways in which society defines, processes, reacts to, and attempts to cope with those it labels as mentally handicapped.

The importance of this article lies not in its conclusions or indeed in all its arguments[10], but in the issues it raises and in the suggested directions for future research. Indeed, the major theoretical and empirical development in the sociology of mental handicap has been concerned with the labelling process.

2.4 Theoretical Developments in Sociology

Research by sociologists in the field of mental handicap has grown since the 1950's, when it began to be realised that they could contribute to an understanding of mental handicap as a social phenomenon and critically evaluate welfare provision. However, few sociologists have seriously challenged the dominant medical models and attempted to develop sociological perspectives, although theoretical developments within the discipline have led

some researchers to believe that there is a possibility of doing so.

In the early 1950's Mendeholm[11] and Perry[12] published separate articles pointing to the need for sociological research to supplement the existing psychological and medical research. This concern has echoed down the years since, especially in the United States, where there is apparently far more research into all aspects of mental handicap than in Britain.

Mendeholm[13] suggested three areas into which sociologists could research: the attitudes of the public towards mentally handicapped people; the problems faced by families with a mentally handicapped person as a member; and the effectiveness of community care programmes for the mentally handicapped. In 1964 Kurtz[14] argued that sociological research could help to bring about a more social perspective on the understanding of mental handicap. Sociologists should concentrate on epidemio-logical studies, research into attitudes towards mentally handicapped people, and research into the ways in which mentally handicapped people interact with non-handicapped people. Ten years later Rowitz[15] was still stressing the same need:

> Sociological research should be concerned
> with epidemiological studies of service use,
> patterns in different service dealing systems
> and the family in the community.

The main role for sociologists has, then, been perceived as one of evaluating social policy provisions and has accepted the proposition that

> Mental retardation is a clinical problem
> susceptible to sociological analysis.[16]

The inadequacies of this approach and the need for sociologists to step outside of the medical perspective has been acknowledged by a few sociologists[17] but as Booth[18] has stressed:

> Few sociologists have tried to make sense
> of mental handicap. For the most part they
> have been content to study one stage or another
> in a retarded person's career through life
> without attempting to step outside the
> meaning attributed to subnormality by
> clinical definitions.

The major exceptions are researchers who have examined mental handicap within what I will broadly refer to as a deviancy perspective; in the majority of cases they have been specifically concerned with the mildly subnormal. They have worked within a phenomenological framework and been heavily influenced by 'underdog' perspectives.

Thus the development within sociology, in the United States in the 1950's and in Britain in the 1960's, of dynamic, interpretative models of human behaviour, and more specifically Symbolic Interactionism, stimulated Verstehen studies of mentally handicapped people as 'underdogs'. Studies have subsequently been made of the way in which society 'creates', labels and structures the career of the mentally subnormal. These studies have also been concerned to explain the concentration of the mildly subnormal in racial minority groups and the manual working class and to stress the inadequacies of clinical definitions.

In Chapter 8 I will discuss the contribution that these studies, theoretical and empirical, can make to the development of a sociological perspective on mental handicap. In the rest of this chapter I intend to review the literature which I consider to have contributed to our understanding of mental subnormality as a social phenomenon and which appears to suggest possible approaches or insights for the development of a sociological framework within which to reach an understanding of mental handicap.

3. The Deviancy Approach

While the extent to which the mentally handicapped should be regarded as deviant can be questioned (and I discuss this point more fully in Chapter 8), nevertheless the main theoretical developments and bulk of empirical research by sociologists have been heavily influenced by the new deviancy theories, and especially labelling theory. The one recent theoretical contribution to the understanding of the role/status of the mentally subnormal not within this tradition is nevertheless heavily influenced by the ecological research of the Chicago School and functionalist sub-cultural theories and concludes that the mentally handicapped, especially the mildly subnormal, are part of the surplus population-members of the 'culture of poverty'.

3.1 The Mentally Handicapped as part of the surplus population.

Farber[19], within a broadly functionalist perspective, attempts to develop a sociological framework within which to understand the role/status of mentally handicapped people in industrial society. The three-fold aim of his study is (i) to indicate how the retarded play an important role in maintaining the existing social structure, (ii) to analyse previous social research, and (iii) to suggest avenues for further investigation.

The main thesis of Farber's study, and the one that is of interest for the development of a sociological perspective, is that the mentally handicapped, as part of the surplus population, play in important role in maintaining the existing social structure - that is, they are functional to the maintenance of the system. The marginal population is comprised of the old, the sick, the disabled and the culturally deprived as well as the mentally handicapped - in short, *all those groups of people* that can be seen as 'surplus' to the smooth economic functioning of industrial society. It arises out of organisational needs; organisations attempt to maximise

efficiency and output, and these groups are seen as
being incapable of 'adequately' performing productive tasks.
However, this population is regarded as functional to
society in three ways: they generate a number of specialised
institutions which create jobs; they make possible the
effective operation of the basic social institutions;
and they aid in the perpetuation of the existing system
of social stratification.[20]   .

The mentally handicapped become part of the surplus
population because of their incompetence and as a result
of being labelled deviant. But the very presence of a
surplus population 'creates' the need to justify the
classification of groups of people as 'surplus' - in
the case of the mentally handicapped as being intellectually
incapable of adequately performing adult social roles,
and to develop procedures for identifying and classifying
them - in the case of the mentally handicapped, psycho-
metric tests. Farber suggests, however, that the two
factors generally assumed to determine the social life
chances of mentally handicapped people, the condition
itself and/or the consequences of being officially
identified, are only contributory factors and that:

> "Actually, this situation probably emerges from
> the 'need' for a labour surplus in a production
> system based on rational placement of personnel.
> This surplus is especially apparent at the
> unskilled, semi-skilled and service occupational
> levels, which are sensitive to fluctuations in
> demand in production. For these slots, there
> are always more candidates in the population
> than there are slots available. This surplus was
> present in the early stages of industrialization,
> and with the growth of automation, is even more
> prevalent today.[21]

Drawing on the epidemiological studies and arguing
that intellectual development is the outcome of a complex
interaction of genetic, physiological and socio-cultural
factors, he points to the fact that mild subnormality is
most frequently associated with other characteristics
which can operate to prevent incorporation in the dominant

culture.   These include coming from an ethnic minority group, from a low socio-economic background and/or from an unstable family.   Indeed, these other social handicaps can affect life chances as much as being labelled mildly subnormal, as other individuals from these backgrounds, who have never been labelled mentally handicapped, also have a tendency to become part of the surplus population.   Farber argues that this is because certain groups in society are isolated from the dominant culture and consequently only learn the 'private' culture of their own group - a 'culture of poverty'. Secluded from the major institutions of the 'public culture', even the genetically and physiologically capable fail to develop norms, attitudes and values essential for active participation in the dominant culture.   This sub-culture becomes self-perpetuating, because the children of those who have 'failed' to learn the dominant culture are socialized into the alternative culture - the culture of poverty.

Furthermore, Farber argues that it is because of the organizational need, in modern industrial societies, for a surplus population, that inadequate resources have been allocated to the alleviation of the problem. Thus,

> ... to maximize efficiency the organisation of modern society demands a surplus population in order that its selection procedures may work. The techniques that modern society has developed for dealing with the mentally handicapped have been insufficient, probably because society is motivated to maintaining them as a surplus population.[21a]

Farber suggests that regarding the mentally handicapped as part of a surplus population has the advantage of both incorporating and superseding the two dominant perspectives on mental handicap.   During the latter part of the nineteenth century and the early part of the twentieth century the mentally handicapped came to be regarded as deviant in a biological sense, and mental

subnormality was assumed to be closely associated with
other forms of deviant behaviour, especially criminality.
As a result the mentally handicapped were seen as a
'genetic threat' to the rest of society, and a group
from whom society needed to be protected.   More recently,
Farber suggests, the mentally handicapped have been cast
in a sick role and this has led to a concentration of
resources into research on possible 'causes' of mental
handicap and attempts to 'treat' the subnormal.
Both these approaches concentrate attention on the
individual and his assumed pathology; Farber points to
the importance of social factors in the 'creation' and
'sustaining' of the mentally handicapped as outsiders in
industrial societies, and suggests that they are likely
to remain 'outsiders' while the need for a surplus population
continues to exist.

   This analysis does represent an important step forward,
but there are a number of theoretical and practical
problems with it.   One can level the same criticisms
against Farber's approach as against the functionalist
approach to other social problems: its assumption of a
shared set of norms and values, the ignoring of conflict
and power, an ahistorical approach and a taking of the
social system as a given in which the members of society
are required to operate the role/statuses connected with it.
Thus his analysis ignores the class nature of capitalist
societies, and the possibility that deviance, including
mental handicap, is only functional within a particular
ideological framework which itself contributes to the
maintenance of the socio-economic system.

   Furthermore, his acceptance of the 'culture of poverty'
thesis means that he 'blames' the marginal population
for their outsider position and does not examine the way
in which structural inequalities perpetuate poverty,
rather than the attitudes and values of the poor.

As a consequence of this he confuses a 'rejected population' with a 'marginal population'. The latter can be seen as a group who can be brought into productive work when they are needed and forced into unemployment when they are no longer required. Migrant workers fulfil this role in some capitalist societies, and possibly women. However, in industrial societies the majority of the mentally handicapped as well as. the old and the sick have been rejected - as groups incapable of adequately performing work tasks. The final problem with Farber's analysis is related to this. He appears to argue that all the mentally handicapped are part of the 'surplus' population. In one sense this may well be correct, but the severely handicapped are not only currently 'surplus' to requirements but also have not been able to perform economic tasks in less complex societies. It may well be correct that they way in which our society cares for the mentally handicapped and our attitudes towards them are shaped by their inability adequately to perform productive economic roles, but to lump the mentally handicapped together with other marginal groups does not appear to provide an adequate explanation. This is at least partly accounted for because Farber's account is ahistorical. We need to ask when the mentally handicapped first became labelled as outsiders and managed as deviants, who has the power to label and in whose interest it is to label them as deviant.

3.2 Labelling Theory

Much recent deviancy research has been centrally concerned with three foci: deviancy is seen as a subjective reality, as a process and as a consequence of societal and self-reactions. Attention has shifted from looking at the 'causes' of deviant behaviour, and moved to looking at the way in which individuals are labelled as deviant and their subsequent careers. Sociologists have been able, within this perspective, to look at who defines certain behaviour as subnormal and at the subsequent 'career' of the officially labelled person, and to try to

understand what it is like to be 'incompetent' and/or
to be a parent of a mentally handicapped person.[21b]

Dexter: A theoretical framework

Dexter[22], over a period of some thirty years, has
in a number of articles and a book attempted to develop
a sociological perspective on mild mental subnormality,
within a deviancy framework. His theoretical paradigm
is derived from symbolic interactionism and specifically
its development in the sociology of deviancy by Lemmert
and Becker.

Although he does not commit himself on the nature/
nurture debate[23] he does accept that environmental factors
are extremely important for intellectual development.
He stresses the need for sociological research into the
cultural and environmental determinants of intellectual
retardation and development, and he seems to suggest
that at least some mild subnormality is the result of
inadequate socialization.

However, he is more concerned to examine the way
in which individuals come to be labelled as mentally
handicapped and the consequences for the individual of
being labelled. He points to the fact that the school
is the main labeller of mildly handicapped people and
concludes that mild mental subnormality is 'created' by
industrial societies, mainly because of the demands of
the educational system.

> I have, I believe, established a 'prima facie'
> case for believing that mild retardation,
> garden variety retardation, is a serious
> problem in our society chiefly because it
> challenges values of the school and school-
> connected institutions. [24]

In an industrial society there is an emphasis on rational
efficiency and an associated assumption that verbal and
written skills are a necessary and sufficient qualification
for obtaining work. Those who are unable to achieve

minimum levels of literacy and numeracy are therefore
unable to take up adult roles, because of their
'failure' in school, even though they might be able
adequately to perform 'adult' social and economic tasks.

Dexter argues, then, that the introduction of mass
education and the spread of the protestant ethic 'created'
a large proportion of the mildly mentally handicapped.
Furthermore, he suggests that the school only labels
a proportion of eligibles (that is, those with I.Q's
below 70) and that non-labelled eligibles are able to
cope adequately in adult roles because they have never
been labelled mentally handicapped. Once labelled as
mentally handicapped the individual faces two main problems
in industrial society. Firstly, in the field of employment
he is restricted to low-grade, low-paid manual work,
and frequently faces unemployment. Secondly he experiences
role conflict. He is seen as incapable of managing his
own affairs and frequently referred to as a child, and
on the other hand those responsible for his care often
treat him as if he were sick or a prisoner. Further-
more, as a consequence of having been labelled and being
treated as mentally handicapped the individual develops
a negative self-image. Thus

> The socially acquired picture of self is
> 'the looking glass self' [25]

Dexter has pointed to the way in which industrial societies
create the 'problem' of mild mental subnormality and
the vital role played by the school in this process.
However, he does not offer an adequate explanation
of why it should be so unacceptable for a group to
challenge the values of the school and education in
industrial society. But his conclusions concerning
the consequences for the individual of being labelled
are open to question. On the one hand empirical research,
in both the United States and Britain, suggests that the
majority of the mildly subnormal merge with the rest of
the population on leaving school On the other, there is

a strong possibility that many of those who require help in coping with the demands of everyday living from welfare agencies would be eligible for labelling as subnormal if they were officially assessed.   It is also likely that many of these individuals were not officially labelled and managed as subnormal while they attended school.   (The inadequacy of Dexter's theoretical perspective is discussed more fully in Chapter 8).

While Dexter himself has not tested the adequacy of his theoretical analysis empirically, Abliza-Mirranda et al[26] have carried out a study in Puerto Rico to test the hypothesis that mild mental handicap is 'created' by industrial societies, that retarded behaviour is the outcome of having been officially labelled and that the 'fate' of the labelled subnormal in any society is a result of the attitudes of that society towards stupidity.

The unique position of Puerto Rico as a developing society (in the process of transition from a non-industrial to an industrial and from a rural to an urban society) enabled the researchers to examine attitudes to the subnormal in a non-industrial society and an industrial society, and to see to what extent industrialization 'created' the problem of mild mental handicap.

In rural Puerto Rico the peasants do not distinguish a 'subnormal' class but rather think of themselves as all being 'stupid' in comparison with the small group of literate people who are seen as intelligent - that is, those who have, as a consequence of their privileged position, had or have access to books and schooling. 'Stupidity' is, then, regarded as a consequence of not having received a formal education, rather than as an inability to be 'successful' in the school system. Thus, while in rural areas fifty percent of the population test out on psychometric tests at a level that would make them 'eligible' to be labelled as mentally handicapped, only the severely handicapped are seen as different.

> The poverty ... is more bearable in that it is
> considered the root rather than the result of
> stupidity ... It is palpably obvious that the
> poor's lack of opportunity perpetuates
> stupidity. That many of the poor might not
> be able to take advantage of opportunities is
> masked. Only in a society where opportunities
> are available can one become aware of differential
> responses. [27]

The researchers were also able to look at the 'fate'
of eligibles, in terms of I.Q. score, for the label of
mental handicap in the urban areas. They found that
measured intelligence was not a good predictor of social
and/or occupational 'success'. The results of a sample
survey, when generalised to the total population, indicated
that while probably 31.6% of the population had an I.Q.
score that made them eligible to be labelled mentally
handicapped, only 3.2% of the male popualtion were
subnormal if a measure of social competence - in this
case the ability to cope adequately in a given environment
as assessed by the researchers - was used as a criterion.
Twice as many of those with 'subnormal' as those with
normal I.Q. scores 'failed' to adjust adequately to the
demands of urban society. However, a considerable
number of those with subnormal I.Q. scores did adjust and
others with I.Q. scores in the normal range did not.

> What distinguishes the retarded from the normal,
> then, can be viewed as the ability of the normal to
> adjust to the urban, complex society as compared
> with the comparative inability of the retarded
> to make this adjustment. Similarly, the
> successful retardate is characterised by
> this similarity to respond in this respect. [28]

They argue that the important factor in bringing about
adjustment to the urban environment is not I.Q. level but
self-image. Individuals with an autonomous self-image
were found to be highly tolerant of frustration, had an
ability to take advice and were emotionally stable,
whereas those with dependent self-images demonstrated
the opposite tendencies. The former adjust to an urban,
industrial society while the latter fail to do so.

As a result of their research they conclude that the
incompetent behaviour and adjustment 'failure' of the
mildly retarded is a consequence of their having been
labelled as incompetent and not vice versa. Being
labelled subnormal results in the development of negative
and dependent self-images, which hinder social adjustment

Although this empirical study appears to give
considerable support to Dexter's theoretical framework,
that mild mental handicap is 'created' as a society
industrialises because of the demands of the school system
and the labelling of individuals as 'incompetent' by
official agencies, its method is open to question. It is
difficult to see how a third of the population could be
'really' mentally handicapped, and it seems likely that
I.Q. test results reflected the limited amount of education
that most of the sample would have received, and cultural
familiarity with the concept of 'doing tests'. However,
as I will attempt to show later in this thesis, the
introduction of mass schooling is an important factor in
the 'discovery' of mild mental subnormality and the con-
sequent development of attitudes towards and treatment of
the handicapped.

Cultural Relativity and Mild Mental Handicap

Mercer [29] is another who points to the importance of
the educational system in 'creating' mild mental handicap
because of the way in which it selectively labels children
as incompetent. Within a social systems perspective
rather than a clinical one, she develops the thesis that
the school system in the United States 'creates' the
problem of mild subnormality by labelling as retarded those
children who 'fail' in the system's terms and have 'low'
intelligence test scores. These children, she argues,
are not seen as inadequate or subnormal in their own
communities.

This conclusion is based on the findings of a small
empirical study of children in the school system in
Riverdale, California. The survey design utilized was

two-pronged - an agency survey and a field survey,
in order that clinical/psychological definitions of
mental retardation could be compared with community ones.
All agencies with a responsibility for defining and labelling
mentally handicapped children were asked to list all
the mentally handicapped children they were aware of
in the city.   This produced a list of children who had
been clinically/psychologically labelled as mentally
handicapped.   Secondly, individuals living in the
community were asked to nominate memebers of their own
family or neighbourhood that they considered to be
mentally retarded.

The epidemiological findings tended to replicate
those of other surveys.   The agency lists contained,
especially among those labelled as mildly retarded, a far
higher proportion of children from racial minority groups
and/or low socio-economic backgrounds than would have
been expected from their proportions in the total population.
However, those nominated by individuals living in the
community tended only to be the more obviously/severely
retarded and came from all sections of society in
approximately the expected proportions.

The main aim of Mercer's theoretical analysis is to
explain these findings within a sociological framework.
This, she suggests, is necessary because mental subnormality
does not exist as an 'objective fact'; people are only
retarded when they are so labelled by official agencies
and/or members of their community.   Furthermore, the
line between subnormal and normal is arbitary, socially
determined and culturally relative.   Consequently the
clinical perspective, which locates subnormality as a
condition which objectively exists within the individual
and is clinically/psychometrically diagnosable, is
inadequate.   A social systems perspective, however,
enables mental handicap to be seen as an acquired social
status, defined by its location in the total social system

vis-a-vis other social statuses, and by the role
prescriptions that define the type of 'performance'
expected of people labelled as intellectually subnormal.

Mercer argues that society cannot be regarded as a
unified whole with everyone sharing a set of norms and
values, but is made up of a number of sub-groups or
cultures, each with its own set of norms and values.
The norms and values of one sub-culture may well differ
from and even conflict with those of another, including
those of the 'core' middle class culture; it is the
latter set which are embodied in the school system.
The school, then - one of the main agents of labelling
the mildly retarded - has a set of norms and values that
conflict with those of children from many ethnic minorities
or low socio-economic backgrounds. The school values
academic success while the home does not. This explains
why children seen as 'normal' in their own communities may
be labelled as incompetent in the school system and
relegated to a 'special' school.

Mild mental subnormality is thus seen as an achieved
social status, whose perception and definition is
relative to the expectations placed on individuals by the
society/community in which they live. A retarded person
is one who has been successfully labelled - and an individual
labelled as 'incompetent' in one sub-culture in society may
not be labelled as such in another. Psychometric tests
and clinical instruments used to diagnose subnormality are
not, then, objective measures but codifications of middle
class behaviour and reflect the 'core' culture of advanced
industrial society.

Mercer has once more highlighted the role of the
school system in 'creating' mild mental subnormality.
Like Dexter she is arguing within a labelling perspective
that mild mental subnormality is 'created' by the
requirement in advanced industrial society that all citizens
should receive a formal education. They would not be

thought of and treated as incompetent if the school did
not label them as retarded. (As with Dexter's, this is
both a strength and a weakness of her approach).
She also assumes, rather than demonstrates, that being
labelled as 'incompetent' in one or more social insti-
tutions, while not being considered 'stupid' in one's
own neighbourhood, influences an individual's self-
perception and subsequent development.   Furthermore, she
does not consider that the terms she used in her survey
may not convey the same meaning to individuals in the
community as to official agencies.   The school may
classify all children with a tested I.Q. below 70 as
retarded, while the community image of mental retardation
may only encompass the more obviously and severely handi-
capped.   They may think of children in their family or
neighbourhood as 'bad' at school, 'backward' or slow in
learning, but not as mentally retarded.

Finally, while Mercer argues that there are a number
of sub-cultures including a 'core' middle class culture
in industrial societies, she does not place them in a
class society. Thus while arguing that the school embodies
and reflects middle class norms and values, and has the
official power to label children as retarded, she does not
ask where this power is derived from, or where the middle
class core value system derives its ideology from -
that is, what determines the norms and values of the
dominant culture, and more specifically why intellectual
ability is so highly valued in these societies.   These
questions need to be considered if a sociological per-
spective on mental handicap is to be able adequately to
account for the role/status of all mentally handicapped
people.

Mercer's and Dexter's work has demonstrated the way in which
mild mental handicap is a socially negotiated category (though
they tend to ignore or to avoid those cases where individuals
whose I.Q.s put them in the mild range obviously 'look' differ-
ent), but they have problems in conceptualising 'primary deviation'.
Both are ambivalent as to whether mental handicap (or at least,
mild mental handicap) exists as an objective condition or is

socially created - that is, that it only exists where an individual
is labelled, socially processed and develops a negative self-image.[29a]
Consequently it remains unclear in their accounts whether they
maintain that society creates the condition of 'mild mental handi-
cap' or avoid explaining the 'causes' of the initial deviant
behaviour altogether, concentrating instead on the ways in which
society (the school system) reacts to the deviant behaviour
(presumably unmotivated and 'caused' by mild mental handicap)
and consequently shapes the individual's self-image and career.

Booth[30] - Mental Subnormality as an Achieved Social Status

The analysis and research referred to above has
been mainly concerned with the mildly mentally handicapped,
and indeed Mercer argues that the social systems perspective
she develops is applicable to the mildly, but not the

moderately and severely retarded. However Booth attempts
to move outside of the clinical definitions of handicap
in a study of severely subnormal children, and to demonstrate
that

> ... becoming a mentally handicapped person is not
> just a matter of clinical evaluations and diagnosis
> ... [but] ... that it is a social process that can
> be understood in terms of the changing meanings
> given by parents to their child's behaviour and
> revealed in the way they act and feel towards him.[31]

Mental subnormality is then viewed as an ascribed social
status, one created and shaped by human activity. It is
conferred on the individual as a consequence of the parents'
interaction with their child and their growing awareness
that 'something is wrong', that the child is not developing
'properly'.

Two imperatives underlie this approach. The first
is that sociologists should focus on the origins and
unfolding of the social meanings attributed to a pathology
- how do people come to understand what it means to say
that an individual is mentally handicapped? Secondly,
there is the point that it is deviant behaviour that
results in labelling and not the converse; that is, for the

sociologist subnormality is seen as constituted by ways of behaving that the clinician would explain as symptoms or effects of the severe mental handicap.

This approach is developed by studying how the notion of subnormality is created and shaped in the parents as their baby develops and eventually culminates in the child being officially labelled. Booth argues that there are four main stages in the child's career, leading eventually to clinical diagnosis as severely mentally handicapped. The first stage is the arousal of suspicion in the parents - they begin to feel that 'something is wrong', that the child is not developing 'properly'. The second is when suspicion is aroused to the extent that they seek professional advice. At this stage doctors generally prevaricate and try to avoid or at least delay making a clinical diagnosis. During the third stage the parents become convinced that 'something is definitely wrong'. They then seek professional advice, with the intention of obtaining confirmation that the child is severely mentally handicapped. The fourth stage is reached when medical diagnosis confirms that the parents are correct - that the child is indeed severely mentally handicapped.

The parents are now in the possession of a diagnosis which describes their child's 'condition', but what exactly this means for the child and its future development remains unclear. The social meaning and reality of mental handicap is now built up by the parents in the everyday process of caring for and coping with a severely mentally handicapped child.

> ...the idea of subnormality is brought into being by the imputation of social meanings to physical states

and

> ... following on the diagnosis, it was left ... to the parents to elaborate the idea of subnormality into an organised social role.

-   For these parents their child bears witness to the
    social reality of subnormality. From this point
    onwards the child's actions and behaviour are
    assumed as those of someone who is subnormal
    and thereby work back on themselves to define
    what subnormality is.[32]

Within a phenomenological framework Booth shows how the
parents of mentally handicapped children develop an
understanding of what subnormality is and means.
He demonstrates the way in which the parents of mentally
handicapped children erect procedures to cope with the
growing doubts and uncertainties and subsequently re-
organise their lives once the child has been clinically
diagnosed and labelled.

However, by concentration on the micro-level, the
parent-child interaction, he fails to take account of
the possible influence of social attitudes and definitions.
The parents do not live in a vacuum, they already have
some ideas about what mental handicap means prior to the
birth and subsequent labelling of their child; they will
have been influenced by societal attitudes to ability
and intelligence, the role of the child within the
family, and built up certain expectations of what it
will be like to have a child. Once the child is
labelled they will be influenced by the attitudes of
doctors, nurses, family, friends and other members of
the community; their expectations will be shaped by what
'experts' and lay people tell them to expect. Micro-
sociological analysis of this type needs to be informed
by and located within a macro-sociological account that
permits an understanding of why the mentally handicapped
are cast as outsiders and managed as deviant in our society.

4.   Sociological Studies of Social Policy

One further group of studies which have been carried
out by sociologists have concerned themselves not with
the place of the mentally handicapped within society,
but with administrative and social policy towards them.
After growing concern with the problems caused by the
institutionalisation of problem groups almost wherever
it has been used - among the mentally ill, the physically

handicapped, prisoners, war-time detaineees and even
orphaned and destitute children - attempts have been made
to find a way of housing deviant groups, including the
mentally handicapped, in the community and offering them
something approaching a 'normal' life.

Some of the main results of such studies are outlined
in this section. It will be argued, however, that they
can produce little of permanent value unless they take
account of the broader question of where the mentally
handicapped stand within our society and what role they
are forced to play in it, which in turn demands that a
historically informed macro-sociological account be
developed. [32a]

4.1 Institutions for the Mentally Handicapped

The major concern of researchers into what Goffman[33]
has called Total Institutions has been the effect of
living in large, often isolated buildings, where the
individual has little control over his everyday
existence, has on the inmates. A syndrome - 'institution-
alisation' - seems to occur in long-stay inmates which is
perceived to be caused by the institution; characterized
mainly by apathy, reduced motivation and perhaps
psychological withdrawal, it is seen as rendering the
inmates unfit to cope with life outside. Early accounts
from hospitals (for example, Martin[34], Titmus[35], Barton[36])
suggest that the causal factor is the régime, with patients
being rewarded by staff for good, quiet, resigned and
co-operative behaviour to the point where such attitudes
become habitual. Later work on mental illness and mental
handicap hospitals suggested that the physical environment
and 'quality of life' may have a part to play; Tizard[37],
Morris[38], Wing and Brown[39] and King et al[40] all found that
environments which are drab, unstimulating and poor in the
range of choice they offer tend to produce drab, under-
stimulated, dependent patients. Staff-inmate relation-
ships have also been shown to be relevant (King et al[40]).

Morris's[41] sociological study provides a graphic
picture of the way our society provides for mentally
handicapped people incarcerated in hospitals. Morris
found that mental handicap hospitals are isolated geo-
graphically and socially and from the mainstream of
medical and educational advances and that the inmates had
few contacts with relatives and friends. They lived in
large wards, had little privacy, retained few personal
possessions, and many, having no day-time occupation,
spend all their time on the ward. Subnormality hospitals,
then, tended to reinforce the dependency of their inmates
and to encourage helplessness.

Furthermore, subnormality hospitals experience
difficulty in providing the basic facilities necessary
for the adequate care of their mentally handicapped inmates.
Hospitals tended to be short of trained nurses and of

skilled professional workers. This meant that the main
function of these hospitals became custodial rather than
providing care and training.

Following the results of earlier studies which
showed that the standard and type of care usually provided
in mental subnormality hospitals was inadequate, King
et al[42] set out to investigate the variables which
determine adequacy of residential care wherever it might
be provided. They compared hospital wards, local
authority homes and private institutions for mentally
handicapped children and concluded that the adequacy of
residential care is not related to the degree or type
of handicap or to the size of the institution, but to the
management orientation and practices.

In hospitals, the management practices are institution-
ally orientated, whereas in local authority hostels they
are inmate-orientated. In the former, wards are staffed
by nurses working within a medical model, whereas in the
hostels child-care social workers are employed who are
influenced by child-centred philosophies. In hospitals

organizational needs are paramount, but in hostels the needs of the children are put first. The considerable improvements since 1945 in the provision made for 'normal' children deprived of a family life have hardly touched the lives of 'subnormal' children.

These two studies demonstrate vividly the inadequacies of the institutional care that our society provides for mentally handicapped people. Although the implications are not developed, it is possible to suggest that this way of warehousing deviants tells us as much about our society as it does about the mentally handicapped residents.

4.2 Living in the community

Policies of decarceration, community-care and normalization mean that provision should be made for mentally handicapped children and adults to live lives as near those enjoyed by the 'normal' population as is compatible with their degree of handicap. This includes the possibility of totally independent living for the mildly handicapped and the provision of care and support services for those unable to cope alone, whether they remain with their families or not.

Sociological research into community living for the mentally handicapped has concentrated on two aspects: the ability of mildly handicapped people to lead independent lives, and the adequacy of the community care facilities provided, especially those aimed at enabling families to care for mentally handicapped members at home. An important factor underlying both these types of study is the attitudes/behaviour of members of the community at the official and individual level to those labelled as mentally subnormal. (The importance of this in relation to social policy will be discussed more fully in Chapter 6, and empirically examined at the community level in Chapter 7).

It has been argued that mental handicap is the most stigmatizing of all labels because it implies a less than human mind.[43] Goffman defines stigma as:

...the situation of the individual who is disqualified from full social acceptance. [44]

But policies of normalization, to be successfully implemented, necessitate that mentally handicapped people are fully accepted in the community in which they live. Edgerton[45] set out to study the everyday lives of a group of mildly retarded people recently released from an asylum, to discern the factors that enabled them to cope adequately in the community. He found that the mentally handicapped appeared to be a highly stigmatized group - and that it was a basic stigma, in that the retarded were seen as incompetent in the management of their own affairs.

One of the most important aspects of their lives was their continuing attempts to 'pass' and to 'deny' in order to maintain self-esteem and to avoid the stigma of being regarded as mentally handicapped. These efforts to 'pass' and 'deny' have to continue despite a 'defective' brain and a general lack of social competence. Indeed, Edgerton found, paradoxically, that despite strenuous efforts to pass, the majority of the subnormals studied relied on 'benefactors' to enable them to manage their day-to-day existence, although they regarded this reliance as 'normal' behaviour.

This study was carried out in the early 1960's, when the ex-patients had lived in the community for an average of six years. Ten years later Edgerton[46] undertook a follow-up study to see if over the intervening period they had adapted more adequately to the demands of living independent lives in the community. He found that the mentally handicapped people had become less obsessed with efforts to pass and avoid stigma, and the majority regarded themselves as 'normal'. Also 'benefactors' played a less central role in the daily lives of these people.

An interesting conclusion of the research, and one
that may reflect an important modification of attitudes
in Western societies and which is of crucial significance
if mentally handicapped people's lives are to be normal-
ized, is that the ability to get and hold down a job is
not crucial in demonstrating adequate adjustment:

> Community adjustment or normalization may be
> independent of vocational success - the majority
> of them felt happier now than then, and their
> happiness was not a function of their employment.
> What is more, many of these people now appear
> to define themselves as 'normal' despite their
> lack of vocational success.

and furthermore

> ...if unemployment continues, we shall recognise
> that maintaining our present commitment to a
> work-ethic may be counterproductive.[47]

Edgerton has shown how apparently felt stigma and
community attitudes to what is 'normal' behaviour impede
the integration of ex-hospital patients into the
community. The self-perception of the individual
and his conception of how other people feel about him
influence his adaptation to community living.
His study was, however, limited to a small sample of
mentally handicapped people who had been institutionalized
for a number of years prior to their release.

Not all those who are labelled as mentally handi-
capped are incarcerated, and of those labelled subnormal
during the school years the majority appear to merge
imperceptibly into the 'normal' population once the period
of compulsory schooling has ceased. The ability of the
mildly mentally handicapped to cope adequately in the
community may be related, therefore, to whether 'or not
they have been institutionalized rather than to the fact
that they have been officially labelled as incompetent.

Farber (see above) has argued that the mildly mentally handicapped are a part of the surplus population and are indistinguishable from other members of the lowest socio-economic group in industrial society.

Henshal[48] carried out a small study in Texas, of Chicanos and Anglos with measured I.Qs between 40 and 70 who had been labelled as educationally subnormal and attended a training centre. The vast majority of subnormals came from low socio-economic backgrounds. Some of them were socially and economically dependent on parents or benefactors, but the majority of them coped adequately without such support. The main findings were that the majority of the group were functioning at a much higher level than would have been predicted from their tested I.Q. score and were coping adequately in the community; those from low socio-economic backgrounds were indistinguishable from other members of the communities in which they lived.

Another important aspect of 'normalizing' the lives of the mentally handicapped is 'permitting' them to enjoy relationships with the opposite sex and to marry. Matteson[49] carried out a study in this country which sheds light on this aspect, as well as providing evidence on the community adjustment of ex-inmates of subnormality hospitals, that suggests that the 'problems' experienced by them are similar to those encountered by the ex-patients studied by Edgerton. She looked at a small number of ex-hospital residents who had married each other after their discharge. She found that the majority, but not all, of the couples made adequate community adjustment - that is, that they were indistinguishable from others occupying a similar socio-economic status.

The three studies referred to above demonstrate that mildly mentally handicapped people can, in general,

cope adequately with the demands of leading independent
lives in the community - given no more social work support
than many other groups.   What they do not adequately
explain is why, given this, such a stigma attaches to the
label 'mentally handicapped', and why members of this group
are frequently cast as outsiders and managed as deviants.

4.3 Facilities in the·community

The policy of 'normalization' and the advocating of
care in the community also extends to the more severely
handicapped - those who, presumably, will always need
some help and guidance.   If the low status of mental handi-
cap influences the provision made for those who are only
mildly subnormal, how much more does it influence that
made for the more obviously and severely handicapped?
Bayley[50] carried out a survey of community care for the
mentally handicapped in Sheffield in the early 1970's,
and his conclusions have been supported by the findings
of more recent studies (including one by Wilkin[51]).
The main conclusion of Bayley's study is that in practice
community care means care by the family - the main burden
of coping with and caring for a mentally handicapped person
falls on his family. (Wilkin goes further than this and
argues that the main burden falls on the mother - I take
up this aspect of care and develop it more fully in
Chapter 6). Consequently when we talk about community
care we are in reality talking about care in the community
rather than care by the community. Bayley argues that
this creates a need to distinguish between 'community care'
- a form of care where the community is involved in an
active way in the care of the mentally handicapped - and
'care in the community' - where parents struggle to cope
with a mentally handicapped 'child' in isolation from
friends, neighbours and other members of the community.
Bayley suggests that if community care is to work in
the way envisaged by tnose who advocate 'decarceration

and normalization', the community must become more
actively involved in caring for the mentally handicapped.
This involves voluntary workers helping families and
visiting those in hostels, as well as the provision of
more and better support services and the closing down of
large isolated hospitals.

A major problem with Bayley's argument is that it
tends to veer towards an 'arcadian' view of the family.
He argues that in the past, close-knit working class
communities and the associated extended families provided
mutual self-help and support.   In these communities,
community care was a reality, and if this type of community
could be re-created then it could become a reality in
the future.   Apart from recent research questioning his
assumptions about the existence of these communities in
the past (at least to any great extent), it seems unlikely,
given the structure and idology of our society, that they
will develop in the future. [51a]

Jaehnig[52] in a study of a small number of families
with a mentally handicapped child, goes beyond critical
descriptive studies of welfare provision to question the
psychologists' assumption that it is the pathology of
the child that creates problems for the family;[52a]

he suggests, rather, that it is the ideology of a society
that structures attitudes towards the mentally handi-
capped and their families.   He also argues against the
assumption that in the past highly supportive extended
families lightened the burden of caring for handicapped
members.   Furthermore, he contends, social workers,
working within the prevalent and pervasive view that the
isolated modern nuclear family cannot cope with a handicap,
have created handicapped families out of families which
just happen to have a mentally handicapped member.
Thus, he concludes:

The object of this study was to examine the

effect of modern industrial society upon a
family with a handicapped child. Its main
conclusion was ... that the nuclear family
is resilient, adaptable and highly dedicated
to caring for its disabled child, and most often
carries out this task satisfactorily in spite of
formal and informal efforts to intervene -
actions which, it might be added, are usually
presumed to be benevolent and efficient, but
can have pernicious consequences for the family.[53]

As far as the family is concerned they do not accept
the 'official' view that having a handicapped child is
a tragedy, but see the child as a member of the family,
an individual with a unique personality. It is not the
child's handicap which causes him to be a burden on his
family, but problems caused by his behaviour and the
additional financial costs. The felt needs of the parents
are for extra financial and social support; indeed one
of the main reasons why parents seek residential care
for their children is the financial burden rather than
the difficulties of coping with the child.

5. The Developing Social Perspective

Sociological studies of social policy such as those
discussed in the last section have cast a great deal of
light on what it is like to be mentally handicapped in
our society. Some of the conclusions are of value as
warnings: the institutional (mostly hospital) care which
is associated with the view of the mentally handicapped
as sick people is consistently inappropriate to their
needs and may be positively deleterious. Others are
encouraging: some of the mentally handicapped can merge
back into their parent sub-culture and apparently become
accepted as 'normal', once they escape from stigmatizing
institutions such as schools. Attempts are now being
made to see to what extent all can be returned to the
community, given adequate support services. Yet other
studies are frankly critical of the provision which is
made - or rather not made - for the support of the
mentally handicapped living in the community. However,
none of these studies can really give us any understanding
of what it means to be mentally handicapped in our society,
because they are only snap-shots - ahistorical cross
sections of society and social provision at a particular

moment in time. Without an appreciation of the under-
lying historical forces which contribute to that 'moment'
they can understand neither how and why things came to
this pass nor the direction of likely (or possible)
development.

This charge of ahistoricality and lack of macro-
sociological perspective can also be levelled at most
of the more theoretical sociological literature,
as we saw in an earlier section of this chapter.
What the sociological literature has succeeded in doing
is to move away from the implicit assumptions of the
clinical and psychometric models of mental handicap -
that is, that the 'problems' posed by mentally handicapped
people can adequately be explained by reference to the
assumed pathology of the individual. They have pointed
to the vital 'fact' that in order to understand mental
handicap as a social as well as an individual problem we
need to examine the norms and values, and indeed the
ideology, of the society in which the individual lives,
and within which he is labelled as an outside and managed
as a deviant. Dexter has pointed to the need to examine
the 'problem' historically, Mercer has highlighted
that being labelled as mentally handicapped is relative to
institutional/cultural expectations of behaviour, while
Farber has suggested that industrial societies have a
functional 'need' for a surplus population, and that the
mentally handicapped are a part of this population.
Morris and Bayley have shown how inadequate is the
provision that our society makes for mentally handicapped
people - that they are the "forgotten ones". One of the
most interesting and promising lines of research is that
developed by Jaehnig, who examined the role of ideology
and the images held by professionals in creating 'handi-
capped' families and relates this to the lack of financial
and social support provided to families caring for a
handicapped member.

What sociologists have not yet succeeded in doing
adequately is to develop a historical and macro-sociological
perspective in which to locate micro-sociological insights.

The rest of this thesis is aimed at beginning to overcome
this deficit - examining the role and status of the
mentally handicapped and relating this to the ideology of
society. Indeed it is my contention that it is the
ideology of society, and not the pathology of the individual,
that determines social perspectives on 'outsiders' and
determines the way in which they are managed. It is this
that I intend to develop and demonstrate in what follows.

REFERENCE NOTES, CHAPTER TWO

1: It is a common assumption, for the most part accepted
uncritically by sociologists, that the mentally handicapped
form a category of people who are essentially different from
others. Furthermore there is a tendency in the literature,
including the sociological literature, to homogenise or at
the most to dichotomise the category of mental handicap.
However, there is no reason in terms of form of handicap,
aetiology or identification and management practices to
assume that there 'really exists' such a unity or dichotomy.
The division into sub-groups is arbitrary, based on I.Q. and
possibly on social competence (itself a value judgement).

1a: Adapted from Boswell and Jaehnig, 1975. P 80

2: Adapted from Kirman, 1968. P 687

2a: E.G. Fletcher (1972) argued that

..any individual of the species 'homo sapiens' who falls
below the I.Q. 40 mark on a standard Stanford Binet test
...is questionably a person; below the 20 mark he is not
a person. P1

3: Sarason and Gladwin, 1958   4: Edgerton, 1970

5: Ryan, 1976 Ps 152-154   6: Morris, 1973

7: E.G. Stein and Susser, 1960 (although some sociologists may
have assumed too readily that mild mental handicap is socially
created that social facts can explain its existence in industr-
ial societies - see section 3.2 of this chapter, and Chapter 8).

8: Kushlick, 1967. P37

8a: See, e.g., Stein and Susser (1960), Birch et al. (1970), Mercer
(1973), Rowitz (1974).

9: Sarason and Gladwin, 1958.

9a: Grossman (1972) argues that in this article Sarason and Gladwin
were the first to state formally a social-psychological perspect-
ive on mental handicap.   '

10: See Dexter (1960) for a critical sociological evaluation of
the article.   ⏐

11: Mendeholm, 1954   12: Perry, 1954

13: Mendeholm, 1954   14: Kurtz, 1964   .

15: Rowitz, 1974 P411   16: Perry, 1965 P19

17: E.G. Mercer (1973), Booth (1978), Tomlinson (1981)

18: Booth, 1978 P203   19: Farber, 1968

20: For a summary of the functionalist perspective on social
stratification in these terms see Davis and Moore, 1945.

21: Farber, 1968 P19   21a: Farber, 1968 P263

21b: See Tomlinson (1981)for an account of the process by which
children are labelled as mildly educationally subnormal in
the English educational system.

22: Dexter, 1956, 1956a, 1958, 1958a, 1960, 1960a, 1963, 1964,
1966, 1973.

23: Dexter, 1956   24: Dexter, 1964

25: Dexter, 1960   26: Ablizυ-Mirranda et al, 1966

27: Ablizυ-Mirranda et al, 1966 P14 28: Ablizν-Mirranda et al, 1966 P55

29: Mercer, 1973. See also Tomlinson (1981) on the process of
labelling children as mildly educationally subnormal in the
English educational system. This study also points to the
class and ethnic biases in selecting and labelling children
as E.S.N. (M.) highlighted in Mercer's study.

29a: This difficulty with conceptualising 'primary deviation'
is one common to labelling theory in general and will be taken
up and discussed more fully in Chapter 8.

30: Booth, 1978   31: Booth, 1978 P204

32: Booth, 1978 P219

32a: However, see Tomlinson (1981) for an attempt to develop
such a theoretical perspective in the case of the mildly
educationally subnormal.

33: Goffman, 1961   34: Martin, 1955

35: Titmuss, 1958   36: Barton, 1959

37: Tizard, 1964   38: Morris, 1969

39: Wing and Brown, 1970   40: King et al, 1971

41: Morris, 1969   42: King et al, 1971

43: Ryan, 1976   44: Goffman, 1968 P12

45: Edgerton, 1967   46: Edgerton and Bercevici 1976

47: Edgerton and .Bercevics 1976 P 493- 48: Henschal, 1972
                                 494
49: Matteson, 1970   50: Bayley, 1973

51: Wilkin, 1979

51a: However, see Abrams et al (1981) for an evaluation of
Good Neighbourhood schemes - schemes designed to develop
informal community help:

        The projects...represent a distinct social ideal:
        an effort to develop patterns of social care that
        put special emphasis on informality, reciprocity
        and locality

but found that they needed to be carefully planned, required
formal organisation and had to be integrated with other schemes
if they were to 'succeed' in delivering primary help.

52: Jaehnig, 1974

52a: See, e.g., Gath (1978) for a recent restatement of the
     argument that the mentally handicapped child results in a
     pathological family. However, Grossman (1972) found responses
     of families varied and not all became pathological. Hewett
     (1970) and Darling (1979) support Jaehnig's conclusion.

53: Jaehnig, 1974. P310

CHAPTER 3

A SOCIOLOGICAL ASSESSMENT OF THE MEDICAL AND
PSYCHOMETRIC MODELS OF MENTAL HANDICAP

1.   Introduction

In Chapter 2 I have argued that one major weakness
with much of the sociological literature on mental handi-
cap is its implicit, if not explicit, acceptance of the
dominant medical model of mental subnormality.   In this
chapter I intend to critically assess the medical and
psychometric models – the latter having incorporated many
of the assumptions of the former – arguing that they are
inadequate mainly because they focus attention on the
individual and his assumed pathology and ignore the wider
social context within which the mentally handicapped
pérson lives.

One of the major problems facing any social scientist
studying mental handicap is that of definition.   Mental
subnormality is not a 'thing' that can be touched or
defined in terms of shape and substance, but an invented
concept suffused with social values, traditions,
unintended as well as intended prejudices, and degradation.
The concept itself, in our society, appears to serve two
major purposes: to separate a group of people, and to
justify social action in respect of those set apart.
This separation is not necessarily physical, but it does
imply that mentally handicapped people are seen as being
sufficiently different to need special 'care' and
'treatment' (see Chapters 4, 5 and 6 for an analysis of
'care' and 'treatment' contemporaneously and historically).

The use of the concept 'Mental Handicap' (or equivalent
alternative terminology) is not therefore neutral, nor is
the identification of individuals as belonging to the
category.   The labelling process is a preliminary to
'care' and 'treatment' while the initiation of the
diagnostic process is the outcome of somebody suggesting
that an individual is not developing 'properly'.

It is the result of the development of an idea – the
feeling that something is not quite right, that other
lives are being affected, that we must find out the
source of the trouble and that it is essential to come
up with solutions – to alter the individual's status – that
will allow us to experience our lives in the way we
wish to.

Consequently, while diagnosis is a pathology-
orientated process, initiated by someone who feels that
something is 'wrong' with another person, and a process in
which objectivity and precision are sought, in actual
fact it is a process permeated with personal values and
judgements. Diagnosis is concerned with the individual
and his pathology and tends to be conducted and justified
as if only the individual required assessment and help,
as if the whole problem is inherent in him. However,
diagnosis is always, and inevitably, the outcome of a
perceived problem in an individual's development which
arises out of a social situation. Thus the labelling
process denies the transactional element.

Sociologists need therefore not just to move outside the
clinical model but also to examine critically both the
defining process itself and the instruments used officially
to label an individual as incompetent. We need to ask
to what extent this process and the diagnostic tools
used reflect the norms and values of a society. and to
demonstrate that they are used within a social structure
for a purpose – they are not an end in themselves.

The diagnosis of mental handicap in our society
would seem to be at once easy and difficult.
Some people are so obviously handicapped that it is
immediately or almost immediately possible to recognise
them – although even then there is room for mis-labelling –
people with severe spasticity have in the past been
wrongly diagnosed as severely mentally handicapped as the
Joey Deacon story' so graphically illustrates, and some

extreme depressives might well be taken to be subnormal.
On the other hand, at the other extreme mentally
handicapped people merge imperceptably with 'normal'
people.   Indeed, the number of people in the population
'eligible' (at least in psychometric terms) to be
labelled subnormal probably far exceeds the numbers
actually labelled and managed as retarded people.
Underlying all attempts to define and diagnose mental
handicap is the problem of defining socially acceptable
behaviour, adequate development and adaptability to
the demands of the society in which a person lives.
These are always based on normative judgements and
those with the power to label may not share the same
view as to what is evidence of subnormal functioning
as other sub-groups in society, or indeed the individuals
who are labelled.   This has been demonstrated in some
of the descriptions of the lives of the mildly retarded
in the community discussed in Chapter 2.

The main official labellers of the subnormal are
doctors and psychometricians.   While clinical diagnosis
usually suffices with the more severely handicapped, many
of the mildly subnormal are 'discovered' as a result
of school failure and subsequently 'failing' on an
intelligence test.   In the United States psychometric
testing is apparently routine for all children[2], but in
Britain (especially since the large reduction in the
number of local Education Authorities setting 11+ tests)
only children referred by the school to the local authority
will be tested.[3]   Additionally in Britain, since the 1959
Mental Health Act (see Chapter 1), for a person to be
described legally as mentally handicapped it has been
necessary to demonstrate subnormality of intelligence
(an I.Q. of 70 or less) as well as general social
incompetence.

Although psychometric tests are not the only instrument
used in diagnosing mental subnormality they have retained
an extremely important role, not only in the diagnostic
process, but also in classification, which in turn

influences decisions as to future 'care', 'treatment' and placement.[4] It is necessary to ask why they have retained a central position, despite criticism of them, both from within and outside of psychology. In this chapter I will suggest that the way in which these tests are constructed, the content of them, and the assumptions underlying the use of intelligence tests reflects the ideology of our society – that the instrument used in diagnosis, and the very process itself, tells us as much about our society as it does about the individual deviant. Furthermore, we usually label for a purpose, yet the dominant method of diagnosis in the field of subnormality according to Mittler[5] ignores the fact that an inability to learn may be related to our inability to teach. In as much as the labelling process leads to essentialist labels it would seem to solve a problem for society rather than for the individual.

Intellectual assessment is not an end in itself, but it is an important career stage for the person tested. Together with the school 'failure' it can confirm his status as subnormal or can prove that he is 'normal'. Despite the fact that for the individual a great deal hinges on the outcome of the test, many testers continue to use tests as if they were unaware of the limitations of the instrument they are using. An I.Q. is not a magic number, but I.Qs have become correlated, in the public as well as the official mind, with a significance out of all proportion to their scientific status or their relevance to the problems of mentally handicapped people. Indeed, intelligence tests have acquired a mystique, and the official and unofficial societal expectations of their value may often exceed those of many of the testers. Mittler[6] has suggested that many psychologists continue to administer tests because of institutional expectations and pressure.[6a] Furthermore, intelligence tests have been used primarily to segregate and classify. Consequently the continued and dominant use of psychometric

tests in the field of subnormality may reflect the
fact that society provides little more for the
mentally handicapped than institutional 'care', rather
than a 'belief' that test results can be used as a basis
from which to help the mentally handicapped person.

This is not meant to suggest that psychology as a
discipline is of little or no value in the field of
mental handicap.   There are psychological theories of
cognitive development that would seem to offer the
possibility of more adequate diagnosis and classification
and provide a basis from which to develop programmes to
ameliorate the condition, but   psychometrics continues
to dominate the field.   While in the last twenty years
the majority of research in the field of mental handicap
has been medical and psychological, these studies

> ...whether psychometric, ethological or experimental,
> are basically concerned with describing the subnormal
> rather than with the problem of ameliorating or
> preventing handicap?

In the same period there has actually been a decline in
research into training, rehabilitating and educating
mentally handicapped children and adults.[8]   Whether
this is a reflection of academic interest, the decisions of
research grant bodies or a realization that political
and economic rather than any other reasons determine
whether research findings are implemented or ignored and
consequently the futility of research that comes up with
'costly' solutions, is difficult to determine.
What can be said is that the type of research carried
out does seem to reflect the attitudes and values of
the society within which it is carried out, and that
governments do not necessarily implement recommendations
arising out of research findings even when they would seem
likely to provide a possible solution to a problem.
Furthermore, the current 'economic crisis' , with us
since the mid-1970's, has made it exceedingly unlikely
that the government would agree to implement any new
schemes that involved increased public expenditure.

The very act of diagnosing and labelling can, then, be said to be a reflection of the social practice in a society for dealing with the 'deviant'. While, of course, informal labelling goes on all the time, it is officially sanctioned labelling that is of crucial significance for the individual's future growth and development. Although informal labelling can influence an individual's self-image and may be the first stage in a process resulting in formal assessment and labelling, the labels attached to an individual or group of individuals by 'experts' - in the case of the mentally handicapped doctors and psychologists - are regarded as authoritative and scientific. In the case of the mentally handicapped the label is also stigmatizing, resulting in diminished status, and so has profound consequences not only for the individual and his future, but also for family, relatives and friends.

In this chapter I intend firstly to argue that the medical model's reification of mental handicap as an identifiable and incurable disease or medical condition akin to being born, for example, with no legs, obscures the nature of the culturally relative judgement involved. Then I will examine the role of psychometric tests as 'hardening the edges' of the definition of the disease, and at the same time giving apparent validity to its 'objective' status. Intelligence, originally a common language concept, becomes to an extent what the tests mean; psychologists have felt bound to come up with concepts like 'creativity' and 'achievement motivation' to catch what are also essentially all aspects of ability but which its newer and more specialised meaning fails to include. Intelligence tests tend to rule the field because it is claimed that intelligence is 'now' measurable while concepts like 'social competence' or 'personal development' are woollier. It will be suggested that the intelligence test has a special place even among other psychometric instruments in that it is, and was indeed developed to be, a normative rather than a descriptive

instrument.   Finally in this section it will be pointed
out that the assumptions underlying psychometric tests
about the nature of people and of ability, when applied
to the medical model concept of mental handicap, change
it into something subtly different, a distinctive
'psychometric model'.   In the last section I consider
alternative models of mental handicap available within
psychology - the approach through social competence and
two variants of a 'cognitive development' approach
which could treat mental handicap as more like (perhaps
temporarily) arrested development than like a permanent
and untreatable incapacity.   These are still 'medical
model' ideas and I would argue that they are insufficient
for an understanding of mental handicap because they
take little account of historically conditioned social
factors, but they do have fundamentally different
implications for social policy.   In particular they shift
the emphasis from diagnosis to amelioration and remedial
education.   Such shifts, as I hope to demonstrate
in Chapters 4, 5 and 6, can have a profound influence on
official, community and individual perceptions of and
attitudes towards those individuals we label as mentally
handicapped.

2.   Pathology and Social labelling

· Unlike physical calibre, which is readily discernable
and measurable by clinical examination, mental handicap
involves the measurement of 'intellectual calibre'
and/or social competence, which is less easily judged.
O'Connor and Tizard have suggested that six factors of
the perceived condition are considered relevant when
deciding if a person is mentally deficient: anatomical
and physiological development, intellectual capacity
(presumably I.Q.), intellectual attainment (presumably
school achievement), social competence (presumably the
ability to 'cope' in the community at an acceptable level),
occupational adequacy (presumably the ability to obtain
and keep a job), and temperament.   Obviously the importance

of each of these aspects will depend on the age of
the individual and the degree of obvious handicap.
Additional relevant factors, they argue, are the history
of the family, its circumstances including current
socio-economic status, and the occupational competence of
the rest of the family.   The interpretation of the
relative importance of these factors has not resulted in
an agreed definition of mental handicap, although, as
Jordan[10] points out, most psychologists and doctors would
accept as a working definition the very basic notion
that mental handicap implies a sub-average intellectual
functioning, present from or soon after birth, and
associated with difficulty in learning and/or social
adjustment.   In most cases it is assumed rather than
'known' that the condition has existed from or soon
after birth, and indeed environmental rather than inherited
factors are seen as increasingly relevant in the aetiology
of mental handicap.   Furthermore, the expected level of
functioning is determined by reference to the behavioural
standards and norms for a given society, and more
specifically for an individual's chronological age-group.
Coupled with this is the general acceptance of a 'sponge'
view of intelligence - that is, that each individual is
born with an 'aptitude' to learn - a genetic 'ceiling'
to his learning potential.

It follows from this that mental handicap is generally
seen as a permanent condition that at the most can be
ameliorated but never cured.   This basic and fundamental
assumption about the nature of mental handicap results
in the individual being cast in the role of 'incurably
sick', rather than say in that of 'developing person'.
In turn this results in a continued search for the
essentially 'biological' causes of the behaviour, and
even when environmental factors are acknowledged to be
relevant there is still a search for the changes in the
biological organism that result from the environmental
factors.   The consequence is a continued focus on the
individual and an emphasis on individual pathology.

The diagnosed deficiency is projected into the individual, and little attention is paid to social and societal factors.

In Chapter 2 I have suggested that one way of classifying the mentally handicapped, on the basis of assumed aetiology, is into the organic/pathological (normally the more severely handicapped) and the sub-cultural/familial (normally the mildly handicapped). The former group are usually diagnosed by clinical examination conducted by doctors, the latter by psycho-metric tests. However, formal diagnosis of all mental handicap is considerably complicated by the wide variation in assumed aetiology, and the wide range of abilities that exist among those eventually labelled as subnormal. In the rest of this section I intend to discuss the underlying assumptions of the models used by doctors and psychometricians when they are concerned with the diagnosis of mental handicap - the medical model and the psychometric model. These two models are considered separately, but they interpenetrate each other, and the former has particularly influenced the latter. However, in terms of diagnosis they do differ: in the former the individual under consideration is diagnosed as subnormal by medical examination and then intelligence tests may be used for clarification purposes, whereas in the latter the I.Q. test score is the major relevant factor in diagnosis - the psychometric test provides the 'scientific' proof of stupidity.

2.1 The Medical Model

Medical involvement with the field of mental sub-normality is comparatively recent. As far as can be discerned from the scanty historical evidence (see Chapters 4 and 5), medical men showed little interest in the condition until the early nineteenth century. In the initial phase of interest doctors thought that mental handicap could be 'cured'; when this hope was

shattered they tended to take the opposite view and
see it as an 'incurable sickness', the sufferer needing
life-long custodial care (although at the time, and
indeed since, the provision of residential places has
never been sufficient for all or even the more severely
handicapped).   Parallelling this was the growing
dominance of the medical profession in the whole field
of mental disorder[11], where they managed to obtain, and
have subsequently retained, administrative control of
mental handicap hospitals, and the overall control of
diagnosis and treatment.

The medical model still retains at root the idea
of mental handicap as an 'incurable sickness', and its
way of thinking results in seeing people primarily in
terms of what is wrong or abnormal about them, rather
than in terms of the community in which they live, the
way in which other people behave towards them or the
needs arising from this.   As Sarson and Doris[12] argue:

> The fact that brain injury and certain types
> of behaviour exist is in itself no basis for
> concluding that one is the cause of the other

and furthermore

> To the extent that we imply or infer such a
> correlation we obscure the complexity of knowledge
> which would alter our perspectives of the
> potentialities of these children.

The inadequacies of the clinical model relate primarily
to the fact that it has developed in medicine as a
conceptual tool for understanding, controlling and
testing physical illness.   It is concerned basically
with diseases which interfere with the physical functioning
of the organism, and consequently the model focusses
on individual pathology.   The disease is defined by
biological signs and symptoms, with a strong emphasis
on defining the nature of the abnormal.   The medical
category of 'mental subnormality' and the diagnosis
are seen as descriptive of pathological defects in the
individual which are the 'cause' of the retarded intellectual
growth.

The only relevant social questions within this paradigm are epidemiological - the incidence and the prevalence of the 'disease'. The model, rather, encourages research on the elaboration and refinement of instruments for the detection of defects, and their biological causes and/or associated consequences. Relatively little attention is paid to the social and personal consequences of labelling and categorization. These are not seen as acts that have any particular social maning except in terms of administrative decisions about present and future 'care' and 'treatment'. This is because diagnosing mental handicap is seen as exactly the same process as diagnosing any other medical condition. The outcome of the scientific diagnosis is a recommendation for a care and treatment regime. Prognosis is also an integral part of this process - with the mentally handicapped individual it usually involves predicting future intellectual development - what mental age he will eventually reach.

In the case of the mentally handicapped the philosophy of the clinical approach, apparently beneficial to the individual, is used to confirm him in a stigmatizing, diminished status rather than to offer the possibility of changing this status from, say, a 'sick person' to a 'healthy person'. The individual is cast in the role of 'incurably sick' rather than, say, 'developing person'. Furthermore, the 'illness' serves to explain the total behavioural pattern of the individual, and possible environmental/social determinants of behaviour are disregarded, ignored or dismissed as irrelevant.

2.2 The Psychometric Model
The medical model reifies mental handicap as a culture-free condition which is objectively identifiable, and psychometric tests in general, and specifically intelligence tests, validate this position by providing a supposedly objective and scientific measure.

However, they have two effects: they harden and clarify the
boundaries of the 'disorder' and they contain different
assumptions about the nature of the person and the
curability of handicap - these differences are enough
to make them form a distinctively different model
from the straight medical one

The psychometric model is the one dominant in the
diagnosis of mild mental handicap - the diagnosis usually
takes place after some years of formal schooling.
It is the responsibility of the school medical officer to
determine if a child is educationally subnormal, and his
diagnosis is based mainly, but not solely on the results
of a single intelligence test.

The psychometric model is then concerned with
measurement and classification. The intelligence test is
a screening device used to determine if an individual is
capable of benefiting from 'normal' schooling. It does
not have to make assumptions about the causes of 'low
intelligence' or indeed to make recommendations about what
should be done. In this model the mentally handicapped
are those with an I.Q. below 70. The consequences of
being labelled within this model are not, as they are
in the medical model which confers the status of   •
'incurable sick', implicit in the model. When the
assumption is made, as it was in the early part of this
century, that the 'feebleminded' are qualitatively
different and that the condition is genetically transmitted,
official diagnosis can result in being treated as a
dangerous deviant and result in life-long incarceration.
On the other hand, if a low I.Q. score is seen as partly
the result of environmental factors, official classification
could have the positive consequence of resulting in the
placement of the mentally handicapped individual in
a 'special' educational environment designed to develop
his abilities to the full.

However, the National Society for Mentally Handicapped
Children suggests that even now the procedure is designed

mainly for administrative convenience and is a negative procedure not aimed at deciding what is best for the child.[13] Psychologists have been employed to assess rather than provide possible programmes of remediation for the educationally and mentally subnormal.

> ...assessment is of limited value in the field of
> subnormality. In Britain it has been clearly
> regarded as the main contribution of psychologists.
> As ... employed it appears more often as an epi-
> phenomenon keeping them busy, stimulating often
> unprofitable research and leading to the perpetual
> quest for the philosopher's stone (better and
> better tests) which will secure more and more accurate
> prediction.[14]

The model of child development at least implicit in this approach is antitheoretical with respect to the process of development - that is, with regard to what constitutes change in ability and competence, and how it happens. The stages of development are defined statistically; change is seen as a series of quantitative accretions, not related in any special way to the preceding or succeeding ones. Furthermore, the content of each stage is determined mainly by the desired statistical properties of the resulting test rather than any consideration of what is developmentally meaningful.

Intelligence tests are based on the concept of the normal distribution In this model, then, abnormality is defined according to the extent to which an individual deviates from the population average. In establishing the statistical norm and the boundaries of the 'normal' the psychometrician uses the distribution of the characteristic in the population. The model defines two types of abnormality, one at each end of the distribution - for example when weight is under consid- eration, at one end are the abnormally heavy and at the other the abnormally light; when intelligence is under consideration, at one end are the intellectually gifted and at the other the incompetent. The statistical model is itself neutral; what is good or bad, desirable

or undesirable is culturally defined. So, while in
our society it is generally considered bad/undesirable
to be overweight, in some Eastern countries it is
regarded as good/desirable. In Western societies it
is good/desirable to have a high I.Q. and bad/undesirable
to have a low one. This social evaluation is partly
related to occupational demands, but also to the require-
ments of mass education and social control in capitalist
societies. (This point will be further developed in
Chapters 5 and 8). It also helps to maintain and
justify a system of social stratification, in that it is
at least partly justified by arguing that those in
high-status occupations 'deserve' their socially and
economically superior position because they have not
only worked hard but are also intellectually gifted.
(Although whether or not intellectual ability alone
determines occupational success in extremely debatable[15]).

The problem is what we mean by 'intelligence' - does
it have a 'factual' 'objective' existence or not?
It is easy to say that intelligence is 'what the test
tests', or 'what is necessary to do well in school in
academic terms', but this does not go very far.
Furthermore, there is research evidence to support the
view that the demands the society puts on individuals
play an important role in determining the level and
type of abilities developed.[16]

> Culture determines the degree and kind
> of intellectual ability required for adequate -
> including measurably adequate - performance in
> our society.[17]

Psychometricians, however, proceed to measure
'intelligence' as if it does have a 'factual' existence.
Although, to be fair, they are aware of the problem of
cultural relativity and have attempted, with little
apparent success, to develop culture 'fair' or 'free'
tests. Furthermore, they tend not to take cognisance

of the 'fact' that cultural relativity also plays an
important part in defining what is intelligent behaviour.
Thus many test items implicitly assume a middle-class
value system.

2.3 The Normative Role of Intelligence Testing

The major problem with both the medical and the
psychometric models is that while they claim to be
descriptive and non-evaluative, they are in practice
normative. They are normative because as a result of
being diagnosed as mentally handicapped, an individual
is either included in the sick class (medical) or
excluded from the 'normal' school (psychometric) and
in either case is thrust out of 'normal' living into
a stigmatized 'surplus' population. Furthermore,
clinical diagnosis and intelligence tests interact with
the schooling system and the child health system to
provide something akin to universal screening for
mental subnormality.

The intelligence test plays a central, if different,
role in both the medical and psychometric models of
mental handicap, and the assumptions underlying the
tests and the reasons why they were developed still
influence official and community perceptions of and
attitudes towards the mentally handicapped. Despite
considerable criticisms of the underlying assumptions
of intelligence tests they continue to be used as a tool
for the assessment of and placement of the mentally
handicapped. In order to explain why this is the case
I will discuss why intelligence tests retain a central
role in the field of mental handicap, but as a preliminary
to this I will briefly point out the major criticisms of
intelligence tests as measures of innate ability/under-
lying potential.

Standardized tests of intelligence are designed to
measure intelligence and to place an individual in
relation to the total population. A basic assumption

underlying the test is that intelligence is normally
distributed and that a standardized test is one on
which the scores of the total population will produce
a normal distribution of scores.   The model determines in
advance that a given proportion of the population will
have 'high', 'average' and 'low' intelligence.
This would not be a fundamental problem, however, if the tests
were indeed used purely for description - if intelligence
were not a normative concept.   (In any case, the assumption
that intelligence is normally distributed is not correct -
although it would be if the biologically subnormal
were excluded).

On standardized tests an I.Q. of one hundred is the
statistical norm, and the standard deviation is fifteen
points.   An individual with an I.Q. below about eighty
would be considered at least below average in our society
and with an I.Q. below fifty severely subnormal.
The 1944 Education Act laid down that those with an I.Q.
between fifty and seventy were educationally subnormal,
and those with an I.Q. below eighty dull.   The 1959
Mental Health Act stated that subnormality of intelligence
had to be present for an individual to be 'diagnosed'
as mentally handicapped.   The upper I.Q. limit for
classification as severely subnormal is usually taken as
fifty and for classification as subnormal usually
seventy.   However, in practice, the lines of demarcation
are blurred; the severely subnormal merge with the
subnormal and the subnormal with the normal - arbitrary
cut-off points are, in themselves, of little value.

Intelligence tests are used not only to assess an
individual's present level of functioning, but also to
predict his future developmental potential.   The ability
to be able to do this is based on the assumption that
intelligence tests are both highly reliable and entirely
valid.   One of the major assumptions of the test is
that it measures some 'thing' called intelligence, and
that this 'thing' is a fixed, unalterable quantity -

usually assumed to be genetic in origin, but it could be
fixed irreversibly by early environmental factors.
The test is also assumed to measure 'pure' intelligence –
the quantity the individual possesses independent of
cultural and teaching influences.   It is then assumed
that the test not only measures present attainment,
but that the results can be used as a basis on which to
predict future developmental potential.   Psychometricians
consequently place great emphasis on its reliability as
a standardized measuring instrument.

> Note however the paradox emphasised by Kelly
> (1955) when he defined 'reliability' as the degree
> of an instrument's insensitivity to change:
> concern for reliability of measurement may weaken
> research into transitory or mutable phenomena.
> Some argue that this has happened in academic
> psychology, where a view of personality as
> fixed rather than changing follows all too
> readily from the search for a reliable measuring
> instrument.[16]

(If we substitute 'psychometrics' for 'academic psychology'
and 'intelligence' for 'personality'   this point applies
equally to intelligence tests).

An even more fundamental weakness of intelligence
tests, and indeed one recognised by many psychologists
is the threat to internal validity posed by confounded
variables: the test is contaminated by the influence of
a number of variables related to the social activity of
testing.   As a result it is not possible to tell when
considering scores on intelligence tests what differences
are due to differential intelligence and what to these
other factors – even on the assumption that the test
can actually test generalised ability as opposed to
attainment.   These confounding variables include
factors such as differential teaching, differential
emphasis placed on school work, differential fear and
experiences of tests, differential motivation to do well
on tests, especially as between individuals from different
cultures, ethnic groups and social classes, different

local vocabularies - between regions, ethnic groups and social classes, and the influence of the social situation of the test - the interaction between the tester and testee - on the test results.

This is an important factor given that in our society children from ethnic minority groups and working-class homes are more likely to be labelled as educationally subnormal than children from white middle-class homes.[19] This is at least partly a result of test bias, although it probably also reflects the type of children considered to be a 'problem' by school teachers. However, all the time that intelligence tests test attainment, and the social factors that influence the test are the same as those that influence school success/failure, then tests are only going to confirm the suspicions of teachers.

The underlying assumptions of intelligence tests need to be examined in order fully to understand the ways in which the results of such tests are used, ideologically in our society. (This role of intelligence tests is developed more fully in Chapter 8). This opens wide a fundamental debate about the nature and origin of what we call 'intelligence' and 'intelligent behaviour' - the nature/nurture debate. Despite frequent assertions that this debate is now dead, that we are all now inter-actionists at least to some extent, the undisputable fact remains: that the historical and theoretical assumptions underlying intelligence tests include the view that intelligence is a unitary, hereditary and basically stable 'thing' - something we possess like the colour of our skin. Despite a changing emphasis within psychology, a move away from a reliance on intelligence tests, they still play a dominant role in medical and educational psychology and the results of such tests are used as if they did measure a fixed capacity - the classification and placement of the child is made to a large extent on the basis of a test score. As Mittler has pointed out:

> Some psychologists working in health and education
> services were unwilling to discard tests which
> they saw as providing a form of standard interview
> of which they had extensive experience, and
> about which there was a great deal of published
> information. Even those who were in principle
> willing drastically to curtail the routine use
> of tests doubted whether they would be able
> to resist the demands of their employers and
> professional colleagues, who conceptualise
> their role primarily as that of testers, with [20]
> perhaps some involvement in research and teaching.

While the continued existence as a profession and the
employment of psychometricians depends, at least to
some extent, on the continued use of tests, the search is
not for 'new' methods of assessment, but for more
refined tests, tests that 'do the job better'. Thus
the underlying acceptance of fixed capacity persists,
despite the accumulating evidence that suggests that
expectations have a considerable influence on outcome -
at all levels of ability and attainment.

The nature/nurture debate becomes relevant at this
point because, as Ryan points out,

> What is ... important is the way in which this
> debate within psychology reflects a wider
> social debate on the inclusion or exclusion
> of mentally handicapped people from so many
> social institutions. Unfortunately this
> reflection is not always a conscious process
> as far as the psychologists themselves are
> concerned.[21]

Not only does it influence placement, but also whether the
'condition' is seen as remediable or not, and if so how.
As Rose has argued, with our present state of knowledge
we cannot modify the genotype (what is inherited), but
we can improve/modify the environment - that is,
provided we accept an environmental component, we can
enable every individual to develop his potential by
improving the housing, the schooling and the general
environment of the more deprived members of our society -
the sector from which most of the mildly handicapped come.[22]

However, while Rose is not alone in stressing environmental
influences, and Ryan has pointed out that

> Evidence can be produced to support either
> position or neither, depending on the
> conditions of the experiment, the exact kind
> of behaviour investigated and the methods
> and intent of the researcher[23]

nonetheless there is still a general and persistent 'myth'
that intelligence and achievement are distinct, and that
it is possible to measure innate intelligence and
predict future behaviour and achievement on the basis of
this.

The assumption that intelligence is totally or mainly
genetically determined and the reliance on intelligence
tests in assessment results in an emphasis on the
individual and his 'failure'.   The 'poor' result on
the test is accounted for by his 'low' intelligence, but
it is the test results which 'prove' he has a low intelli-
gence.   Apart from the fact that this view, at the level
of use, dismisses any notion of cultural bias in the test,
and the problems involved in the 'fact' that testing is
a social activity, it also provides no information which
can be used to design programmes of education and
habituation.   In sum, intelligence test scores can only
state that the individual cannot 'pass' the test, not
why, or what can be done to improve the situation.[24]

In order fully to understand what the assumptions
underlying intelligence tests are and the purpose
which their use serves in our society it is necessary
to go beyond analysing the implicit assumptions and
examine the historical development of tests.   It is only
then that the social, political and ideological under-
pinnings of the testing paradigm become clear.[25] Furthermore,
we need also to examine why intelligence tests were developed
in the first place – the perceived need that they were
developed to meet.   (This is discussed more fully in
Chapters 5 and 8).   Adequate accounts of the development

of intelligence tests and the implicit and explicit
ideologies underlying them have already been developed
elsewhere[26] so it will only be necessary, at this point,
to look at this briefly in order to demonstrate the
importance of these factors in the field of mental
subnormality.

Intelligence tests were first 'successfully'
constructed in the early twentieth century by Binet
in France, who was concerned with selecting those
children who were incapable of benefiting from 'normal'
schooling and needed 'special help'. However, Galton,
a geneticist and the 'father' of Eugenics, had already
'unsuccessfully' attempted to develop tests of general
intelligence designed to help select the 'fittest' in
a programme of positive eugenics. (The factors leading
to the perceived need for programmes of 'positive'
eugenics and the influence of the eugenics movement on
attitudes toward and the 'treatment' of the mentally
handicapped and especially the 'feebleminded' is developed
more fully in Chapter 5).

Thus, as Boring[27] points out, intelligence tests were
originally developed by non-psychologists, and in
opposition to the experimental psychology dominant at
the time. Indeed, from the start experimental psychologists
questioned the scientific status of intelligence tests.
Although the tests, introduced into the United States in
1916, where used widely during the first World War, by
the 1920's faith among psychologists in the tests had
begun to diminish.[28] Following the publication of the
Yerkes Report, which argued that the average American only
reached the level of a fourteen year old and that this
fact put democracy in jeopardy, and of data which suggested
that recent immigrants from Eastern and Southern· Europe
had average mental ages lower than those of previous
immigrants from England and Western Europe, debate ensued.

During 1922 and 1923 an enormous controversy flared over this, but it died down as quickly as it flared up. Despite these developments the variety of tests continued to expand and the day of the pre-eminence of I.Q. tests was at hand. The partial schism between experimental psychology and psychometrics was healed after the second World War, according to Boring,[29] because testing provided employment for psychologists and because, whatever their theoretical inadequacies, tests appeared to work. As a result, experimental psychology no longer 'looks down' on testing. The cynically minded might suggest that this change of heart is not because they now regard intelligence tests as scientific but because testing provides not only jobs for psychologists but also a professional role in medical, educational and criminal institutions.

Intelligence tests were not originally developed as part of a scientific attempt to understand the nature of human intelligence. Galton[30] explicitly set out to 'prove' that intelligence was a biologically fixed inherited capacity, found in different proportions throughout society. The upper classes were innately superior in intelligence, the lower classes innately inferior. The former, therefore, 'deserved' their wealth, influence and high social status as they had 'won' in the fight of the 'survival of the fittest'. Intelligence tests can be seen as part of an extension of social Darwinism, of the struggle for the replacement of 'religious' by 'scientific' explanations. To have suggested in late nineteenth century England that intelligence was not due to genetic inheritance (scientific factors) would not have been to suggest that environmental/ social factors were relevant but to have accepted that ability and indeed social stratification was determined by divine intervention.

Intelligence tests were being developed shortly after the introduction of mass schooling (see Chapter 5) and society was concerned about those who 'failed' to benefit from schooling and who frequently came from 'social problem' families. While Binet wanted to develop intelligence tests to 'discover' and help children who were unable to benefit from schooling in the 'normal' classroom, Terman, who translated .the Binet test into English in 1916 (The Stanford-Binet Test), explicitly wanted to use the test to identify the permanently defective individual who posed a threat to civilization.

> It is safe to predict that ... intelligence tests
> will bring tens of thousands of these high-grade
> defectives under the surveillance and protection
> of society. This will ultimately result in
> curtailing the production of feeble-mindedness
> and in the elimination of an enormous amount of
> crime, pauperism and industrial inefficiency ...
> the high-grade cases of the type now so frequently
> overlooked, are precisely the ones whose guardianship
> it is most important for the state to assume.[31]

Thus intelligence tests were quickly seen as a 'scientific' tool to identify this group who proved a threat to society and from whom society needed to be protected.

Not only were intelligence tests used to 'discover' and segregate the mildly subnormal - a group thought to pose a threat to civilization - but they also assumed that school 'success' and 'failure' showed who was and was not intelligent. The test items, assumed to measure an innate, fixed capacity, were selected so that they confirmed teachers' judgements of which children were 'bright' and which ones 'dull'. However, the ability to do well at school is related to many factors other than the assumed 'innate' intelligence, ranging from physical factors such as ability to see and hear to individual attitudes to school and teachers' expectations of pupils' progress.[32]

The weakness of intelligence tests as diagnostic and predictive tools results from the underlying assumptions about the nature of intelligence. Psychometricians

> ... claim, on the one hand, that it makes no assertion about essential intelligence, and that what it refers to is simply measured intelligence. On the other hand, however, it protests that this measured intelligence has no reference to practical, social and political context [33]

and

> When a psychometrician protests that what he says about measurable differences has no political significance but simply refers to the facts which may be classified as true or false, the intelligence test to which he refers is, as a matter of empirical fact, used in practical contexts to assign children to different forms of education, to choose between one individual and another in job placement, and generally to set one man above another. What he does when he rates individuals or groups of individuals on a scale of measured intelligence is to say and predict that one group of individuals rather than another should have privileges ... scientific observations have political implications and the scientist should be aware that that which he reveals may contribute to or ease human suffering.

Psychometricians see intelligence as a 'thing', an attribute possessed in a given quantity by an individual, not as a function of a social matrix - behaviour which is sanctioned and approved by certain powerful groups in society. Intelligence tests were originally developed and continue to justify the status quo. They are used to select and classify individuals and

> The function of such selection is not to diagnose the truth, but to prove the inevitability of the status quo. [34]

2.4 Intelligence tests and labelling

Intelligence tests are used, especially in the case of the mildly handicapped, to confirm their status by labelling them officially as subnormal. This is an initial process in the individual's career - the outcome of the test, conferring deviant status, determines the way that the individual is 'dealt' with in the future and may influence his self-image. Labelling need not have negative consequences for the individual; it can have positive results - enabling the individual to be allowed to develop his potential. In our society, however, to be labelled subnormal is to be denied opportunity, to be cast aside, to be provided with insufficient help and services and to be labelled as someone who will never develop 'adult' competence. (See Chapter 6 for a discussion of current provision for the mentally handicapped).

The continued use of psychometric tests, then, can clearly be seen as related to what society 'chooses' to do with those it labels mentally handicapped. While the main outcome of selection and processing is class-ification, and not the development of programmes designed to facilitate individual growth and development, then they remain inadequate. This relates not only to our knowledge or lack of knowledge about how to help the incompetent, but also to how much economic investment and time society is prepared to put into helping a group who are seen as being able to contribute little to society in return.[34]

3. Alternative psychological approaches to Mental Handicap

So far I have attempted to highlight a number of practical and theoretical problems that arise from the dominance of the clinical and psychometric models of mental handicap and the use of intelligence tests as diagnostic/placement tools. I have suggested that one reason that intelligence tests continue to be used is

because they serve an ideological and political purpose
in our society, in that they provide a 'scientifc'
justification for the status quo.   They rationalise the
existing distribution of social, economic and political
power - the social class system.   In a sense the
mentally handicapped are victims of this process.

This does not mean that if we stopped using
intelligence tests, or indeed medical and psychometric
assessment, then the mentally handicapped would
magically disappear.   Those who are incapable or have
problems with coping with the day-to-day demands of our
society would continue to exist, and many would still be
seen as contemptuously different.   They would still
need special help and support, the exact amount depending
on the degree of their handicap.   However, a radical
re-orientation of basic assumptions and methods of assess-
ment could result in more 'adequate' help being given to
the mentally handicapped and the development of more
positive attitudes towards them.

What does seem to emerge is that the medical and
psychometric models merely confirm the status of the
mentally handicapped and implicitly contain the notion
that little can be done to 'improve' the situation.
Furthermore, the use of intelligence tests to assess and
classify the mentally handicapped does not help in the
development of programmes designed to enable the mentally
handicapped to develop their full potential.   In the case
of the mildly subnormal the social and cultural bias of
intelligence tests means that many children are
labelled, not because of social incompetence, but because
of their general inability/unwillingness to conform to
the middle-class norms, values and expectations of the
school system.   The dominant models of mental handicap
mean that people are seen primarily in terms of what is
wrong or abnormal about them rather than in terms of the
community in which they live, the ways in which people
behave towards them, and the needs arising from them.

The dominant models support the status quo in that the subnormality of the individual, rather than the inadequacies of the environment are 'blamed' for his failure and inadequacy.

> Focussing on the differences between people,
> in preference to the similarities, is a
> form of exclusion - exclusion from the
> possibilities of a shared reality.   In this
> way our common ways of thinking about
> mentally handicapped people reflect society's
> exclusion of them from any shared life.[35]

I have suggested that the continuing dominance of these models and especially of the intelligence test in the field of mental handicap results from an apparent lack of an alternative model. The role of the psychologist continues to be that of testing, partly because that is what is expected in the system and partly because no alternative method of assessment has yet been adequately developed.

> The need for alternative approaches to assessment
> springs on the one hand from the failure of the
> intelligence test to provide information which
> can be positively harnessed to the design of
> a programme of education or habilitation, but
> also arises from the need for assessment techniques
> which allow for an ideographic approach to the
> wide individual differences found within the
> mentally handicapped population. [36]

The interesting point to raise here is that there <u>are</u> alternative theories of cognitive development which may be of practical use in the field of mental handicap, but few psychologists have carried out research into their implications for subnormal people[37] (although on the practical side Piagetian theory has influenced educational practices in Great Britain for about the last twenty years and behaviour modification is being used increasingly, especially in the training of the more severely handicapped). My purpose is not to provide a comprehensive review of all possible alternative theories of development, but to show that such theories do exist and in a preliminary way to raise the question of why their implications for the mentally handicapped have not been more fully explored. I would suggest that this relates to dominant attitudes

and values, which place the mentally handicapped low
on any priority list that involves public spending.

3.1 Behaviourism and behaviour modification

A radically different psychological theory from that on which
psy hometrics is founded , and which has greatly influenced
programmes of remediation and the education of mentally handi-
capped people, is behaviourism. Behaviourism is an empiricist
school of psychology interested in the observation of tangible
behaviour and in changing such behaviour by modifying the
environment rather than the individual. The approach emerged at
the end of the nineteenth century in reaction against·the assump-
tions made by many psychologists of a world of the mind to
explain man and his doings and a physical world to explain
animals and mechanical objects.

Watson was one of the first behaviourists (in fact he coined
the term)[38] . Impressed by the success of the natural sciences
he determined to make psychology a science of human behaviour
and rejected introspection, pointing out the difficulty of
self-observation and its unreliability. He argued that psychology
should restrict itsef to studying things which can be observed
and to formulating laws concerning these things and only these
things. Although after him behaviourism tended to move away
from the extreme emphasis on visible behaviour and the
avoidance of mediating concepts, he represents its early spirit,
intentions and hopes. He was an extreme environmentalist and
stress d the fundamental equality of man and the possibility (and
desirability) of social engineering. Watsan laid down the main
tenets of the theory in his book Behaviourism, published in
1924, although an article which he wrote in 1913 set out an earlier
formulation. Consequently he was writing at just the time when
hereditarian though was influencing social policy and the
development of intelligmace testing. Indeed, he expressly
rejects and argues against eugenic arguments:

> Does the behaviourist mean to say that great talent
> is not inherited? That criminal tendencies are not
> inherited? Surely we can prove that these things can
> be inher·ted?...The behaviourist recognises no such
> things as mental traits, dispositions or tendencies.
> Hence, for him, there is no use in raising the
> question of the inheritance of traits...[39]

and

Objectors will prob bly say that the behaviourist is
flying in the face of the known facts of eugenics and
experimental evolution - that the geneticists gave
proved that many of the behaviour characteristics of
the parents are handed down to the offspring...Our

reply is that the geneticists are working under the
banner of the old 'faculty' psychology...We no longer
believe in faculties, nor in any stereotyped patterns
of behaviour which go under the names of 'talent' and
inherited 'capacities'.

Furthermore, he argued that it was possible, by changing the

environment, to determine the cognitive development of the

child.

I should lke to go one step further now and say
'Give me a dozen healthy infants, well-found, and my
own specified world to bring them up in, and I'll
guarantee to take any one at random and train him to
become any type of specialist I might select - doctor,
lawyer, artist, merchant-chief and, yes, even beggar-
man and thief, regardless of his talents, penchants,
tendencies, abilities, vocations and race of his
ancestors.

Thus Watson redefined psychology as the study of behaviour and

placed an emphasis on controlling as well as predicting it;

moreover, he argued that every psychological event could be

described in terms of stimuli and responses. Watson was a

populariser of psychology, and from the 1930s to the 1950s

Americal psychology was dominated by behaviourism, which indeed

continues to be an influential theory[40]

It is the notion of controlling or altering behaviour by

modifying the environment that has had proactical application

as Behaviour Modification. The practice of behaviour modification

is influenced by behaviourism in that the behaviour therapist

is not concerned with the underlying causes of behaviour, but

with overt behaviour which they assume to be controlled by social

forces and consequently open to manipulation by operant condition-

ing. In evaluating behaviour the focus is on the immediate,

observable and measurable behaviours that characterise the

individual's present functioning or malfunctioning. The aim is

to control unacceptable behaviour - which is assumed to be the

result of a failure to learn.

Thus the essential features of the behaviour modification model are first that behaviour is learned, secondly that it can be analysed and changed, and thirdly that it is best learned , through positive reinforcement. It is influenced by behaviourism in that it accepts a deterministic account of human development - Skinner's 'mechanical maturation' - and that it has adopted the scientific method and the language of behaviourism - that is, the primacy of the observable remains, despite some modification. However, it must be pointed out that a number of writers[41] have argued that the basic principles of behaviourism are largely irrelevant to the proactices of behaviour modification, which are developed and refined on the pragmatic basis of what seems to work best in the situation.

In the field of mental handicap the behavioural model provides a basis for remediation bcause it accepts that behaviour can be changed and provides the tools - conditioning techniques - for doing so. Therefore, unlike the psychometric approach, which emphasises that the mentally handicapped child cannot perform and reinforces an underestimation of potential, behaviour modification sees the child as having the potential to be changed - to have his behaviour modified so that it becomes acceptable - as well as the ability to be taught new skills.

> Subnormal behaviour is seen as a failure of learning.
> Aetiology and history are critical only to the extent
> that they may affect the formation of stimulus-response
> relationships. A full analysis of the current behaviour
> and the factors maintaining it may reveal procedures which
> will overcome apparent limiting biological factors...[42]

Behaviour modification techniques have been used successfully with the mentally handicapped in America and Britain, though questions have been raised as to whether operant techniques or other factors are responsible for the observed changes.[43]

3.2 Social competence as the defining variable

Brooks and Baumeister have suggested that as mental subnormality is a social phenomenon, then in order to determine who is mentally handicapped we need to work from the basic premise that the important point is the

view of deviance held by families, friends, educators
and the members of society in general. The mentally
handicapped are those whose behaviour does not conform
to the conventional rules of 'normal' behaviour.
In order, then, to diagnose mental handicap it is
necessary to develop tests of social competence and
adaptation which make 'explicit' what skills are necessary
to cope in the 'real' world.

Apart from the 'fact' that there is a tremendous
financial and intellectual investment in I.Q. tests and that
it is difficult to see how they could easily be supplanted,
tests of social adjustment would still be culturally
biased, relative, and involve social judgement. They would
suffer from many if not all the defects from which
I have suggested I.Q. tests suffer. We would merely
be replacing one test by another.

A more recent development has been the suggestion that
we abandon tests altogether and observe behaviour instead;
that ethological and ecological studies of the assumed
mentally subnormal in their 'natural' surroundings
be developed. Sackett [45] has pointed to the advantages
of these methods

> ...these data (I.Q. scores) do not answer
> questions about what mentally retarded people
> actually do with their motor, perceptual,
> learning, communication and social skills ...
> quantitative observational methods can be used
> to address both basic research questions
> concerning mental retardation and to help solve
> practical problems of retarded people. These
> practical problems involve economic, political
> ecological, social and ethical decisions
> concerning the life styles of retarded
> people living in a complex society'

The main contribution of such studies in the field of
subnormality is to demonstrate just what subnormal
people are capable of doing. The small amount of
research already carried out within these perspectives
suggests that even profoundly subnormal people can be
trained to earn a living, while living independently
in non-institutional residences.

These methods still use a quantitative, scientific approach, however, and Edgerton and Langress[46] have pointed to the disadvantages of these methods and the advantages of ethnographic studies. There would appear to be four main problems. Firstly, they do not consider reactive behaviour: how other people react to the mentally handicapped and how this in turn influences the behaviour of the subnormal. Secondly, the method is expensive and difficult to use in public settings. Thirdly, it distances the meaning of behaviour because it chops continuous human behaviour up into discrete units or categories to facilitate counting, and these discrete units are then combined into higher order concepts, a process which results in further distortion. Fourthly, the observer is outside of the phenomenon he is studying; he is recording sequences of behaviour strictly in terms of the observer's understanding of them and therefore cannot penetrate the world of meanings which guide human behaviour.

Edgerton and Langress[47] suggest that ethnography is a more appropriate method for understanding the everyday lives of the subnormal and determining what they are capable of. Edgerton's[48] own research *has already* demonstrated that 'success' in the community is not easily determined: factors such as I.Q., length of time institutionalized and even the ability to get and hold down a job are not especially good indicators.

If we can 'discover' the important variables in successful community adjustment, then it could be possible to develop remedial programmes to help prepare the mentally handicapped to live independent or semi-independent lives.

While observational studies, whether from the 'outside' or the 'inside', would seem to have distinct advantages over tests, both in terms of assessment and/or developing programmes of remedial treatment, few have been carried out. This is probably related to the time and cost involved as well as the lack of research

interest in subnormality   on the part of psychologists
and sociologists.

3.3 Mental Handicap as arrested or incomplete development
      Morrison and MacIntyre[49] have suggested that an
alternative to the psychometric approach to intelligence
is Piaget's emphasis on the way in which intelligence
develops.   This approach leads us to search for the
conditions and experiences necessary or valuable for the
development of intelligence.   Piaget's model is
a developmental theory of intelligence which postulates a
definite sequence of developmental stages, a sequence
which is invariant for all individuals.   Intelligence,
in the Piagetian model, is an attribute of an active
organism in some environment.   Thus, in common with
most theories of intelligence, the theory assumes that
the organism develops in a kind of quantitative way -
that is, the individual is born with a certain way of
handling experiences and in development there is an
increase in the amount of data to be handled.
Piaget, in addition, proposes a _development_ of _the ways_
in which data are handled.   These data-processing methods
constitute intelligence.

    The two complementary core processes are assimilation
(organization of experience in terms of existing schemata)
and accomodation (the reorganisation of schemata through
disequilibratory experience). When there is a balance between
assimilation and accomodation the organism is said to be
in a state of equilibrium. The basic structural unit
of intelligence, the schema, is a response pattern
which is said to have both behavioural and physiological
aspects.   Schemata are named by the sequences of
behaviour to which they refer .   , ˙ Some
schemata are innate.   The innate schemata are processed
and produce new schemata, a process responsible for all
intellectual growth.

    Thus in Piaget's work there is an emphasis on the
activity of the organism and on interactions between
the organism and the environment in which the individual

is constructing his own schemata.

> But the psychological facts allow us to
> refute this hypothesis of complete social
> determinism. Society does not act on growing
> individuals simply by external pressure,
> and the individual is not, in relation to
> the social any more than to the physical
> environment, a simple 'tabula rasa ' on which
> social constraints reprint readymade knowledge.[50]

Piaget's work is based on the view that

> ...cognitive development is a coherent process
> of successive equilibriums of cognitive
> structures, each structure and its concomitant
> equilibrium deriving logically and inevitably
> from the preceding one.[51]

This development proceeds through a number of discrete
stages - an invariant sequence with each stage typified
by particular ways of behaving. However, these stages
are not tied to chronological ages.

Piaget's interest was in developing a system which
would account for 'typical' development, rather than
with the factors that would result in variations in
this pattern. However, an organism/environment interaction
model which takes account of the variability of environ-
ments could lead to the view that intelligence develops
in a non-linear manner, which would challenge the view
of static intelligence and demonstrate the poverty of
chronological age-based tests. Thus

> the main difference between Piagetian theory and
> the theory behing traditional I.Q. testing is that
> the latter holds that development is a progressive,
> continuous process, whereas Piaget's argues that
> development involves frequent repetitions and even
> reversals, with an older child at times doing less
> well than a younger child on the same task. [52]

It is important to raise the question as to how the
Piagetian school view the subject of continua in developmental
disorders as well as in the normal child, and how this relates
to remediation/education programmes. (This is especially import-
ant given the influence that Piagetian psychology has had on
educational practice in Britain in the last twenty years). The
main work in this area has been by Inhelder[53], a close
collaborator of Piaget's. Working with mentally handicapped

children and young people it was possible to demonstrate that
children with different grades of defect were qualitatively
distinct from one another in terms of their mental operations
in ways analogous to stages that Piaget had described in
the development of the normal child. Mental handicap did not
only involve different degrees of intellectual backwardness, as
defined by some linear scale; there are different kinds of
mental retardation that differ both from each other and from
the normal.

Rees   evaluates the contribution of Piaget's
developmental psychology for mental retardation and
argues that

> The final test of the value of a Piagetian
> interpretation of mental retardation must
> depend on an evaluation of its effectiveness
> in increasing our understanding of retardation
> as well as providing new and better tools for
> dealing with its attendant problems ...
> thus far there has been only a slight beginning
> in investigating this.[54]

He suggests that the value of Piagetian tests for
evaluating the mentally handicapped has yet to be established
and that if they are to be of value they must help in
the development of remedial programmes. With regard to
special education, the available evidence suggests that
accelerating development is not possible, but Piaget's
theory adds emphasis to the view that children learn by
experimentation and provides a basis for developing
remedial programmes for educating the mentally handicapped.
Furthermore, Inhelder's work with retarded children suggests that
mentally handicapped children differ from each other and from
normal children in terms of their mental operation, and this has
important implications for prognosis and consequently for educat-
ion. It highlights the fact that there are different kinds of
mental backwardness, with correspondingly different educational
requirements.

3.4 The work of Luria

Luria[55] has stressed that human learning takes place primarily by means of language in social intercourse, in a man-made setting which itself incorporates the achievement of human development. He argues that the human child learns through joint practices and speech with human beings and it is by means of the language he acquires, the tools he learns to handle and so forth that the achievements of the human species are embodied and passed on.

The emphasis is on the formation of complex functional systems, found in the course of development, which underly qualitative changes in mental process. Luria rejects the view that mental characteristics are simple manifestations of internal properties which develop in the course of maturation independently of living, and argues that intellectual development, in the process of learning, marks a change to qualitatively new levels of thought.

There are four basic features of this approach to development. The emphasis is on human learning. There is a stress on the role of speech in the process of mental development. It is a developmental approach, and there is an emphasis on longitudinal methods of research.

Luria works from Pavlov's basic assumption that it is language which distinguishes man from the animal. He suggests that there is a direct link between the development of language and the ability to reason. This relationship develops out of and alongside social-mental development. Mental and linguistic development reciprocally determine each other, though they are never synonymous. But it is the development of language that enables man to represent the world to himself, to develop the ability to transcend the here and now, and to go beyond immediate experience. Therefore, there is a close relationship between linguistic development and complex

human behaviour. The development of complex mental processes is dependent on the development of language.

The development of mental processes is a result of complex interactions between the individual and his environment, and is not an innate property of mental life that develops with maturation. At each stage of development, concrete forms of activity are presented to the child which pose new problems and new demands; these in turn necessitate the development of new forms of reflex action. A child's mental activity must be seen as the outcome of his life in certain determined social circumstances; human-mental activity takes place in conditions of actual communication with the environment, in the course of which the child acquires from adults the experiences of many generations: language, which incorporates the start (for example, the naming of objects). The child's speech develops in practical activities - in play - in the here-and-now. Later it can be used to predict, and this enables abstraction. Speech, which reflects objective reality, directly influences the formation of complex human activity; it enables the development of abstract thought to take place, which introduces a new process of activity - abstraction - which raises mental processes to a new level.

Luria was able to develop his theory of cognitive development by research in rural parts of the U.S.S.R. in the 1930's when collective farming and mass literacy programmes were being introduced. He was able to compare the cognitive development of peasants who remained illiterate with those who took literacy courses and worked on collective farms. By doing this he was able to demonstrate that the ability to think complexly and abstractly developed with socio-economic development. The structure of all thought, then, depends upon the structure of the dominant type of activity in different cultures. Practical thinking will predominate in societies that are characterised by practical manipulation, whereas the more abstract forms of theoretical activity

in technological societies will involve more abstract
thinking.   There is, then, a parallel between individual
and social development and this enables the interpretation
of behavioural differences in developmental terms.

> It seems surprising that the science of psychology
> has avoided the idea that many mental processes
> are social and historical in origin, or that
> important manifestations of human consciousness
> have been directly shaped by the basic
> practices of human activity and the actual
> forms of culture. [56]

Luria argues that psychology, in its attempt to be
an exact science, has looked for laws of mental activity
within the organism and has ignored the social origins
of higher mental processes. Psychologists have argued
that the patterns determining mental processes are the
same for all human subjects, whether from different
cultures or from different historical periods, and the
same for elementary mental processes as complex forms
of mental activity.   But Luria suggests that it is
necessary to understand

> ...that higher cognitive activities remain
> sociohistorical in nature and that the
> structure of mental activity - not just the
> specific content but also the general forms basic
> to all cognitive processes - change in the
> course of historical development. [57]

Consciousness does not represent an intrinsic property
of mental life, invariably present in any mental state
and independent of historical development.   It is the
highest form of reflection of reality - not given in
advance, unchanging and passive, but shaped by activity and
used by human beings to orientate themselves to their
environment, not only in adapting to conditions but in
restructuring them.

> ...mental processes depend on active life
> forms in an appropriate environment. [58]

In the same way as human action changes the environment,
so human mental life is a product of the continually new
activities which manifest themselves in social practice.
New motives for action appear under extremely complex

patterns of social practice, as new problems are created, new modes of behaviour, new methods of taking in information and new systems of reflecting reality develop.

Thus the social forms of human life determine human mental development. From birth, children live in a world of things which social labour has created and which are the products of history. They learn to communicate and to develop relationships. They assimilate language, which is itself a product of socio-historical development, and use it to analyze, generalize and encode experiences. Language moderates human perception and enables complex mental operations to develop - the analysis and synthesis of incoming information, the perceptual ordering of the world, the encoding of impressions into systems, and the abstract represent-ation of objects and events.

Luria's and Vygotsky's[59] study of twins with speech defects enabled them to demonstrate the changes in the twins' cognitive development which occurred as they acquired complex speech patterns. At the age of 5 years the twins could only use primitive speech, interlocked with concrete actions. They had an insufficiently differentiated structure of consciousness; they were unable to detach word from action, to master orientation or planning activities, to formulate the aims of activity with the aid of speech and so to subordinate their future activity to mental formulation. They were not able to organise complex play of a kind usually indulged in by 5-year olds, and were unable to take part in or organise production of meaningful activity. Their intellectual abilities were very limited and well below those 'normally' developed by 5-year olds. In other words, they could be said to be mentally subnormal.

The twins were separated, and as a direct result the rapid acquisition and use of language developed. The 'primitive' speech they originally used receded into the background and 'normal' language structure developed.

Not only was there a substantial improvement in speech,
in terms of clarity, grammar and structure, but speech
was also fulfilling a new function.   In place of speech
interlocked with direct activity and expressive speech,
they developed first narrative and then planning speech.
More significantly, the whole structure of the mental
life of the twins was simultaneously and sharply changed.
The acquisition of an objective language system enabled
them to formulate the aims of their activities and to
begin to construct meaningful play.   The possibility of
productive, constructive activity on the basis of
formulated aims was opened up.

> Therefore the results of our experiments show
> that with the creation of an objective
> necessity for speech communication, the
> children were satisfactorily prepared for the
> acquisition of a language system: not only did
> they develop new forms of communication with the
> aid of development verbal speech, but also
> there were called forth significant changes in the
> structure of their conscious activity, built
> upon the basis of verbal speech.[60]

Luria[48] rejects the use of I.Q. tests and argues that a
test score tells us nothing about the child or how to
solve his or her problems.   Furthermore, he suggests,
to assume that children who have the same I.Q. in common
are eoual is a mistake.   He argues that attention needs
to be given not only to diagnosis, but also to
the prognosis of the developmental potential of subnormal
children.   Thus the causes of subnormal intellectual
functioning may be biological and/or environmental factors,
and diagnosis must be clearly linked with future treatment.
That is, the 'cause' of poor school performance/social
adaptation should determine the future programme of
remedial help and treatment.   A child who is making
slow progress at school because of loss of schooling
due to illness will need different treatment to that of a
child with the same I.Q. and school performance but who
has brain damage, or again from a child who comes from
an adverse environment.

But how does Luria's (and Vygotsky's) theory of
cognitive development help us in the diagnosis of mental

subnormality and the provision of remedial programmes?
Luria argues that only those with brain damage or
genetic abnormality are 'true mental subnormals';
those whose subnormality is the outcome of an impoverished
environment are merely handicapped.[61] It is in under-
standing and helping this latter group that the theory
would seem to have relevance. It enables us to understand
how cognitive development is related to the demands of
the environment, and the importance of language
acquisition for intellectual development. However, it is
important to remember that dialectical materialist psychology
is about much more than language and incorporates a stage
theory of development. Furthermore, the defectology derived
from it in Russia does not have an emphasis on language
development as its main focus[62].

3.5 Conclusion

It is then evident that theories of cognitive
development other than the psychometric one have been
developed within psychology, but that relatively few
attempts have been made to investigate the implications
of these theories for assessing and helping mentally
handicapped people. Furthermore, as Ryan has suggested,
even when psychologists have attempted to devise programmes
aimed at developing teaching/remedial education

> The focus ... is still very much on changing
> the behaviour of each mentally handicapped
> individual, the behaviour of others ...
> or the effects of the total environment, are
> seldom investigated. And because most
> psychological approaches do not have a
> sufficiently comprehensive view of what it
> is like to live one's life as a mentally
> handicapped person ... the measure of success
> hoped for does not always materialize.[63]

4.   Conclusion: The need for a sociological approach

In this chapter I have attempted to evaluate, from a
sociological perspective, the inadequacies of the
dominant medical and psychometric models of mental handicap.
This is not to suggest that the severely subnormal, and even
many of the moderately subnormal, do not have an organic
basis for their handicap, nor that if we abandoned these
models incompetence would magically disappear.

However, both these models assume rather than explain
the existence of a 'real' condition of handicap - even
if there were such a condition and it had an organic
basis, that would still not explain why it is a social
problem in our society.   Furthermore, the assumptions of
these models - that mental handicap is incurable -
influence the care and provision made for, and perceptions
of and attitudes towards, mentally handicapped people.

One of the main diagnostic tools used in the field
of mental handicap is the intelligence test.   While many
academic psychologists acknowledge that these tests are
an inadequate instrument for the diagnosis and classifi-
cation of mental handicap, and are virtually useless for
aiding the development of remedial programmes, they
continue to play a dominant role.   This cannot be
explained by the 'fact' that there is a lack of possible
alternatives.   Psychologists have developed alternative
theories of cognitive development, which would seem to
contain the possibility of providing more adequate tools
for diagnosing mental subnormality and providing
guidelines for remedial educational and training programmes.
It is therefore necessary to ask why psychometric tests
continue to play such a dominant role in the official
diagnosis and classification of the mentally handicapped.
I have already suggested that this is related to the
ideological and political structure of our society, and
later in this study I shall also argue that it is inextric-
ably linked to the way in which, and the reasons why,
the mentally subnormal are seen as outsiders and managed
as deviant in capitalist societies.

Thus while psychologists have been concerned with the
selection and classification of individuals for management
within a given system, it is the role of the sociologist
to explain why classification takes place on a given
basis, and the consequences of this for the individual,
his family and society in general.   While psychologists
will aruge that the mentally handicapped are those who
are diagnosed to be incompetent on the basis of a
'scientific' measure, sociologists are interested in the
processes by which someone becomes labelled and the

'purpose' of labelling.   One of the contributions sociology
can make in the field of mental handicap, then, is to
evaluate the dominant models, to lay bare their underlying
assumptions, demonstrating the way in which their use
helps to maintain the status quo and influence social
perceptions of and community attitudes towards
the mentally handicapped.

REFERENCE NOTES, CHAPTER THREE

1: Deacon, 1974   2: See Block and Dworkin, 1972

3: This is not strictly true - some schools do test all
   children routinely - but as far as I am aware this is
   not the policy of any Local Educational Authority.

4: See Tomlinson (1981) for an analysis of the process by which
   children are labelled E.S.N.(M) in England.

5: Mittler, 1980

6: Mittler, 1973. See also Locke, 1978, and Tomlinson, 1981.

6a: Chazan, (1974) in a recent survey, found that the main role of
    educational psychologists was assessment and that they spent
    a relatively small proportion of their time in direct and
    indirect 'treatment' activities.

7: Clarke and Clarke, 1973a. P S   8: Clarke and Clarke, 1973a.

9: O'Connor and Tizard, 1956   10: Jordan, 1974.

11: See Scull (1975, 1977, 1979), Parry and Parry (1976).

12: Sarason and Doris, 1969 P24   13: N.S.M.H.C., 1974

14: Clarke and Clarke, 1975 P 29-30 15: e.g. Bowles and Gintis, 1976

16: E.G. Rosenthal and Jacobson, 1968; Luria, 1976.

17: Luria, 1976.   18: Sapsford and Evans, 1979 P 13

19: See, e.g., Stein and Susser, 1960; Coard, 1971; Mercer, 1973;
    Tomlinson, 1981.

20: Mittler, 1973 PV   21: Ryan, 1976

22: Rose et al., 1976   23: Ryan, and Thomas 1980 P124

24: See Mittler, 1980, for a more detailed discussion of this point.

25: For a more extended critical discussion see, e.g.,
    Kamin, 1974; Lawler, 1978; Evans and Waites, 1981.

26: See, e.g., Block and Dworkin, 1972; Kamin, 1974; Lawler, 1978.

27: Boring, 1950   28:E.G. Block and Dworkin, 1972

29: Boring, 1950   30: Galton, 1869

31: Terman, 1919 Ps 6-7

32: See, e.g., Rosenthal and Jacobson, 1968

33: This and the remaining quoted passages in the paragraph are
from Rex, 1973.

34: See Shearer, 1981, for a discussion of how state financial
benefits are weighted in favour of those who are economically
active.

35: Ryan and Thomas, 1980 P 27   36: Mittler 1973 P 2.

37: Indeed, some of these 'theories' do not conceptualise
development in these terms at all, but are more concerned
with trainability.

38: Watson, 1913

39: This and the following quoted passages are from Watson, 1924
Ps 95, 104 and 113

40: For example, Skinner, 1972.

41: E.G. London, 1972; Schweiso and Hastings, 1980

42: Kiernan, 1974 P 731

43: See, e.g., Kiernan, 1974; Barason and Doris, 1979. For a
recent critical review see also Strivons, 1981.

44: Brookes and·Baumeister, 1977   45: Sackett, 1976 Ps 3-4

46: Edgerton and Langress, 1976   47: Edgerton and Langress, 1976

48: Edgerton, 1967   49: Morrison and MacIntyre, 1971

50:            Inhelder, 1958   51: Flavell, 1963 Ps 36-37

52: Bower, 1979 Ps 119-120   53: Inhelder, 1943

54: Reis, 1987

55: Luria and Vygotsky, 1961; Luria, 1976. See also Sutton, 1980;
Douglas and Sutton, 1978.

56: Luria, 1976 P 3   57: Luria, 1977 P 114

58: Luria, 1976 P 9   59: Luria, 1961
                    P 107
60: Luria and Vygotsky, 1961. For a replication of the experiment
see Douglas and Sutton, 1978.

61: Luria, 1961. This view also underlies official Soviet policy
towards mental handicap; see, e.g., Katy, 1962; Sutton, 1980.

62: See chapter 8 and Sutton, 1980.

63: Ryan and Thompson, 1980 Ps 127-128

CHAPTER 4

THE HISTORICAL APPROACH: THE CARE AND CONTROL OF
THE MENTALLY HANDICAPPED IN PRE-INDUSTRIAL SOCIETY

1.   Introduction

In Chapter 2 I suggested that one of the deficiencies
in much of the existing sociological literature in the
field of mental handicap was that it had paid insufficient
attention to history. Furthermore, I contended that in
order to develop a sociological perspective it was first
necessary to undertake a historically informed macro-
sociological analysis of changing perceptions of the
mentally handicapped. This derives from the view that
it is not possible to understand the current situation
of the mentally handicapped in our society without
examining how they came to be so situated.

Therefore, in this chapter, I will examine historical
perceptions and handling of the mentally handicapped up
to the end of the eighteenth century. In the next
chapter I will complete this historical analysis by
examining changes in the nineteenth and twentieth centuries.
The main purpose of this will be to argue that definitions
of, attitudes towards and handling of the mentally
handicapped have always been and still are a function of
the nature of a society and its history. The currently
dominant models of mental handicap, examined in Chapter 3,
tend to assume that the concept 'mental handicap' has not
been influenced by time, place and society. I will
attempt to demonstrate that the identification, description
and explanatory accounts of the people we now call
mentally handicapped have varied as a function of time,
place and social situation, and that to label someone as
mentally handicapped implies a decision about a course of
action. Thus all of these always and inevitably reflect
a society's views at a particular time about what is
right/wrong, appropriate/inappropriate behaviour.

it is of course not possible to 'prove' this without extensive
cross-cultural comparison as well as historical analysis,
but it will be possible to provide considerable confirmatory
evidence.

1.1 The Identification of the Mentally Handicapped

One of the main problems in developing a historical
perspective on mental handicap is that there is little
evidence on attitudes towards the mentally handicapped
and the handling of them before the nineteenth century.
Apparently no clear distinction was made between the
mentally handicapped and other groups of people who were
seen as different or presenting a social problem.
More specifically, it was not until the end of the
eighteenth century that systematic attempts began to be
made by medical men and others to distinguish between
the mentally handicapped and mentally ill and to 'treat'
them separately.

Legal distinctions were made between those who were
permanently (and presumably congenitally) arrested in
intellectual development and those who were temporarily
incapable of assuming responsibility for their actions
in the ancient world.   A legal distinction of this type
was also made in England in the thirteenth century.
This distinction was made primarily for administrative
pruposes and it is doubtful if the categorization of
individuals would correspond with modern distinctions.

In the seventeenth century Thomas Willis[1] maintained
that it was vital for doctors to distinguish between
the mentally ill and the mentally handicapped and
suggested two separate clinical categories - the 'foolish'
and the 'stupid'; the term 'idiot' however continued to be a
generic term for the mentally ill and the mentally handi-
capped until well into the nineteenth century.
Pinel,[2] the French physician who released the 'mad' from
their chains at the Bicetre Hospital in Paris at the end
of the eighteenth century,made no clear distinction,

in his writing, between the mentally handicapped and
the mentally ill.   Hobson has pointed out that

> insanity in McNaughton's day [1843] was
> commonly used, even by doctors, in such a
> way as to include 'imbecility' [3]

The English Lunacy Act of 1890 applied to the mentally
handicapped as well as the mentally ill, despite the fact
that by this time attempts to make a distinction between
the two conditions were at least fifty years old.
Indeed it is still common for the 'general public' to
confuse or fail to distinguish mental handicap and
mental illness, and Emerson[4] has suggested

> ...the distinction between the mentally ill
> and retarded is often difficult to make
> and impossible to prove even with the
> professional assistance available to us.

Thus, although there is clear evidence that the existence
of people we now call mentally subnormal was recognised
in pre-nineteenth century Europe, there is little
indication that they were handled as a distinctly separate
group.   While the more severely handicapped would have
been identified as obviously different, many would have
died young, victims of the high infant and general
mortality rates.   The mildly subnormal would have
managed in general to have appeared 'normal' but may
well have been among those who were unemployed, especially
in times of rapid socio-economic change such as the
period of Enclosures in Elizabethan England and the
beginning of the Industrial Revolution in the eighteenth
century.   They would have joined the unemployed beggars
and vagrants on the margins of pre-industrial society,
receiving charity in pre-reformation Europe and being
incarcerated in the workhouse after the Poor Law Act of 1601.
There is little evidence to support the view that the
unemployed/unemployable were cared for by their families.[5]
Indeed, in pre-industrial Britain the majority of the
population merely subsisted, and a non-productive member

of the family would have imposed an intolerable burden.

It would seem justifiable to claim that while the
definite identification of the mentally handicapped as a
distinct separate category is a recent development,
they have throughout recorded history been part of a
socially marginal or deviant group.   An examination
of historical attitudes towards, and social provision
made for these groups, with special reference to the
mentally subnormal, should enable us to understand the
relationships betwen socio-economic structures,
socially constructed attitudes towards the subnormal,
and the type of provision made for those labelled and
managed as deviants.   As Rosen[6] has suggested:

> History derives from challenges experienced
> by various groups of people, and the ways in
> which they respond to them. The result is a
> variety of actions and reactions under different
> circumstances and in widely divergent ideological
> climates. Yet these actions and reactions have
> in one way or another brought us to the present -
> institutions, patterns of behaviour, systems of
> ideas - all have developed from something there
> before. Attitudes towards mental disorders,
> theories of mental illness, arrangements for
> the care of the individuals afflicted - all
> illustrate this tension which is too often
> overlooked.

A person's social perception is influenced by the core-
values and orientations to life of the society or sub-
society in which he participates.   This has profound
implications for the identification and management of
deviants.   It is not the *pathology of the individual*
that determines how he is managed, but the attitudes
and values of those who perceive him.

1.2   Historical Attitudes towards Deviants and their
      Implications for the Mentally Handicapped.

The mentally handicapped are in many ways deviants;
they are apparently unable to behave in a 'normal' way
in society.   Indeed it is this inability that marks them

as outsiders needing special handling. Consequently
if we are to understand trends within the field of
mental handicap we need first to understand social
attitudes towards deviants in general in any socio-
historical istuation. As Scull[7] has pointed out,
it is not until the late eighteenth century that careful
differentiation of different sorts of deviance was made,
with the consequent consignment of each type to 'experts'.
Thus in the pre-modern period little attempt was made
to distinguish one type of deviant from another and
they were all lumped together in a single ill-defined
amorphous entity and responded to in essentially the
same way. The reasons for this are, at least in the
case of the mentally handicapped, probably two-fold:
firstly, the difficulty of identifying causes of deviance,
the problem of distinguishing between mental handicap
and mental illness discussed below, as well as the
probability that 'incompetence' was the 'cause' of
vagrancy, begging and petty criminality; secondly,
that the available means of 'control' were strictly
limited - the major institution for 'warehousing'
from the sixteenth to the nineteenth century was the
workhouse, and the control of deviants was essentially
a communal and family affair.

A historical analysis of man's attempts to deal
with deviants can be categorized into: destroying the
deviant; segregating him from society either to protect
him or to protect society; attempting to make the deviant
undeviant, ignoring the deviant in the hope that he will
'go away'. These categories are not necessarily mutually
exclusive, and more than one method may be used in any
given society. However, one method of dealing with
deviants tends to be dominant, and changes in the handling
of one group of deviants is usually duly followed by
changes in the methods used to control other groups[8] of
deviants.

There also appears to be a strong relationship.·
between the way in which deviants are socially perceived
and the way in which they are handled.   Wolfenberger[9]
has suggested that historically the mentally handicapped
have, in different times and in different societies,
been cast in several main roles. These roles are:
incurably sick person; subhuman; social menace; object
of pity; burden of charity; holy innocent; and developing
person. The role that the individual is cast in,
to a large extent, determines the way he is handled.
For example, in early twentieth century Britain the
mentaly handicapped individual was seen as a social
menace and was incarcerated so that society could be
protected from him.

While it is clear that there is a relationship
between social perceptions of deviants and the way they
are controlled, what is less obvious is why the mentally
handicapped are cast in different roles in different
societies. What I intend to do in this chapter and the
next (and to develop in a more theoretical way in Chapter 8)
is to suggest that the available evidence strongly
indicates that the way a society 'sees' its deviants is
inextricably linked to the norms and values of a society,
themselves a reflection of the dominant ideology.
Szasz[10] has highlighted this in his discussion of changing
attitudes to the mentally disordered in the seventeenth
century, when the dominant Christian ideology with its
associated belief in divine will was being challenged
by science and its associated belief in reason.

> Hence in the incorporated societies of the Age
> of Reason, science (technology) is the dominant
> institution, the scientist-intellectual is the
> interpretation of the laws of nature, schools,
> hospitals and technological certificates are the
> leading social symbols, scientific jargon is the
> official language, and sickness and health,
> treatment and cure, death and life are the
> images and rhetoric that fill the popular
> imagination.   To be truly human now means to

worship science (technology, progress), to be
virtuous means to be healthy (happy) and to be
evil means to be mentally sick (unhappy).

2.   The Ancient World

There is evidence that mental disorders were recognised
in the Ancient World, although there is no documentation
of any effort to assist those identified as mentally
deranged. Palestine, Greece, and Rome all in
various ways cast mentally handicapped people in the
role of outsiders and responded to them as deviants.
The subnormal were seen variously as objects of derision,
aversion, or to be persecuted. The appelation 'idiot'
implied horror and disgust and most of those who were
labelled forfeited all human rights and privileges.

2.1 Israel

The Old Testament of the Bible[11] gives clear
evidence that mental disorders occurred and were recognised
as such in the ancient world. The available evidence, while
providing no clues as to prevalence or exact diagnosis,
does indicate how those identified and seen as mentally
disordered were regarded and treated by the community.

A strong belief among the Jews was that those
who disobeyed the 'will of God' would be severely punished
and that one form this punishment could take would be
for the sinner himself or a member of his family to become
mentally disordered. The birth of a mentally handicapped
child was regarded as a 'punishment' for the sins of
the parents.

Despite this, the attitudes of the ancient Israelites
to strange, bizarre and inexplicable behaviour was to
accept it even though it was seen as different. Mental
disorder was regarded as a private, not a public, matter,
unless or until public safety was involved. Mentally
handicapped people with wealthy relations would have been
cared for in the home, while those from poor families
would have been turned out to fend for themselves, to be
followed, teased and tormented by children, who regarded
them as objects of ridicule.

λ.2 Greece and Rome

The most extreme form of cruelty to the subnormal can
be seen in the society of the Spartans (900 - 200 BC)
who abandoned and killed anyone who was handicapped.
Soon after birth a child was examined by the Town
Elders who declared whether it was to be reared.
Defective or weakly infants were cast in the river or
left on the mountainside to perish. The whole philosophy
of the society was 'survival of the fittest'.
Infanticide can be seen as the most extreme form of
dealing with the deviant or undesirable members of
a society.

This practice was commonly advocated and acted
upon in other Greek city states. In Athens, children
who were blind, deaf or mentally dull were thrown into
the river by their parents so that they could be relieved
from the burden of their support, while the Greek poet
Theogris of Megara wrote[12]

> ...yet a good man minds not to wed the evil
> daughter of an evil son ... Marvel not that
> the stock of our folk is tarnished for the good
> is mingling with the base.

and Plato[13] advocated biological selection to facilitate
race improvement.

In Ancient Rome, too, eugenics was a common practice.
In the old Roman law the mentally defective were designated
'mente-capti' (those defective in intellect), and the
legal code involved guardianship and prohibited marriage.

2.3 Later developments

In the ancient world mental disorders were generally
regarded as punishment from the Gods. The mentally
handicapped were generally regarded as extra-social beings
and commonly ostracized, derided, persecuted, neglected
and considered incapable of human feelings and consequently
undeserving of help. As sub-human they were not
considered as part of the community and therefore were
unable to participate in politics and to administer land.

Legally property was protected, but apart from this
society generally ignored mental handicap.

The ignominy of mental handicap also extended to the
medical profession, as Weygenalt[14] has pointed out:

> While writers in antiquity gave vivid and
> correct descriptions of specific psychic
> conditions ... idiocy has rarely been mentioned
> until recently.

and Cranefield[15] has noted that there is no clear
description of cretinism in ancient medical writings
despite the fact that it is evident that endemic goitre
and cretinism existed in the Ancient World.

3. Early and High/late Middle Ages

The decline of the Ancient World and the fall of
Rome was accompanied by the spread of Christianity, which
became the dominant religious ideology of the Western
world.   The spread of Christianity and its underlying
doctrine of compassion for the unfortunate led, for a
while at least, to an improvement in the plight of the
mentally subnormal.   Along with other 'unfortunates'
they were provided with clothing, food, shelter, and the
Institutes of Justinian provided guardians for the mentally
subnormal as well as the deaf and dumb.

However, tremendous variability characterized the
treatment of the subnormal (as well as other social
outcasts) during the medieval period.   This ranged from
treatment as innocents, to being tolerated as fools,
to persecution as witches.   Increasingly, however,
behaviour that deviated from the norm was perceived as
caused by Satan.   The treatment of the mentally handi-
capped was closely related to the way in which they were
perceived: when seen as a social menace they were persecuted
as witches, while accorded special treatment when seen
as sacred beings - 'les enfants du bon Dieu'.

In the medical literature there is little mention
of any condition that we would recognise as alluding to
the mentally handicapped, although in non-medical manuscripts

there is considerable evidence of the existence of
endemic goitre and cretinism (a form of mental deficiency
due to lack of iodine).   From this literature we can
glean some idea of the perception of, attitudes towards
and treatment of the mentally subnormal.   The oldest
picture[16] of a cretin is 'Beuner Meisterloch' which
dates from 1215.   The picture depicts a figure with
three large goitres and a stupid facial expression,
holding a fool's staff in one hand.

In the thirteenth century the Encyclopaedias of
Jacques de Victory and Thomas of Cantispre. reproduced
traditional descriptions of monsters and also included
'human monsters', that is cretins, who were included because
of their deformities as well as their idiotic expressions.
Konrad Von Magenburg[17] in an illustration published in
1349 includes a cretin among his fantastic monsters.   Thus:

> ...a real phenomenon which the medieval observer
> regarded as a monstrosity was therefore included by
> him in the same category as fantastic and fabulous
> Indian monsters.[18]

While the extent to which the Christian ethic of
charity and good works permeated the total social structure
is difficult to determine, it is evident that some of the
mentally handicapped would have been 'cared for' in
monasteries and that others were employed by the wealthy
as 'fools' and 'jesters'.   It is likely, however, that
the poor, superstitious peasants and serfs regarded
bizarre behaviour as evidence of evil spirits and
persecuted those who evidenced such behaviour as witches.
Even when this did not happen, the burden of caring for
those who were totally economically dependent would
have resulted in their being turned out of the house and
left to wander as beggars.   Many of those we now label
mildly or even moderately handicapped would, however,
not have been labelled as different to the extent that
they were treated as deviants.   The majority of this
group would have been able to work the land along with the

rest of the members of their community and carry out the other daily tasks requested of them.

3.1 Feudal England

The available evidence on the care and treatment of the mentally subnormal in Feudal England is very sparse - probably because the numbers actually identified as subnormal were very small and scattered widely in isolated communities. There is some indication that a few mentally defective people were cared for in the few hospitals, in the same wards as the sick and infirm, and that those who exhibited violent tendencies and bizarre behaviour were seen as a danger to themselves and society and were chained down for years and - it must seem to us - cruelly treated.

Medieval and early modern ideas and attitudes towards the mentally disordered have traditionally been seen as contaminated by demonological ideas about causation. Zilloog[19] has depicted popular attitudes and treatment of the insane as a mixture of superstition, cruelty, and abuse - a view which, according to Neugebauer[20], is representative of most writers on the subject. However, Neaman[21] has challenged this view and presented new evidence which indicates that in many contexts of everyday life persons with mental disorders were viewed as physically ill and received kind and thoughtful attention.

However, the majority of the mentally defective, unable economically to support themselves or find relatives to support them, would have been left to wander the countryside and to seek Christian charity.

> In the medieval period, the dependent ... relied
> heavily on haphazard and often ineffectual
> tradition of Christian charity and alms giving ...
> But neither the church or private individuals made
> any serious effort to match aid to need ...
> The family was held liable to provide for its
> own, and with the aid of temporary assistance or a more
> permanent subsidy from the community, it generally

did so.   Only a few exceptionally burdensome
cases, and those without family or friends to
call on for support, might find themselves
gathered up under one roof.[22]

With the gradual breakdown of Feudalism, from the
fourteenth century the numbers of beggars and vagrants
increased;   many of these may well have been those we
now label mildly subnormal, those who were least able
to 'cope' with the changing socio-economic structure
of society.

The care of those, including the mentally subnormal,
who were unable to support themselves was generally
undertaken by the church.   Monasteries gave shelter and
hospitality, and almsgiving was regarded as a Christian
duty.   Theign Oswald and King Alfred gave alms to the
poor, while it was the custom of the Anglo-Saxon Kings
to keep 'open house' several times a year.   But by the
fourteenth century, with what was seen as an alarming
growth in the number of 'paupers' (the economically
dependent population), local and central government
became concerned with what was seen as a growing social
problem.   In 1349 the 'Ordinance of Labourers' stated
that no-one was to give relief to able-bodied beggars
(an unknown proportion of whom may have been 'incompetent')
and in 1388 regulations were made restricting the movement
of serfs, and the impotent poor were forbidden to wander
and had to be given relief in the parish in which they
resided in 1388.   This brought about a marked change in
the philosophy underlying charity.   The impotent poor
(the old, the sick and the obviously handicapped) were
entitled to assistance out of public funds or from
charities.   The able-bodied, (a group that would have
included the 'incompetent' as well as the idle) were not.

It was during the Feudal period that a legal distinction
was made in English law between the mentally ill and the
mentally handicapped.   In Saxon and Norman[23] times it was
the family's responsibility to keep a mentally disordered
member under control and, until the drawing up of the

Statute of Prerogatives,to administer his property.
The 'control' was, however, more concerned with the
proper administration of property than with the super-
vision of deviant behaviour.   Statute 17, Edward II, C9 & C10
1255, was concerned with the protection of property
and not primarily with the care and handling of the
mentally disordered.

> The King shall have the custody of the lands
> of natural fools, taking the profits of them
> without waste or destruction and shall find
> them their necessaries, of whose fee over
> the land be holden and after death of each
> idiot he shall render the same to the right
> heirs so that such idiots shall not aliene,
> or their heirs be disinherited and a portion
> shall be distributed for his soul by the advice
> of the Ordinary.

This is section 11 which refers to 'natural fools', whereas
section 12 sets out the arrangement for persons labelled
'non compos mentis'. 'Natural fools' were those defined
as suffering from congenital intellectual subnormality,
and persons 'non compos mentis' those who had developed
their conditions postnatally.   Natural folly was assumed
to be permanent, whereas persons 'non compos mentis'
could experience temporary or permanent recovery.

Individuals suspected of mental impairment were
examined by a jury of twelve or more members.   The
examination was set in motion by a writ issued by
Chancery directed to the Sheriff, escheater, or to a
commission, authorising an investigation of the mental
status of the individual in question, to determine the
exact extent, nature and value of his property.   The
specific medico-legal category in question was stated in
the writ - several versions of a writ 'de idiota inquirendo'
were developed.   One version of the idiocy writ directed
officials to inquire

> ...whether the said I be foolish and an idiot
> ...or not: and if he be than whether from his
> nativity, or from any other time.[24]

Interestingly, the jury evaluated mental status on
questions designed to test social competence.   For
example, when Emma de Beston, from Cambridgeshire,
was tested for idiocy in 1383, she was asked

> in what town she was ... how many days there
> were in the week ... how many husbands she
> had ... how many shillings there were in
> forty pence ... whether she would rather have
> twenty silver groats than forty pence.[25]

Even when an individual was officially 'found' to be a
natural fool the government was unable to provide
directly for care and supervision.   In most cases, therefore,
the Crown transferred its custodial rights to private
persons for a sum of money known as a 'fine', and control
over the idiot's land to a guardian in exchange for an
annual rent.[26]   The guardian was expected to care for the
idiot, to protect him from exploitation and to maintain
his estates.

The law then recognised the existence of the mentally
defective and provided for the protection of the 'fool'
and his property, being primarily concerned with the latter
(which resulted in a source of revenue for the Crown).
However, the processes for determinig whether a person
was a 'natural fool' or 'non compos mentis' frequently
confused the two groups, and it seems even less likely
that a distinction was made between the mentally handi-
capped and the mentally ill in everyday life.   Furthermore
only those individuals who owned land would have come
within the provisions of the Statute of Prerogatives,
probably a very small minority of the mentally disordered.

During the medieval period, we can conclude,
the everyday social perceptions of the severely and
obviously subnormal were horror tinged with awe.
In general, they were probably regarded as supernatural,
as punishment for the sins of the parents or as having
a special relationship with God, although some may have
been thought to have a physical illness.   There is little

real evidence as to how the mentally handicapped were
regarded or treated, except for those few who were
'legally' tested under the Statute of Prerogatives and
placed under guardianship, and even then we do not know how
they were handled.   The art of the period does, however,
depict the 'fool' as a monster, comparable with mythical
creations, and some 'fools' were kept at the courts of
the wealthy to provide entertainment.   However, the
majority were probably managed by their families or
turned out to become wondering vagrants and beggars and
the recipients of Christian charity.

4.   The Reformation and the Enlightenment - Sixteenth
      to Eighteenth Century Europe

      The period from the sixteenth century to the
eighteenth century marked one of transition from a
system of handling social deviants inherited from the
Middle Ages - from one where it was seen as essentially
a communal and family affair - to one based on institutions,
administered by central government.   The origins of
the major departure from medieval practices in handling
the poor, dangerous and disreputable sectors of the
community started in the sixteenth century as a consequence
of the efforts of the Crown to augment state power and
reduce the power of the church.   At the same time there
were increased demands for the maintenance of law and
order.   These two factors resulted in an increase in
central control and direction in the handling of deviants.

4.1 Changing Attitudes towards the Mentally Handicapped
      In the Middle Ages the Christian church had advocated
charity towards those unable to care for themselves.
The changing attitudes to the mentally subnormal in the
sixteenth century are clearly seen in the views expressed
by two of the leading figures in the Reformation, Calvin
and Luther, who both denounced the subnormal as possessed
by Satan.   In one of his 'table talks' Luther describes
a twelve-year-old subnormal boy he had once seen.

> He ... had the use of his eyes and all his
> senses, so that one might think that he was a
> normal child. But he did nothing but gorge
> himself as much as four peasants or threshers
> He ate, defecated and drooled, and if anyone
> tackled him, he screamed [27]

Luther felt that the 'devil' should be taken to the
river and drowned, but those with him were opposed to
this. The boy died a year later and Luther commented
that he was convinced that such changelings were of flesh
with no soul, but a devil where the soul should have been.

The idea that the mentally subnormal were the
incarnation of the devil or Satan is also found in art.
Foucault[28] has suggested that the tree that forms the mast
of the 'Ship of Fools' in Bacles' picture 'Stulliferae
Noviculae' and is above Besch's 'Ship of Fools' represents
the tree from the Garden of Eden - the forbidden tree,
the tree of promised immortality and of sin. He suggests
that

> ... this wisdom of fools ... pressages both the
> reign of Satan and the end of the world.[29]

The mentally handicapped were thus seen as inhuman, as
the incarnation of the devil or Satan and needing to be
destroyed. Witch hunts continued until well into the
eighteenth century. Among those tried for and convicted
of witchcraft would have been mentally handicapped people.

However, Neugebauer[30], as a result of studying the
legal control of the mentally disordered, has suggested

> In the histories of ... psychiatry, macabre scenes
> of witchhunts and witch burnings have commanded
> great fascination. The existence and activities
> of an institution like the Court of Wards have
> been neglected ... But the picture of treatment
> ideals which emerges from this collection of
> legal documents is radically different from that
> which arises from those other judicial records,
> witch trials. Government involvement with
> Court of Wards cases was designated to protect the
> disturbed person and his property.

Furthermore

> In the medieval period royal protection was
> linked with profit. In the sixteenth and
> seventeenth centuries this financial dimension
> gradually disappeared while the welfare aspect
> was significantly expanded.[31]

He points out that while in the medieval period the royal
jurisdiction over the mentally disordered had been
handled on an ad hoc and relatively informal basis,
in 1540 an Act of Parliament brought them within the
jurisdiction of the Courts of Wards and Liveries (abol-
ished during the Civil War in the 1640's) and Guardians
were required to care for the idiot and his family as well
as manage his possessions. While in theory all mentally
disordered subjects came within the province of the Court
and any person, with or without property could be brought
to official notice, in practice, since official referral
depended mainly on private citizens, who hoped to sub-
sequently obtain grants of control, only persons with
wealth sufficient to bear the cost of court procedure
were reported. Neugebauer, however, argues that an
examination of cases handled by royal jurisdiction in
the seventeenth century (the first reliable statistics)
shows a fairly wide social class distribution. Forty
percent were from the landed gentry, twenty percent women
who were heiresses or widows and the rest tradesmen,
yeomen and agricultural workers. He concludes that the
Court of Wards and Liveries

> ... offered protection and to some degree a monitored
> guardianship system for persons across the English
> social spectrum. This points up a small, but
> nevertheless real, social welfare dimension of
> royal jurisdiction.[32]

The mentally subnormal did, however, continue to be regarded
as figures of fun and to provide entertainment for the
wealthy. Horsefield[33] argues that the majority of
entertainers kept at the Spanish Court in the early
seventeenth century were mentally subnormal.
Foucault[34] has pointed out that the Bethlehem Asylum
in London and the Bicetre Hospital in Paris were opened

to visitors so that they could be entertained at the
expense of the foolish and mad inmates.   As late as 1815
a report to the House of Commons revealed that in one
year £400 in admission charges had been collected,
meaning that there had been 96,000 visits in that year.

By the seventeenth century informed knowledge of the
mentally handicapped was growing.   Thomas Willis[35] provides
one of the earliest systematic discussions of mental
subnormality.   He distinguished clearly between mental
handicap and mental illness, between congenital and
acquired mental defect.   The mentally ill are 'foolish'
while the mentally subnormal are 'stupid'.   The mentally
subnormal have a number of characteristics that can be
used to identify them - they are defective in apprehension,
memory and judgement, behave in a dull fashion and display
stupidity in their expression.   The mentally subnormal
can also be divided into a number of categories according
to their degree of stupidity.   Willis concludes his
analysis by arguing that mental deficiency is usually
inherited, although sometimes apparently 'normal' parents
have defective children.   The list of 'genetic causes'
given by Willis heralds those found in late nineteenth and
early twentieth century accounts of subnormality, and
includes alcoholism, epilepsy and licentiousness among
other degeneracies.   Willis concludes that mental deficiency
can be measured in terms of social adaptability and though
it is incurable some of the deficient can be helped to
improve.

John Locke[36] also distinguished between mental
subnormality and mental illness; however, like Willis's,
his classification seems to have more applicability to the
middle and upper classes than the majority of the
population in seventeenth century England who were engaged
in subsistence agriculture.   Obviously, the most profoundly
handicapped would have been easily recognised in the rural
population, but many of the less severely handicapped,
while they may have been seen as less competent, would not

have been labelled as idiots or fools.

Some years after the publication of Locke's work Daniel Defoe[37] advocated the provision of separate asylums for the mentally defective. He was also concerned at the prevalent social attitudes towards and provision made for the mentally subnormal.

> ... I wonder how it came to pass that in the
> settlement of that hospital they make no provision
> for persons born without the use of their reason,
> such as we call fools, or more properly 'Naturals'.
> We use such in England with the least contempt,
> which I think is a strange error, since tho'
> they are useless to the commonwealth, they are only
> so by God's direct providence, and previous fault.
> I think 'twill very well become this Wise Age
> to take care of such.[38]

While Defoe was apparently advocating better treatment for the mentally subnormal and did advocate the licensing and inspection of private Mad-Houses, it is necessary to bear in mind the appalling conditions that existed in institutions for the mentally disordered. We can understand these conditions from a description of the Bicêtre as it was in the eighteenth century:

> The buildings were untenable, the cells were
> narrow, cold and dripping, unlit and unventilated,
> and furnished with a litter of straw, which was
> rarely changed and often infested with vermin.
> Men crouched there covered with filth, in hideous
> lairs in which one would have hesitated to confine
> a beast. The insane, imprisoned here, were at
> the mercy of brutal keepers, who were often
> malefactors from the prisons. The patients were
> loaded with chains and tied with ropes like
> unruly convicts.[39]

Despite gradually changing attitudes towards the mentally handicapped, the general, everyday social perception of subnormals changed little. They continued to be cared for by their families, or turned out to wander as·beggars. Their existence was explained by reference to supernatural forces, and as Jones[40] has pointed out:

> Superstition, moral condemnation, ignorance
> and apathy, these were the mental attitudes
> which dominated the treatment of the mentally
> disordered in the eighteenth century.

4.2 The handling of the Mentally Handicapped

To understand the social provision made for the
incompetent and subnormal it is necessary to understand
the social and economic changes that marked the .end of the
Feudal period and the emergence of capitalism. The
mentally subnormal must be seen as part of a larger group
which were seen as creating a social problem. During the
sixteenth century the numbers of unemployed labourers
increased as the enclosure movement continued, at the same
time as the one major source of charity, the monasteries,
had been dissolved, and the reformation had resulted in
changed attitudes to the giving of alms.

By the sixteenth century the large increase in the
number of vagrants and beggars was seen as presenting a
threat to law and order. The maintenance of law and order
was essential to the construction of effective central
government and consequently official policies to deal with
poverty and the socially marginal groups were determined
by the need to maintain law and order, which necessitated
the suppression of vagrancy and begging. As Foucault
has pointed out

> In the classical period indigence, laziness, vice
> and madness mingled in equal guilt with unreason.
> Madmen were caught in the great confinement of
> poverty and unemployment ... [41]

Thus the Poor Law Act 1601 focussed attention on the poor
and unemployed but made no separate provision for the
mentally ill or handicapped. As a consequence harmless
idiots and lunatics continued to be left at liberty as
long as they were not considered to be dangerous and
caused no social disturbance. If necessary, their relatives
or others prepared to care for them were provided with
a permanent pension for their support. Those who were
seen as a danger to themselves or the community would

probably have been chained in the few existing hospitals
or in the Poor Law Institutes that started to be
established from the 1630's. They may also have been
chained in the 'houses of correction' whose construction
an Act of 1575 had recommended.

By the end of the seventeenth century a change in
social attitudes to marginal groups, including the mentally
handicapped, was taking place marking the beginning of
of the period of the 'Great Confinement', when idiots,
lunatics, criminals, vagrants and the unemployed were
seen as a 'threat' to society and were locked away.
It is necessary to question what is meant, however, by 'threat'
to society. I have argued that the increase in unemployment was
a direct consequence of the process of industrialisation and
that a large number of idle people were seen as posing a direct
threat to the established order and were consequently incarcerated.
This does not fully explain why they were 'confined' rather than
excluded in some other way from society, nor why those who were
apparently harmless but without employment were also incarcerated.
Foucault suggests that this was because it was idleness as such
that was condemned, coming to be seen as 'the greatest sin'
during the reformation. Society could not allow people to remain
idle because this would incur God's wrath. The obligation to
work was an ethical exercise and a moral guarantee. Consequently
the workhouse was not a mere refuge for the old, sick and infirm,
nor just a forced labour camp, but also an institution responsible
for correcting a certain moral 'abeyance'.

The first organised effort to provide for the mentally
disordered in a total institution was in Paris at the
Bicetre hospital established in the seventeenth century.
In England this change was reflected in the increased
use of Houses of Correction and the Workhouse to incarcerate
deviants and the development of Private Mad Houses.
The development of the last of these was stimulated by
an Act in 1714 that distinguished between the lunatics,
and rogues, vagabonds, sturdy beggars and vagrants.
Two Justices of the Peace could order the confinement
of the mentally disordered and one method that parishes
adopted to 'deal' with them was to board them out in

Table 3   Private Mad Houses established by the end
of the Eighteenth Century

Institution	Date opened
Small Receptable - Norwich	1713
Ward for Incurable Lunatics - Guy's Hospital	1728
St. Luke's Hospital, London	1751
St. Luke's Hospital, Newcastle upon Tyne	1764
Lunatic Hospital, Manchester	1766
Lunatic Hospital, York	)
Lunatic Hospital, Leicester	) by end of
Lunatic Hospital, Exeter	) 18th century

private houses which gradually acquired the description
of 'mad' houses.

During the eighteenth century Houses of Correction
and Poor Law Institutions acquired a new purpose in
addition to that of providing for the unemployed in
periods of crisis, that of regulating the economy.
Thus a dual system of treatment of the mentally handicapped
developed. Those with wealthy relatives, and some pauper
lunatics, were sent to the private enterprise mad houses,
where they spent years chained up in terrible conditions.
Mad House owners were concerned with making profits,
not with the care of their charges. Those whose relatives
could not afford to pay the charges of the Mad House, along
with the unemployed, the old and the sick, continued to
be incarcerated in Poor Law Institutions, where the main
emphasis was on putting them to work, making them
economically productive, although this practice gradually
fell into disuse as it was suggested that it took work
away from 'honest' men in the community.

In everyday practice the mentally subnormal continued
to be seen as an integral part of the marginal population -
those unable to be economically productive and to take

their place as full members of capitalist society.
In legal terms, the distinction between mental subnormality
and mental illness continued to be seen as important,
because of the need to protect property rights.
The case of Henry Roberts Esquire in 1743 illustrates[42]
how a jury was used to judge if a person was incapable
of managing his own affairs, whether because of idiocy or
lunacy.

> He was put in a private room with a jury and
> they (he said) came round me and asked their
> questions together, without giving me time
> to answer. They asked me what a lamb and what
> a calf was called at one, two and three years
> old. They gave me a sum of money to tell,
> which I miscounted, and then I heard them say
> 'he is not capable of managing his affairs,
> we will return him incapable' ...
> (From an anonymous pamphlet of 1747 published
> in London and quoted in Hunter & MacAlpine).

This case also provides examples of the assessment
procedure used - the type of questions used to assess an
individual's intelligence. An 'idiot' or 'natural fool'
was diagnosed on the basis of inabilities such as not being
able to count to 20, measure a yard of cloth, name the
days of the week, answer questions concerned with his
daily life, or learn to read.

In the eighteenth century the law continued to
recognise, essentially, two categories - the idiot and
the lunatic - despite the abolition of the Court of Wards
during the Civil War in the 1640's. These were not medical
categories, but legal categories determined in relation
to civil capacity and legal responsibility as judged by
a jury.[44] Juries seldom found a man an idiot, but
preferred to find him 'non compos mentis' for a time.
In any case a man was only an idiot if he was totally
devoid of intelligence. The main legal concern was the
protection of property, and in the case quoted above of
Roberts, the jury were instructed by the Judge to test if
he was capable of managing the considerable properties left
him by his father. Thus only those who owned or potentially
controlled property would have been 'tested' to determine

if they were incurably subnormal. The vast majority of
those incapable of supporting themselves financially
would have been cared for by their families or incarcerated
in Mad Houses or the Workhouse.

5.   Conclusion

Kathleen Jones[43] has succinctly summed up the
prevalent conception of mental disorder at the end of the
eighteenth century in England:

> There was no clear distinction of what mental
> disorder was and certainly no recognition of the
> mentally ill or handicapped as a category requiring
> a distinct form of treatment. The problem was a
> submerged one ... If their mental condition
> reduced them to penury they came within the purview
> of the Poor Law. If it led them to break the
> criminal code, they were judged by the penal law.
> If they wandered abroad from their legal place
> of settlement without means of support they were
> involved in the rigours of the vagrancy laws.

Mental disorder was explained in terms of supernatural
forces, but the mentally handicapped were not seen as
'children of God', but as incarnations of the Devil or
other evil spirits. The management of those of the mentally
subnormal who <u>were</u> indeed managed along with other marginal
groups who were seen as a 'threat' to the developing socio-
economic order was to incarcerate them, to protect society
from the deviant. However, the majority remained at
liberty in the community, to be cared for by their families
or to fend for themselves. The radical transformations
in the social perception of the mentally handicapped and
their handling occurred, as we will see in the next
chapter, in the nineteenth and twentieth centuries when
they first became clearly differentiated as a separate
category of outsiders and managed as deviants in a
distinct manner.

1: Willis, 1672

2: Pinel, 1802

3: Hobson, 1955 P116

4: Emerson, 1969 Note 4, P94

5: E.G. Poster, 1978

6: Rosen, 1968 P5

7: Scull, 1977

8: E.G. Scull, 1975, 1977, 1979

9: Wolfensberger, 1970

10: Szasz, 1970

11: See, e.g., Rosen, 1968

12: Quoted in Rosen, 1968 P134

13: Plato, 1966

14: Weygenault, 1915

15: Cranefield, 1962

16: in Merke, 1960 P995

17: in Merke, 1960

18: in Merke, 1960 P997

19: Zilboorg, 1941

20: Neugebauer, 1978

21: Neaman, 1975

22: Scull, 1977 P17

23: Walker, 1968

24: Public Record Office, 1898-1955

25: Public Record Office, 1916-1968 P, 127-128

26: Public Record Office (Henry VII 298)

27: Luther, 1652

28: Foucault, 1971 P259

29: Foucault, 1971

30: Neugebauer, 1978 P167

31: Neugebauer, 1978 P167

32: Neugebauer, 1978 P164

33: Horsefield, 1940

34: Foucault, 1971

35: Willis, 1672

36: Locke, 1690

37: Defoe, 1697

38: Defoe, 1697 P165

39: Nowray, 1945 P343

40: Jones, 1972 P10

41: Foucault, 1971 P259

42: Quoted in Hunter and MacAlpine, 1963 P42

43: Jones, 1972 P3

CHAPTER 5

FROM DEVIANTS TO DEVELOPING PEOPLE -
THE MENTALLY HANDICAPPED IN NINETEENTH
AND TWENTIETH CENTURY BRITAIN

1. Introduction

Perceptions of the mentally handicapped have changed considerably since the beginning of the nineteenth century. The development of apparently more humane attitudes to the mentally disordered, the growth of medical concern and an attitude that mental handicap was curable resulted in a superficial improvement in their situation at the century's beginning. However, this quickly changed when, firstly, it became clear that mental subnormality was not 'curable' and secondly, that the numbers of mentally subnormal people were far greater than had been realised - a 'fact' discovered with the introduction of compulsory schooling. This coupled with the increasing dominance of science and the growing influence of Social Darwinism meant that by the end of the nineteenth century the mentally subnormal were seen not only as social menaces but as a threat to civilization. Scientific knowledge had replaced religious superstition, but the result was the same - the incarceration of the deviant. The powerful eugenics movement continued to have a strong influence on attitudes towards the mentally subnormal, especially those seen as part of the 'social problem group', until well into the twentieth century. This position is well expressed in a report published in 1903[1]

> The chronic insane, the epileptic, the paralytic, the imbecile, and idiots of various grades, the moral imbecile, the sexual pervert, the klepto-maniac, many if not most of the chronic inebriates, many hospitalled paupers, especially the ignorant and irresponsible mothers of illegitimate children so common in poor houses, many of the shiftless poor, ever on the verge of pauperism and often stepping over into it, some of the blind, some of the deaf-mutes, some consumptives. All these classes in varying degrees, with others not mentioned, are related as being effects of the one cause - which itself is the summing up of many causes - degeneracy.

The development of intelligence tests (which I have briefly outlined in Chapter 3), partly in response to the eugenics movement, enabled the 'scientific' diagnosis of the mentally subnormal, and the findings of 'family studies' gave scientific weight to the thesis that degeneracy was indeed inherited. Gradually, however, professional opinion became modified; environmental factors were shown to be relevant in generating 'degeneracy', and events in Europe made the more extreme forms of eugenics unacceptable. Since the second World War social science research, social factors and economic changes have resulted in the modification of extreme attitudes towards the subnormal. They are no longer seen as a danger to society, and while few believe in 'magic' cures, mental subnormality is seen as an improvable condition. Segregation is no longer seen as an appropriate way of dealing with the majority of the subnormal, and 'normalization' and 'community care' have become widely advocated (and to some extent implemented). However, community attitudes are still basically apathetic if not hostile to the mentally subnormal, and the ideas of the eugenics movement widely disseminated in the early twentieth century still appear to be influential. Furthermore, while professional attitudes may have changed, the mentally subnormal are still seen as outsiders, along with other groups of deviants, by the general public.

2.   The Nineteenth Century

At the end of the eighteenth century the mentally handicapped were an integral part of the marginal population who were all handled in the same way. By the middle of the nineteenth century the mentally handicapped were, theoretically at least, seen as a separate problem and handled as a distinct category. We need to consider what changes took place in Britain (and indeed in the whole of the Western world) that caused this shift in practice to come about.

The main influences in the early nineteenth century on attitudes towards and care of the mentally handicapped would appear to be on the one hand the development of psychiatric medicine and its attempts to dominate the care of the mentally subnormal , and on the other the growing fear felt by the Victorians of the 'submerged ten percent', and a concern to instil the Protestant Work Ethic and maintain law and order.

However, the growth of psychiatric medicine and the fight of doctors to control the treatment of the mentally disordered can itself be seen to be influenced by the dominant ideology.

> Moral management is seen as the achievement of
> an impartial and unselfish concern for the plight
> of the insane ... moral management can also be
> seen as one among a number of attempts to combat
> the forces of disorder so threatening to the
> Victorians. In abandoning the methods of the
> eighteenth century, nineteenth century physicians
> were not abandoning their role as guardians of
> the moral order and agents of social control [1]

Theoretical developments in psychiatry in the nineteenth century can be shown to be influenced by and can only be understood by reference to the wider social context, so that while the reformed asylum was more humanitarian than the institutions it replaced, nevertheless it was

> ...a structure that formed a kind of microcosm
> in which was symbolized the massive structures
> of bourgeois society and its values. Family-
> child relations centred on the theme of paternal
> authority. Transgression-punishment relations
> centred on the theme of immediate justice.
> Madness-disorder relations centred on the theme
> of social and moral order. [3]

While the attitudes towards and treatment of the mentally disordered were undergoing an apparent dramatic change, so too were attitudes towards the poor and poverty. Changes in the means of production and of the economic structure of society created the need for an efficient and

mobile labour force.   This necessitated making a sharp
distinction between on the one hand the able-bodied poor,
who needed to be instilled with work habits, to be
'forced' into productive labour, and who needed to be
free to move to where labour was needed, and on the other
the non-able-bodied poor, who needed to be maintained by
society.   It was consequently realised that poor relief
and confinement in Poor Law Institutions was a bad
mistake economically, not only because the unemployed
were unproductive and a drain on community resources,
but also because the cost of production could be reduced
by increasing the workforce.   The unemployed, the vagabonds
and paupers must be forced to become part of the economically
productive workforce.   This was legally enacted in England
in 1834, when the Poor Law Act introduced the concept of
'less eligibility' - the conditions in the Workhouse
were to be made less desirable than the worst conditions
outside.   The 'poor' would then, in theory, be encouraged
to take employment outside rather than seek relief.
This change affected the mentally handicapped because
many of them continued to come within the provisions of
the Poor Law and to be confined to the Workhouse.
Furthermore, it reflected a deeply ingrained attitude
about the marginal population and the need to maintain
law and order and instil a 'work discipline'. Men, women
and children were seen as productive labour, their worth
was measured by their ability to be economically productive,
and those who refused to or could not work were cast aside.

       During the course of the nineteenth century the
realisation that there existed an unknown, but large
group of people who were, because of mental subnormality,
apparently incapable of managing their own affairs slowly
dawned.   However, apart from some attempt to 'care' for
the more severely mentally handicapped, little was done
to handle the mentally deficient as a separate category
until the late nineteenth century.   With the introduction
of compulsory schooling in the last decades of the century

(which acted, as we saw in Chapter 3, as a mechanism
for screening and labelling the mentally 'defective'
especially the feebleminded) not only did the identifi-
cation of this 'dangerous' group become easier, but the
group was also seen to be much larger than had previously
been realised. Simultaneously the newborn interest in
eugenic improvement of society among English and
American scientists began to indicate a possible 'final
solution' to them as a problem (and a catalyst for the
development of intelligence tests) - for the good of
humanity, their characteristics should be bred out of
the race.

The nineteenth century can, then, be seen as a period
when, firstly the mentally handicapped became widely
recognised as outsiders and then, secondly, began to be
managed as a separate deviant group.

2.1 Attempts to 'cure' the Mentally Handicapped

Itard,[4] a French doctor and student of Pinel, is
credited with being the first person to make a systematic
effort to educate an idiot. Itard was influenced by
'sensationalism' (the idea of the eighteenth century French
philosopher Condillac that the basics of all mental life
could be reduced to sensory elements), by the humanitarianism
of Pinel, and by the romanticism of Rousseau (especially
Emile).

In 1799 a boy of about twelve years was found in
Avignon. Victor, as the boy became known, was naked, ate
all hi.. food raw, drank like a dog, walked on all fours,
fought with his teeth and was unable to speak - in sum,
he appeared to be a complete idiot. Itard set out to
educate Victor. He continued to work with Victor and
published two accounts of this work, but eventually,
because he was unable to 'cure' Victor, he gave up his
work with him. Despite Itard's disappointment, Victor
did make considerable progress. He learnt to live in human
society .and to show affection, and he showed signs of some
intellectual growth.

Despite his 'failure' with Victor, Itard maintained that
it was preferable to view him as a wild man rather than as a
congenital idiot (that is, a creature born ill-favoured, rejected
by society and abandoned by medicine). The fact that Victor had
made so much progress strengthened the view that man is a product
of his environment and not his heredity and influenced develop-
ments in the field of mental handicap in the first part of the
nineteenth century. (Indeed, the theory of sensationalism, or
at least the practice that derives from it, would seem to have
affinities with behaviour modification - see Chapter 3).

The importance of Itard's work with Victor is that it
was seen as 'proving' sensationalism, a psychology developed
by Condillac, and as demonstrating that idiocy was remediable,
even if not curable. When Victor was first discovered, Pinnel,
who believed that many madmen could be cured, advised Itard not
to work with Victor as he was an incurable idiot. This view
was taken by a number of Itard's other contemporaries, including
Bousquet and Esquirol; the latter, interestingly, although he did
not develop a theory of degeneration - see below - did point out
the importance of developmental facts in mental subnormality and
noted that there tended to be a familial tendency towards idiocy
(and that 'sometimes also in the same families there is one idiot
and other children who are insane'[6]). However, Itard maintained
that the hereditary form of idiocy was very rare, that environ-
mental causes were the most frequent, and that most cases could
be cured by education. As far as Victor was concerned Itard agreed
that he was an 'idiot' but asserted that his condition might as
well be explained by cultural loss as by defect of birth. He
maintained that he, Victor, was more like an infant of 10-12
months than a simple youth and consequently that he could be
treated and cured.

Profoundly influenced by Condillac, Itard maintained that
man is not 'born' but 'constructed' - that is, that the envoron-
ment is the important factor in understanding human development.
Thus

> Cast on this globe, without physical power, and
> without innate ideas....man is only what he is made to
> be by his external circumstances...he enjoys....a
> capacity of developing his understanding by the power
> of imitation and the influence of society.[7]

Condillac's sensationalist psychology was a theory of the way
man develops his capacities and knowledge, which argued that man
is the product of the reactions of his sense-organs to the
stimuli provided by the physical environmentHe had demonstrated
his theory by using the analogy of the statue man, which had
ehabled him to explore the functions of senses and the growth
of mental life by imaginatively re-creating the hypothetical
experiences of the statue as its senses were unlocked one by one[8].

> Motivated by the experiences of pleasure and pain and
> guided by the mechanism of the association of ideas,
> the statue man acquired practical knowledge, formed
> abstract ideas and even moral and aesthetic judgements.
> In other words he exhibited the full mental capacity of
> man.

However, Condillac saw himself as essentially an educator and put
his own ideas into practice. This practice, the method of education
which derives from the theory, has been of equal importance in
the field of mental handicap. Thus Itard accepted that man is
made, and that he is made as a result of the stimulation of his
senses. Consequently, in laoking at Victor he developed a program
of educating him by awakening his senses. Itard, then, not only
influenced attitudes to 'idiots' but, more importantly, developed
a method of educating them and demonstrated that even if it did
not 'cure' idiots, it at least improved them. Despite his own
'failure' with Victor the view that 'idiocy' was generally the
result of environmental factors and that idiots could be educated
using a method derived from Condillac's theory of sensationalism
was extremely influential.

One of the people significantly influenced by Itard's work
was Edouard Seguin, the first acknowledged teacher and leader in the
field of mental subnormality. Seguin worked with the
mentally subnormal first in Paris and later in the
United states. In 1846 he published a text book[9] on
mental subnormality which became very influential in
Europe and the United states and resulted in the.wide-
spread adoption of his methods for educating and caring
for the mentally handicapped. He was convinced that
idiocy was 'curable' and was extremely influential in
what has become known as the 'age of optimism'.
This was the period, in the early nineteenth century, when

professionals concerned with the mentally handicapped
believed that the subnormal could be educated to a standard
where they could play a full social and economic role in
society.   A few special schools for educating the mentally
subnormal began to be established in Europe and the United
States, those running them being convinced that they
could cure the subnormal.   These schools were few in
number and privately run.   (See section 2.3 below).

2.2   The Emergence of the 'Social Problem Group'

The optimism of the early nineteenth century soon
gave way to doubts and fears as it became 'realised' that
the mentally subnormal could not be 'cured' but were a
life-long burden on society.   Also, with the gradual
introduction of formal state education (especially following
the Foster Education Act of 1870), the greater visibility of
the problem presented by the 'subnormal' with the growth of
urbanization, and the changes in the skills necessary at
work, it became evident that the number of mentally sub-
normal people was far greater than had previously been
thought.   Attitudes towards the subnormal, and especially
the feebleminded, began to change; they began to be
regarded as a threat to racial survival and as a life-long
burden on society - as presenting, in other words, a
real and distinct social problem.   The idea began to circulate
that there was a need to protect society from these
'dangerous' groups not only as part of the general fear that
the dangerous classes would contaminate the respectable
working classes, but also because of the fear that by
being allowed to breed the numbers of social degenerates
would grow, posing a threat to civilization.

The first steps in this process was the realization
that the 'problem' existed, that there were apparently
large numbers of people dependent on society for their
care and maintenance because of mental deficiency, and the
development of the claim that mental deficiency was
hereditary, passed on from generation to generation, and
associated with other forms of degeneracy.

One of the first experts to claim that mental
deficiency was a hereditary trait was Howe (1848) who

claimed that it was a condition inflicted on those whose
parents violated 'the natural laws of man' (paupers,
alcoholics, petty criminals - the social degenerates).
He was influenced by the School of 'faculty psychology'
which in contrast to associationism (which saw the child's
mind as a 'blank slate' at birth) attempted to classify
innate capacities. Howe not only argued that degeneracy,
including mental deficiency, passed on from one generation
to the next, but also that it presented a 'real' social
problem. [10]

> Idiots form one rank of that fearful host which
> is ever pressing upon society with its suffering,
> its miseries, and its crimes, and which society is
> every trying to hold off at arms' length - to keep
> in quarantine, to shut up in jails and almshouses,
> or at least to treat as a pariah caste.

Soon after, in 1866, a report from the British Lunacy
Commissioners revealed that [11]

> The number of 'idiots', 'imbeciles' and 'febbleminded'
> is very great in the United Kingdom; those in
> asylums, schools and workhouses form but a fraction
> of the whole and they abound in all classes of society
> from the wealthiest to the poorest. It would appear
> that the errors of our civilized people are rarely
> noticed in races leading a natural life ... Hidden
> > all too often amongst civilized people and
> > exposed to perish by the savage, these barely
> > gifted members of the human species demand
> > our attention ...

The growth in the fear of social degenerates and of the
conviction that there was a need to protect society
from them continued during the rest of the nineteenth
century. Gradually the emphasis shifted from training/
educating the mentally-handicapped so that they could
become productive members of society, to protecting society
from them by 'warehousing' them. These attitudes were
reinforced and given 'scientific' status by the growing
acceptance of Social Darwinism, which influenced the
development of degeneracy theory and of the eugenics
movement.

Degeneracy theory was developed by a Frenchman,
Morel, who was arguing that hereditary taint was polymorphous
in the late 1850's. (Lombroso, the Italian 'Father of

Criminology', who is usually associated with degeneracy
theory, did not publish his theories until the late 1870's.)
Sarson and Doris describe Morel's theory as arguing that [12]

> degenerations were deviations from the normal
> human type, which were transmissible by heredity
> and which deteriorated toward extinction.
> Deviations from the normal human type included
> those afflicted with certain physical and psychiatric
> diseases, for example the epileptic, the scrofulous,
> the psychotic, the mentally deficient, the ·moral
> deviate and the alcoholic. The degeneration
> was subject to the 'law of progressivity'.
> The first generation of a degenerate line might
> be merely nervous, the second would tend to be
> neurotic, and the third psychotic, while the fourth
> consisted of idiots who would tend not to reproduce
> and so lead to the extinction of the line.

Degeneracy theory essentially held:

i) that hereditary taint is polymorphous - that is, the degener-
ative tendency expresses itself in different ways and with differ-
ent forms of deviance; and

ii) that acquired traits are transmitted to, and thus that
parental experiences have an effect on, the offspring.
(The second of these hypotheses was widely accepted in the nine-
teenth century, and its adherents included *Darwin and Spencer* .
The first of them profoundly influenced the 'proofs' of heredity
put forward in the early twentieth century - see below). However,
while Morel and Howe[13] accepted degeneration, they did not
subscribe to the 'pessimistic' or 'alarmist' attitudes to the
problem of mental handicap which *began to develop in the late
nineteenth century*. The acceptance of a hereditarian view which
allowed for the transmission of environmental effects would not
in itself lead to pessimism - one could alter the environment
and consequelntly forestall or reverse degeneration. (In fact,
the pessimistic implication does not appear even to have occurred
to Howe or Morel.)

It was the Darwinian Theory of Evolution, combined with the
theory of degeneration, that contributed to a radically different
perception of the mentally handicapped. The theory of evolution
and the idea of the survival of the fittest in the struggle for
existence put degeneration in a broader context: the physically
and mentally unfit are no longer seen as the unfortunate victims
of the environment and/or hereditary taintbut as demonstrably
members of an inferior race which ought to be allowed to die

out as quickly as possible. (Note, however, that no special theory of degeneration is needed for this purpose; many Social Darwinians systematically applied the theory of the survival of the fittest without reference to degeneration, simply maintaining that deviant members of society had proved themselves unfit).

However, Social Darwinianism, which so profoundly influenced the Eugenics movement, was not simply the product of evolutionary theory. Its roots can be traced back to classical economic theory, especially Smith's advocacy of free competition in the market-place and the Malthusian theory of population. Spencer, ten years before the *Origin of Species* was published, expressed views about how society should deal with the incapable that find an echo in Social Darwinianism[14].

> Blind to the fact that under the natural order of things society is constantly excreting its unhealthy, imbecile, slow, vacillating, faithless members, these unthinking, though well-meaning,men advocate an interference which not only stops the purifying process, but even increases the vitiation - absolutely encourages the multiplication of the reckless and incompetent by offering them an unfailing provision and discourages the multiplication of the competent and provident by heightening the prospective difficulty of maintaining a family. And thus, in their eagerness to prevent the really salutory sufferings that surround us, these sigh-wise and groan-foolish people bequeath to posterity a continually increasing curse.

It was Social Darwinianism mediated through the Eugenics movement that had a direct effect upon attitudes to the mentally handicapped. The movement systematised and organised the newer attitudes to them and provided a vehicle for conveying these attitudes into a social action programme ; it therefore had a profound influence on social policy towards them in the early twentieth century (see section 3 below). Galton, the founder of the movement, coined the word 'Eugenics' - the science of the improvement of the human race - in 1865 and published in 1869 his study purporting to establish that ability was inherited by demonstrating the high social and economic standing of the forefathers of eminent Victorians. (It is interesting to note that Samuel Smiles (1859) carried out a very similar study which included industrialists among the eminent and came to entirely contrary conclusions -

that many currently eminent men came from undistinguished
ancestries).   The Eugenics Movement, however, quickly
attracted a number of eminent members who began to publish
books and articles aimed at doctors and teachers, spelling
out the danger that mental defectives posed to society.
Among the most influential of these was Down's
Mental Afflictions of Childhood and Youth (1887),
F. Beach's Treatment and Education of Mentally Feeble
Children (1895), Mentally Deficient Children (1895) by
Shuttleworth and Potts, E.S. Talbot's Degeneracy (1898)
and W. Ireland's Mental Afflictions of Children (1898).
These studies were a prelude to increasing official concern
about the 'problem' which was expressed in a Report on
Education in 1898 [16] and reflected in the powers given to
Local Education Authorities in 1899 [7] to establish schools
for the 'feebleminded'.

One of the 'problems' highlighted by the movement at
this time, and which influenced the assumptions underlying
and the developmental course of intelligence tests (see
Chapter 3 and section 3 below) was the problem of diagnosis
and classification.   The National Association for Promoting
the Welfare of the Feebleminded, which included Warner,
Langdon Down and Shuttleworth on its committee, turned
its attention to the problem of diagnosis in 1896, and
in the same year the British Association had sponsored
a report on the mental and physical conditions of childhood.
The principle was finally established that intelligence
was inherited and that tests were needed to measure
what this fixed capacity was.   In the early twentieth
century, when botanists brought to light and verified the
long-forgotten Mendelian principle of heredity, it
was applied by some eugenicists to the transmission of human
characteristics including intelligence. (In fact it resulted in
a split between the biometricians - who included Galton and Pear-
s n and emphasised the blending of parental traits in the
offspring - and the Mendelians, who emphasised the particulate
nature of heredity. However, it was not the mode of inheritance
that was crucial; rather it was the 'fact' that mental sub-
normality was inherited at all which influenced the programmes
of the Eugenics movement.)

The work of Galton and his followers in the Eugenics
Movement was to result in profound changes in the handling
of the mentally handicapped in the early twentieth century
and in attitudes towards them, especially (as I have
already indicated) in the move towards warehousing
and the search for 'accurate' tests of innate mental
ability.   Moves towards these began at the end of the
nineteenth century as the state began to become 'concerned'
with the problem and to make provision for the separate
handling of the mentally handicapped.   In the nineteenth
century the only separate provision that had been made
until the last two decades, was the 'private asylums',
the majority who did not live in the community being
warehoused in the lunatic asylums and the general workhouse.

2.3   The Handling of the Mentally Handicapped in
       Nineteenth Century England
       The first special provisions made for the mentally
handicapped were private schools/hospitals known as
'idiot' asylums; they were founded originally at a time
when at least some concerned individuals still believed
that idiocy was curable.

> In general we may say that the object of the
> asylums is primarily educational, and that,
> originally at least, they were the outcome of
> a belief that in many cases special education
> would prepare for the duties and employment
> of life the children or young persons who
> gained admission to them. 18

Britain was slow to provide, compared with some European
countries and the United States, and the first 'schools'
were not founded until the 1840's.   These institutions
were privately owned and catered either for children
whose parents could afford to pay for them or pauper
children paid for by the Poor Law Commissioners.   The first
large-scale public provision made was the Darreth
Training School, built by the Metropolitan Asylum Board,

and opened in 1878. (See Table 4).   However, as I have
already pointed out, the majority of mentally handicapped
people were not accommodated in institutions specifically
desinged or intended for them by the end of the nine-
teenth century.   In 1881, of the 29,452 idiots in public
institutions only three percent were in institutions
specifically designated for the subnormal; the remainder
were incarcerated in general workhouses, lunatic asylums,
private mad houses and prisons.[19]

Table 4   List of Institutions for the Mentally Subnormal
          in 1900

Institution	Date of founding
Eastern Counties Asylum, Essex Hall, Colchester	1859
Western Counties Asylum, Starcross, Exeter	1864
Midland Counties Idiot Asylum, Birmingham	1866
Gorlswood Asylum, Redhill, Surrey	1847
Royal Albert Asylum, Lancaster	1864
Magdalen Hospital, Bath	(1846)*
Middlesex County Asylum, Annexe for Imbeciles	1868
Darenth Schools, Dartford, Kent	1878
Winwick Hall for Boys, Lancashire	
Ancaster House, Richmond, Surrey	
Winchester House, Kingston Hill	
Normansfield, Hampton Wick, Middlesex	

* Established as a small school in 1846 and later became
  Magdalen Hospital

It was also widely believed that there were many more
mentally subnormal people, whose existence was not known
of by the authorities.[20]

     The introduction of mass schooling, especially after
1880 when education was made compulsory for all, resulted
in the 'discovery' of a large number of children who were

apparently incapable of benefiting from instruction in
the normal classroom. In 1889 the Royal Commission on
the Blind, Deaf and Dumb recommended that feebleminded
children should be educated separately.   After this
a few Local Education Authorities did establish such
schools, but the cost was very high as they were not
supported by government grants. In 1890 a special
committee of the Charity Organisation Society recommended
special educational facilities for feebleminded children.
In 1895 a committee under the auspices of the British
Medical Association, the Charity Organisation Society,
the British Association for the Advancement of Science
and the International Congress of Hygiene and Demography
issued a pamphlet on the 'Scientific Study of the Mental
and Physical Conditions of Childhood with particular
reference to Defective Children'.   This influenced the
establishment of a Departmental Committee on Defective
and Epileptic Children (1896) which reported in 1898
that there existed a group of children who, while not
imbecile or idiotic, were too feebleminded to be taught
in the ordinary school.   In the following year (1899)
the Elementary Education (Defective and Epileptic Children)
Act empowered, but did not compel, Local Education
Authorities to make provision for feebleminded children
to be educated in special schools.

The nineteenth century was a period of wide social
reform and philanthropic movements which also witnessed
the formation of pressure groups who spoke for the poor
and underprivileged.   The Charity Organisation Society,
founded in 1868, a powerful and prestigious body that co-
ordinated charitable efforts of all kinds, included among
its numbers Sir C. Trevelyan, a champion of the mentally
handicapped.   At his instigation the Council of C.O.S.
recommended to the government in 1877[1] that they make
special provision for the feebleminded (a term introduced
by Trevelyan to refer to the educable mentally subnormal),
as they were not adequately provided for in the workhouses

or asylums. They advocated state intervention because they felt that this group could be helped so that they would become less of a burden on the community.

The work and ideology of the C.O.S., however, was not purely humanitarian. The organisation was formed as a response to the fears expressed by the middle classes in London in the 1860's. It was concerned with instilling the Protestant Work Ethic and encouraging self-help and thrift.[16] This is of course reflected in its argument that the mildly handicapped should be trained so that they would be less of a burden on society. The attitude to the more severely handicapped was clearly expressed by Miss Denby and Miss Pissent, the founders of the National Association for Promoting the Welfare of the Feebleminded in 1896, an organisation formed to secure the full implementation of the C.O.S. recommendations with respect to the mentally handicapped. Miss Denby was also involved in the foundation of the Lancashire & Cheshire Society for the Permanent Care of the Feebleminded (1898).
These two women, supporters of the Eugenics movement, firmly believed in the life-long segregation of the mentally handicapped as the only means of erradicating the problem of the subnormal and were firmly opposed to their reproducing under any circumstances.

3. The Early Twentieth century - The Eugenics Scare
The social attitu des that began to gain momentum in the late nineteenth century continued into the twentieth and became more widely distributed. The views of the Eugenics movement began to dominate all attitudes towards the mentally subnormal, and continued to do so until the 1930's. A firm conviction developed that mental handicap was incurable and that the subnormals were social menaces who posed a constant threat to civilization. The only possible solutions were life-long segregation or perhaps the sterilization of the unfit. The most feared group were the feebleminded (the mildly subnormal), who had been 'discovered' with the introduction of mass schooling and

were seen as part of the marginal population - the degenerates. (The theoretical implications are developed in Chapter 8).

Public alarm was aroused as the result of three main factors: the systematic studies of the Eugenics Movement, especially the work of Galton; the development by Binet of 'successful' intelligence tests, and the publication of family studies which purported to provide scientific proof that intelligence was hereditary and that degeneracy was passed on from one generation to the next genetically. These were reinforced by the realization that the mentally handicapped could not, in general, be trained to play a full social and economic role and the 'discovery' of an increasing number of 'feebleminded' children by educators in the school system.

The growing concern about the mentally handicapped must, however, be seen in the context of a change in attitudes to the social residuum in the early twentieth century and general fears concerning deterioration of the race. The Boer War had revealed that there was widespread physical disability among the working class, and this led to a re-examination of the old assumptions about the inevitable superiority of the British social system and of the British race. The concern over physical deterioration gave impetus to the political movement for national efficiency and resulted in the advocacy of social reform. It was argued that human resources were being wasted and that the declining birthrate among the upper, middle and respectable working classes, while the residuum was still breeding at a high rate, meant that there would be a deterioration of the race. Influenced by Social Darwinism, scientific reform was advocated in place of evangelical humanism and deterrent poor relief.

However, many of those who advocated social reform and welfare benefits for the poor also accepted the argument that the race was deteriorating because of the defferential fertility of the reputable classes and the residuum. This belief continued despite the fact that the 1903 Interdepartmental Committee on Physical Deterioration found no proof that the race was deteriorating, although they did find that there was widespread poverty,

malnutrition and disease. Although much of this concern was
bound up with physical deterioration, the general acceptance
of Social Darwinism and degeneracy theory meant that the
residuum (the physical degenerates) were seen as a general
reservoir of associated hereditary degeneracies (feeblemindedness
being the final stage).

The strong influence of Social Darwinism and the fear of
the residuum meant that biological science was looked to, to
solve the problem, and the arguments of the Eugenics movement
became very powerful. There was a general consensus among
political parties that the residuum posed a threat and that deg+
eneracy was hereditary. Consequently liberal and Fabian politic-
ians as well as conservative ones advocated eugenic solutions -
although there was not a complete consensus over this, and con-
siderable disagreement as to whether positive eugenics or negative
ones should be employed. Beveridge, who played a vital role
in formulating liberal party policy in the Edwardian period,
justified segregation policies thus:

> The ideal should not be an industrial system arranged
> with a view to finding room in it for everyone
> who deserves to enter, but an industrial system in
> which everyone who did find a place at all should
> obtain average earnings at least up to the standard
> of healthy subsistence ... The line between
> independence and dependence, between the efficient
> and the unemployable, has to be made clearer and
> clearer ... the men who through general defects
> are unable to fill such a whole place in industry
> are to be recognised as unemployable. They must
> become the acknowledged dependents of the state,
> removed from free industry and maintained adequately
> in public institutions, but with a complete and
> permanent loss of all citizen rights, including not
> only the franchise but civil freedom and fatherhood.[22]

Pearson[23] and Sidney Webb[24] argued that as the proliferation
of untalented and malformed children continued,while the
intelligent and well-fed failed to reproduce themselves, no
amount of reform aimed at clearing up the slums would improve
the general condition of the race. What was necessary was state
action in favour of the respectable working class and the
talented classes - that is, a programme of positive eugenics -
possibly coupled with negative eugenic measures, as the only
solution to the problem.

The general consensus over the arguments and policies
of the Eugenics movement (at least in academic and political
circles) is shown by the fact that Russell[24a] not only shared
their views concerning the possible deterioration of the race but
also felt that negative eugenics were desirable for the mentally
defective:

> It must be admitted.. that there are certain dangers.
> Before long the population may actually diminish...and
> government opposition to birth-control propaganda gives
> a biological advantage to stupidity, since it is chiefly
> stupid people whom governmentr succeed in keeping in
> ignorance.

and

> We may perhaps assume...governments will acquire the
> right to sterilize those who are not considered desirable
> as parents. This power will be used at first to diminish
> imbecility, a most desirable objective.

The general consensus over the need to prevent the deterioration
of the race was based on an acceptance of the 'scientific facts'[25]

> That the physically and mentally fitter stocks produce
> physically and mentally fitter offspring

and that

> Ability not entirely, but largely, runs in stocks, and
> these stocks by a long process of social evolution form
> in bulk the upper classes

coupled with an acceptance that eugenic solutions were appropriate.
These views were widely disseminated in, for example, the literary
works and plays of Wells.[26]

However, the underlying concerns of the various political
groups need to be examined. *Conservatives and liberals were con-*
cerned to maintain the Imperial supremacy of Britain and with the
provision of a stable, diligent and quiescent workforce with the
minimum level of public expenditure. The Fabians, on the other
hand, wanted to establish a 'collectivist' social order where
everyone worked for the good of all and where everyone received
a minimum level of education, welfare and income. It was the
latter's acceptance that the residuum were biologically inferior
that led them to accept eugenics. Indeed, in the late nineteenth
century both Sidney Webb[27] and Ball[28] had argued that society
should be reorganised to solve the problem of degenerates:

> ...the modern problem is not so much to get theweak
> out of the way, as to help them to be useful. There
> is no reason in the process of natural selection, as

such, why every member of society..should not be
preserved and help to live as effectively as possible.[29]

In the early twentieth century they apparently became convinced
by the arguments for hereditary degeneracy. However, Sidney
Webb became persuaded after the First World War that the
existence of the casual poor had not been the effect of some
'deviant mutation'. The casual poor were shown to have been a
social and not a biological creation, and their lifestyle was
not the outcome of some hereditary 'taint' but a consequence of
poor housing, inadequate wages and irregular work. The acceptance
of environmental theories was further strengthened by his visit
to Russia in 1935. Of course, the acceptance of environmental
rather than biological causes results in radically different
attitudes and policies towards the 'residuum'. Nonetheless it
remains true that in the early part of the twentieth century
there was still general agreement that the residuum were a
biologically inferior class that posed a threat to the race
and that political action was necessary to avert the danger
that they presented. The degree of penetration of this view can
be seen by the fact that it was held by influential members of
professions outside politics and the academic world.[29a] (It is
important to remember that as far as mental handicap is concerned
the group that were identified and were the recommended subjects
for eugenics programmes were the 'feebleminded' - those who
represented the final stages of degeneracy. Also, apart from
policies of segregation, neither positive nor negative eugenic
solutions were ever legally enacted in Britain, though
sterilization of the unfit was legislated for in many states
in America and in a number of European countries).

5.1 Science and the Mentally Handicapped

The development of intelligence tests in the early part
of the twentieth century provided a 'scientific' method
of diagnosing mental subnormality. Intelligence tests,
as I have already argued in Chapter 3, were based on the
view that intelligence was inherited and fixed or at least

relatively fixed for life. Mental subnormality, especially
feeblemindedness, was seen to be the result of hereditary
factors,the inheritance of 'poor' intelligence genes.

> ...there are laws of inheritance of general mental
> ability that can be sharply expressed; low mental
> ability is due to the absence of some factor and
> if this factor, that determines mental development,
> is lacking in both parents it will be lacking
> in all their offspring. [30]   .

The Eugenics Movement, and specifically the Eugenics
Education Society (founded in 1907) stressed the need to
develop diagnostic techniques to ensure the accurate
identification of the mentally defective. They argued
that there was no doubt that subnormality was inherited
and that society needed to be protected from degeneracy.
Auden, a eugenicist, a prominent member of the British
Association and Medical Superintendent for Birmingham,
emphasised in his 1911 and 1912 Reports the need for
accurate intelligence tests.

> In the case of the feebleminded there is a
> general diminution of the general intellectual
> faculties ... the object of the mental test
> employed should be to measure not so much the
> intellectual acquisition already made as the
> inborn all-round efficiency which we have
> described under the term 'general intelligence'. [31]

In 1911 Newman had advocated the use of intelligence tests to
diagnose defectives in his annual report of the Board
of Education. An article by Burt in the Eugenics Review
in 1913 made it clear that his own growing interest in
intelligence testing was dominated largely by the problem
of the mentally handicapped - quoting the work of Galton
and the recommendation of the 1908 report, he stressed
that "there is no such thing as manufactured feeblemindedness"
and

> The fact of mental inheritance can no longer
> be contested; its importance scarcely over-
> estimated ... there assuredly can be no problem
> upon which experimentalists, statisticians and
> psychologists could so fruitfully concentrate
> their wisdom as the problem of heredity and its
> influence upon the mind. [32]

In the same year, at a meeting of the British Association,
a joint session of the Physiology and Educational Science
session discussed the dispute on the laws of inheritance
and the need to develop intelligence tests and the 1913
Mental Deficiency Act gave further impetus to the develop-
ment of mental tests by forcing more precise diagnosis.
The Board of Education gave clear indications that they
regarded tests as scientific when they replied to a
letter criticising the role of Medical Officers of
Health in diagnosing mental deficiency.

> ...the question of determining whether a child
> is or is not incapable by reason of mental
> defect of benefiting by the instruction in
> an ordinary elementary school is ultimately one
> which must be decided by a qualified medical man
> on the application of certain scientific tests.[33]

The development and refinement of intelligence tests
was, then, spurred on by a perceived need to identify
the mentally deficient.   Tests in turn 'confirmed' that
subnormality was the 'cause' of other social problems
including criminality.

> The theses of Lambroso have been wholly
> discredited by the results of intelligence
> tests. Such tests have demonstrated beyond any
> possibility of doubt that the most important
> trait of at least twenty-five percent of our
> criminals is mental weakness. The physical
> abnormalities which have been found so commonly
> among prisoners are not the stigmata of
> criminality but the physical accompaniment of
> feeblemindedness. [34]

Further 'scientific' proof of the laws of inheritance
of intelligence and degeneracy was provided by the family
studies, which were undertaken, mainly in the United States,
in the last part of the nineteenth century and well into
the twentieth century.   These studies purported to
demonstrate that not only was feeblemindedness inherited
(that is, ran in blood lines as do haemophilia, eye colour
and blood group), but also that it was closely associated
with criminal behaviour, alcoholism, immorality, pauperism,
and vagrancy.   Degenerates, it was also discovered, tended

to have large families and this added to the fears of
the dilution of national intelligence.

In Britain, Auden, Medical Superintendent for
Birmingham, noticed in 1908 when studying the families of
mentally defective children that

> it is clear that family records such as these
> point a moral which cannot be permanently disregarded
> ...society must protect itself from the unrestricted
> propagation of tainted stock. [35]

But probably the most influential study of inherited
degeneracy in blood lines was H.H. Goddard's study of
the Kallikak family. [36] Goddard studied the family back-
grounds of the children admitted to the Vineland Institution
in the United States where he was Medical Superintendent. [37]
He prepared charts which he claimed 'proved' that feeble-
mindedness was inherited and closely associated with all
types of moral degeneracy, although he recognised, as did
the other 'hereditarians', that some forms of mental
subnormality were not inherited. However, these latter
types of subnormality ususally resulted in severe subnormality,
were not associated with other forms of social degeneracy
and were equally likely to be found among the children
of middle- and working-class parents whereas feeblemindedness
(mild subnormality) was found among the lower working class
and closely associated with other social degeneracies.

The study of the Kallikaks was published in 1912 and
was very influential in England as well as the United States.
The study traced the descendents of Martin Kallikak,
both from a pre-marital· liaison with a girl who Goddard
claims was feebleminded, and from his legal marriage.
The genealogical chart demonstrated that

> ... the line of descent of the Kallikak family
> from their first colonial ancestors. It was
> Martin who divided it into a bad branch on the
> one hand and a good branch on the other. Each of
> these branches is traced through the line of the
> eldest son down to a person of the present
> generation. On the bad side it ends with Deborah
> Kallikak, an inmate of the Training School at
> Vineland, on the good side with the son of a prominent
> and wealthy citizen of the same family, now a resident
> of another state. [38]

Goddard maintained that Martin Jr. the son of the pre-
marital liaison, had 480 descendents, of whom 143 were
mentally deficient and only 48 definitely normal, the
rest being either unknown or doubtful, although 36 were
illegitimate, 33 sexually promiscuous, 24 alcoholics,
3 epileptics, 3 criminal, 8 kept 'houses of illfame'
and 83 died in infancy.   In contrast, the descendents
of Martin's lawful marriage, who totalled 496, all became
good, reputable citizens, including doctors, lawyers, judges,
and other community leaders.

This study was widely regarded as 'conclusive' proof
that feeblemindedness was hereditary.   Its conclusions
were supported by other studies including Estabrook's[39]
study of the Wans (1912) and Devenport's[40] Hill Folk.
The fears of the Eugenics Movement were fuelled by these
findings and added to the 'belief' that the feebleminded
posed a threat to civilization.

> For many generations we have recognised and pitied
> the idiot. Of late we have recognised a higher
> type of defective, the moron, and have discovered
> that he is a burden, that he is a menace to
> society and civilization, that he is responsible,
> in a large measure, for many, if not all, of our
> social problems. [41]

One of the main consequences of these studies was the
development of the view, especially in the United States,
that the mentally defective should be sterilized as well
as segregated.   Lapage,[42] writing in England in 1920,
argued that sterilization was not necessary if life-long
care in institutions was provided from an early age.
It was felt that not only would the numbers of the
feebleminded increase, imposing an ever increasing burden
on society, but also that the level of general intelligence
in the population would decline if mental defectives were
allowed to breed.

> Degeneration is thus a cancerous blight,
> constantly spreading, tainting and spoiling
> sound stocks, destroying race values and increasing
> social burdens. In fact degeneracy not only

handicaps society but threatens its very existence.
Congenitally incapable of adjusting themselves to
an advanced social order, the degenerate inevitably
becomes its enemy - particularly those high-grade
defectives who are natural fermenters of social
unrest. 43

The 'scientific' research and findings of the American
studies were replicated, and widely disseminated and
echoed in Britain.[44] Tredgold in 1903 stated:

Therefore in 90 percentage of patients suffering
from marked defect, the condition is the result
of a marked state of the ancestors, which so
impairs the vital powers of the embryo that
full and perfect development cannot take place ...
Amentia   is thus not only hereditary, it is also
the final expression of progressive neuropathic
degeneration. 44a

However, while Goddard was convinced that the transmission
of a mental defective condition followed the Mendelian
mode, Tredgold and Lapage were unable to satisfactorily
demonstrate that it was inherited in the strict sense of
the word - that is, that the condition is carried in the
germ plasma of the parents.   Instead they regarded mental
handicap as more often the expression in the offspring
of various forms of mental disabilities in the ancestors,
as Tredgold argued

In my experience it is commoner for the ancestors
of defectives to suffer from such conditions as
insanity, epilepsy, dementia and allied psycho-
pathological states, than it is for them to
be actually mentally deficient.[45]

While Lapage[46] maintained that ninety percent of mental
deficiency was caused by Neuropathic Inheritance - that is,
inherited and inbred, not caused by bad influence of
environment or disease, in the first two decades of the
twentieth century it became accepted as scientific 'fact'
that mental subnormality was hereditary and closely allied
with other types of social degeneracy, and in particular
that the feebleminded posed a threat to civilization.

The only 'solution' was the life-long segregation of
the deviants.

> We have seen that lifelong care is essential, and
> that the most forcible argument in its favour is
> that every feebleminded person who is not under
> restraint is a menace to the community: not
> only is such an individual very likely to become
> a so-called criminal, drunkard or prostitute,
> but also he or she may propagate and spread a
> taint that is wholly bad by having children,
> legitimate or illegitimate.[47]

These views were widely expressed in medical and
psychological writing on mental deficiency, and in the
writings of the Eugenics Movement.   It is difficult to
determine how deeply the views and attitudes penetrated
into everyday consciousness, but many of the stereotypes
and fears still held concerning the mentally handicapped
can be seen to be underpinned by these views.   (In Chapter 7
I discuss attitudes to the mentally handicapped).

3.2   Social Policy and the Mentally Handicapped in early
      twentieth century England

The changing conception of the mentally subnormal in
the early twentieth century was quickly reflected in social
policy.   The growing concern about the problems presented
by, and the danger of, the mentally subnormal resulted in
the government setting up a Royal Commission in 1904.

The Commission was set up specifically

> to consider the existing methods of dealing with
> idiots and epileptics and with imbeciles, feeble-
> minded, or defective persons not certified within
> the lunacy laws, and in view of the hardship or
> dnager resulting to such persons and the community
> from insufficient provision for their care,
> training and control, to report as to the amendment
> in the law and other measures which should be
> adopted in the matter, due regard being had to
> the expense included in any such proposals and
> to the best means of securing economy therein.[48]

The Commission, under the Chairmanship of H.J. Gladstone, started receiving evidence in 1904 and published its report in July 1908, having received submissions from 248 witnesses, including inspectors and medical officers of special schools, reformatories, prisons, lunatic and idiot asylums, as well as representatives of all groups who were considered able to give information on the subject. The Commission also obtained details of how other countries dealt with the mentally defective as well as writing to institutions for the mentally subnormal in the United States, Europe, Ireland and Scotland.

The Report expressed considerable concern about the existing provision made for the mentally subnormal especially in view of the size of the problem (it was estimated that at least one in 217, i.e. 0.46 percent of the population, was mentally defective and that at least one in 127, i.e. 0.79 percent of school children, were either idiots, imbeciles or feebleminded) and of the fact that they needed to be adequately controlled in order to protect society.

> Of the gravity of the present state of things,
> there is no doubt ... there are numbers of
> mentally defective persons whose training is
> neglected, over whom no sufficient control is
> exercised and whose wayward and irresponsible
> lives are productive of crime and misery, of much
> injury and mischief to themselves and to others,
> and of much continuous expenditure wasteful to
> the community and the individual family. 49

Considerable concern was expressed about all the mentally defective, but one group, the feebleminded, were selected out as needing special attention. Many of the feeble-minded were not properly trained, according to the report, and as a consequence became criminals, paupers or members of other social problem groups. This meant that they placed an intolerable social and economic burden on the community. Considerable evidence was presented to the inquiry, which led them to come to this conclusion.

The Medical Officer for Pentonville insisted that forty
percent of juvenile offenders were feebleminded, and
the Medical Officer for London County Council maintained
that there was a high correlation between mental handicap
and criminal behaviour, while Dr. Ashley, Medical Officer
of the Manchester special schools, maintained that mental
defectives who were not properly cared for

> ...tend to an increase of the criminal and
> immoral classes, as well as of course
> the pauper classes. 50

The evidence submitted to the Commission suggested
that a large number of feebleminded men and women drifted
into the workhouse before they reached the age of 30 years.
In the case of women there was also a tendency for mentally
subnormal ones to have illegitimate children.   Dr. Millard
of Manchester found that of nineteen feebleminded women
in the laying-in ward of the workhouse infirmary, all but
two had illegitimate babies.   Dr. Tredgold found in a
group of sixty-one feebleminded mothers that nineteen
were legally married and that forty-two had illegitimate
children.   The Physician Superintendent of the Royal
Edinburgh Asylum argued that

> Feebleminded young women are subject to over-
> whelming temptations and pressure towards sexual
> immorality. Many of them have had illegitimate
> children and this often at very early ages ...
> I look on this source of immorality as an
> extremely grave one in our social life. When
> illegitimate children are born by such young
> women the chances are enormously in favour
> of their turning out to be either imbecile or
> degenerate or criminal. 51

The perceived 'danger' of the mentally defective
also led other expert witnesses, such as Sir W. Chance
and Dr. M. Cooke, to advocate their life-long segregation.
Miss Denby of the Association for the Permanent Care of
the Feebleminded also pointed to the 'dangers' of leaving
mentally subnormal children in the community. The Royal
Commission concluded:

> ... we have pointed out how strong is the argument
> for the detention of the mentally defective in
> suitable institutions ... segregation and
> control should follow immediately on their leaving
> a special class ... The evidence ... emphasises
> the necessity of segregation or detention on
> the widest grounds of public policy. It is
> very representative and comes from the authorities
> of prisons, medical officers of special schools,
> superintendents of county asylums, members of
> county councils, Poor Law inspectors, medical
> experts on questions of insanity and disorders
> of the mind, and from men of general authority
> and large legal experience, and others ...
> And ... the mass of evidence is absolutely consistent
> with our own experience and with the result of our
> perceived investigations?ᵃ

The recommendations of the report reflected very clearly
three current concepts concerning the nature and extent
of mental deficiency. They felt that society needed to
be protected from the mentally deficient, and that
considerable efforts needed to be made to identify all
mental defectives. While in general the mental defectives
should be segregated in hospitals, asylums or colonies,
it was felt that in a few cases family care or a guardian-
ship orders would suffice.

The report received a very mixed reception. In
particular, the Eugenics movement, especially the Eugenics
Education Society which had been founded in 1907, did not
feel that the recommendations went far enough if society
was to be protected from the subnormal. As a result the
government decided not to introduce legislation immediately
but to await further developments.

Two powerful pressure groups - the Eugenics Education
Society and the National Association for the Permanent Care
of the Feebleminded-launched a campaign to keep the public
informed of the importance of the eugenic problem and to
persuade the government to introduce legislation ·enforcing
the permanent care and segregation of the mentally
defective. A.F. Tredgold lobbied M.P's to propagate the
idea that mental deficiency was hereditary and was leading

to the degeneracy of the race. Galton and Montague
Crackenthorpe (first President of the E.E.S.) used the
columns of The Times to argue the hereditarian case,
while Auden, co-founder of the Birmingham branch of the
E.E.S. and school Medical Officer for Birmingham, emphasised
the problem of racial decay in one of his earliest reports

> The recommendations of the Royal Commission ...
> still await consideration and the problem of
> mental deficiency remains one of the most
> pressing and urgent social questions ...
> Nothing is more striking than the frequency
> with which more than one member of the family
> exhibit mental deficit ... In other words,
> heredity plays a great part in the continuance
> of mental deficiency.[53]

In 1910 Miss Pissent[54] advocated the permanent care of
the feebleminded in a speech made to a church congress.
She justified this policy by referring to the American
Family Studies and by giving examples of families in
England who despite considerable social work support
were too defective to care adequately for their families.

The work of these two pressure groups aroused public
opinion,[55] and considerable concern was expressed about
the 'danger' that defectives posed to ordinary citizens
and to the community. By 1912 the Home Office had received
more than 800 resolutions from public bodies, advocating
the permanent care and segregation of the mentally defective,
including the feebleminded. The submission of resolutions
by public bodies does not of course 'prove' that public
opinion was aroused; it does, however, show that there
was some general concern. Councils and Education Authorities
are elected bodies and they reflect to some extent the
concerns of the local electorate, or at least what they
feel concerns the local electorate. It is of course
likely that only a few vocal and influential citizens
expressed 'real' concern, and that this coupled with news-
paper campaigns and the work of the two pressure groups,
both supported by leading and influential figures,
created a 'moral panic', the 'man in the street' being

considerably influenced by the media and official views
and fear being widely disseminated.

As a result of this pressure two bills were introduced
in 1912, one by M.G. Stewart M.P. and one by the Home
Secretary. Both passed the Second Reading and were
referred to Standing Committee. After several post-
ponements the latter bill was re-introduced in.March 1913
and received the Royal Assent on August 15, 1913. The
delays occurred because the Bill was widely attacked
both in and outside Parliament. Four newspapers,
The Citizen, the Daily News, the Daily Herald, and the
Manchester Guardian all criticised the Bill. The fears
of the Bill's opponents were expressed in Parliament by
among others, the Conservative M.P. Robert Cecil who
justified his concern thus:

> I confess I feel very nervous about applying
> any remedy on the grounds of eugenics in the
> present condition of our knowledge of that science.[56]

It was felt that the Bill went too far in its recommendations
and despite a campaign in The Times[57] newspaper by the
Bill's supporters the government withdrew it.

The withdrawal of the Bill immediately led to a
campaign for its re-introduction, in the media and from
pressure groups and powerful citizens. Articles appeared
in the Lancet in support of the Bill.

> We live in days when even the most sentimental
> humanitarians can hardly be blind to the fact
> that for nations, as for individuals, the
> struggle for existence is still a stern reality
> and that in the struggle, efficiency is the price
> of survival ... It is a lesson which is applicable
> to other matters beside the propagation and
> conduct of war and nowhere is it more pertinent
> than in what to do with the furthering of racial
> fitness. [58]

A new Bill was introduced in 1913, which left out the
most controversial clauses in the previous Bill - the
clause forbidding marriage and the one permitting compulsory
sterilization. Parliamentary opposition virtually disappeared,

the official opposition agreeing not to oppose the Bill.
The only effective opposition came from a few back-
benchers. One of these, Wedgewood, pointed to the
class nature of the Bill and argued that it was aimed
at social control and at improving the wealth-producing
power of the working class, by incarcerating those who
were not able to work at the required level. The
measures in the Act were not aimed at all the mentally
subnormal but the 'feebleminded', who came from deprived
working class backgrounds. But these few voices raised
in opposition were hardly heard in the hurry to get the
Bill through Parliament and on the Statute Book as
quickly as possible.

The 1913 Mental Health Act incorporated the main
recommendations of the Royal Commission and also reflected
the concern that had been expressed about the inadequacies
of some of the conclusions of the Report. Four classes
of people were defined as coming within the terms of the
Act: idiots, imbeciles, the feebleminded and moral
defectives. The first three were clearly referring to
people with varying degrees of mental handicap, but it was
unclear if moral defectives had to be mentally subnormal.
The Act set up a Central Board of Control, and required
County and County Borough Councils to ascertain the
numbers of mental defectives in their area and to provide
and maintain sufficient institutions to 'care' for them.
Local Education Authorities were required to report all
children over seven years who were ineducable, and were
responsible for informing the Local Authority of those
leaving special schools who required supervision.
Legal requirements were laid down governing the reception
and detention of mentally defective persons. Feeble-
minded females giving birth to illegitimate children,
habitual drunkards, vagrants, criminals, feebleminded
minors (i.e. those under 21 years) and imbeciles and idiots
of any age could be compulsorily detained. Mental deficiency
had to be diagnosed by two doctors; once diagnosed an

individual could be detained indefinitely, although
provision was made for periodic review of the condition of
those detained under the Act. Local Authorities were
empowered to put mentally handicapped individuals under
guardianship orders in the community, although the
provision was not widely used.

The 1913 Act, then, formally laid down the principle
of making special provision for the mentally subnormal -
it identified them as a social problem group, and gave
wide powers of permanent detention of those officially
diagnosed as mentally defective. It also marked them out
as outsiders, as a group incapable of self-support,
a burden on the community, to be hidden away permanently
for the protection of society. They were stigmatized as
not fully human in a society where to be a 'good citizen'
was to be economically and socially productive and where
a man's worth was measured by his ability to secure and
hold down a job. This view can still be seen to underlie
current attitudes to the mentally handicapped, when even in
a time of high unemployment it is socially unacceptable to
be unemployed. The unemployed are stigmatized and
have a diminished status, the mentally handicapped seem
more so because they are seen as a burden on society
and, in some unspecified way, a threat or danger.
(See Chapter 7, where I discuss attitudes and behaviour
towards the mentally handicapped at the interpersonal
and community level).

Although the mentally handicapped had now become
officially outcasts of society, they continued in many
ways to be ignored. Many Local Authorities were slow to
implement the provisions of the Act. By 1927 Local
Authorities still only provided 5,301 beds for the mentally
handicapped although the number of ascertained 'defectives'
was over 60,000. This seems to have been due to the
cost of providing permanent segregation, and suggests
that public concern about the 'danger' of the mentally

handicapped may not have been as great as that of government, a few influential public figures and the Eugenics Movement.

> It is difficult to convince members of the council
> that the expense of maintaining the feebleminded
> who cannot maintain themselves must eventually
> be borne by the community and that it is a choice
> between maintenance under improper conditions in
> Poor Law Institutions, in provision by out-door
> relief or unemployment benefit, or maintenance in
> institutions where they are under continuous
> training and care.[1]

The Board also sugge ted that mental defectives were a source of danger to neighbours and the community generally, and for this reason it was essential to detain them for life in asylums.

As it became vident that the 1913 Act was not being fully implemented. the government decided to set up a committee in 1926[6] investigate the current situation with re pect to h ldren. The terms of reference of the committee were later extended to include adults. The Wood Committee reported in 1929. It made its recommendations within a c nception of mental deficiency that regarded 't i l as a social and a genetic problem. Mental defectives w re seen as the last stage of the inheritancy of degeneracy — the degenerate group making up at least ten perce it of the population. Particular concern was expressed about mental defectives of the primary amentic type, and it was argued that if all the families of mental defectives of this type were collected together

> It would include ... a much larger proportion of
> insane p rsons, epileptics, paupers, criminals
> (especiallv recidivists), unemployables, habitual
> slum dwell rs, prostitutes, inebriates and other
> social inefficients than would a group of families
> not containing mental defectives.[7]

An epidemiologi al urvey carried out for the Committee estimated that 1 percent of the population was mentally deficient, and of these 25 percent were idiots or imbeciles and 75 percent fe ble inded. The group seen as the real 'threat' was also the mo t numerous. he Committee recommended

life-long segregation as the only effective means of
dealing with the problem. However, recognising the
cost of this, they argued that mental deficiency asylums
were to be places of detention, not hospitals. The Wood
Committee did not, however, go to the extreme of recommending
sterilization as a solution, as had happened in the United
States. In 1933, however, the Brook Committee did [62]
recommend voluntary sterilization for the mentally
defective, not because they felt that it would solve the
'problem' of mental deficiency, but that it might check
the growth of a spreading group of people that were not
wanted by their parents or anybody else.

The Brook Committee did recommend improved care for
mental defectives as well as the provision of training
and productive work for those detained in asylums.
The economic situation of the depression meant that there
was little headway made in the provision of institutions,
although by 1937, 81 local Authorities in England and Wales
out of 123 were making provision for the accommodation of
the mentally defective. [63] There was instead a turn to
community care as the 'solution', mentally subnormal people
being cared for in the community rather than incarcerated
in institutions (see Table 5 and Table 6). This trend can
be seen as a response to an economic crisis rather than
a change in attitudes towards the mentally handicapped
as in 1933 it was still 'officially' held that

> High grade mental defect occurs proportionally
> more frequently in the lowest social stratum than
> in the rest of the population. In this stratum there
> appears to be an unduly high incidence of mental
> efect, insanity, intellectual dullness and epilepsy,
> as well as tuberculosis and other physical defects.
> Cause and effect of the conditions found in the social
> problem groups are debatable but it is possible
> that selective mating may to a large extent account
> for this concentration of physical defects and mental
> defects and disorders. There is evidence that in
> the poorest districts neighbour marries neighbour
> and like marries like. [64]

Table 5: Total Numbers of known Adult Defectives in
England and Wales 1929 and 1936/7 [65]

| | 1937 | 1928 | Per 100,000 pop. | |
			1928	1936
Known to local Authority	120,731	61,522	157	297
Ascertained subject to be dealt with	88,699	38,979	99	218
In Institution or under Guardianship	46,170	21,333	54	113
Under statutory supervision	36,307	18,159	46	89

Table 6: Mental Deficiency Authorities Provision Jan. 1 1936 [66]

Under Statutory Supervision	36,307
Unver Voluntary Supervision	25,048
Under Guardianship	3,729
On Licence	3,023

4. Social Policy and the Mentally Handicapped in the period after World War II

In the period immediately following the Second World War, Britain became what is usually referred to as a Welfare State. As a result of the Welfare legislation of the late 1940's the care of the mentally handicapped was split between two bodies - the mental handicap hospital came under the control of the Health Authorities, while community services and education were the province of Local Authorities. The mentally handicapped have, however, remained a 'Cinderella' group in terms of resources provided

for them both in hospitals (see Table 7) and in the
community. (See Chapter 6 for a more detailed discussion
of the philosophy underlying social policy for the
mentally handicapped in the last three decades.)

Table 7: Cost per Inpatient Week for Selected Services
in Different Types of N.H.S. Hospitals in England
1969/1970 (in sterling)[67]

	Acute non-teaching - over 100 beds	Long-stay chronic sick	Mental illness	Mental handi-cap
Net total cost	55.70	22.50	17.63	14.96
Medical staff	3.10	0.46	0.81	0.39
Nursing staff	13.67	9.55	6.26	5.28
Domestic staff	2.77	1.67	0.60	0.44
Catering	6.07	2.81	2.64	2.23
Laundry	1.20	0.74	0.40	0.46
Power, light & heat	1.88	1.21	0.88	0.78
General cleaning	0.55	0.32	0.15	0.13

The care of the mentally handicapped has, at least
superficially, become more humanitarian, and attitudes
less negative. Evidence has gradually accumulated which
suggests that the mentally handicapped do not pose a
threat to civilization, and that it is not necessary to
segregate subnormals for life in order to protect society.
Even if this were not so, events in Europe in the 1930's
and the first half of the 1940's have given distasteful
flavours, in the minds of many, to policies or lines of
thought which might even appear to be aimed at 'improving
the race' by eugenic means. The emphasis has been on

reducing the cost to the community of caring for the handicapped by looking after them in the community, instead of in large institutions [68] (see Chapter 6).

The history of social policy towards the mentally handicapped in the last thirty years has been one of increasing advocacy of community care, but while the policy has been widely advocated, in practice little change has occurred. The Royal Commission (1954-57) [69] received evidence from a large number of professional and other bodies and individuals concerned with the care of the mentally subnormal. These included considerable information on the fact that large numbers of people were detained in mental subnormality institutions even though they had intellectual abilities above the level accepted as the maximum for mental subnormality to be present by many authorities. The National Council for Civil Liberties in particular pointed to many abuses in the existing methods of dealing with the mentally subnormal and argued that the incarceration of people in a subnormality hospital frequently occurred because they were seen as socially undesirable and not because they were subnormal.

The 1959 Mental Health Act, which incorporated many of the recommendations of the Royal Commission, advocated community care for the mentally handicapped who did not require specialised treatment only available in a hospital. The government advocated the expansion of community facilities for the subnormal, but Local Authorities have been very slow to develop community facilities for the mentally subnormal. In practice community care has meant that the families, and especially the mothers, of the mentally handicapped have had to devote their lives to the care of the handicapped. Indeed the Younghusband Report argued [70]

> Perhaps most important of all are efforts to
> make it possible for the family to care for
> its physically or mentally handicapped member.

While Local Authorities have been slow to develop community-based facilities for the mentally subnormal, even following 'Better Services for the Mentally Handicapped (1971), a White Paper designed to improve services for the mentally subnormal, hospitals have continued to be criticised. Conditions in subnormality hospitals have been shown to be undesirable for the care of the majority of the subnormal. The facilities are poor, the hospitals have difficulty in recruiting nursing staff and professionals, and are usually isolated from the communities from which their patients come.[71]

The reasons for the changes, or rather the lack of change, in the provision made for the mentally subnormal in the last 30 years are complex. Social, economic and political factors are all extremely relevant. The mentally subnormal are a stigmatized group, who have little economic or political power and consequently are low on the priority list for public spending. Furthermore, as Townsend has[72] pointed out, those in charge of the large subnormality hospitals, who wield considerable power, have a vested interest in the retention of these institutions.

5 Conclusion

The social conception of the mentally handicapped has changed markedly in the last two centuries, the period of the rapid growth and development of industrial capitalism. These changes are closely related to the way in which the problem of social control is conceptualised and are a response to the 'needs' of the new socio-economic order. In common with other groups of social deviants/outsiders, the mentally handicapped became seen as different and managed as deviants.[73] They are seen as a 'threat' to the new social order – a group who could not or would not conform to the work ethic, in a rapidly expanding industrial society which was becoming increasingly dependent on a skilled, efficient and co-operative labour force.

The optimism of the early part of the nineteenth century quickly gave way to 'fear', a fear of degeneracy as it was realised that not only was mental handicap incurable, but the numbers were much greater than had been supposed. The introduction of mass schooling resulted in the 'discovery' of the feebleminded, a large, hitherto undetected group. This, together with the development of the 'science' of Eugenics and of psycho- metric tests, resulted in the 'scare' of the early twentieth century and the period of incarceration of the mentally handicapped.

Since the middle of the twentieth century it has gradually become accepted that the mentally handicapped

do not pose a threat to society. The emphasis in handling the mentally handicapped has changed from the advocacy of segreg- ation from the community to arguing that they should be cared for in the community, although in practice little change in the prevision of services has taken place. (The economic, social, political and attitudinal factors underlying this change in emphasis are discussed more fully in Ch apter 6).

It must be born in mind that in trying to relate changes in the conception of the mentally handicapped to the social provision made for their care, one is describing ideal types - what <u>dominates</u> during a given period. However, change is gradual and therefore there co-exists within any given stage social conceptions and forms of carefrom the preceding one and the succeeding one. This is further complicated by the way in which professional, public, and official/government attitudes and conceptions change in different ways and how the changes in one area influence changes in others. Furthermore, governments are influenced by political, social and economic factors that

determine the ways in which resources are allocated
between the various competing demands. Even in the affluent
period following the Second World War the handling of the mentally handi-
capped in capitalist society can be seen to involve a
tension between 'protecting' society and the cost of
maintaining those who are officially labelled as subnormal.
The most recent developments in the official philosophy
towards the care of the mentally handicapped can be seen as
easing this tension - the more towards community care.
This is explored more fully in the next chapter.

1: Report of the Committee on Colonies for the Segregation of Defectives (U.S.A.), 1903

2: Skultans, 1975

3: Foucault, 1971, P274

4: See Itard, 1801

5: Condillac 1755

6: Esquirol 1845

7: Itard, 1801, P91

8: Knight, 1968 P82

9: Seguin, 1846

10: Howe, 1848 P1

11: The Lunacy Commission. 1866

12: Sarason and Doris, 1969 Ps210-211

13: Howe, 1848

14: Spencer 1851 Ps323-324

15: Galton, 1869

16: Report of the Departmental Committee on Defective and Epileptic Children, 1898

17: The Elementary Education (Defective and Epileptic Children) Act 1899

18: Quoted in Lapage, 1920 P3

19: Quoted in Davenport, 1911

20: Report of the Charity Organisation Society, 1877

21: Report of the Charity Organisation Society, 1877

22: Beveridge, 1906 P327

23: Pearson, 1905

24: S. Webb, 1906

24a: Russell, 1924 P47 2 Ps48-49

25: Pearson, 1905 (Letters Page)

26: See, e.g., Wells, 1904, 1905, 1908, 1930

27: S. Webb, 1896

28: Ball 1896

29: Ball 1896 P19

29a: For example Blunt, 1907

30: Davenport, 1911

31: Auden, 1912 P64

32: Burt, 1913 P183

33: Public Record Office Ed 50/116

34: Terman, 1919 P7

35: Auden, 1904 P76

36: Goddard, 1912

37: Goddard, 1910

38: Goddard, 1912

39: Eastabrook, 1912

40: Davenport, 1911 P66

41: Goddard, 1915

42: Lapage, 1920

43: Stoddard, 1922 P227

44: E.G. Tredgold, 1908; Lapage, 1920; Cruikshank, 1924.

44a: Tredgold, 1908

45: Tredgold, 1908 P16

46: Lapage, 1920   47: Lapage, 1920 P 197

48: Royal Commission, 1904 (Terms of Reference)

49: Report of the Royal Commission, 1908 *Vol 8 P3*

50: Report of the Royal Commission, 1908

51: Report of the Royal Commission, 1908 *Paragraph 104*

52: Report of the Royal Commission, 1908   .

53: Auden, 1909 *P75*   54: Pinsent, 1910 *(Quoted in Jones 1972 P 197)*

55: Jones, 1972 *P199*

56: R. Cecil: Hansard 19-7: 1912: 721-738

57: Times, 28.11.1912, 29.11.1912.

58: Lancet, 14.12.1912.   59: Board of Control, 1927

60: Wood Committee, 1929   61: Wood Committee, 1929 *Part III*

62: Brook Committee, 1933   63: P.E.P., 1937
    Departmental Committee on Sterilization 1938
64: *(Quoted in PEP 1937, P315)*   65: P.E.P., 1937 *P 27*

66: P.E.P., 1937 *P278*   67: Navarro, 1978 *P40*

68: See, e.g., Jaehnig (1974) for a more detailed account of
    changes in social policy towards the mentally handicapped
    in the last thirty years.

69: Royal Commission on the Law Relating to Mental Illness and
    Mental Handicap.

70: Younghusband, 1970 *P161*   71: See, e.g., Morris, 1969

72: Townsend, 1974   .

73: See, e.g., George (1973), Scull (1978)

                              .

CHAPTER 6

CURRENT POLICIES AND PRIORITIES IN THE HANDLING
OF THE MENTALLY HANDICAPPED

1. Introduction

> We are all concerned to improve services for
> mentally handicapped people and in particular
> to develop those services which enable a
> mentally handicapped person to live as normal
> a life as possible whether in hospital or in
> the community.
>
> (P. Jenkin, Secretary of State for Social
> Services, 1980)[1]

This statement, recently made by a Cabinet Minister,
sets forth clearly a continuing aim to improve services
for the mentally handicapped.   More than this, it
explicitly enshrines the 'normalization' principle –
a principle first enunciated with respect to the mentally
handicapped in the Scandinavian countries in the 1960's
and now widely advocated as a policy objective in other
developed countries, including Britain and the United
States.

As I suggested in Chapter 5, the 1960's and 1970's
witnessed an apparently revolutionary change in declared
public policy (although not necessarily in practice, as
I shall argue below) in the handling of the mentally handi-
capped, the consolidation of the changes being the
publication in 1971 of the White Paper Better Services for
the Mentally Handicapped.   The major policy objective
became community care and 'normalizing' the lives of
mentally handicapped people.   This included the aim of
discharging as many mentally handicapped people as possible
from hospital and providing suitable accommodation and
facilities for them in the local community.   Furthermore,
the mentally handicapped were no longer to be regarded
as second class citizens but rather increasingly to be
integrated into the existing general provision of social,

educational and health services provided for the community
in which they lived. The stated aim is, therefore,
for as many mentally handicapped people as possible not
only to live in the community but also to become integrated
into it - to become full members of society. These aims
have been reiterated by the government in the last year,
and it has been explicitly stated that the intention
is to provide a comprehensive community-based service
for the mentally handicapped. They would not only be
entitled to the same range and quality of services as
are available to other citizens, but also to services
designed to meet their special needs, to enable them and
their families to live as 'normal' a life as is compatible
with their kind and degree of handicap. 'Normalization',
at least in the way it has been interpreted officially
in Britain, means positive discrimination - giving extra
help to the handicapped so their lives can be, as far as
is possible, the same as those of every other citizen.

As I have already indicated, these policy objectives
have been considerably influenced by the Scandinavian
model of handling metnally handicapped people, originally
developed as a response to the mounting criticisms of
the effect of 'warehousing' and the associated medical
model of mental handicap which I have discussed in Chapters
2 and 3. (A number of research studies already discussed
indicated that living in the community did not have these
adverse consequences.) Denmark was the first country
that introduced legislation specifically designed to
'normalize' the everyday existence of the mentally handi-
capped, but Sweden's handling of the mentally handicapped
is more frequently cited as a model to be emulated.

In this chapter I intend to examine the Swedish
philosophy and policies for the mentally handicapped
and the extent to which they have been adopted and implemented
in Britain. It will be necessary to examine, critically,
both the policy of 'normalization' and that of 'community
care', to determine to what extent they have been and can be

implemented, to determine to what extent 'normalization' and 'community care' are the same objective, and to ask why these policies became adopted by the Scandinavian countries, North America, Britain and other European countries in the last two or three decades.

2.   Sweden and the Normalization Principle

Sweden is generally regarded as a capitalist society that provides a comparatively high level of welfare provision for its citizens and caters for the needs of all the members of the society. Thus Scase has argued that Sweden is

> ... often viewed as a synthesis of the
> most desirable features of both capitalist
> and state socialist countries. [2]

Specifically with regard to the mentally handicapped, Lippman[3] suggests that it is precisely because Sweden has this general attitude to social welfare that it has been able to provide a high level of care and facilities and to develop and implement a policy of 'normalization'.

The precise historical antecedents of the policy in Sweden are difficult to determine. However, psychological research appears to have influenced both the leaders of a parent pressure group[4] and those officially concerned with policies for the mentally handicapped - namely, research on the adverse effects of institutionalization and research which suggested that mentally handicapped people could develop more fully in a more 'normal' environment[5]. (K. Jones[6] has specifically cited Tizard's 'Brooklands experiment' as being about the idea of 'normalization', although to what extent this research influenced the Swedes is difficult to determine). However, Grunewald, the Director of the Department for the Care of the Mentally Retarded of the National Board of Health and Welfare, stated in 1969:

> In Scandinavia we have been seeking new goals
> and methods of caring for the mentally handi-
> capped and these have gradually attracted inter-
> national interest. These goals are part of the

so-called 'normalization principle' ...
the normalization principle has come as
a natural reaction against over-special-
ization and institutionalization. 7

The principle of 'normalizing' the lives of mentally
handicapped people is not only a policy objective;
it is also enshrined in Swedish law. (In fact the
mentally handicapped are the only disabled group to have
legal rights to services specifically designed for them -
'normalization' for all other groups has meant that no
'special' provision is made for them legally - although
Swedish law does ensure that public buildings and other
public facilities are designed so that all citizens have
equal physical access to them). The Swedish law on
Mental Retardation became effective on the 1st July
1968 and has been described as a 'Bill of Rights'.
It provides for a wide range of services and stresses
that they should be made available to every retarded
citizen and tailored to suit individual needs.

'Normalization' as developed in Sweden involves a
cluster of ideas, methods and practices designed to
enable the mentally handicapped person to have an exist-
ence as near the 'normal' as is compatible with his or her
degree and level of retardation. Underlying the principle
is a perceived 'need' to provide facilities and help for
the mentally handicapped to enable them to lead a life
as near as is possible to that led by every other citizen.
Consequently, one of the main aims is that the vast
majority should live in the community rather than be
'warehoused' in large hospitals.

Grunewald[8] has undertaken a detailed study of the
existing provision in Sweden and suggested how services
for mentally handicapped should be developed in the future
in order to bring about 'normalization'. He has emphasised
that 'normalization' involves more than just providing
accommodation in the community if the mentally handicapped
are to lead a relatively normal existence. It means
enabling them: to live in their own personal accommodation;

to live in a bisexual world; to experience a normal
daily rhythm of life; to eat in small groups; to work
(or be educated) in a place physically separate from the
place where they live; to be paid for the work they do
at a 'fair' rate; to decide for themselves how they will
spend their free time; and, in the case of young people,
to be able to move away from the parental home to
separate accommodation if they wish, as other young adults
do.   Accommodation for the mentally handicapped should
not normally house more than ten residents and should be
located in a community that is large enough to assimilate
them.   Residents in institution-type accommodation should,
as far as is possible, have their own bedroom, have
holidays away from 'home' and be encouraged to establish
and maintain contacts with their families, relatives and
other residents in the local community.

In practice, residential accommodation for the
mentally subnormal in Sweden is of three main types,
all of which are still being modified to meet the
demands and requirements of the 'normalization principle',
and especially to make possible the integration of the
mentally handicapped into local communities.   The emphasis
has thus been on providing accommodation in the community.
The three types are hospitals (which it is hoped will
eventually be phased out), residential homes (for those
requiring considerable care and attention), and group
homes (for those capable of a high level of independence).
According to Grunewald, and based on medical and social
care needs of mentally handicapped people, it is antici-
pated that eventually thirty percent will live in
residential homes, fifty percent in group homes or
completely independently and twenty percent with parents
or relatives.

.

Table 8: Living Conditions for 23,000 Mentally Handi-
capped People in Sweden in 1975 [8a]

Place of Residence	Proportion
Residential homes	38%
With parents/relatives	33%
Independently	12% ·
In hospitals	4%
In group homes	7%
In foster homes	2%
Other	3%

Although the policy of 'normalization' would seem
to have been implemented in Sweden, at least to the
extent that the majority of the mentally handicapped are
not incarcerated in hospitals, nevertheless the degree to
which their lives have actually been 'normalized' is more
difficult to assess. Apparently politicians have accepted
the policy, at least in part, because it is a less
expensive way of handling the mentally handicapped (although
whether it would be less expensive if a full range of
supportive services were provided is debatable), but the
moves to house the mentally handicapped in local communities
have met with public opposition arising from the general
negative emotional and intellectual attitudes towards the
mentally handicapped among the general public.[8b]
(See Chapter 7 for a more extended discussion of community
and individual attitudes to the mentally handicapped).
This means that it is unlikely that the mentally handi-
capped have become integrated into the community, and at
another level we can ask to what extent hostels or
residential homes provide a 'normal' environment.

However, although we can debate the extent to which
'normalization' has become a realised policy objective in
Sweden, the principle has gained wide acceptance
with pressure groups and decision-makers in both Britain

and the United States. It is advocated on the grounds
that it is a more humanitarian and effective way of handling
the mentally handicapped, enables them to develop at
all levels of retardation to a degree previously thought
impossible, and in Wolfenburger's terms lets them be
treated as developing people rather than as incurably sick
or as social menaces. (The historical origins of these
conceptions of mentally handicapped people were developed
in Chapters 4 and 5).

A graphic account of what 'normalization' can mean
in practice in the United States has been provided by
Robert Meyer. In his book Like Normal People he describes
how his brother Roger Meyer (a mildly retarded man)
was enabled to move from a residential home to independent
living, holding down a job in a restaurant and eventually
marrying a girl he had met in the residential home.
This was achieved through a careful programme of
counselling as well as gradually exposing Roger to the
requirements of 'normal' day-to-day living.
Edgerton,[9] Henskal[10] and Mattesen[11] (see Chapter 2) have
also given accounts of mentally handicapped people leading
'normal' lives, although the extent to which they 'coped'
with the requirements of independent living is, in some
cases, debatable.

All these examples, however, are of mildly subnormal
people, who can apparently be helped to a high degree of
independent living. What, though, does 'normalization'
mean for the more severely handicapped, who will never
be able to live independently? In Eastern Nebraska the
Community Office of Retardation has attempted to implement
a policy of 'normalization' that has been reported on
favourable.[12] Basically the aim is to provide accommodation
and facilities in the community for all mentally-handicapped
people, except for those requiring specialised medical care.
Services included educational facilities, integration
in 'normal' schools where possible, for all children, adult
work centres for all the mentally handicapped incapable of

open employment (for which those capable of it were
prepared) and crisis intervention facilities to assist
families caring for a mentally handicapped member.

In the rest of this chapter I will examine the
extent to which 'normalization' has become a policy
objective and been implemented in Britain, and attempt
to explain why advanced capitalist societies, or at least
their governments, have so readily accepted the principles
of'normalization' and 'community care' as policy objectives
in the last two decades.   Finally I will suggest that
'normalization' and 'community care' are not clear-cut
concepts but mean different things to different people.
In particular, public policies are based on an interpretation
that does not necessarily agree with that of the major
advocates of 'normalization'.

3.   Britain: 'Better Services'- The Reality

>   Our services for the mentally handicapped have
>   passed through the same historical stages as
>   those in other developed countries which
>   separated men, women and children off into large
>   and forbidding institutions in remote places
>   to protext the mentally handicapped from the
>   community and the community from the mentally
>   handicapped; providing intra-mural care from
>   birth to death in the belief that mental handicap
>   was a completely static condition requiring
>   life-long institutional support.   Hence their
>   professional and social isolation from other
>   services in the community: hence the long history of
>   neglect and lack of public interest, and hence
>   their low priority rating in terms of allocation of
>   resources, even at a time when the public increasingly
>   campaigned for better services for other non-
>   productive and underprivileged groups ... and in spite
>   of the fact that many of the staff in the service
>   have been calling attention to the grave deficiencies
>   that existed for a very long time.[13]

(Baroness Serota, 1971)

This statement by a member of the government was
made in the same year as the White Paper Better Services
for the Mentally Handicapped.   This document laid down
plans for the implementation of a fully comprehensive

community service for the mentally handicapped and
advocated that

> Each handicapped person should live with his
> own family as long as this does not impose
> an undue strain on them or him, and he and his
> family should receive full advice and support. [14]

However, by 1971 the case for care in the community for
the mentally handicapped was at least forty years old.
Indeed, as I suggested in Chapter 5, despite an official
policy of incarcerating mentally handicapped people in
the early part of this century, probably a majority
remained in the community.   The 1929 Wood Committee
recommended greater use of all forms of community care,
and by the 1930's experts[15] were suggesting that given
favourable circumstances the mentally handicapped could
be cared for at home.   In the post World War II period
the Royal Commission on the law relating to Mental Illness
and Mental Deficiency (1954) recommended a shift in
emphasis from hospital to community care, and the 1959
Mental Health Act advocated the development of community
facilities and the care of the mentally handicapped in
the family home.   Local Authorities were to provide
advice, support, training facilities and other services
required by the families of mentally handicapped people.
This was followed in 1963 by a government report
The Development of Community Care, which recommended the
development of a family-orientated service and an expansion
of community care, but also suggested that more mentally
handicapped people might need residential care.
However, in 1968 The Seebohm Report argued that the belief
that community care did exist for the mentally handicapped
was still a sad illusion.

Kathleen Jones,[16] soon after the publication of the
White Paper, argued that the reason for this lack of progress
in providing community services for the mentally handicapped
was that

> There are two long-standing problems in
> the services for the mentally handicapped -
> 'stigma' and 'inertia'. These are linked and
> underlie all the other problems. They do
> not get any less, though they perhaps take
> less overt forms than in the past.[17]

She suggests that there are a number of other problems
in bringing about change: problems arising from earlier
and now outdated policies for the mentally handicapped,
problems arising from current societal attitudes to the
mentally handicapped, problems arising from the nature
of the mentally handicapped as a group, and problems created
by recent changes in National Health Service policies.

In 1979 the Jay Committee, while noting that community
care was not a reality, argued that there was a need to
go beyond decarceration and to 'normalize' the lives of
the mentally handicapped. (It is interesting to note
that Bosanquet, in a Note of Dissent, pointed to the fact
that this was unlikely to come about because Local
Authorities are reluctant to expand services for the
subnormal, especially the severely subnormal). Indeed,
financial considerations interact with 'willingness' to
spend money on the mentally handicapped. A policy of
community care means that local authorities have to finance
residential provision, facilities and services, while
hospitals are *financed by central government*. *As the*
central government has been reluctant to provide additional
funds to local authorities, they have been unwilling to
provide those services which are not mandatory.[17a]

What I intend to examine is the extent to which
there has actually been a shift from hospital to community
care of mentally handicapped people in the 1970's.
Also I examine the extent to which a comprehensive community
service has been developed and what efforts have been made
to 'normalize' the lives of mentally handicapped people.

The 1971 White Paper proposed that Mental Subnormality
Hospitals should in the future provide 'treatment', not 'care',
and that only mentally handicapped people needing specialised
medical facilities and nursing should be hospitalized.

All other mentally handicapped people not living with their families should live in residential facilities such as group homes, hostels, flatlets and foster homes provided by the local authorities. The stated aim was to decrease by 25,100 beds the provision made for adults in hospitals while community provision should be increased by 31,950 places. In the case of children, hospital beds were to decrease by 1,000 and community provision was to be increased by 4,000 places. There was also to be a thirty percent expansion in educational facilities for children of school age and of 4,000 places in Adult Training Centres. Jones has argued that

> The intention is that the mentally handicapped
> will no longer be treated as a segregated, second-
> class service, but will take an increasing part
> in the general provision of social, educational
> and health services for the whole population.
> Lines of demarcation which have hampered
> development in the past can be removed,
> developments which are in accord with current
> social and administrative thinking are to take
> place and the provision of more money should be
> an indication of good intentions. All we need
> now is goodwill, co-operation and clear priorities.[18]

Five years after the White Paper, the Department of Health and Social Security in a consultative document, <u>Priorities for Health and Personal Social Services in England</u> (1976) claimed that a good start had been made in implementing the 1971 proposals. It stated that between 1969 and 1974 the number of places in residential homes had increased by 3,500 - from 6,000 to 9,500 - and the number of places in Adult Training Centres had increased from 23,000 to 32,000. In the same period the number of hospital beds had decreased by 500 and the amount of over-crowding in hospitals had been reduced. The document advocated the continued expansion of community care so that the 1971 targets could be achieved by 1991.

Despite the official optimism concerning the develop-ment and growth of community services in the mid-1970's and a reiteration of a continuing commitment to achieving

the 1971 targets within a twenty-year period, Jaehnig
in 1979 suggested that

> Community care is nearly as much a myth as it
> was in 1961 when Richard Titmus questioned the
> country's commitment and preparation to carry
> it out. In spite of the seemingly irresistable
> case for fundamental reform made in recent
> years, the policies that have emerged are
> narrow in their conception of the problem,
> timid in their prescription and ambiguous in
> their execution.[19]

In the same year the Jay Report found that even what
they referred to as 'the modest targets' set in 1971 had
not been reached and that the government had quietly dropped
the target date of 1991 for full implementation. Even
more recently Shearer[20] has suggested that the government's
lukewarm response to the report of the Jay Committee
means that the commitment to a shift to community care
of mentally handicapped people is in danger of being
reversed. Nevertheless in 1980, in a D.H.S.S. review of development
in mental handicap services since the 1971 White Paper, Patrick
Jenkin stated

> The basic principles..are clear...in brief, that of recognis-
> ing the rightful place of mentally handicapped people in our
> community and of making the services available accordingly.

The review does, however, go on to point out that restraints
on local authority spending make the assumptions of the 1971 White
Paper unrealistic, and a D.H.S.S. review of community services
published in 1 81 ex licitly recognises that the White Paper
targets will not be met by 1991. Indeed, a study of community care
undertaken by the D.H.S.S. had as one of its major aims 'to clarify
policies for the development of community care for the Health and
Personal Services in terms of the resources now expected to be
available'. Furthermore, three recent papers by the D.H.S.S.
recognise that a considerable improvement in community services
is necessary, as well as a continued movement from hospital to
community-based care. It is necessary to examine with care what
changes have actually taken place in the handling of the mentally
handicapped - both moves to decarceration and to providing
community services, and to determine to what extent the
day-to-day lives of the mentally handicapped have been
'normalized'.

3.1 Decarceration

Community care and normalization imply that mentally handicapped people should live in and become integrated into a local community (although Gunzburg[2l] has suggested that even the hospital can provide a normalizing environment) yet in the last ten years six new Mental Subnormality hospitals have been opened. Furthermore, plans have been drawn up for more. It is true that these hospitals are smaller than the old ones, but they are still hospitals and work within a medical model of mental handicap. By the mid-1970's one fifth of the 50,000 adults in hospitals were in ones accommodating more than one thousand five hundred patients, one fifth in hospitals accommodating between one thousand and one thousand five hundred patients, and a quarter in hospitals of between five hundred and one thousand inmates.[22] It has also been pointed out that a majority of these patients do not need the specialised medical facilities or nursing care of the hospital.[23]

In addition to large numbers of mentally handicapped people remaining in hospitals, admission of new patients has continued. On average, in each year since 1971, one thousand three hundred mentally handicapped people have been admitted for the first time to a hospital. In 1980 the number of adults still in mental hospitals was 45,000 and the rate of release was about two hundred a year - a rate of reduction of less than two percent per year. There are also over seven thousand children and young people in long-stay subnormality hospitals.[24]

Furthermore, while spending on the community care of mentally handicapped people increased between 1976/7 and 1979/80 and is expected to increase further in the fiscal year 1981/2, so has spending on hospitals (see Table 9).

This low-level expenditure is not only a reflection of the different needs of the physically ill, the mentally ill and the mentally handicapped, but also indicates differing priorities as well as the lack of medical

Table 9: Revenue Expenditure (England) on the
Mentally Handicapped [25]

	Actual Expenditure 1976/7	Proposed Expenditure 1981/82
N.H.S. In-patients	£ 189 m	£ 209 m
Local Authority Residential care	£ 22 m	£ 32 m
Local Authority Day care	£ 30 m	£ 41 m

Despite the continuing level of expenditure on hospital services, mental handicap has remained the 'Cinderella' of the National Health Service in terms of expenditure (see Tables 10 and 11).

prestige in mental health specialities, including subnormality, and the lack of economic power and productive potential of mentally handicapped people (or at least that this is assumed to be the case).

Table 10[25]: Cost per In-patient Week in different types of hospitals (non teaching) 1976/7

Acute	£ 104.78
Mental illness	£ 36.00
Mental handicap	£ 33.68

Indeed, not only is spending on the mentally handicapped low in comparison with other groups receiving National Health Service treatment, but there is also a major problem in attracting and retaining staff in subnormality.
The Royal Commission on the National Health Service which reported in 1979 argued that the staffing situation was a major problem and was likely to get worse. They found that the recruitment of doctors to the field was poor

in both quantity and quality, that many of the trained nurses were approaching retirement age, that a high percentage of staff were untrained, and that there was a high staff turnover (a situation described by Morris[26] in her study published ten years earlier). They concluded that

> The fact that several enquiries have had to be set up in England and Wales and have reported adversely on the conditions they have found in hospitals for the mentally handicapped shows that, whether or not it is carrying too extensive a responsibility, the National Health Service is, in certain places at least, failing badly to fulfil its obligations.[28]

Table 11:[27] Cost per In-patient Week of different services in different types of hospitals as percentages of costs in acute non-teaching hospitals 1976/7

Type of service	Long Stay	Chronic	Mental Illness	Mental Handicap
Medical	27	13	26	13
Nursing	65	66	45	49
Domestic	58	60	27	27
Catering	55	48	45	43
Cleaning	68	55	35	32
Total net cost	44	39	32	30

The official policy of moving the mentally handicapped out of large hospitals and settling them into housing in the community has not proceeded at the rate aimed at by the government in the 1971 White Paper, despite repeated statements that they are still committed to these aims.[27a] However, decarceration is only one aspect of a policy aimed at providing comprehensive community care and normalized life-styles for mentally handicapped people. The other major aspect is the provision of services

and facilities for those not in hospitals. In 1978 the Department of Health and Social Security estimated that there were 110,000 severely and over 350,000 mildly subnormal people in England and Wales. Of these over eighty percent of severely subnormal children, forty percent of severely subnormal adults and the majority of the mildly subnormal, adults and children, lived at home with relatives or in some form of residence in the community. Consequently any policy aimed at improving the everyday lives of the mentally handicapped must be concerned with those already living outside of hospitals. Yet as a number of studies have clearly demonstrated, community care still tends to mean care by 'Mum' or living in a hostel and still in practice isolated from the community.

3.2 Community Care in Practice

Community care in Britain has, in effect, meant leaving mentally handicapped people to live with their families, on the assumption that this provides a more 'normal' environment. (It is of course also cheaper for a child or adult to be looked after by the family than in a hospital or other residential home.) However, where care in the home is impossible then hostels or other residential accommodation within the community is advocated. As well as by place of residence, it is also assumed that the mentally handicapped will become integrated into the community in other ways and enjoy the social and medical facilities provided for all citizens in addition to receiving extra help where necessary. It is, consequently, assumed that this type of care will overcome many of the problems associated with residential care in hospital, including isolation and institutionalization.

However, as Bayley's[29] study in Sheffield has shown, mentally handicapped people can be isolated from the community even when they live with their families. Townsend has suggested that hostels can easily become mini-hospitals, replicating all the 'bad' aspects of the hospitals they are supposed to overcome. Shearer[30], in criticising the Swedish 'group homes', has pointed out that they end up becoming nothing more than a very smart

version of subnormality hospitals - the life-style inside the residence may be most 'normal'but the residences are still isolated from the community in which their inmates are supposed to live.   (For a graphic example of this see Söder[31] - discussed in Chapter 7). Establishing a hostel in the community is not all that has to be done to ensure that the residents receive the facilities and services they require and have a 'normalized' life-style. People can be just as isolated and institutionalized living in a relatively small hostel as behind a high wall in a large subnormality hospital. (However, it is not 'normal' for people to have their 'friends' come in to see them out of some sort of volunteer commitment.   People 'volunteering' to come in and befriend the mentally handicapped residents may help them to become more a part of the community, but it is <u>not</u> 'normal').   If the lives of the mentally handicapped living in hostels and with their families is to be 'normalized' in the way advocated by those committed to the principle, then they have to become accepted members of the community. (This may well involve changing the attitudes and behaviour of many members of the public).   Also they have to use the same services and facilities, as far as possible, as other local residents.

For community care to become a reality and for the day-to-day lives of the mentally handicapped to become normalized a fundamental change in current social policy is necessary.   Mentally handicapped people will have to become seen as people who need a variety of services and cease to be regarded as a 'category' who require different and inferior services to the rest of the population. More fundamentally, it will be necessary to abandon the medical model and adopt an alternative model, which sees the mentally handicapped not as incurably sick, but as people who can be helped to lead a more 'normal' life-style.   This does not, however, mean ceasing to provide specialised facilities and care where required. Indeed, it may be necessary to provide more specialised help in order to enable a mentally handicapped person to lead as independent a life as is possible.

(However, it does mean ceasing to over-protect as parents
and care-providers have often done in the past - it means
encouraging independence).

What appears to have occurred in Britain is a
failure on the part of policy-makers to think what patterns
of care are appropriate for mentally handicapped people,
and to recognise that different facilities and forms of
care may be necessary for different groups of mentally
handicapped people. The needs of the mildly subnormal
are different to those of the severely subnormal, and
indeed there are wide differences in needs between
these two groups.   The multiply handicapped will also
need to be handled in different ways. (A number of
studies have shown that I.Q. is not a good indicator of
ability to cope adequately in the community - see Chapter 2).
Thus, in principle at least, the government has rejected
the large subnormality hospital as the major form of
care, but the alternatives do not seem to have been
adequately investigated.

There has, however, been an increase in educational
provision for mentally handicapped children in the 1970's,
together with increased provision of Adult Training Centre
places; of temporary and permanent hostel accommodation;[31b]
of financial help (the attendance allowance) for relatives
(usually parents) caring for a mentally handicapped member
of the family; but basically the services in the community
to support mentally handicapped people and their families
have remained the same.   This is especially true of
services for the severely handicapped, whose families often
need the most help if they are to cope.   Norris[32] after
studying day care facilities for severely mentally handi-
capped teenagers and adults in five separate geographical
locations, argued that we deceive ourselves if we believe
that the day-care facilities now provided represent a
marked improvement in conditions,surroundings or training
techniques.   He concludes:

> Whilst these units included in this investigation
> were housed in brand new premises without
> exception these premises were dull in concept
> and limited in provision.   The activities

conducted were too often unstructured, the staffing
arrangements were too similar to too many hospitals,
the ready availability of expert advice was often
less than that to be encountered in these hospitals
whose effectiveness we have been questioning ...[33]

Studies in the 1950's and 1960's suggested that one
of the major factors resulting in parents placing their
mentally handicapped children in hospital was the lack
of back-up services in the community and financial
assistance[34].   Studies in the 1970's by Bayley[35],
Jaehnig[36] and Wilkin[37] (see Chapter 2) have suggested
that families still face these same problems.   Bayley's
study in particular has graphically illustrated how, in
reality, community care has meant imposing a social and
financial burden on the families of mentally handicapped
people.   Families have been left to 'cope' as best
they can with little professional support or financial
assistance.   He points out that parents are often not
only prepared, but indeed wish, to care for their mentally
handicapped child, because they love the child and regard
him or her as an integral member of the family (MacCormack[38]
and Jaehnig also found this to be the case).   However,
parents often continue to care for the 'child' when he
has become an adult and they have difficulty in handling
him adequately, because of a lack of what they see as a
viable alternative.   There is no alternative to the
subnormality hospital for many who want to find permanent
residential accommodation for their mentally handicapped
'child'.   This means, for the majority of the mentally
handicapped, that they are unable to enjoy life experiences
shared by other citizens of the same chronological age -
to lead a more 'normalized' life.   Indeed, what moves
have been made to implement 'normalization' in Britain have
been aimed at creating 'normal' families rather than
'normalizing' the day-to-day existence of mentally handi-
capped people.

The degree to which it is possible to normalize
the lives of mentally handicapped people is debatable
(the concept itself is unclear). However, leaving this
aside, it is evident that Community Care (a necessary

precursor to any form of 'normalization') has not yet
become a reality in Britain. The available facilities and
services would appear to be inadequate, and will become
even more so if more people are 'sent home' from
hospitals and less are admitted than previously. Thus,
as Doyal has suggested,

> Priorities of this kind may appear superficially
> progressive ... In practice ... the ultimate
> effectiveness of these proposals is likely to be
> extremely limited. Local authorities are under
> as much financial pressure as the National Health
> Service, so that any health planning which is
> based on increased support from local authorities
> is likely to be a rhetorical rationalization of
> central government cuts rather than a feasible local
> alternative. Moreover, the concept of 'the community'
> has been widely used to foster the illusion that
> outside institutions there is a network of caring
> relationships consisting of individuals with
> both the will and also the material resources to
> help those in need. In fact, as services are
> cut back in both the National Health Service and
> the local authority sector, it is usually individuals
> (usually women) without the necessary resources who
> are forced to care for those with whom the system
> can no longer cope. Disillusion about 'the
> community' and 'community care' have become
> increasingly important in marking the realities
> of the situation.[39]

The reality of the situation would seem to be that the
mentally handicapped are a low-priority group, in terms
of social and economic resources, whether they are living
in the community or in hospitals. The Royal Commission
on the National Health Service(1979)[40] concluded that while
it was possible that community care was cheaper than
hospitalization, more research on relative costs and
effectiveness was necessary. However, it is fairly
obvious that if the families of mentally handicapped people
living at home were paid a sum equal to the cost of
caring for the person in hospital, or even paid the current
rate of wages for 'homemakers', the cost to the public
sector would be very large. Indeed, when it is realised
that eighty percent of severely mentally handicapped
children and forty percent of severely mentally handicapped
adults are cared for at home, it becomes evident how much
our society relies on the unpaid, non-professional care
provided by families and especially the mother. Thus a

recent (1981) D.H.S.S. study of community care concluded that

> the 'cost effectiveness' of these packages [of community
> care] depends on not putting a financial value on the
> contribution of informal carers who may in fact shoulder
> considerable financial, social and emotional burdens.[40a]

When reference is made to community care of the mentally
handicapped, often a sleight of hand is being employed;
what is actually meant is care, in financial as well as
practical terms, by an individual family for a handi-
capped member for whom in the past the whole community,
though a hospital, might have taken the responsibility.

It is possible to go beyond this and suggest that
a policy of community care, as implemented in Britain,
imposes a special burden on women. (A recent survey[41]
found that over forty percent of men and women thought
that women should be prepared to care for a disabled/
handicapped family member). The actual implementation of
the policy means that the mother is expected to take on
the main burden of caring for a mentally handicapped child.
The policy has not in practice meant a shift in resources
from hospitals to the local communities (indeed this is
cited as one of the major reasons why local authorities
have not provided more services where they are discretionary
and not mandatory), but a shift in the type of labour
employed in caring for the mentally handicapped - paid,
trained, professional labour (or at the very least, paid)
being replaced by unpaid, untrained, seemingly cheap
labour. This burden is much greater than that experienced
by the mother caring for young children: the mentally
handicapped 'child' goes on requiring fairly intensive and
regular care long past the time when 'normal' children
have become relatively independent; the mother becomes
'tied' by a life-long child. She is no longer able to
enjoy the normal life-experiences of other women -
relative independence when the children have grown up,
possibly returning to paid employment - and this affects
not only her but also the rest of the family, including
siblings of the handicapped. (See Meyer's[42] account
of his family's experiences, to see the profound influence
that a mildly subnormal child had on the whole family
and its way of life).

An extremely important factor, over and above the relative social isolation of being tied to the home by the demands of the handicapped 'child', is the inability to return to productive employment as the child grows older. Sociological research has pointed to the social and economic plight of women forced to remain outside the employment market while they care for young children[43] - women work not only for the money, and the relative financial independence that it brings, but also for the social contacts that 'going out to work' brings and the increased social status which being engaged in paid employment brings in a society which devalues the domestic role of women.

In conclusion, successive governments since the 1950's have advocated community care for the mentally handicapped without providing adequate facilities for this to become a meaningful means of handling them. Coupled with community apathy and even hostility to mentally handicapped people, this has in reality meant that care either becomes the responsibility of the family or the mentally handicapped are isolated in hostels instead of in hospitals. (Indeed, a substantial number of mentally handicapped people still live in hospital). An apparently progressive and humanitarian policy turns out in practice to make little difference to the lives of the mentally handicapped, although it may impose addiitional burdens on their families and especially mothers.

4. Why Community Care?
The factors usually referred to as influencing the development of policies of community care and 'normalization' are the findings of social scientific research and field experimentation in the 1950's and 1960's - although, as I have stressed several times, a large number (probably a majority) of the mentally handicapped were never institutionalized even at the height of the 'eugenics' scare. This research was taken to 'prove' that hospital 'warehousing' was dehumanizing, inappropriate and totally

inadequate for the needs of the vast majority of mentally
subnormal people, and the researchers advocated
decarceration as a policy objective. (It is of course
the case that psychological research came to similar
conclusions concerning 'normal' children deprived of
their family, the mentally ill, the elderly and delinquents
in the same period).

> I shall argue, first that the accumulating
> evidence of social influences upon intelligence
> has weakened if not destroyed the eugenic
> case for social segregation, secondly that the
> evidence ... throws great doubt on the hospital
> as the right environment for the care of the
> subnormal and finally that the social,
> occupational and emotional needs of the great
> majority of the subnormal might be better met
> within various forms of sheltered, family or
> community care than in existing hospitals and
> hostels. [44]

Psychological research suggested that the family, and
especially the mother, provided the kind of love and
attention necessary for 'normal' development in children,[45]
and gradually the notion grew that this was also the case
for handicapped children. Research in developmental
psychology (especially the work of Piaget) began to
suggest that children could be enabled to develop at a
faster rate and to a higher level in a stimulating and
more demanding environment. These ideas, coupled with
research specifically on mentally handicapped children
which argued that large hospitals retarded development
while small group homes or living in a 'normal' family
did not,[46] led to the adoption of a model of mentally
handicapped people which saw them as 'developing' rather
than 'social menaces' and/or 'incurably sick'. (The ways
in which scientific knowledge has interacted with models
of the mentally handicapped and with social policy
objectives will be discussed more fully in the final
chapter).

These advances in social-scientific theorizing and
the resultant research findings influenced professionals in
the field of mental handicap. Parents of mentally handi-
capped children were actively encouraged to keep them at
home, and it was also suggested that as many mentally
handicapped people as possible should be cared for in
the community rather than warehoused in subnormality
hospitals. Initially this policy resulted in the
discharge from hospital of a substantial number of
residents who appeared no longer to be 'subnormal'.
(The 1959 Mental Health Act changed the definitions so
that many of those incarcerated as feebleminded or
morally imbecile under the 1913 legislation no longer
came within the 'official' definition of mentally handi-
capped). By the 1960's and 1970's this process was
widened to include the suggestion that only those in
need of the specialised medical and nursing care provided
in hospital should remain there - the majority of mentally
handicapped people should live in homes and hostels in the
community. (This development was stimulated by research
which demonstrated that severely mentally handicapped
people not only <u>could</u> be cared for in hostels but also
developed more social competence and independence there
than when cared for in a hospital).

The government apparently accepted the case for
'community' care and normalization. They passed legislation
and issued policy documents apparently designed to bring
it about. The idea fitted in neatly with the ideology
of Welfarism and equality of opportunity that developed
in post World War II Britain - all citizens should be
 cared for from the 'cradle to the grave' and given equal
opportunity to develop their full talents and abilities.
Coincidentally it appeared not only to be a more humani-
tarian policy but was apparently cheaper. (Indeed, in
the 1930's many mentally handicapped people had remained
in the community for this very reason).

Decarceration has become the watchword in Western
societies not only for the mentally handicapped but also for
other groups of deviants, including the mentally ill,
the elderly and 'petty' criminals. The main justifications
are, as in the case of the mentally handicapped, not only
that it is more humanitarian but that it is also more
'effective' in bringing about desired goals.
However, while there has been research into total
institutions which has highlighted the inadequacies of
that form of 'treatment', with the possible exception
of 'petty' criminals little research has been conducted
into the 'effectiveness' of the alternatives. It is
assumed that it is the institution that has the detrimental
consequences, and that non-institutional care does not.
(Note that in the case of the mentally handicapped at
least it has been argued that hostels in the community -
one of the mainstays of the 'new' policies - replicate
many of the assumed detrimental aspects of the hospital).

The question is, then, why community care has been
so readily accepted by policy-makers as an alternative
way of handling the mentally handicapped and other deviant
groups. MacIntyre[47] has argued that in the case of the
elderly, community care has been advocated and adopted
because of organizational needs and not because it is a
more humanitarian form of care than old people's homes.
Elderly people are encouraged to stay in their own homes
by being told that 'it is better for them', but they are
not then provided with the community services they need
if they are to enjoy a relatively comfortable existence.
(Apart from social and medical reports suggesting that
there is a 'real' need for services such as meals-on-wheels
and home helps, recent local government economies have
meant large price increases for services such as these.
Few local authorities now provide home helps free, and
those on supplementary benefit are no longer able to claim
the money to pay for the service). In this way community

care reduces the financial burden of caring for a growing elderly population. A comparable situation exists with respect to the mentally handicapped; the burden of care - social and financial - is shifted from the community to the family in cases where the family provide for a mentally handicapped member. (MacCormack[48] and Oswin[49] have graphically illustrated the real 'burden' experienced by many families). Policies of decarceration have also resulted in many incompetent individuals being left to fend for themselves - frequently ending up living in inner-city areas on welfare benefits. Many of the ten thousand mentally handicapped people living in England and Wales in 1974 accommodated in foster homes and lodgings would have been leading this type of marginal existence.[50] Many of the more severely subnormal have remained in hospital, and those who have been moved into the community tend to live in hostels that are as isolated from the community as are the larger institutions. This does not necessarily mean that mentally handicapped people should be forced to remain in hospital (and the majority of those who are able to make their wishes known do not want to), but it does suggest that services and support facilities have not been developed to provide them with an adequate standard of living and quality of life when they are discharged. Morais and Morais found, for example, that

> Working within a hospital complex where I have been constantly aware that patients regard discharge and 'freedom' as their ultimate 'shangri-la', it has become a salutary experience also to work as a voluntary club-leader catering very largely for former patients once they have achieved their ambition. Many of them fall out of work and often sleep rough. They become bewildered, lonely and disillusioned and sometimes they talk nostalgically of 'the good old days in hospital'. 51

'Community care' and 'normalization', when employed
by decision-makers, appear to be little more than slogans -
a way of seemingly introducing more humanitarian policies,
but in practice a way of reducing spending on a group
who have always been low on the list of priorities.
Whether or not the aims of 'community care' and 'normal-
ization' can be achieved does not seem to have been
carefully researched, but what is evident is that in
Britain de-institutionalization and non-institutionalization
have not been accompanied by the development of adequate
services and facilities in the community to enable the
mentally handicapped either to become integrated or to
have a more 'normalized' day-to-day existence.
(This is not to suggest that facilities for the mentally
handicapped have not been improved in the last twenty years;
of course they have, both in hospitals and in the community
but there is a long way to go before a comprehensive
community-based service becomes fully established).

It seems evident that welfarism, humanitarianism
and advances in social-scientific research are not adequate
to account for the move towards policies of decarceration
in Western societies in the last twenty years.   Scull
has suggested

>...that this far-reaching change in social control
>styles and practices can be explained both more
>completely and more parsimoniously by reference
>to deep-seated changes in the nature and
>functioning of modern capitalist societies

and furthermore that the

> ... State's receptivity in the modern era to
> a policy of decarceration can be traced back
> to fundamental transformations in the social
> organisation of advanced capitalism.
> The pervasiveness, intensity and mutually
> reinforcing character of the pressure to adopt
> a policy of decarceration ... are intimately
> connected to the rise of welfare capitalism. [52]

The pressure on governments to reduce spending in the
last ten years has resulted in their looking for 'easy'
economies. Cutting back on the building of new subnormality
hospitals reduces capital spending and cut-backs in the
number of beds provided in existing hospitals (and indeed
closing some) reduces current spending. The provision
of general welfare services in the community means that
a minimum provision can be made in the community without
increasing spending. Indeed, a government minister
has recently suggested that the disabled must share the
burden of reduced spending in the current 'crisis', [52a] and
another has argued that by careful scrutinising of
the current way of handling mentally handicapped people [52b]
their lot can be improved without increasing expenditure.
As Scull, again, has suggested

> ... it is scarcely surprising to learn that
> decarceration in practice has displayed
> remarkably little resemblance to liberal
> rhetoric on the subject. Indeed, the primary
> value of that rhetoric (though far from its
> authors' intent) seems to have been its
> usefulness as ideological camouflage, allowing
> economy to masquerade as benevolence and
> neglect as tolerance. Clearly a certain
> proportion of the released inmates are able to
> blend unobtrusively back into the communities
> from whence they came ... But for many other
> ex-inmates and potential inmates the alternative
> to the institution has been to be herded into newly
> emerging 'deviant ghettos', sewers of human misery
> ... within which society's refuse may be repress-
> ively tolerated. [53]

Scull is referring primarily to the mentally ill, but
with the addition of the pressure that policies of
decarcerating the subnormal places on the family, his
description applies equally to the mentally handicapped.

Governments have, furthermore, adopted policies of
decarceration in the face of opposition from their citizens
(see Chapter 7), who do not want hostels and other day
and residential facilities provided for the mentally handi-
capped within their neighbourhood. Recent research in the

United States has shown, for example, that people's
apparent positive attitudes to mentally handicapped
people move in a negative direction when they are faced
with the prospect of a hostel in their neighbourhood.[53a]
Parents may welcome additional facilities and financial
help to assit them in caring for a mentally handicapped
child, but Ferrara[54] found that while these parents
approved of 'normalization' in principle they rarely
considered it appropriate for their own children.[54a]

It is also interesting to note that the detrimental
aspects of hospital environments, so often cited as the
official reason for policies of decarceration, were put
forward by philanthropists and other critics of institutions
in the last century.[55]   These did not, however, result in
the government advocating decarceration.   Economic
considerations and the lack of welfare facilities is one
obvious reason why not, but it was also obviously related
to the dominant view of the mentally handicapped as
social menaces from whom society needed to be protected.
Policies of community care are also based on a myth of
pastoralism - of the possibility of creating a 'new
golden age' analogous to an assumed 'golden age' that
existed before industrialization when the community,
and especially the extended family, provided care for
their sick, old and handicapped members. This myth has
been exploded by Laslett's[56] and Anderson's[57] research
into the family in pre-industrial England and Jaehnig's[58]
research into the care provided by families for a mentally
handicapped member.   As Bayley's[58a] research has also so
clearly shown, care in the community does not mean that
mentally handicapped children and adults become integrated
into the community.   Many are just as isolated living
'in the community' as they would be if they lived in hospital.

The crucial question is, then, as I have already
indicated, why social-scientific research findings on
the 'horrors' of institutionalization had such an impact

on decision-makers in the 1950's and 1960's and why
it resulted in the adoption of policies of community
care. There is no necessary logical relationship between
the research findings and the adoption of particular
policies. Governments could just as easily have decided
to improve the hospitals and to provide a more 'normal'
life-style within the institution. While advances in
knowledge of child development and specifically. the
development of mentally handicapped children (referred
to above) and of an ideology of welfarism (also referred
to above) were also relevant factors, they would appear
not to constitute <u>sufficient</u> causes. It is evident that
economic factors were very important - that governments
were especially receptive to these 'new' ideas because
they would be less expensive.

For instance a review of community care published by the
D.H.S.S. in 1981 argued that

> Underlying the policy of encouraging the movement away
> from hospital or residential care for 'boundary' groups
> towards alternative community based packages of care has
> been the belief that these will prove to be 'cheaper' and/
> or at l-ast as effective.[51]

However, the same survey suggeste⁀ that it is necessary to consider
all the public expenditure costs involved when deciding on the
pattern of service for the mentally handicapped and warns that

> community based packages of care may not always be less
> expensive....alternatives to hospital or residential
> provision

especially as there is a failure to recognise the fact that commun-
ity care is often only cheaper because parents are karing for the
mentally handicapped persons. Thus

> families, friends and neighbours make an essential..
> contribution to providing more cost effective community
> based alternatives to long-term hospital or residential
> care.

It would seem that community care may well be cheaper - when
it in fact means care by the family. Indeed, in a consultative
document published in 1981 by the D.H.S.S.[60] which argues (despite
the research referred to above) that community care would in general
cost less and constitute better value, it is stated that

> ..services for mentally handicapped people will enable
> them to live with their families, or failing that in a
> supportive local community setting

It is necessary to point out that three recent government publicat-
ions have shown that while there has been a move away from hospital
towards community based care, few of the support services that the
1971 White Paper envisaged would be provided to lessen the burden
on relatives have materialised. It has been suggested that there
needs to be a re-evaluation of policy in this area in terms of cost
and effectiveness.[61]

> More generally, there would seem to be a case for
> authorities to review the priority they attach to
> different aspects of community based services. It
> appears that increases in provision since 1975
> have not been geared directly to providing a genuine
> alternative to those on the margins of institutional
> care. It may be that other objectives of community
> services are considered more important: for example,
> improving the quality of life for people where there
> is no need for institutional care or dealing with
> episodic illness in the community. However, given
> current and forseeable resource constraints, the
> ability of the statutory authorities to pursue all
> these objectives simultaneously must be in doubt. In
> these circumstances it is particularly important for
> local authorities to be clear about their priorities.

Policies of decarceration need thus to be understood
not merely as the response of a 'humanitarian society',
but also as a consequence of changing ideologies in
capitalist societies that develop with the growth of the
welfare state, and more specifically as a response to the
recurrent economic crises in capitalist societies, when
governments are concerned to reduce public expenditure.
(It is of course true that the idea of community care
developed in the 'affluent 60's' but was most vociferously
advocated by the government in the 1970's - a period of
economic crises). Magically the use of multivalent
concepts like 'community care' and 'normalization' means
that two goals - cost reduction and humanitarianism -
come together: costs can be reduced at the same time as
care is apparently improved. But, in Britain, de-
institutionalization/non-institutionalization has not been
accompanied by a compensatory development of services and
facilities in the community. Thus Tyne concludes the
report of a survey carried out in 1978 and designed to
investigate what improvements had occurred in community
provisions since 1971 by suggesting that there had
in fact been little change:

None of these findings would have been in any way
exceptional if they had been published in 1968.
Yet in the last ten years we have heard repeatedly
about the progress which is being made in the
development of services for the mentally handi-
capped people ... My own feeling is that we have
made progress, but often only in superficial ways ...
The fundamental problems in the organization and
funding of our services, however, still remains,
and fundamental ideologies about institutions still
have not been seriously rethought.62

5. Conclusion

Whether or not 'community care' and 'normalization'
are realizeable policy objectives in the short or even
long term is difficult to determine - not only because of
current economic circumstances but because of attitudes
towards the mentally handicapped and more fundamentally
because the precise meanings of these terms are not
always clear. However, what is obvious is that little
progress has been made in the provision of a comprehensive
community service in England and Wales. Also, the
mentally handicapped and their families are still
stigmatized (see Chapter 7) and little progress has been
made in integrating them into the community. Slogans
like 'community care' and 'normalization' have, then,
become rationalizations for decreasing spending in real terms.

The social policy aspects of mental handicap discussed
in this chapter are a further demonstration of the need for
a social theory of mental handicap rather than a specifically
sociological one. Social policy, importantly, involves
people as individuals - it profoundly affects the lives
of mentally handicapped people and their families,
and is influenced by prevailing individual and community
attitudes towards the mentally handicapped. This more
micro-level analysis which I have largely neglected up
until now, will be explored in greater detail in the next
chapter. In Chapter 8 I shall go on to examine the
extent to which it is possible to develop a social theory

of mental handicap.   Finally, as I have also suggested,
the interaction between psychological and sociological
theories and social policy in this area is a fascinating
one, and mental subnormality is a good example of the
way in which these interpenetrate each other and are
both informed and influenced by economic structures
and circumstances.   This wider implication of the
subject matter of this thesis for the sociology·of
knowledge will be explored in the final chapter.

1: Quoted in Mittler, 1980 *Piii*   1a: D.H.S.S., 1980

2: Scarse, 1976 *P614*   3: Lippman, 1972

4: See, e.g., Meyers, 1979   5: See, e.g., Grunwald, 1968

6: Jones, 1974   7: Grunwald, 1969 *P1*

8: Grunwald, 1969 *P9*   8a: adapted from Grunwald, 1977 *P5*

8b: Grunwald, 1969   9: Edgerton, 1967

10: Henschel, 1972   11: Matteson, 1970

12: See, e.g., Campaign for Mental Handicap, 1978.

13: Quoted in National Society for Mentally Handicapped Children,
    1971. *P66*

14: D.H.S.S., 1971 *Para 40, P9*   15: Shrubshal and Williams, 1932

16: Jones, 1974   17: Jones, 1974 *P205*

17a: See D.H.S.S., 1981a, 1981b   18: Jones, 1974 *P3*

19: Jaehnig, 1979 *P2*

20: Shearer, 1980. See also Shearer (1980a) for an account of
    the lack of progress in improving public care provisions
    for mentally handicapped children since 1945 and especially
    the lack of progress in improving care provisions in the 1970s

21: Gunsburg, 1972   21a: D.H.S.S., 1980 *Foreword*

21b: D.H.S.S., 1981c   21c: D.H.S.S., 1981a *P1*

22: D.H.S.S., 1979   23: See, e.g., Mittler, 1980

24: Shearer, 1980
                      DHSS P129
25: Jay Report, /1979. However, D.H.S.S. have stated that expenditure
    on social services, in real terms, will not increase in the
    forseeable future, and this will be reflected in spending on
    community services for the mentally handicapped.
                                                    DHSS
26: Morris, 1969.   27: Jay Report, /1979

27a: See D.H.S.S. 1980, 1981a,b,c   28: D.H.S.S., 1979

29: Bayley, 1973   30: Shearer, 1972; see also
                                            Heshusius, 1981

31: Söder, 1972.

31a: Despite the increase in Adult Training Centre places, the
     rate of increase has fallen short of that envisaged as
     necessary to meet demand in the White Paper (D.H.S.S., 1981a)

31b: Although the number of adult hostel places has grown year by
     year since 1975, the rate of increase has declined and is
     considerably less than the 1971 White Paper envisaged was
     necessary. The number of hostel places for children has

not increased despite the large decline in hospital places (D.H.S.S., 1981a).

32: Norris, 1975

33: Norris, 1975 *PS*

34: See, e,g., Tizard and Grad, 1961; Moncrieff, 1966.

35: Bayley, 1972

36: Jaehnig, 1974

37: Wilkin, 1979

38: MacCormack, 1978

39: Doyal, 1979 *P210*

40: D.H.S.S., 1979

40a: D.H.S.S., 1981a *P3*

41: New Society, 1981

42: Meyers 1979

43: E.G. Young, 1974; Oakley, 1974, 1976

44: Townsend, 1969 *PXIII*

45: E.G. Bowlby, 1954

46: E.G. Tizard, 1964

47: MacIntyre, 1977

48: MacCormack, 1978

49: Oswin, 1978. See also Bayley, 1973; Jaehnig, 1974; Wilkin, 1978.

50: Manning, 1977

51: Marais and Marais, 1976 *P87*

52: Scull, 1977 *P: 12 & 152*

52a: New Society, 1981

52b: Mittler, 1980

53: Scull, 1977 *P152*

53a: Persons et al, 1979

54: Ferrara, 1979

54a: MacCormack (1974) suggests that the majority of parents who
seek permanent care for their mentally handicapped 'child'
want a caring, secure environment similar to the one provided
at home and do not want their 'children' to be allowed to
lead independent lives when they can no longer care for them.

55: See Scull, 1977

56: Laslett, 1972

57: Anderson, 1971

58: Jaehnig, 1974

58a: Bayley, 1973. See also Oswin, 1978

59: D.H.S.S., 1981a *P: 12, 34 and 1*

60: D.H.S.S., 1981b *P1*

61: D.H.S.S., 1981a *P6*

62: Tyne, 1978 *P7*

COMMUNITY AND INDIVIDUAL ATTITUDES TOWARDS
MENTALLY HANDICAPPED PEOPLE

> Mentally handicapped people are stigmatised:
> the services they receive are poor and segregate
> them from the rest of us. These two main
> threads in their lives are closely woven
> together and each strengthens the other ...
> Its [Better Services for the Mentally Handicapped]
> account of the historical background to
> segregation of mentally handicapped people
> makes no attempt to look at the misinformed
> public fear and prejudices, fed by the 'eugenics
> movement', which added another layer of stigma
> to an already increasingly stigmatised group ...
> Poor services to mentally handicapped people
> have not just developed by chance. They reflect
> deep-seated social attitudes and values and
> serious defects in the principles underlying them.[1]

1.   Introduction

Up until now I have argued that there is a dialectical
relationship between social perceptions of the mentally
handicapped, attitudes towards them and the way a society
'chooses' to handle them.   In this chapter I intend to
explore in more detail attitudes and behaviour towards
the mentally handicapped in modern Western societies
(most of the research referred to is American or British)
at the individual and community level.

It is difficult to determine to what extent public
attitudes towards mentally handicapped people influence
the policies implemented by governments, or indeed the
extent to which changes in policy can bring about a
change in attitudes.   Lippman[2], for example, has argued
that attitudes towards the mentally handicapped determine
the way in which they are handled, but I suggested in
the last chapter that economic factors would also seem
to play an important role.   In Chapters 3 and especially 4
I argued that public attitudes to the mentally subnormal,
formed by the 'scientific discoveries' of the eugenics
movement in the early twentieth century, were one factor

leading up to the 1913 legislation.[3] It is
difficult in retrospect to determine how widespread
these negative attitudes, fears and prejudices were.
We can of course attempt to determine to what extent
the fears and prejudices still influence individual
attitudes towards mentally handicapped people and probably,
even more importantly, how individuals and communities
react to and behave towards the subnormal.[3a]

In the last chapter I argued that current government
policy aims at handling the mentally handicapped in the
community rather than in isolated hospitals, but that
despite statements that the aim is to create a compre-
hensive community service for mentally handicapped people
little headway has been made in actually establishing
such a service. Those who claim to speak on behalf of
the mentally handicapped and their families have not
only criticised local and central government for lack of
progress in implementing community care but also argued
that mentally handicapped people should be integrated
into the community in which they live and that their
day-to-day lives should be 'normalized'. Attitudes may
influence policy-makers - or at least what they perceive
as the attitudes of the 'ordinary citizen'- but at the
level of interaction (integration) it is reactions and
behaviour that may be of crucial importance. It is of
course eminently possible that beliefs, attitudes, reactions,
and behaviour do correlate highly, as is often assumed in
attitude research, but this need not necessarily be the case.
(See below for a more detailed discussion). Simon, for
example, has argued that

> There is a growing emphasis on community care ...
> But many people have reservations about the success
> of such a movement not least because they doubt
> the community's willingness to accept the
> mentally sick and handicapped as near neighbours.[4]

Thus if we are to move towards a social theory of mental
handicap we need to explore attitudes and behaviour not
only at the macro-level of policy, but also at the community

and individual level.   Only then can we fully understand
the ways in which these two levels interact and how they
combine to form social perceptions of the mentally handi-
capped and their role and status in our society.   The
analysis which follows in this chapter, then, complements
that in previous chapters, but also, importantly, it
asks to what extent social policy is influenced by
attitudes and behaviour at the community and individual
level and examines how far current attitudes are informed
by outdated 'scientific' perceptions of the mentally handi-
capped that result   in their being seen as either 'social
menaces' or 'hopelessly incurably sick'.

As originally conceived, I had intended this chapter
to review critically the research on attitudes to the
mentally handicapped - research which suggests that where
not openly hostile they are negative or at best apathetic
and informed by a large number of misconceptions about
the nature of mental handicap.   This analysis would have
raised (as this chapter still does) a number of problems
with this research, including salience (how much people
actually think about it), centrality (how important a part
the concept actually plays in their mental world), and
to what extent knowledge of people's attitudes can enable
prediction of reactions and behaviour.   (Salience and
centrality are attributes that are often confused and
even more often ignored altogether in research on attitudes).
It would also have pointed out the need, if we are to under-
stand community attitudes, to take into account at least
three factors: the attitudes of other people in the community
towards mentally handicapped people; the personal attitude
and feelings of the parents towards their mentally handi-
capped children which inform their awareness and under-
standing of other people's attitudes; and the parents'
ability to cope with their own feelings and to deal with
situations where they 'feel' embarrassed or it becomes
apparent that other people have negative attitudes towards
the subnormal member of the family.

As I read the literature on attitudes towards the mentally handicapped I became increasingly aware that little of it was concerned with how people *actually* reacted to and behaved towards the mentally handicapped and how much of it was designed to determine *people's* attitudes in the abstract. At this time the opportunity arose for me to carry out some empirical research which may provide an illustrative study of how sociologists can examine reactions to the mentally handicapped, by studying the way people behave in the community when they are confronted by mentally handicapped people. The Chairperson of a local branch of the National Society for Mentally Handicapped Children suggested that some of the members of her group might like to talk to me. Eventually I interviewed 11 families with a mentally handicapped member in order to explore how they understood other people's attitudes, reactions and behaviour towards them and the mentally handicapped member of their family. Shortly afterwards an adult student of mine suggested that I might like to meet a group in her village who were 'friends' of a local hostel for mentally handicapped women and discuss with them the reactions of the villagers (generally hostile) to the fact of these women living in the local community. I met the group and recorded some of the conversations I had with them. Finally, almost just to see what happened, I decided to try getting some groups of my 'O' and 'A' level G.C.E. students to discuss mental handicap. I had some notion that I might be able to discern if young, fairly intelligent people had more knowledge of mental handicap than most research suggests is typical of the general population and if they had more positive atittudes. (An analysis of *my* results is discussed more fully below). These opportunities for empirical research enabled me tentatively to explore the ways in which sociology might be able to contribute to an understanding of mental handicap as a socially constructed phenomenon, and the results are offered as illustrative of the sort of research which could be carried out in a more systematic manner in the future.

Thus in previous chapters I have explored medical and psychological models of mental handicap, past attitudes towards and methods of handling the mentally handicapped, and the way our society currently deals with the 'problems' they present. In Chapter 6 I suggested that the 'second-class' status of the mentally handicapped is at least partly perpetuated by economic factors and that governments in deciding on priorities for the allocation of resources are influenced by what they think are public attitudes. In this chapter I propose to explore these attitudes in order to assess to what extent they, and the reactions of communities and individuals, do perpetuate the 'second-class' status of mentally handicapped people. For as Becker has suggested,

> Sociologists ... are not content to make
> surveys of existing conditions ... They
> concern themselves with how problems come
> about and are perpetuated ...[5]

2. The problem of Community Attitudes and the Question of Community Care

The care provided for the mentally handicapped can be analysed at two levels: the provision made for their care and treatment by local and national government and voluntary bodies, and the way that people in the community are prepared to help and accept them on a day-to-day lviing basis. (The way in which the attitudes of others may influence the self-image and behaviour of the mentally subnormal is discussed in Chapter 8). These two levels may well interact; that is, official policies will to some extent reflect and influence 'public opinion', although current government policies are probably more influenced by Budgetary Policy, concern over 'Public Spending' and 'public demands' for a reduction in direct taxation than by pressure for 'normalization' by the electorate (see Chapter 6). Indeed, in the United States it is the official move to adopt policies of 'normalization' that has stimulated attitudinal research, although there

has not, as yet, been comparable research in Great Britain.

Many studies of the mentally handicapped have assumed rather than demonstrated the existence of negative attitudes towards the mentally handicapped. In a theoretical paper Ryan[6] suggests

> Most of the readers of this paper ... will probably feel a mixture of indifference, disgust and guilt about it.

while D'Alton argues

> society in general ... views retardation with alarm, a situation emphasised and overstated by the nature of the treatment and social roles ascribed to those who have been defined as retarded.[7]

The negative stereotype of mental handicap, according to Farber[8], includes clumsiness, irresponsibility, sloppiness, nervousness, timidity, reticence and abnormality – all characteristics viewed as undesirable – and Townsend argues that Morris's study of mental subnormality hospitals demonstrates that

> ... strong views are held even among psychiatric and nursing staff. In particular there are fears and prejudices, about violence, promiscuity ...[9]

The influence of these assumed negative attitudes is also of considerable importance, whether or not research proves that they do exist. Kathleen Jones[10] suggests that these 'assumed' fears and prejudices have strongly influenced government spending on services and facilities for the mentally handicapped.

> Behind these economic factors lies an attitudinal factor: the mentally handicapped rate a low priority in the eyes of the general public.

and

> There are two long-standing problems in the services for the mentally handicapped: stigma and inertia. These are linked and they underlie all other problems.

It is important to consider not only how public attitudes influence public spending (see Chapter 6) but also how stigma impinges on the lives of the mentally handicapped and their families. Bayley's[12] study in Sheffield demonstrates how the interaction of the two causes isolation and strain for many families caring for a mentally handicapped member. Edgerton found that the mentally subnormals released from a hospital in his study did all they could to conceal their 'past'. In referring to the mentally subnormal stereotype he suggests that it is

> a stigma which galvanizes the most basic feelings
> of these retarded persons into a single-minded
> effort to 'pass' and to 'deny'. To find oneself
> regarded as a mental retardate is to be burdened
> by a shattering stigma ... for a former patient
> to be labelled as a mental retardate is the
> ultimate horror.[13]

Conferences organised, with the mentally subnormal participating, by the Campaign for Mental Handicap to discuss the welfare of the subnormal have added to our knowledge of how the mentally handicapped experience stigma. The writer of one pamphlet summarizing such a conference concludes

> Delegates to 'Our life' taught us that they
> have sharp and often powerful perceptions of
> their lives and the way society and providers
> of services see them. They taught us that among
> people labelled as mentally handicapped there
> is a deep and often entirely realistic desire
> to share experiences the rest of us take for
> granted in our daily lives. They taught us
> just how much of their disability can be imposed
> by our own preconceptions of their capabilities
> and the limits we deliberately set on their
> experiences.[14]

Not only are the mentally handicapped stigmatised but by association so are their families. (Indeed, the stigma may be a primary one, as my own research suggests - see section 4.4 below). It is frequently suggested that

a family with a handicapped member is a handicapped
family. This idea persists (Radio Times)[15] despite
Jaehnig's[16] argument that this is an image imposed by
professionals rather than what the families themselves
feel. Gunzberg[17] argues that it is generally considered
that having a mentally subnormal member reflects badly on
the family. This may influence not only the way that
'outsiders' behave towards the family, but the way in
which the nuclear family is treated by other kin.

Goffman[18] refers to the sharing of another's spoilt
identity as bearing a 'courtesy stigma' - the family members
have a spoilt identity because of their close affiliation
to someone who bears the primary stigma. Birnbaum[19]
found three possible adaptations to this situation:
a total acceptance of being stigmatized; a compromise;
or an attempt to convey the impression of being unspoilt.
He suggests that the mothers of the mentally subnormal
provided a very good example of a group of people who have
a courtesy stigma and who seek to maintain a normal
appearance by carrying on with a 'normal' life-pattern.
In order to do this they maintain a 'normal' family life,
avoid stigmatising situations and retain social relation-
ships. The main problem confronted by the mothers is
when the mentally retarded child reaches adulthood, and
it becomes increasingly difficult to retain an appearance
of normality.

However, the father of a mentally handicapped teenage
boy argues

> ... of all the people in the world we parents
> were selected to become different for ever -
> to carry the stigma.[20]

A correspondent to a Social Work paper feels that

> ... there seems to be shrinking space and
> tolerance for the members of our community
> regarded as subnormal.[21]

Bayley[22] argues that there is an interaction between parents'
own attitudes towards the mentally handicapped member and

the way they experience other people's attitudes.
He suggests that

> It is difficult to know whether other people's
> responses were really so curious or insensitive
> as the parent reported. It is hard to say
> to what extent the parents who were embarrassed
> projected on to other people their own feelings
> towards the subnormal.[23]

Furthermore, the mentally handicapped member, and other
people's negative responses to his presence, may be used
as an excuse to withdraw from social activities rather
than being the cause of withdrawal.

> The parents' interpretation of society's
> attitudes to them and to their subnormal
> children was related closely to their attitude
> to social activities in general.[23a]

To support this Bayley quotes as an example the situation
of two families, each with a mentally handicapped member,
who lived 300 yards apart. One family knew half the
neighbourhood while the other knew only one neighbour.

> Bayley is, however, aware of the importance of
other people's attitudes in determining the degree of
integration of the family and the handicapped member in
the community. The main argument of his report is that
if community care is to become a reality, the handicapped
and their families must become an integral part of the
community, they must be accepted by the community, as well
as the local authority providing services.

> Many factors combined to decide the extent to
> which the families' activities were curtailed
> by the subnormal being what, and who, he was -
> the parents' attitude, friends' and relatives'
> attitudes, the public attitudes and the actual
> characteristics of the subnormal himself.[24]

Thus considerable importance must be attached to people's
attitudes when determining what services to provide for
the mentally handicapped. (Alternatively, however, it
could be argued that if mentally handicapped people lived
openly in the community then attitudes and reactions might

become more positive as people realised that many of their fears and prejudices were groundless). Indeed, the very success of 'normalization' policies depends on favourable attitudes towards the mentally handicapped and acceptance and tolerance within the community.

> What is needed is to give a better service —
> more money, hostels in the community and more
> tolerant attitudes.[25]

This is equally recognised by politicians and officials. Barbara Castle argued in 1975 that

> I am convinced that it is not administrative
> but rather philosophical and attitudinal
> changes which are now so vitally needed.[26]

Five years on we may agree with the second part of her statement, but question the former (see Chapter 6).

3. Empirical Studies of Community Care and Public Attitudes in Britain and elsewhere

While administrative and political decisions have determined that more and more of the mentally handicapped are cared for in the community rather than 'hidden away' in hospital, this has not apparently been preceded or accompanied by a development of more tolerant attitudes to the mentally handicapped. Whatever the political, economic and ideological factors that have underlain changes in official policy (see Chapter 6), it would certainly seem to be more humanitarian for the mentally handicapped to live as normal a life as is consistent with their degree of incompetence. The main barrier to the mentally handicapped becoming full members of the community would appear to be the attitudes and prejudices of other members of the community as well as the provision of support services by local authorities for mentally handicapped people and their families.

In Great Britain the lack of empirical research evidence on attitudes means that we assume negative attitudes.

This assumption is probably reinforced where there is
public protest at, for example, the suggestion that a
hostel for the mentally handicapped be built in a
residential area and by reflecting on our own views.
Most of the available evidence on attitudes comes from
surveys conducted in the United States. Much of this
has used attitudinal scales and been concerned with
abstract attitudes rather than how these are translated
into behaviour (see below).

Söder[27] in a study in Sweden, however, was able to
study the way that attitudes influenced behaviour -
although his work also demonstrates some of the problems
involved in studying the workings of community care.
Söder studied a Swedish community's attitudes to the
mentally handicapped in a residential housing area before
and two years after provision was made for twenty-one
mentally subnormal adults.   Two other areas were studied
as controls.   He found that in the integrated area,
although there was physical integration, there was little
functional integration, because there was little contact
between the mentally handicapped and local residents
because they did not share public facilities such as
buses and shops.   No evidence was found to indicate that
physical and/or functional integration resulted in any change
in attitudes.

> There was little effect of integrating retarded
> workers in an area occupied by 'normal' workers
> and their families. On the one hand no negative
> reaction and no open discrimination took place.
> On the other hand no intimate contacts or
> positive change of attitude could be found.[28]

The example of the town of Geel in Flanders, Belgium
shows that the mentally subnormal can live in the community
and be accepted.   Since the twelfth century the inhabitants
have taken the mentally impaired into their own homes and
treated them as if they were members of the family -
as fully integrated members of the community.

However, the extent to which these residents were totally accepted by all of the community is more debatable.

The evidence cited above is inconclusive and contra-dictory as are the results of American studies. While the research does indicate that most people have negative attitudes, some researchers have suggested that there has been a shift of attitude in a positive direction in recent years. Farber[29] has argued that community attitudes to the subnormal are ambivalent. On the one hand there is fear and rejection, but on the other hand an apparent willingness to accept subnormals within the community and to assume some responsibility for their care and rehabilitation. We might argue that this relates to whose community/neighbourhood the subnormals are living in, and whether we are referring to individuals living with families or to those living in hostels and group homes. The former may be more easily accepted than the latter, and it may be easier to accept that the subnormal should live in the community when it is not one's own neighbourhood that they are living in (see below).

The lack of consensus of research findings may equally be a reflection of the weakness of the methodology used in much of the research. Most attitude surveys, carried out in the United States by social psychologists, have used attitude scales. Taylor has pointed out,

> Research into social perceptions of the mentally retarded requires that one deals with two dilemmas. The first is the tendency to affix the definite article 'the' to the mentally handicapped, which creates the assumption of homogeneity and thereby generates the error of overexclusion. The other dilemma is the assumption of simple positive regard toward mental retardation as both necessary and sufficient, which causes one to founder upon the 'reductionist' fallacy.[30]

Gottlieb and Siperstein[31], for example, point out that variation in mental handicap descriptions evoke different attitude responses, and Hollinger and Jones[32] found that

the label 'educationally retarded' was considerably
more acceptable than that of 'mentally retarded'.
Research has also indicated that the mildly subnormal
are viewed more favourably than the severely subnormal,
and children more favourably than adults. Puccetti[33]
has argued that the evaluation of the mentally handicapped
will reflect what is considered necessary for one to be
a moral 'person' and suggests that 'a person' must be
seen to possess certain physical characteristics and
a state of consciousness. Richardson[34] et al found that
children's preferences for pictures of other children
are related to the ability to ascribe a moral worth,
and Vosey concludes

> When moral character is not imputed, the
> entity concerned is not regarded as a person.
> Since the ascription of intellectual character
> is a necessary condition of that moral character
> and to the extent that ascription of intellectual
> character is influenced by physical characteristic,
> then the described person may not be regarded
> as a person.[35]

A related problem in ascertaining attitudes towards the
mentally handicapped is age. Kershaw has correctly
pointed out that the subnormal are

> ... tolerated or not in the light of highly
> irrelevant considerations. If they do not
> obviously look like 'defectives' and have
> learnt elementary social behaviour they
> are quite readily accepted up to the point
> at which intellectual contact is attempted
> and fails.[36]

While management of the subnormal is often achieved by
those who interact with them referring to them and
thinking of them as children (for example MacAndrew
and Edgerton[37]), their physical size contradicts this view
and makes it difficult to sustain. However, babies and
young children benefit from the 'aren't children wonderful'
syndrome.[38] All the time that they can be treated and
looked upon as babies or young children, dependent in the

same way as others of their age, they do not assume
a deviant identity.   It is when they are older children
or 'adults', obviously different in appearance and degree
of dependence, that other people react negatively
towards them and stigmatise them.

'   Attitude surveys also give rise to problems of
accuracy of response. Gottlieb and Carmen[39] suggest that
people may not express hostile or negative attitudes
because they feel that they may not be acceptable; that is,
people complete the questionnaire on the basis of what
they think or believe to be acceptable answers. However,
even if people's 'real' attitudes could be measured,
the further assumption has to be made that it is possible
to predict people's reactions and behaviour on the basis
of knowing their attitudes.

A major problem with attitudinal research in the field
of mental retardation is the failure to distinguish
between beliefs, attitudes, and behaviour. Fishbein[40]
argues that this problem arises in attitude research not
only because the concept 'attitude' is used by social
psychologists to include beliefs, cognition (attitudes/
predisposition to act) and   conation   (overt behaviour),
but also because these three aspects are not necessarily
highly correlated.   Ableson[41], criticising the 'naive
view' of the relationship between attitudes and behaviour
suggests that attitudes make ready certain behaviour so
that the appropriate situation will elicit the relevant
action.   Attitude scales only measure the cognitive
dimension and tell us nothing about the affective or
connotational dimension.   Thus we are very good at doing
what we find reasons for rather than vice versa and
considerable evidence leads us to doubt that knowledge of
attitudes will enable us to predict overt behaviour.

> People readily justify what they have done by
> accommodating their attitude statements
> accordingly.

The reverse connection has proved even more refractory.[42]

It may well be of academic interest to 'know' what people's attitudes towards the mentally handicapped are, but it is doubtful that this will give us any real indication as to how they will behave towards the mentally subnormal and their families when confronted with them in their day-to-day lives.

3.1 Attitudes towards the Mentally Handicapped in Britain

Although the view is often expressed that the mentally handicapped are a stigmatised group in modern Britain, there are few empirical studies of people's attitudes to the mentally subnormal. In order to try to ascertain attitudes it is necessary to look at research not specifically concerned with attitudes to try to develop some tentative ideas. Equally important as the attitudes/behaviour of the lay members of the community are those of people in positions of authority and power - doctors, nurses, social workers and politicians - those whose professional role gives them power to influence and determine the day-to-day lives of the mentally handicapped and their relatives. In practice the two groups are not totally separate, and the attitudes/behaviour of the two groups, lay and professional, will mutually influence each other. But as Mittler argues,

> In the final analysis ... it is public attitudes however explicitly or implicitly conveyed that determine policy toward the subnormal ... since definitions of deviance depend largely on the extent to which the public is prepared to accept or exclude such minorities.[43]

He goes on to suggest that current public attitudes in Britain are influenced by the heritage of Victorian attitudes which led to the exclusion of the mentally subnormal from the community (see Chapter 5). While the public appear more enlightened when they condemn 'bad' hospital conditions and press for better treatment, their behaviour is less

enlightened when they 'find' reasons why a hostel for
the subnormal should not be built in their neighbourhood.

Lippman[44] compared attitudes towards the subnormal
in several European countries.   An American, he argues
that attitudes towards and provision for the mentally
handicapped is better in Britain than in the United States
(although even better in Sweden).   He maintains that
this is because of the general acceptance of a philosophy
that society should care for those who cannot look
after themselves in Britain.   He concludes his survey of
European countries by suggesting that

> There is a different pattern of attitudes on mental
> retardation in several countries in Europe, and
> that difference does relate to the higher quality
> of services available for the mentally retarded.

and

> ... there is a thread which runs through the
> social orders of Catholic Ireland, Judaic Israel,
> Welfare-state Scandinavia, socialised-medicine
> England ...
>
> 1. Respect for the dignity and potential of each
>   individual
> 2. Genuine conviction (on the part of the
>   professionals at least) that the retarded
>   can be helped ...
> 3. Acceptance of social responsibility.
>   In England and Scandinavian coutnries, the
>   taxpayers expect that the government will
>   deliver on this obligation.[45]

Lippman's optimistic view of attitudes in Britain
is supported by the findings of a postal survey of a random
sample of 3,000 people living in the South-East of
England.[46]   The survey was first carried out in 1973
and repeated, with the same sample, in 1976.   Respondents
were asked to indicate which groups of welfare claimants
should and should not be helped.   While in all cases
the number of unsympathetic responses increased between
1973 and 1976, the mentally handicapped were fifth in
order of receiving the least number of unfavourable responses
in both years, the groups receiving less being the elderly

the physically handicapped, epileptics and the homeless.
They received considerably fewer unfavourable responses
than, for example, alcoholics, delinquents, the unemployed
and gypsies.

A survey published in New Society[47] in 1981 suggests
that people are prepared to help the handicapped and
disabled socially and financially and feel that they
should not suffer as a result of the economic situation.
It was evident that some of the sample could distinguish
between those with a disability (physical) and a handicap
(mental impairment), but that most were confused.
Detailed questions were not asked on attitudes towards the
handicapped/disabled, but the answers to two questions give
some indication of these. While forty-six percent of
respondents thought it would be a good idea if a son,
daughter or close friend said they were going to marry
a physically disabled person (as against nineteen percent
who thought it would be a bad idea), sixty-four percent
thought it would be a bad idea if the proposed future
partner was mentally handicapped (as against eight percent
who thought it would be a good idea). With regard to
children, seventy-one percent of respondents thought the
integration of physically disabled children into the
normal school was a good idea (and twenty-two percent a
bad idea); thirty-five percent thought that mentally
handicapped children should be integrated (and fifty-five
percent thought they should not).

The lack of public knowledge, and the persistence
of negative or at best apathetic attitudes towards the
mentally handicapped may be due to the fact that the
majority remain isolated, even when they are not in
hospitals. Mentally handicapped children go to 'special'
schools and adults to training centres or other sheltered
workshops. They are transported to and from schools/
raining centres by special buses, and as a consequence
ven those living with their families or in hostels have
w contacts with members of the community in which they live.

As a result of this the majority of citizens have
no first-hand knowledge of the mentally handicapped.
They have stereotyped images, often influenced by
outdated 'scientific' knowledge and occasionally
stirred up by sensationalised newspaper articles.
(Attitudes towards sex and the mentally handicapped,
discussed below, are a good example of this tendency.)
These images more often refer to the severely subnormal
rather than to the mildly subnormal. Shearer, for example,
has suggested that

> ... it is still widely believed that mentally
> handicapped people are uncontrolled and
> perverted in their sexual appetites.
> In the past this belief has been one of the
> main incentives for shutting them away in
> segregated institutions.[48]

and Greengross that

> The fearful myth that the mentally sick and
> subnormal ... are promiscuous and have
> voracious sexual appetites which they
> are incapable of satisfying responsibly or within
> a socially acceptable pattern of behaviour, is one
> that still holds water for many, and although
> statistics keep pouring out to explode the myth,
> old prejudices and fears die hard.[49]

This would seem to be a good example of how arguments
developed by the eugenics movement and others to justify
the permanent segregation of mentally handicapped people
have filtered through and still influence people's
perceptions of the mentally handicapped. The 'outdated'
views referred to in the above quotations were clearly
expressed in books and articles on the mentally subnormal
in the first two decades of this century. For example,
in 1903 Barr maintained

> In both idiocy and imbecility, the sexual
> desires are exaggerated in the various
> grades in proportion to the predominant
> power of the mere animal over the psychic
> forces.[50]

However, the view that at least some mentally subnormal men and women have abnormal appetites is still openly stated by 'experts'. Tredgold and Soddy argued as recently as 1970 that in the case of subnormal men

> Open masturbation in the presence of others,
> indecent exposure, indecent assault
> especially on immature girls, occasional
> rape and sexual murder are possible.[51]

In the case of

> subnormal girls ... in some ways the problems ...
> are even more intractable ... Some subnormal
> g rls have comparatively strong direct sexual
> drives ... The gratification aspects of their
> sexuality will be uppermost. Some girls will
> descover how to use their bodies to give them
> power over men and drift into prostitution ...
> The self-gratification aspects of their need
> can also drive girls into sexual promiscuity ...[52]

There is indeed some evidence that mentally handicapped men commit more than their fair share of sexual offences, and that although they are not very often violent their victims are often young children. However, the total numbers of mentally handicapped men charged and convicted of such offences appears to be very small.[53]

Kushlick and Cox,[54] in a survey carried out in 1967, found that the stereotype of the mentally subnormal as sexually dangerous was still widely held. However, they also found in their survey of mentally handicapped people living in the community that only fourteen percent of the severely subnormal and five percent of the mildly subnormal displayed sexual behavioural disorders.

The mentally handicapped themselves appear to deny their subnormality and try to pass as normal. Mentally subnormal participants in conferences organised by the Campaign for Mental Handicap refused to acknowledge that they were subnormal and rejected explicitly the 'negative' perceptions of others that went with labelling them as subnormal. The Edgerton[55], in the United States, also found that the subnormals in his study tried to 'deny' and 'pass'.

The negative stereotype of the mentally handicapped influences professionals as well as laymen. McCormack[56] in a study of the experiences of families with a mentally subnormal member, found that many parents felt that doctors (especially General Practitioners) social workers and other professionals that they came into contact with had little knowledge of the mentally subnormal or the problems involved in caring for them. For example, Rees quotes a social worker as saying

> I am not experienced in dealing with the
> mentally handicapped and assessment of places
> for them. I feel out of my depth in that
> situation ... I have a bit of a block about
> the mentally handicapped anyway.[57]

Jaehnig[58] has argued that it is professionals that make handicapped families out of families with a subnormal member. Mack reports that a gynaecologist told the parents of a mongol baby:

> We hear from time to time of mongols who learn
> to read and write, but in my forty years of
> experience I have never met one.[59]

Even more depressing was the prognosis given to the parents of a newly-born mongol.

> He will grow immensely fat, be incontinent,
> never talk, never read and not walk very well.[59]

Professional and public attitudes to the mentally handicapped are apparently negative and while they may have become modified in recent years there is little evidence that people are prepared to participate in the community care of the mentally handicapped. Financial help for relatives caring for a mentally handicapped member has increased in recent years but is still insufficient (see Chapter 6) to meet needs. Needs, however, go far beyond monetary help. Ballard,[59a] a social worker and the parent of a teenage Downs Syndrome boy, has argued that while parents coping with a mentally

handicapped child at home need financial help, their
'real' needs are far more wide-reaching - they need
help, especially in practical coping.   McCormack,
herself the mother of a subnormal boy, concluded after
a survey of a number of families caring for a mentally
handicapped child, that

> the situation of the mentally handicapped and
> their families has improved terrifically
> over the last decade ... but the needs are
> there and urgent.[60]

The mentally handicapped remain a deprived group in
terms of public spending and are awarded low priority
in terms of provision. A report of the National Society
for Mentally Handicapped Children in 1974 argued that
unless this situation was altered social disaster would
result - the government needed to get its priorities right.

> We can catch up with the delayed motorways or
> the council offices, we can never replace
> the wasted years of people's lives.[61]

Jaehnig[62] has pointed out that many parents, especially
working-class ones, are not aware of the financial assistance
and aids and adaptations they are entitled to.   Parents
often have to fight for the assistance that is theirs as
of right. However, parents also frequently need social and
practical help[63] with homework, 'babysitting', and holiday
relief. These are often not provided by local authorities,
and the research that has been carried out argues that it
is not provided on a voluntary basis by relatives and
neighbours either. We can see, then, how the negative/
apathetic attitudes of ordinary citizens and professionals
interact with the inadequate provision of services (and
indeed influence those who decide what services should
or should not be provided).   However, even more the
families share the stigma of the handicapped member and
become isolated from the society in which they live.
Indeed, many of the advocates of community care and

normalization (referred to in Chapter 6) are often
talking about the provision of services that will
'normalize' the family rather than the mentally handi-
capped member.

4. Empirical Research Findings: Attitudes, Reactions
and Behaviour

My major criticism of attitude surveys is that they
do not necessarily give any clear indication as to how
people react when confronted with mentally handicapped
people. Indeed, in the last chapter I suggested that some
recent research findings indicated that there was a definite
shift to more negative attitudes if people were actually
faced with the possibility that a hostel for the mentally
handicapped was to be built in their neighbourhood.
(This can clearly be seen as a reaction to an event - the
possibility of having mentally handicapped neighbours).
Thus Carver and Rodda have suggested that

> ... although we may declare our lack of prejudices
> towards handicapped people, how we behave when we
> have to meet them ... may be quite different.[64]

It appears, then, that we need research not only into
people's attitudes towards the mentally handicapped but
also into how people react to and behave towards mentally
handicapped people. This involves analysing patterns of
interaction, action, reaction, behaviour and how others
including the mentally handicapped interpret these.

In the sections below I discuss the illustrative
research referred to in the introduction to this chapter.
As I said there, this is intended to indicate the type of
research that would fill in the gaps in our knowledge
concerning reactions and behaviour and the ways in which
mentally handicapped people and their families interpret
and understand these reactions and behaviours towards them,
and how they in turn influence the ways in which they react
and behave towards other people.

Most of the attitude research has used a positivistic
methodology - attitude scales - designed to obtain 'hard'
quantitative data. To the extent that the scales do
measure people's 'real' attitudes the results indicate the
extent of negative/neutral/positive attitudes. However,
they do not tell us how salient or central the attitudes
are nor necessarily indicate how people will behave.
One way of obtaining data on how people react and behave
towards the mentally handicapped would be to count, by
observation, how people actually did react/behave when
they came into contact with a mentally handicapped person.
Alternatively it would be possible to ask people to recall
incidents when they have met a mentally handicapped person
and to say how they reacted/behaved and to ask people
concerned with the care of a mentally handicapped person
to recall, in response to a pre-coded questionnaire, how
people have reacted/behaved towards them and the mentally
handicapped person in their care. However, there are
a number of problems with these methods: apart from the
fact that they are time-consuming and the difficulty of
obtaining a large enough random sample of respondents,
there is the problem of faulty memory, of not wanting to
put oneself in a 'poor light' with the interviewer,
and in the case of those caring for the mentally handicapped,
the problem of how they interpreted other people's
behaviour/reaction. I decided instead, because of the
problems of obtaining quantitative data and because the
research is in the nature of a pilot/explorative study
to use ethnographic/qualitative research methods.
This type of research makes possible the identification of
the relevant problems (negative reactions/behaviour) and
populations. For example, one part of my research is
carried out in a village; some of the problems found to
exist in such a community might not arise in a 'transient'
inner-city area.   There is already some evidence that
there is less resistance to hostels for 'deviant' groups
in working-class areas than in middle-class areas - though
this does not mean that negative reactions/behaviour

towards the residents of the hostels does not occur in
working-class areas. Qualitative methods are better
suited to the nature of a problem such as this one,
because they lessen the risk that the researcher's pre-
conceived categories will be imposed on the research
area to the detriment of the categories through which the
participants themselves conceive their situation.
(However, it would be necessary at some stage to return
to more quantitative approaches, particularly in the
service of social policy; one would need reliable estimates
of the relative frequency of identified problems in the
relevant populations).

Thus in order to begin to explore the problems of
reactions/behaviour I:

i) asked three groups of students in a Further
Education College to participate in discussions,
chaired by me, on mental handicap;

ii) interviewed, informally, a small group of residents
in a village where a hostel for mentally handi-
capped women had recently been opened; and

iii) interviewed, again informally, at least one adult
member of eleven families with a mentally handi-
capped dependent.

4.1 The Students

As a lecturer in a further education college I had
the possibility of a 'captive' group of respondents.
Originally I considered using an attitude scale and pre-
coded questionnaire on a random sample of the full-time
students in the department in which I worked (an Academic
Studies Department catering mainly for 16- to 19-year-old
students following full-time courses leading to G.C.E. 'O'
and 'A' level examinations). This would have provided
quantitative data on their attitudes towards and their
knowledge of and amount of contact with mentally handicapped
people. It would have enabled me to compare the responses
of a young, relatively intelligent group of English people

with the results of previous research. (It seemed to me
that if attitudes were becoming more positive and people
beginning to have more 'correct' knowledge of the mentally
handicapped, then this kind of group would reveal this.)

However, I decided that my position in the college
would compound all the problems of reliability and
validity associated with such research, and that I needed
to develop a research tool which would enable me to get at
the students' 'real' feelings.   I therefore decided that
if I asked students to discuss the mentally handicapped
in groups which I could chair, they might in the heat of
discussion reveal more of their 'real' thoughts and ideas
than they would filling in pre-coded forms.   The discussion-
group is after all a fairly natural setting for the student.

The findings reported and discussed below are
based on an analysis of typed recordings of three separate
group discussions.   All the students who took part in the
groups were studying either 'O' or 'A' level sociology and
were taught by me.   I did not obtain detailed information
on social class, but all the students involved were beyond
the compulsory school-leaving age and were studying to
obtain academic qualifications.

The first group consisted of 14 cadet nurses, 2 boys
and 12 girls, aged between 16 and 18 years. All were
employed full-time by a local Regional Hospital Group
and were allowed day-release for two days a week to study
for G.C.E. 'O' levels.   Some of the students had experience
of working on the wards in a subnormality hospital.
The second group comprised 20 full-time students studying
for G.C.E. 'O' and 'A' levels. All the students in this
group were aged between 16 years and 20 years.   The third
group was made up of 14 full-time students, aged between
16 years and 22 years, studying for G.C.E. 'A' levels,
and two part-time students in their mid-forties studying
for G.C.E. 'A' level sociology.

I am not suggesting that these students are in any
way a representative sample of the population, of their
age group or of the college's students.   However, some
knowledge of their attitudes towards and reactions to the
mentally handicapped enables us to form some idea as
to whether the educated young do have more knowledge and
tolerance and to see what negative attitudes towards
and misconceptions concerning the mentally handicapped still
appear to be prevalent.

The major problem I encountered in chairing the
discussions was to get one started in the first place.
The majority of the students did not have any first-hand
knowledge of mental handicap and had obviously not thought
about it.   In a sense I was asking them to consider a
'problem'that was not only not central to their lives but
was in fact something they had never really thought about.
(If this were true of the total population it would demon-
strate again how little use surveys of abstract attitudes
are and the importance of studying concrete reactions and
behaviour).   If I had not had a position of authority
over them it would have been extremely difficult, if
not impossible, to get them to discuss the issue.
(They were not aware, at this time, however, that I was
carrying out sociological research in the area of mental
handicap, and the idea of discussing the subject was
presented as 'getting them to talk about a social problem'
prior to my telling them about the way in which sociologists
approached it.)

Apart from the cadet nurses who had worked in the
subnormality hospital, only one student claimed to have
had any contact with a mentally handicapped person.
Their knowledge of mental handicap was also extremely poor .
Few of the students had any clear idea of what mental handicap
was.   One group – the second- spent at least twenty minutes
trying to decide what it was and eventually asked me to
give a definition/description .   One of the major diffi-
culties they had was in differentiating between mental handicap

and mental illness.   In one group this only became obvious when a number of them started to discuss the behaviour of the patients in a local psychiatric hospital under the misapprehension that they were mentally handicapped.

Once the students realised which group of people they were supposed to be talking about they revealed the negative attitudes and reactions described in previous research.   Their image of the mentally handicapped was, however, based on the more severe cases, who often exhibit unexpected and bizarre behaviour, and many referred to the physical, especially facial, features associated with Downs Syndrome (Mongolism).   All the students, including the cadet nurses who had worked with mentally handicapped people, admitted some feelings of fear and hostility;   a number advocated euthanasia, especially when 'defect' was obvious at birth.   They justified this by pointing to the social and economic burden that mentally handicapped people placed on their families in particular and society in general.   (When I intervened and asked whether this applied equally to physically handicapped people they were more ambivalent, arguing that their 'brains' were not damaged and that they could support them-selves economically.)   The majority clearly felt that they, their parents and the neighbours would react adversely to a hostel being opened for mentally handicapped children or adults (especially the latter) in the vicinity of their homes.   They justified this reaction by referring to the danger that such people posed to children and elderly people, and although they did not seem clear as to what this danger was there was some suggestion of sexual attacks and other socially unacceptable behaviour.   The main concern seemed, in fact, to be that it would lower the 'tone' of the neighbourhood and make it generally a less desirable place in which to live.

It seems, then, that at least among this group of young people more positive attitudes to the mentally handi-capped have not developed, and that they have little

knowledge of its nature.   A more detailed and systematic
study of young people may reveal data that contradict
these, of course.

There is one interesting side-light to this study.
Some weeks after these discussions had taken place I
discovered that another student whom I did not teach,
but who was a close friend of several members of group 3,
had a younger sister who was moderately mentally handicapped
(Downs Syndrome). The one student who said that she had
informal contacts with a mentally handicapped teenager
was in fact referring to this student's sister, whom she
had met when visiting her friend. I spoke briefly to the
student, who claimed to be fond of her sister and to
take her out on trips occasionally.   However, she appeared
not to talk about her sister with her friends or fellow-
students and had only introduced her to her 'best' friend.
She seemed to feel that she shared her sister's stigma
and that her status would be diminished if she revealed
her sister's 'condition' to people sh vanted to 'like' her.

4.2   The Village: Reactions to a Hostel being Opened

If the policy objectives discussed in Chapter 6
are to become fully implemented so that mentally handi-
capped people become 'accepted' in local communities and
integrated into the existing services, then hostels and
their residents must be accepted rather than just tolerated.
The available research has suggested that community reactions
to hostels are usually hostile, and even when there is not
adverse community reaction few people in the area are
prpeared to befriend the residents.   There is, however,
research that indicates that residents of hostels and
group homes can become integrated into local communities.
A report of a successful group home in Birmingham stated
that it had been

>   now a group home for two years, neighbours
>   are friendly and helpful.[65]

but the report also stressed that

> If group homes for the mentally handicapped
> are to play an important role in the future,
> good neighbours with an understanding of the
> needs of the mentally handicapped are vital.[65]

In this case an important factor in the residents being
'accepted' may have been that they had been carefully
selected and prepared and that none of them were visibly
abnormal or disabled.

Another 'successful' example is that of Delph Manor,[66]
where the residents have become integrated into the local
community. In this case the positive approach of the
Warden, who has actively encouraged local people to come
into the hostel and the hostel residents to go out into
the community, seems to be an important factor. Other
relevant considerations could be related to the locality
in which the hostel is to be sited, the extent to which
local people are informed about the hostel before it is
opened, the number of residents to be housed there, as
well as the factors referred to above - degree of handicap
and the approach of the Warden and others connected with
the residents.

However, I was not just interested in how people
said they felt about having a hostel in their immediate
neighbourhood, or even if some local people were prepared
to befriend the mentally handicapped residents of an
already established hostel. I was more interested in
explaining reactions to and behaviour towards mentally
handicapped people - in the audience in a real scene,
not just the actors. The opportunity arose for me to do
some research in a village where a hostel for moderately
mentally handicapped women had recently opened. In a
sense this gave me an extreme example; the village had not
been prepared for the hostel's opening in advance, it had
mainly middle-class residents and was a relatively small,
closed area. Furthermore, the initial adverse reaction
to the opening of the hostel was fuelled by the Warden
of a local youth campsite who pointed to the 'dangers'

of housing women 'like that' near children. (The women
that I spoke to clearly felt that he meant sexual danger -
although it was unclear if he ever said this explicitly).
I was interested in local reactions to the hostel,
whether these had changed in the three years since the
hostel had opened, and the behaviour of the villagers
to the 'girls' (as they seemed generally to be referred to).

I could again have carried out some type of random
survey of the local residents, but this again presented
all the problems of getting at people's 'real' feelings
and at 'true' descriptions of how they had reacted and
behaved. Alternatively I could have lived in the village
and carried out participant observation, but I would not
have been able to obtain sufficient data in the time I had
available and would have had to spend the time exploring
what to look for rather than getting any 'real' data.
My entry to the village (being told about the hostel and
the reactions to it) had been via a mature student who
offered to introduce me to a group of 'friends of the
hostel'. I was subsequently introduced to the group and
they agreed to discuss with me what had happened in the
village when the hostel had opened and subsequently.
I spent several hours with them talking about the hostel,
its residents and the village, directing the discussion
in order to get them to talk about their own reactions to
the hostel and those of other villagers and the ways in
which villagers had subsequently behaved towards the
'girls' living in the hostel. While this method had
the advantage of getting the group talking and remembering
incidents as well as talking about the 'problems' in
general, they were aware of what specifically I was interested
in and the particular incidents they recalled may well have
been the exceptions, examples of <u>extreme</u> behaviour rather
than of <u>typical</u> behaviour. However, most of the group
were themselves sympathetic to the hostel being in the
village, and while in some ways they may have wanted to put
the opponents 'in a bad light', what they said about their

own reactions should counteract this trend by giving the opposite point of view.

As I have already said, the village was inhabited mainly by middle-class people. All the housing in the village was privately owned. The village itself is on the edge of London and about five miles from a main shopping centre. Many of the inhabitants commute daily to London. The group I spoke to was comprised of women, and although I did not ask them for information that would enable me to determine their social class definitely, their life-style was middle-class.

The hostel was converted from a hosue that had previously been a Seamen's Home. The residents all came from a subnormality hospital and were all moderately handi-capped; some had physical disabilities, some speech impedi-ments, one member had frequent epileptic fits, and some had *other socially* unacceptable behaviour such as dribbling and open masturbation. Thus the 'girls' looked and behaved deviantly but were representative of the type of mentally handicapped people for whom care in hostels in the community is advocated.

As I have already stated, the members of the group I spoke with were basically sympathetic to the hostel and its residents at the time I carried out my research. They felt that while the opponents of the hostel had been more vocal and persistent in expressing their views, most of the villagers were apathetic. They had not actually supported or opposed it.

> The reaction has generally been from those villagers who don't want a home rather than from people in general that might come into contact with them.

The news that a hostel for the mentally handicapped was to be opened in the village was greeted initially with mixed feelings by the villagers. They were very upset that the first indication they had that a hostel was to be

opened was a report in the local newspaper. The initial
reaction was to call a village meeting, at which a
considerable amount of concern about and opposition to
the proposal was expressed. A qualified nurse said that
at this meeting many displayed a complete lack of knowledge
of the mentally handicapped, obviously confusing them
with the mentally ill and referring to them as 'raving
nutters'. Many parents expressed concern for the
sexual safety of their children, this fear being added to
by the Warden of the local campsite for young people, who
put forward the existence of the camp and the danger to
campers as an argument against the establishment of the
hostel. As one person put it

> ... the majority of the people were horrified
> to think that we were going to have - to quote
> their own words - 'lunatics' in our village
> that might murder their children.

Not all of the villagers shared the 'fear' of the mentally
handicapped, and some expressed sympathy for their plight,
but nevertheless they felt that the hostel should not be
built in 'their village'. In general few had any 'real'
knowledge or contact with the mentally handicapped. As one
elderly schoolteacher said,

> Well, I had never had any contact with mentally
> handicapped people until they came to our village.

Three years after the hostel had been established
there was little evidence that villagers had modified their
attitudes or their opposition to the hostel. One woman
in the village, the qualified nurse, had organized a group
of 'Friends of the Hostel', and a number of women from
the village visited and helped at the hostel, but they
had generally not been those who were opposed to it originally.
Contact with the residents had to some extent modified
the attitudes and beliefs of those who belonged to this
group. As one respondent put it,

Now my reactions were mixed. I was a little
bit frightened as I sat amongst them. I felt
slightly nauseated the first time I went
because some of them weren't very good to look
at. All of them liked physical contact and
wanted to come up and touch you and this added
to my fear and my reactions, but it went on for
several weeks - going along on Tuesday afternoon -
and then suddenly, I am speaking personally now,
one person who hadn't ever spoken since she was
brought to the home (but was quite capable of
doing what she was told to do after a period
of meditation) suddenly looked up when I came
into the room and shouted out in a very hoarse
voice 'my friend, my friend' and got hold of
my arm and from that moment I felt all the
feelings I had about not wanting to be there
and distasteful feelings fall away and I became
totally involved.

However, a hard core of the village remained opposed
to the hostel being sited near the village. As a number of
people told me regarding their own acceptance of the 'girls',

But it hasn't covered the whole district.
We still have a group of people who won't
accept them.

Additionally some of the villagers felt that the mentally
handicapped residents had too comfortable an existence,
as I was told:

Their life at the home is, well, to quote some
villagers, to be envied.

Although none of the residents from the home had
committed a 'serious' offence their behaviour in the
village had been interpreted by some villagers as justi-
fication for their original opposition and confirmed
for them that they had been right to oppose the hostel.
Local people had objected to their behaviour in church
and in the village generally and had succeeded in having
them prevented from attending church services, and
their access to the village was restricted. I was
informed by one villager, who was not 'really' opposed
to the hostel

But I think that if they weren't strictly
supervised we might get the conditions that
the nucleus fear.

This view was based on an incident that had been witnessed
at the home and which was described as evidence of the
inherently violent nature of the girls.

> One one occasion, when the sister was absent on
> holiday, we had a lot of cast-off clothing
> brought to the home, and it is customary for
> sister to allocate these to various girls,
> and one particular girl saw a dress that she'd
> like and she took it unbeknown to us. And
> another girl knew that she had taken it and started
> a violent argument with her and before we knew
> where we were not only were the girls fighting
> and scratching each other's faces, but the nurses
> were getting the worst of it ... So you see some
> of their fears are not unfounded ...

> (All the fears of the village?)

> Yes I think so, because one can't predict their
> reactions unless they are under medication.
> For my own part I've no fears but I think that
> anyone that's around then that they weren't fond
> of might suffer.

The general impression of the villagers who helped
at the home was that the negative reaction to the residents
had come from those villagers who didn't want a home
rather than from members of the public in general that
they might come into contact with. A member of the
volunteers always accompanied the residents on shopping
trips to a nearby shopping centre.

> You see, we take them into big places like
> Woolworths and supermarkets and I think they
> sort of get lost in the crowd, people don't
> seem to notice them ... No real reaction to
> their features or the fact that they are
> mentally handicapped - not in public.
> Not the public in general.

Despite the fears and apprehensions of the villagers
there seemed to have been few incidents to confirm their
continued fears. The majority of the disabled women
are not allowed into the village on their own, and there
had been no serious incidents involving any of them in
the village. However, the behaviour of those who had been
allowed out on their own was perceived as 'rather a nuisance'.

> We had a village shop - you see we have one
> that's light-fingered, that is why she's
> there, and every time she goes into the shop,
> she asks for something which has to be got
> from under the counter or from the next room,
> and takes things, so she had to be stopped.
> Another one is an inveterate smoker and will
> pester people for cigarettes and cups of tea.
> She's had to be stopped.

All these incidents combined with the original
negative attitudes and reactions result in a continued
general hostility to the hostel and its residents.
It was difficult for me to gauge what proportion of the
villagers were actively hostile, but they were obviously
vocal and influential. Few villagers had campaigned on
behalf of the hostel and its residents, and there was
little evidence that any of the villagers had developed
more positive attitudes to the mentally handicapped as
a result of meeting the hostel's residents. Even some
of the women I spoke to, who were actively helping at the
hostel, had some doubts as to whether or not it should have
been opened and showed some of the fears of the 'girls'
that they claimed were voiced by those opposed to the
hostel. In general, then, we can conclude that,
in this village at least, there was considerable opposition
to a hostel for mentally handicapped women being opened in
the first place, and that this opposition had not diminished
three years later. It also seems that villagers
selectively remembered what were probably fairly isolated
incidents of unacceptable behaviour exhibited by a small
minority of residents, to confirm their 'worst fears'.

4.3   The Experiences of Families with a Mentally Handicapped
      Member

While a number of the studies of the mentally handi-
capped have described the problems confronting the families
which contain a subnormal child, in both caring for and
in deciding to seek residential care,[67] few have been
concerned with the way other people's behaviour and
attitudes affect the family.   I was interested to discover

how the parents felt about other people's attitudes
and behaviour towards them and whether they experienced
it as stigmatizing. While accepting Bayley's[69] point
that the relations' sensitivity to the way other people
behave will be conditioned by their own attitudes,
I would nevertheless argue that the experience of parents
will give us insight not only into people's attitutdes
but also their reactions to behaviour towards the mentally
handicapped. I have already suggested that there is
considerable evidence that the mildly subnormal feel
stigmatized and are 'hurt' by other people's behaviour
towards them. It is not practical to question the more
severely subnormal or even to know if they are aware of
the meanings of the reactions or behaviour of other people
towards them. Those nearest to the subnormal are their
families who share their stigma and diminished status.

The Sample

I was given the names and addresses of fifteen
families prepared to co-operate in my research by the
Chairwoman of a branch of the National Association for Mentally Handi-
capped Children. All were resident in a London Borough
and members of the association. Eleven of these families
were located and interviewed.

In seven cases the mother was interviewed, in
three the mother and father were seen together, and in one
case a grown-up sister.

The Subnormals

     6 adults – All attending a local authority training
                        centre and living in the parental home
     1 adult   – Resident in a mental subnormality hospital
     1 child   – Pre-school age

     4 children   School age, attending E.S.N. (S) schools

The Families

All the families regarded their mentally subnormal
members as handicapped and as requiring fairly constant
care and attention. Although four of the adults had been
ascertained as mildly subnormal, none were thought of
as capable of independent living, of high levels of
self-care or of 'open' employment. This contrasts
sharply with the experiences of the research department of
the local authority who attempted to carry out a sample
survey of the mentally handicapped and their families using
the case records of the Social Services Department as
a sampling frame[70]. They found a number of cases where
this 'mentally handicapped' label was denied by the
family and several where the 'subnormal' had   married
and the spouses had no idea that their partners had ever
been ascertained as handicapped.

These families may be typical of those who have
come to accept the fact that they have a mentally handicapped
member, but not necessarily of all those with a subnormal
member. They have also 'publically' acknowledged this
acceptance by joining the *association*, from which they
also receive a certain amount of mutual help and support.

The degree or type of handicap of the subnormal in
the sample families meant that all of them were fairly
obviously subnormal, either because of behaviour   or
appearance.   Therefore these families are likely to
experience the negative attitudes, reactions and behaviour
of other members of the community in which they live,
and additionally have experience of the knowledge, behaviour
and attitudes of those professionals who routinely come
into contact with the families of the mentally handicapped.

These families are atypical in that they were self-
selected; that is, they had agreed to take part in research
at the request of a third party.   They were all members of
a local branch of an association for the mentally handicapped
and the majority were actively involved in the activities

and running of the branch. The association provided mutual support, information on rights and entitlement to services and acted as a pressure group at the local level. Much of the social life of ten of the families centred around the association and its activities. This means that they might to some extent have been cushioned from community attitudes and insulated by their group membership. Indeed their membership and participation in organizational activities may have been deliberately to enable them to maintain the appearance of a normal family while avoiding situations that would be likely to be embarrassing or involve stigma.[71]

Furthermore, these parents had chosen to become members of and participate in the activities of a voluntary organization. There is, for example, some evidence that the middle-class are more likely to join voluntary organizations, and although not all of these families would be classified as middle-class on the basis of father's occupation, all except one family lived in owner-occupied houses. One family lived in a council house, and the mother was a qualified art teacher, but the Chairwoman of the Association described the family as 'poor'. Thus while most epidemiological studies have found that severe subnormality is distributed randomly among all social classes, and mild subnormality concentrated among the working-class, the sample were heavily biased to the lower middle class.

The sample also did not contain any families where the mentally handicapped member was non-organically mildly handicapped. The secretary of the association told me that the parents of mildly subnormal children that they contacted usually maintained that their child was not mentally handicapped and that they did not want to have any contact with the society. The problems faced by these families and their experiences of other people's attitudes and behaviour may well be different from those of parents with more severely handicapped children.

Nevertheless, the evidence from other research into
the families of the mentally handicapped does not seem
to indicate that social class is an important variable.
The slight indications that it could be are self-contra-
dictory; while some researchers (e.g. Mercer[72]) have
argued that working-class families are more accepting of
and more likely to care for a mentally subnormal member, others
have argued the reverse (e.g. Jaehnig[73]), and have
suggested that it is lack of knowledge of rights to
financial help and services which hinders the attempts of
working-class parents to care for their subnormal child
at home.

The experiences of these eleven families are not the
same. Some feel intensely that they are stigmatized as
a consequence of having a handicapped member and that
other people openly display negative reactions towards
them and the mentally subnormal. These negative reactions
were displayed by relatives, friends, the 'general public'
and professionals. Conversely, others felt that every-
one had been and was very helpful and kind. Despite
this, my own subjective impressions - gained from looks,
inflections in the voice and other cues - indicated that
they had all had disturbing experiences and all felt that
other people regarded them as 'different', pitied them
and to some extent avoided them. Also, they all seemed to
structure their lives as families so as to avoid possibly
embarrassing situations - for example, by not asking
friends to babysit, by not inviting friends or relatives
who they felt would object to or be embarrassed by
the presence of the subnormal member. Probably what
came over most clearly was a feeling that people's attitudes
were ambivalent: that at an abstract level they experienced
sympathy, but when confronted with the possibilities of
direct contact with the mentally handicapped tried to
avoid it. (They reacted in a way that was not consistent
with their previously expressed attitudes).

In a very important way, perhaps, the major influence
on these families' lives were their own attitudes, usually

reinforced by the actual or perceived attitudes and
reactions of others, including the acceptance of the
idea that the mentally handicapped child was their
responsibility, that it was their duty to care for the
child and 'shoulder the burden'. This meant in all but
one case that the mother did not work and that the family
structured their lives around the needs of the mentally
handicapped member. The lack of help from relatives,
friends and neighbours resulted in the isolation of the
families and especially of the mothers.

The Sample Families

Family 1   Father, Mother, 3 sisters.
            M.H. member Trevor (second child) aged 15 years
            S.S.N. (brain damage)

Family 2   Father, Mother
            M.H. member Diana (only child) 9 years old,
            brain damaged, dumb, unable to walk, doubly
            incontinent, looks normal.

Family 3   Father, Mother
            M.H. members (a) John, young adult, I.Q. 56,
            looks subnormal, slight problems with speech.
            (b) Susan, young adult, I.Q. 60, looks normal,
            capable of high level of self-care.

Family 4   Father (deceased), Mother, 1 son and 1 daughter
            M.H. member Mary (eldest) 21 years old, Mongol,
            I.Q. 60+

Family 5   Father, Mother (deceased), sister
            M.H. member Donald (younger sibling) Mongol,
            I.Q. 50, 32 years old.

Family 6   Father (deceased), Mother, 3 married sisters,
            1 brother.
            M.H. member Paul (youngest) 3½ years old,
            Mongol, not talking or walking.

Family 7   Father, Mother
            M.H. member Mark (15 years old). I.Q. 50,
            no official diagnosis but exhibits violent and
            bizarre behaviour.

Family 8   Father, Mother, 2 brothers (1 older, 1 younger)
            M.H. member Gregory, 15 years old, brain
            damaged, severely subnormal, dumb, doubly
            incontinent, mobile.
Family 9   Father, Mother ,1 sister (older, married and
            partially sighted)
            M.H. member Sandra (adult), severely subnormal,
            blind, no formal diagnosis. Walks and talks.
Family 10   Father, Mother, older brother (married)
            M.H. member Elizabeth, subnormal, I.Q. 57,
            30 years old. No diagnosis
Family 11   Father (deceased), Mother, 2 sons, 1 daughter
            (all younger)
            M.H. member Judith (31 years old), Mongol,
            permanent resident in local subnormality hospital.

Method

The interviews were conducted in the homes of the
families.   They were focussed interviews.   Generally
I asked the parents about their experiences and the replies
were tape recorded.   I rejected the idea of using a
formal interview schedule and decided instead to ask the
parents to discuss with me their experiences of having a
mentally handicapped member and particularly to talk about
how other people had reacted and behaved towards the family
in general and the mentally handicapped member in particular.
During the interviews I only interrupted in the flow of
conversation to direct the respondents back to the general
area in which I was interested when they wandered away
from the point.   I did, however, ask questions at the
outset about the occupation of the head of the household and
for details of other members of the family, apart from the
mentally handicapped one.   (Family 3 refused at the outset
to discuss the attitudes and behaviour of other people.)

The main reason for choosing this research method was
that I wanted the parents to talk freely and give me details
of the ways in which they had experienced the reactions

and behaviour of others. I explained at the outset that
I was interested in negative and positive reactions
and those of relations, friends, neighbours, people they
met and professionals they came into contact with.
This meant that I focussed their attention on a certain
aspect of their experiences of having a mentally handi-
capped member of the family. The disadvantage was that
I might be asking them to focus on aspects of their lives
that they had not previously thought about or considered
central in their day-to-day lives. Also they were
likely to remember the few outstanding (probably negative)
reactions rather than the routine, day-to-day ones.
However, the alternative, non-focussed interviews, would
have been too time-consuming and may have provided little
data on my own area of interest. The type of research
method I used provides valuable qualitative data which not
only sheds light on people's reactions and behaviour, but
can also be used to generate hypotheses that can be tested
by more quantitative, controlled methods.

Findings

A number of important factors need to be looked for
in interpreting and understanding the feelings and
experiences of the parents. Of two factors that other
research has shown to be of special relevance, one is age -
young children benefiting from the 'aren't children
wonderful' attitude. In the sample only Paul (Family 6)
was of an age to benefit from this. The other main
factor is degree of handicap - the mildly subnormal being
less stigmatized than the severely handicapped.
Elizabeth (Family 10) and Susan (Family 3) were both
mildly subnormal and not obviously handicapped, while
Mary (Family 4) was only mildly subnormal but was obviously
handicapped (Down's Syndrome). As Mary's mother explained,

> She is so borderline in lots of ways which I think
> makes it more difficult. It's more difficult for
> her and it's more difficult for us ... Mary knows
> that she is the oldest one in the family, so
> therefore she resents being looked after by her
> sister who is 3 years younger.

Furthermore, being obviously Down's Syndrome in
appearance and the fact that she realises that she is
a Mongol make life more difficult for her. Her mother
recalled finding a card that Mary had written as part
of a game of playing nurse:

> It's fun to read them actually, but I was
> very upset one day when I found a card
> saying 'I am a mongol, but I'm not handicapped,
> I'm normal, you know.'

Mary is not accepted by the wider kingroup as a member.

> I found things are difficult ... we have
> invitations to weddings, family affairs -
> Mary is not invited. She is treated in this
> way because she is a mongol, not because her
> behaviour is abnormal. She is being treated as
> an outcast on the basis of prejudice.

Another factor is the experiences of the families of
the different categories of members of the community
that they come into contact with - relatives, friends,
neighbours, strangers and professionals. While some
families (1, 2 and 6) saw all the attitudes and reactions
of other people as negative, others found only some people
or groups displayed negative attitudes and reactions.
Mary's mother, for example, was very critical of the
negative attitudes and unsympathetic behaviour of relatives,
was extremely critical of professionals, but had not
experienced any adverse reactions from neighbours.

> My neighbours are very good on the whole.
> My neighbours next up that way have always
> been ever so good.

However, none of the families had never met stigma or
negative attitudes or faced problems because of the
unsympathetic behaviour of other people at some time.
Many of the families felt that ignorance was one of the
major factors, coupled with a lack of sympathy and under-
standing. Mary's mother referred to her experiences at
an Open Evening at the Adult Training Centre.

> I was detailed to talk to different groups and
> I was quite amazed that even in these days there
> is so much ignorance concerning mentally handi-
> capped people. They just could not understand
> when you took them to the workrooms that even
> the most seriously severely handicapped child
> can be trained to do something. I just couldn't
> understand it.

> We had one group and I think they really thought
> that all mentally handicapped children were
> absolutely mad. Yes I think of course that this
> is a very common failing. People will mix up the
> mentally ill and the mentally handicapped.
> This doesn't only apply to people - it applies to
> people in the social services, people in hospitals -
> unless they actually have contact with the mentally
> retarded as opposed to the mentally ill.

Elizabeth's mother (family 10), who was also
Chairperson of the local branch of the Association, felt
that there was just a general lack of interest in the
mentally handicapped, that they were forgotten by society.
Social workers, health visitors and doctors had little
knowledge of the mentally handicapped, and family doctors
could rarely give the parents the kind of practical help
that they all too frequently needed.   She concluded the
interview by pointing to what she felt most clearly
demonstrated the lack of concern for the mentally handicapped.

> The local Social Services don't keep a register
> for the mentally handicapped. They inherited
> a register which was so utterly out of date, the
> information was unbelievable. I mean people
> were dead, or married and the spouses did not
> know that the spouse was mentally handicapped.
> The house had been demolished. It was a fiasco,
> absolutely. I think that it is vitally important
> that there should be a register for all the
> mentally handicapped of every age within the
> Borough boundary. I am hoping that it will be
> set up very soon, but they are hedging it very
> much indeed with how difficult it will be to
> keep it up to date. How can you talk about needs?
> How can you work out the needs of future residential
> accommodation if you haven't got a register for people
> who are going to use that future accommodation?

(The problem referred to was encountered by the local
council when they attempted to carry out research into
future residential care facilities that needed to be provided.

The researcher generated a stratified random sample of all the mentally handicapped people with an intelligence quotient of less than 60 (according to the register) or who had attended the Junior Training Centre, or were currently (as far as could be ascertained) attending the Adult Training Centre and were, at the time of the survey, over 16 years old. Elizabeth's mother is pointing out how out of date the register was, and not suggesting that the spouses of those who were married should have been/should be told that their partner had been 'diagnosed' as mentally subnormal when they were younger.)

The experiences of the families varied greatly, and of course it is difficult to tell if this is a result of their own feelings and attitudes influencing their interpretation of events and situations or of real differences. Nevertheless, all had bad experiences where they had felt embarrassed or stigmatised by the behaviour of other people. A typical experience was that recounted by Judith's mother (family 11)

> I know once we were at the seaside and we were sitting on the beach and the children were together and this happened. This person's children came down on to the beach early and they were playing with Michael and Judith and they were playing happily together and then the mother came from nowhere and my goodness me did she let out a thing. She said "I would never have let them come down on the beach if they were going to play with someone like that".

Furthermore, parents anticipated adverse reactions. Paul's mother commented (family 5)

> I've found wherever I've taken him he's been accepted. Perhaps now as he's getting a bit older it's going to become more difficult.

Diana's mother (family 2) also felt that things would get more difficult as she (Diana) became older. Judith (family 11) had eventually been permanently hospitalised because of her mother's anticiaption of future problems.

> This is one reason why something would have to
> be done. She went into the ---- hospital when
> she was 21. Caroline was 3 and Michael 19,
> coming up to 20. I have seen so many families
> where the brothers have girlfriends and this
> causes unpleasantness, and I thought 'Oh dear,
> we can't have that ...'   I said we have got
> to do something before Michael starts going
> serious with girlfriends, before Caroline goes
> to school and brings friends home. We don't
> want to make any unpleasantness.

Donald's sister (family 6) felt that people's behaviour was
a result of thoughtlessness and ignorance rather than
deliberately unkind or prejudiced.

> But certainly I think in the general run of people,
> people just seeing mentally handicapped people
> for the fir t time are frightened.

However, she was also aware of the fact that Donald understood
when people were making fun of him and that this upset him.
He had, for example, been very upset when children had
laughed at him when he travelled on the bus.

In contrast to many of the parents, Diana's mother
had received considerable sympathy and help from a friend:

> Well, most people were sympathetic. Well a friend
> I had at the time, well still have - was very
> sympathetic. In fact she looked after Diana
> a lot for me.

But this mother, more than any other I visited, already
felt lonely and isolated, and needed more help and support
than she was receiving from neighbours, friends, family
and the Social Services.

However, Trevor's family was the only family that
expressed a feeling of bitterness at the way the whole
family had suffered. They felt that they had been cut off
from their wider family and from friends and the community.

> Let's put it this way, there were relations
> we have not seen since we found out about Trevor;

and

> We have only been invited to tea with Trevor
> once to my brother-in-law. He thinks we
> should put Trevor away. (Father)

The mother and father felt that in general people
in Britain had 'bad' attitudes to the mentally handicapped
The mother referred to the remarks of a local shop
assistant

> A couple of weeks ago the woman in the newsagent
> said to my husband, 'fancy bringing a child
> like that in here!'

and went on to quote an incident in a local shopping centre
which she suggested was a 'typical experience'.

> We went out shopping in B_____ and this
> young man stared at us. I turned round and
> he was still staring.

Furthermore

> We always go abroad for our holidays, people
> in Sweden have very good attitudes to the
> mentally handicapped, they are far more advanced
> than we are.

In almost complete contrast to this family's experiences
were those of Gregory's family. Gregory is of much the
same age as Trevor, and like Trevor has siblings and is
severely handicapped. The parents felt that Gregory had
not restricted their social life and they had no real
problems obtaining babysitters when they wanted to go out.
As far as relatives were concerned they had experienced no
adverse reaction at all, and referring to neighbours the
father commented

> They go out of their way to make sure their
> children speak to him, tell them to speak to him.
> They say good morning to him, wave to him and he
> waves back, and they are especially kind and
> we have never had any trouble with any of the
> neighbours.

The third family with a teenage boy (family 7) had
experienced mixed reactions - typical of most of the parents.
In general they felt that people were apathetic rather than
negative in their attitudes.

> I feel it is part of our duty in society to
> make people more aware that the mentally handi-
> capped exist, and talk about it rationally and
> logically and not push it under the carpet.
> I cannot say that the reactions I have found
> have been much one way or the other - there
> has been some discussion of it, especially with
> the friend I work with, but again, I suppose,
> largely a case of sorry for you, not saying
> ' this outright of course, followed by indifference.
> The subject doesn't come up again, certainly they
> never advance it ...

They had received considerable help and sympathy from the
wife's relatives, but had been completely cut off by
the husband's. The husband obviously felt deeply hurt
by the reaction of his relations and refused to discuss them.

Mark's mother and father felt that adverse reactions
stemmed mainly from ignorance, and came most frequently
from children.

> Mark loves fishing and the men, adults, were
> marvellous, but the children used to take the
> mickey and they made fun.

But they also suggested that people often betrayed their
'real' feelings by looks on their faces and what they
left unsaid rather than by their behaviour, especially a
fear of 'deviant' sexual behaviour.

> (Mother)   When I talk to people and I say Mark
> is mentally handicapped and as soon as they know
> he is coming up to 16, you see, you know what
> I mean? I don't want to put it into words but
> you see it before they even say it ... Dear God,
> they all think of the average child. It is an
> unspoken look; I suppose maybe I would be guilty
> in the same way, but there is that fear of danger
> to 'my daughter'.

However, the father felt that this might only be their
interpretation of people's looks.

> I agree that there may be an attitude or a look,
> but if so it is a subjective opinion on our part.
> Whether we see it or not we think that we see it
> because certainly I don't think it is ever said ...
> It might be that they have a look on their faces,
> but you see we may become hypersensitive on this
> and also very biased.

What Mark's parents felt most strongly, however, was the lack of more general help and sympathy from the community. Their lives were severely restricted by an inability to find suitable babysitters, and Mark's mother had difficulty getting shopping as Mark refused to go to the shops. Their feelings about lack of provision and priority for the mentally handicapped came out most strongly when they discussed educational provision. Mark was due to leave the E.S.N.(S) school he was attending and his parents had recently been informed that there was no alternative day-care provision available for him. His mother expressed her views strongly.

> you see because I am here all day to listen to, say, Woman's Hour or some programme arguing for nursery schools for children up to 5 years so that mothers can go out to work, and I get so angry I think What the heck! You have a perfectly healthy child with everything going for them; alright, wait until they are 5 to go out to work. How do they think a mother copies with a handi-capped child? The thing is they are pushing and shoving and there is all this propaganda for nursery schools for the healthy child, the child who can cope, who can play and do what they want, but *nobody pushes* for nursery schools for our children, and that makes me angry.

Parents often found the reactions of relatives more perplexing than those of friends and neighbours. Bell[74] has suggested that even when nuclear families live at distance from their relatives there is some degree of social help, and while recent research has revealed that the idea that in pre-industrial Britain strong supportive extended families were the norm may well be false, it could be expected that families would turn to the extended family for help and sympathy. The experiences of the families varied greatly. When Donald (family 5) was young his grandmother helped his mother to care for him, while both of Mary's (family 4) grandmothers had found it difficult to accept and understand her and had refused to help in caring for her. Diana's mother (family 2) had suggested that the reactions of relations were

> ... mostly sympathetic, but none of them really
> understood. I did once try to explain to my
> sister and sister-in-law, I only wanted someone
> to listen to me. Instead they turned round and
> said well why don't you send her away ...
> they couldn't bear to think of me in that
> situation so get rid of it.

Other parents had experienced very hostile reactions from relations (families 1, 3, 7 and 12) while Sandra's (family 8) mother suggested

> Well, I have one cousin who won't come and visit
> us .. he feels guilty when he's got two normal
> children and I've not. I think you get this
> quite a lot

and furthermore

> Relatives can't understand why you can't visit
> and it is very difficult to take a handicapped
> child into a home if you know that the person
> is very houseproud ... I have literally given up
> on some.

The help and assistance of professionals and their attitudes and behaviour were also perceived in different ways by different parents – although the general impression was that they were not especially helpful or knowledgeable *about the problems* faced by the fmailies.

Diana's mother (family 2) was in general extremely grateful and appreciative of the help that she had received from health visitors and social workers. She felt that they had been very good to her, although the main help seemed to have been in giving sympathy and social support rather than in financial or practical help. But during conversation Diana's mother revealed that the social workers basically did not understand her needs and the problems she faced.

> I had a social worker – very kind, came when he
> could ... I wanted her to go into the hostel –
> six weeks' summer holiday used to be murder for me.
> I asked if she could go into the hostel mid-week,
> my husband wasn't able to drive her there and
> I asked if he could find someone to take her there

and he said "just this once" and I never asked
again. Just this once, he said as if I was
asking for the moon. You know, so I never
asked again ...

Mary's mother (family 4) was extremely critical of the
professionals that she had come into contact with

. I've shed more tears because of social workers
and people who have come to the home than
I have over lay people who don't know. I've
found social workers don't really understand
the situation.

She felt that social workers just do not understand the
problems faced by a young mother trying to cope with a
handicapped child and tied to the home. Her main criticism,
however, was the tendency of professionals to

Put down all the difficulties of a mentally
handicapped child to the fact that it is
mentally handicapped

Sandra's mother (family 9) also found that

Social workers seem to know very little about
the mentally handicapped.

and

I found doctors very ill-informed about
mental handicap.

She also experienced a common reaction from professionals
when Sandra was young. They refused to accept her
statement that there was 'something wrong'.

Elizabeth's mother had come up against the assumption
of the Social Services that the parents should provide a
home. The question had arisen because the local authority
was considering the possibility of providing a group home
for the mentally handicapped, but was apparently having
problems finding a sufficient number of handicapped people
capable of managing in such an environment (Elizabeth is
mildly subnormal and in her thirties).

> They haven't got enough applicants that they
> consider capable of living in them. Well,
> I consider Elizabeth is quite capable of being
> in the group home and at a meeting this came up.
> Miss ----- said something about parents not putting
> in applications and I said I had put in an application
> a long time ago, but that I had never had an answer,
> and that I would like Elizabeth to be considered
> to live in a group home. But one of the members
> of the council said the group home is to provide
> homes for those who have no home of their own.   .
> It isn't to provide homes for those who are quite
> adequately taken care of at home.

She also felt that social workers failed to tell parents
of their welfare rights, and that while they were someone
to talk to, they could rarely provide the type of help
that parents really needed. She quoted the case of one
mother she knew of who had a doubly incontinent daughter
and who had to do all her washing by hand. The 'real'
need of this mother was for a washing machine or at the
very least a spin drier, which the Social Services could
not provide.   She concluded

> Well, when you think, the most valuable financial
> benefits that are available are from a charity,
> well that says it all doesn't it really.
> It is the Rowntree Trust which is the most
> valuable contributor and it is a charity, where they
> have all got to make an application and make a
> good case.

Perhaps the general feelings of all the parents with
respect to the attitudes and behaviour of other people,
and the general treatment they and the subnormal member
of their family received, is best summed up by one mother
who said

> You get hardened to people's reactions.

4.4 General Conclusions from the Empirical Research

The general picture that emerges is that most people
have little or no knowledge of the mentally handicapped and
what knowledge they do have is second-hand. People in
general seem rather frightened of the mentally handicapped.

As one student said:

They look so strange, they are so different.

Furthermore, as Carver and Rodda have pointed out

> ... there are many commonly held, but no always
> openly expressed, attitudes towards disability.
> Not all prejudiced behaviour stems from
> consciously held hostility. Ignorance which
> leads to blind stigmatizing, fear and paternalistic
> benevolence - may all play some part in unfavourable
> attitude formation.[76]

What emerges strongly is that there is no one set of
attitudes concerning or reaction to the mentally handicapped,
and that there is a strong social ambivalence to the
subnormal. Many people are   concerned about and
feel sorry for the mentally handicapped, but are often
ignorant about subnormality and frightened by the appearance
of the subnormal and their behaviour.   Social stereotypes
of mentally handicapped people are usually based on the
more severely handicapped with their 'strange appearance'
and 'unpleasant behaviour patterns'. Furthermore, while
one subnormal person living with his or her own family may
be tolerated or even accepted, many people react differently
when a number are housed in a hostel or community home.
This adverse reaction is often a result of the widespread
belief that the mentally retarded are sexually frustrated
and promiscuous and pose a 'threat' to women and
children (a view developed and propagated by the 'eugenics'
movement - see Chapter 5).

The experiences of the parents interviewed were
apparently fairly mixed, some experiencing open hostility
from all they met and others receiving considerable help
and sympathy from friends, relatives, and professionals.
However, I often felt that parents were reluctant to admit
that they had had stigmatizing experiences.   Many of the
parents also appeared deliberately to structure their lives
in order to avoid possible embarrassing or stigmatizing
occasions.   They restricted their social life, so that
they only went to events, visited homes and other places

where they knew in advance that they would be welcome.
Family 3, for example, did not do anything or go anywhere
where the 'children' could not go with them and be
accepted. Consequently, like most of the other families,
their social life centred mainly on social and other
activities arranged by the local branch of the Association.

All the parents felt that there was a lack of general
concern in the community for the mentally handicapped and
that this was reflected in the low level of services and
facilities provided for them and their 'children'.
As Bayley[77] has so adequately shown, parents care for their
'children' in the community, rather than the community
providing care for the mentally handicapped. This is not
so much because of hostility towards the mentally handi-
capped, as ambivalent attitudes, apathy, a lack of knowledge
and a lack of concern. This is reflected in the low
priority of mental handicap provisions in government spending
(see Chapter 6).

5. Conclusion

In this chapter I have attempted to develop some
understanding of the attitudes towards, reactions to and
behaviour towards mentally handicapped people (children
and adults) at the community and individual level.
I argued that studies of attitudes were insufficient
and discussed my research, which provided illustrative
studies of the type which would enable us to develop
a clearer knowledge of how people react and behaviour.
It does not, however, tell us why they have these reactions,
although I have suggested that this may be partly the
result of a filtering process (the filtering down through
the years of the arguments put forward by the supporters
of eugenics at the turn of the century), lack of any real
contact, lack of knowledge and a 'natural' response to
'deviant' appearance and behaviour. Indeed, as Shotter has
pointed out, it is extremely difficult to understand why
people act in the way they do, and to distinguish between
intentions and causes.

> In explaining our actions to others we have,
> ideally, to give our <u>reasons</u>, tell of our <u>aims</u>
> or <u>intentions</u>, say what we expect to result
> and why. In practice, however, our intentions
> are often as obscure to ourselves as to others ...
> Unlike actions, events just happen ... to explain
> them we must seek their causal principles ...
> So we must be clear when investigating ... phenomena
> whether it is reasons (or something having the
> · logical structure of reason) or causal principles
> that we seek; the two belong ... to two distinct
> spheres of thought and investigation.[78]

My own research suggests that the mentally handicapped
and their families are stigmatized and that at the
individual and community level they tend to be outcast.
Thus the lack of 'concern' for mentally handicapped people
demonstrated by the inadequate level of facilities and
services provided for them is compounded by people's
negative reactions. As Hunt claims:

> Community attitudes towards the mentally
> subnormal ... are easily observed. They too
> readily reveal themselves in the lack of
> facilities provided and in a widespread
> reluctance to deal with the severely subnormal
> in as considerate a way as with the physically
> handicapped ... Although even the latter can
> show just how little the general public understand
> *and accept their disabilities.*[79]

However, while some individuals and groups react in a
hostile way to the mentally handicapped this cannot be
generalized to all, although it is interesting to note
how the women that I interviewed in the village shared
many of the fears of those who had actively opposed the
hostel. Also the differing experiences of the families
suggest that not only are there many individuals who
are sympathetic towards the mentally handicapped and prepared
to accept them as members of the community, but the parents'
own attitudes and reactions are an important factor - a back-
ground against which they interpret the way that people
they come into contact with react and behave. It is also
possible that one mentally handicapped person, living
with and 'controlled' by his family is seen as less of a
'danger' and 'threat' than a hostel. One also wonders to
what extent opposition to hostels is based on 'fears' of the

behaviour of the residents or financial considerations,
such as the value of property in the area declining as
it becomes a 'less desirable' area in which to live.
(The village I studied was considered a 'desirable area'
and property values were high compared with the surrounding
areas).

Thus while it is possible to get some idea of attitudes,
reactions and behaviour towards the mentally handicapped,
it is more difficult to determine what underlies these
attitudinal and behavioural patterns - how negative
images of the mentally handicapped are built up and
sustained. Although one suspects that, until their
own lives are actually affected, most people just don't
think about or concern themselves with the mentally handi-
capped. When they are forced to think about the 'problem'
their reactions are negative and tend to reflect and
reinforce the decisions made by central and local government
on the low level of spending on services and facilities
for the mentally handicapped. Apathy rather than hostility
probably most accurately describes most people's attitudes
and reactions towards the mentally handicapped, at least
up to the point when their own lives are affected.
These reactions being based on inaccurate suppositions
about or lack of knowledge of the mentally handicapped.

The 'problem' posed by these reactions to those who
want to 'normalize' the lives of the mentally handicapped
are intractable.   It is easy to say 'educate the public',
'change attitudes' so that people are prepared to have a
hostel or group home next door, to accept them as equal
citizens and to share facilities and services with them.
However, while the existing literature concludes (a con-
clusion that my own research supports)   quite clearly
that the majority of citizens are not fully prepared to
accept the mentally handicapped as integral members of the
local community, there is no definite proof of how people's
images of the mentally handicapped are built up, where
their fears and prejudices come from.   Individual and group

reaction to deviants and deviant behaviour are complex;
only when we begin to look at them within the history
and the social structure of the society within which
they have developed and are sustained can we begin to gain
an udnerstanding.   Attitudes, reactions and behaviour
can be described at the micro-level but they can only
be understood within a macro-sociological perspective -
a perspective I intend to develop in the next chapter.

REFERENCE NOTES, CHAPTER SEVEN

1: Campaign for Mental Handicap, 1972a P1

2: Lippman, 1972   3: Mental Deficiency Act 1913

3a: In a television report on Nationwide, 21 December 1981,
    reviewing the International Year of the Disabled, it was
    stated that the mentally handicapped had benefitted least
    from the year. This suggests that mental handicap arouses
    less sympathy than other disabilities or handicaps - or at
    least is seen as somehow less deserving of charity or help.

4: Simon, 1972 P2011   5: Becker, 1966 P1

6: Ryan, 1976 P153   7: D'Alton, 1970 P38

8: Farber, 1968   9: Townsend, 1969 Pxxi

10: Jones, 1975 &203,205   11: Jones, 1975

12: Bayley, 1973   13: Edgerton, 1967 P205   ·
                                    P1
14: Campaign for Mental Handicap, 1973.∧See also Heshusius, 1981.

15: January, 1980   16: Jaehnig, 1974

17: Gunsburg, 1973   18: Goffman, 1968.

19: Birenbaum, 1970

20: R. Ballard in Community Care, Tuesday 23 February, 1977.

21: Quoted in a letter to Community Care, August 14, 1974.

22: Bayley, 1973   23: Bayley, 1973 P240

23a: Bayley, 1973 P262   24: Bayley, 1973. P240

25: Reported in Community Care, 26 February, 1975.

26: The London conference of the National Society for Mentally
    Handicapped Children, March 1975.

27: Söder, 1972

28a: Referred to in Foucault, 1971

30: Taylor, 1975 P101

32: Hollinger and Jones, 1970

34: Richardson et al., 1961

36: Kershaw, 1973 P16   .

38: Davis and Strong, 1976

40: Fishbein, 1967

42: Abelson, 1972 P25

44: Lippman, 1972

46: Norris, 1978

48: Shearer, 1972 P3

50: Barr, 1903

52: Tredgold and Soddy, 1970 P91

54: Referred to in Townsend, 1969

54a: Campaign for Mental Handicap, 1973. See also Heshusius, 1981.

55: Edgerton, 1967
57: Rees, 1978 P41
59: Mack, in New Society, 15 July 1976

59a: Ballard, 1977 (See Note 20)

61: National Society for Mentally Handicapped Children, 1974. P61

62: Jaehnig, 1974

64: Carver and Rodda, 1978 P33

66: David, 1975

67: E.G. Tizard and Grad, 1961; Bayley, 1973; Jaehnig, 1974.

68: E.G. Birenbaum, 1970

70: Shanks, 1976

72: Mercer, 1973

74: Bell, 1968

76: Carver and Rodda, 1978 P103

79: Hunt, 1961

28: Söder, 1972 P250

29: Farber, 1964

31: Gottlieb and Sipperstein, 1976

33: Puccetti, 1968

35: Vasey, 1975 P32

37: MacAndrew and Edgerton, 1966

39: Gottlieb and Carmen, 1975

41: Abelson, 1972

43: Mittler, 1970 P3

45: Lippman, 1972. Ps 62 and 67

47: New Society, 1 January, 1981

49: Greengrass, 1976 P14

51: Tredgold and Soddy, 1970 P40

53: Walker and McCabe, 1973

56: MacCormack, 1978
58: Jaehnig, 1974

60: MacCormack, 1978 P144

63: See Bayley, 1973.

65: Community Care, 26 June 1974

69: Bayley, 1973

71: Birenbaum, 1970

73: Jaehnig, 1974

75: Laslett, 1972

77: Bayley, 1973

78: Shotter, 1974 P58

CHAPTER 8

CONCLUSION: TOWARDS A SOCIAL THEORY OF MENTAL HANDICAP

1. Introduction: Psychology, sociology and social theory

In this chapter I intend to suggest what a sociological perspective on mental handicap can contribute to our understanding of the phenomenon and how it relates to the existing medical and psychological models. In doing this I will highlight the inadequacies of the existing medical, psychological and sociological perspectives, and argue that it is necessary to develop a historically informed comparative macro-sociological account. Such an account would enable not only an understanding of the role and status of mentally handicapped people and of why they are a stigmatized group, but also why the medical and psychological models, inadequate as they are, have dominated the field and so profoundly influenced official, professional, community and individual attitudes, reactions and behaviour towards mentally handicapped people. However, I also intend to argue that a macro-sociological account is by itself inadequate and that in order to develop a _social_ theory of mental handicap we require not only a micro-sociological input, but also insights from the other social science disciplines including psychology.

In this chapter, then, I intend to integrate the earlier chapters and to develop a theoretical perspective which overcomes the weaknesses of the existing one. In chapter 2 I critically discussed the existing sociological contribution, pointing out both its strengths and its inadequacies, while in chapter 3 I examined the dominant psychological and biological/medical models and their inadequacies. Chapters 4, 5 and 6 demonstrated the contribution which history can add to an understanding of how current institutions came about. In this chapter I want to talk about what is required of a sociology and social theory of mental handicap - indeed for social policy

issues as a whole. I will also point to the importance
of micro-sociological perspectives as one side of a
social theory -   which, however, need to be grounded
in a historical and macro-sociological account.

The chapter deals with the inadequacies of individual-
istic explanations in general and the dominant psychological/
biological/medical models in particular.   This will be
followed by an examination of the contrasting perspectives
in existing sociology and the directions in which
sociological perspectives may be developed further.
Finally I will discuss the requirements of a social theory.
In the process the discussion extends beyond the confines
of mental handicap into what is required of a social
explanation and into the sociology of knowledge - that is,
the interaction of economics, societal institutions,
social policy and 'science' - of which mental handicap is
just a case-study.

2. Medical and Psychological Perspectives on Mental Handicap

Medical and psychological involvement in mental handi-
cap exists at two inter-related levels - the aetiology of
the condition and the diagnosis of the condition. Mental
handicap is seen as due to biological/genetic/environmental
factors, and it is argued that some cases it can be diagnosed
by clinical methods, at or soon after birth (for example by
blood tests in the case of phenylketonuria), in early
childhood (for example by medical examination in the case of
brain damage), or during schooling by psychometric tests
(usually in cases of mild retardation where there is no
apparent underlying biological condition).

In this section I intend to discuss both levels and
suggest why, as they stand, they provide an inadequate
foundation for a fully social theory of mental handicap,
in that they concentrate on the individual and his 'condition'
and tend to ignore the social aspects, including the vital
factor that diagnosis and labelling are themselves social
processes.

2.1 The Inadequacies of Individualistic Explanations.

The major assumption underlying both the medical and the psychological model is that the 'cause' of mental handicap is inherent in the individual – that it is an attribute of the individual and exists whether or not it has been diagnosed and the individual labelled. Consequently mental handicap is seen as a result of biological/genetic factors inherent in the individual or as a result of early environmental deprivation. (Most specialists in the field now agree that a theory of multiple genetic causation cannot explain all I.Q. differences between individuals). The individual is viewed as a machine determined either by biology/genetics (programmed hardware) or early environment (programmed software) or both. In this model little weight is given to immediate environment (input) and none at all to any notion of the individual interacting consciously with his environment. (Even those psychologists who have been critical of the dominant medical and psychological models have in the main only argued for more emphasis on 'input'; this tends to upgrade mentally handicapped people from machines (incapable of experiencing suffering) to animals (capable of experiencing suffering), but it does not raise them to the status of human beings capable of acting on and reacting to their social and physical world).

Individualistic explanations focus on the individual and ignore the wider social context; they do not ask how, why and by whom individuals are selected out and labelled as intellectually (and by implication socially) incompetent. Nor do they ask what mental handicap means to those involved in the diagnostic and labelling process, including the individual himself, his family, his neighbours, the members of the community in which he lives and the professionals who diagnose his condition and decide on how he shall subsequently be handled. Individuals are labelled in a social system and this factor must be recognised; accounts of mental handicap that ignore the

social, political, economic and historical context are
inadequate as they stand (as indeed are those that simply
blame labelling agencies - biological and sociological
reductionism are both inadequate).

We must accept that mental handicap does exist,
if by this we mean a condition which leads individuals to
have difficulties in coping with day-to-day living in a
given society because of limited intellectual functioning.
(We may question, however, what 'cut-off' points are
critical and to what extent society 'creates' many of the
problems encountered by those with limited intellectual
abilities). However, seeking possible 'causes' and pre-
dicting the consequences of this limited ability is more
complex than the existing individualistic emphasis suggests.
Many people in the 'normal' population have a biological/
genetic abnormality which would be 'blamed' as the cause
if they were to be diagnosed as intellectually incompetent.
(The fact that they have not been so diagnosed suggests
that they are competent to stay out of the hands of the
diagnosticians). Conversely, assumptions are made that
individuals are mentally subnormal because there are
obvious signs of C.N.S. damage. This can result in
individuals being classified and handled as if they were
mentally handicapped, when in terms of potential intellectual
functioning they fall within the normal range. Furthermore,
when individuals have the same biological/genetic condition
which invariably 'causes' mental subnormality (for example
Downs' Syndrome) they can vary widely in potential for
intellectual and social devleopment - a fact that is often
totally ignored within the individualistic framework.

The continued search for causes, even when these
are seen as outside the individual in origin, still focuses
attention on the individual. It is now argued by some
workers in the field that the notion that mild subnormality
is 'caused' by a combination of the inheritance of 'poor'
genes and an inadequate environment (however that might be
measured) is a mistaked one. Ryan[2] has maintained that

C.N.S. damage is likely to be the 'cause' of most cases
of mild mental subnormality. (Indeed, in the U.S.S.R.
for an individual to be classified as mentally subnormal
C.N.S. damage must be diagnosed - although it is difficult
to establish this conclusively). In support of this view
research has indicated that mothers of mildly subnormal
children (almost entirely working class) have a signifi-
cantly higher level of obstetric complications than
would be expected by chance. These children also have
low birth-weights (an indication of a poor environment
during gestation).[3] These two factors indicate that the
'cause' of the subnormality is probably minimal C.N.S.
damage rather than a 'poor' environment and inadequate
early socialization in infancy and childhood. It has
also been pointed out that environmental factorssuch as
inadequate diet in infancy, poor standard of child-care
and lead pollution can cause minimal brain damage.[4]
It is then argued that mild subnormality in many cases, if
not the vast majority, is due to minimal brain damage, and
that this explanation accounts, as well as do the eugenicist
or environmentalist ones, for the observed class distribution
of handicap. Furthermore, the 'blame' is no longer put
on the parents but on medical/environmental *causes which*
could have been avoided by society.

To the extent then that discovering the 'causes'
of subnormality can help to solve the problem, if it is the
case that mild subnormality is the result of minimal brain
damage, a step forward has been made. It is possible to
prevent, to a large extent, birth injuries, to ensure
that expectant mothers and babies are adequately nourished
and that lead is taken out of petrol; the extent to
which this happens does depend, nevertheless, on economic,
social and political factors. (However, we still need
to note that the distinction between what is and what is
not subnormal functioning is arbitrarily and socially
constructed and that if there is a functional need for
an under-class or surplus population then the arbitary
cut-off point can always be raised. As Haldane suggested

as long ago as 1938, any increase in the numbers of
people being classified as mentally handicapped is more
likely to result from greater difficulties in finding
appropriate employment for all those seeking it than
from a decline in general intelligence;   to this extent
mental handicap is more of a social than a biological
problem).[5]

Our attention has therefore been directed not only
to possible environmental causes, but also to the fact
that social, political and economic factors may be
important.   The evidence from epidemiological studies
demonstrates that it is extremely rarely that a child
from a higher social class has an I.Q. below 80 unless he
has one of the recognised pathological syndromes.
Consequently almost all mildly subnormal children come
from the sector of the population who tend, for whatever
reasons, to receive inadequate medical care and to live
in poor inner-city areas with their lack of open spaces,
inadequate housing and generally inadequate facilities.
Ill-health, including mild subnormality, at least in
capitalist societies, broadly follows the distribution of
income, and income is the major determinant of the distri-
bution of housing and medical care facilities.   Furthermore,
an individual's quality of life is profoundly influenced
by access to goods and services, both publicly and privately
provided.[6] To the extent that mild subnormality is due
to societally created inequalities and inequalities of
access to financial rewards and publicly provided goods
and services, then action can be taken to reduce the numbers
of mildly subnormal people.

However, while our attention has been directed to
socially created inequalities and the need to examine
social, political and economic factors, the focus of
attention is still on the individual and the 'causes' of
his statistical abnormalities.   The focus is still on the
causes of low intelligence rather than directing attention
to the genesis, structuring and functions of the mental

handicap role.   It leaves open the possibility that if low
intelligence could be prevented then other people would
have to fill the role and occupy the status currently
occupied by mentally handicapped people.

2.2   The Social Functions of Medical and Psychometric models

The two models of mental handicap, with their individ-
ualistic assumptions, are not just theoretical;   they
were developed for and continue to be used for a social
purpose - to diagnose individuals who are mentally handi-
capped.   Indeed, educational psychologists spend most of
their time (and are under pressure from employers to
spend even more time) on assessment and related administrative
work, and clinical psychologists in subnormality hospitals
spend a considerable part of their time assessing patients.

As I argued in chapter 3 these two models - the medical
model defining disease in terms of biological symptoms and
the psychometric defining abnormality in terms of statistical
variations - claim to be impartial arbiters of what is
and what is not 'abnormal'.   The claim is that diagnosis
is based on scientific measurement - clinical diagnosis
and psychometric, especially intelligence, tests.
These two models have traditionally been used to diagnose
mental subnormality, the medical model in cases of severe
subnormality and the psychometric in cases of mild sub-
normality   (although as I have previously indicated,
the latter model is frequently used to confirm clinical
diagnosis and to assist in the process of determining
methods of handling).

However, diagnosis is a first step.   Once an individual
is ascertained as mentally handicapped then decisions
have to be made about future career - both in terms of
future placement, others' perceptions of him and indeed
his own perception of self.   Thus diagnostic decisions
made by doctors and psychologists have a considerable
influence on the individual's future, because he is
assigned to a category and has conferred upon him a role

which in our society carries with it a stigma and a diminished status. (Indeed, as I have pointed out in chapter 7, it is not only the individual but his family as well that becomes stigmatized). Doctors and psychometricians, as scientists, are absolved from responsibility for the consequences that follow on diagnosis, because of the claim that the tools used in the process are scientific and that they are objective arbiters of what is 'normal' and 'subnormal'. Apart from the fact that research has demonstrated that the diagnostic tools (especially intelligence tests) frequently employed are culturally and class biased, resulting in the mislabelling of individuals, it is one role of the sociologist to point out the social and moral consequences of labelling of individuals.

Firstly, it is important to remember that people do not belong to a category until they are placed in one, and that the diagnostician determines his own definitions and sets his own limits for his categories. The model is constructed by the definer, and this model determines not only what he perceives but also the types of questions he will ask of the empirical world. The scientist does not produce a model independently of the purpose for which it is to be used, and he constructs it within a constraining set of circumstances, including social, political and moral ones.

Secondly, by focussing attention on the individual and his assumed pathology there is a strong tendency for the fact that mental handicap is in an important sense socially created to become obscured. We tend to forget that our adjectives come from comparisons - that is they express relative not absolute states - and therefore that 'abnormality' includes many elements of social judgement. This is especially important when the diagnosis and classification is based primarily or exclusively on the results of intelligence tests, where arbitrary cut-off points are used to determine if an individual is or is not

mentally subnormal.   However, it also applies when other
factors are considered.   Children are frequently referred
to psychologists for assessment because they are 'not up
to standard for their age', because they are misbehaving
in school or because they are seen as abnormal in other
ways.   (Coard has described how West Indian children
are mislabelled in the English education system as E.S.N.)[8].
Even in the case of biological abnormality, social
judgement plays a part in classification.   Down's Syndrome
children are almost invariably classified as ineducable
and committed to E.S.N.(S) schools despite the available
evidence pointing to the fact that some could benefit
from being educated in an E.S.N.(M) school.

Thirdly, psychologists and doctors tend to ignore
their role in the process.   While they think of them-
selves as professionals, as neutral arbiters of the facts,
they are employed and paid for a purpose - to screen out
the mentally retarded - although it could be argued that
Educational Psychologists should act, as Binet originally
intended intelligence tests to be used, so as to prevent
children who do not have a low I.Q. being labelled as
subnormal and sent to special schools.   (We do in fact
know that this is not the case and that children do get
sent to these schools with I.Qs above 70, although 70
is the generally accepted cut-off point in theory).

Finally the sociologist, by emancipating himself
from a medical model of biological events and a psycho-
metric model of statistical distribution, can evaluate
these models as just two among a number of ways of
describing mental handicap, in the light of the social
ideologies underlying them.   By adopting this stance it
is possible to secure the ground on which to assess the
social implications of mental handicap diagnostic processes -
and indeed practices and services.   I pointed out in
chapter 3, however, that psychologists are also not
totally unaware of the criticisms I have made of the
medical and psychometric models - especially the criticisms

of the racial and cultural biases of intelligence tests
and the apparent inability of professionals working in
the field to develop programmes of remedial help.
Nonetheless, psychologists still retain an individualistic
stance even when they place more emphasis on the immediate
environment and developing potential. The interesting
question for the sociologist is why the available
alternative approaches have not been taken up and used
more widely when it has been demonstrated that they
enable the mentally handicapped to develop to levels
beyond what was previ usly th u ht possible (alth ugh it is correct
to say that Piaget's work has influenced educational practice , and
behavi ur modification has become more widely used in training/
teaching the mentally handicapped and in the training of nursing
staff, teachers and parents in the use of the advocated techniques).
As I have also argued (see below), the approach to the mentally
handicapped used in the U.S.S.R. and based on the work of
Russian psychologists such as Luria and Vygotsky has
resulted in radically different methods (in theory at
least) of assessing and handling mildly subnormal children.
I would suggest that the major reason is that the medical
and psychometric models as they are currently used serve
a particular purpose - they screen out a population who
are seen as of little value in our society - and as I
have argued in chapter 6, any changes that would involve
additional expenditure are unlikely to find *favour with*
decision-makers.

2.3   The Need for Sociology

    I have already *indicated that* my criticisms of the
current psychological perspectives on mental handicap are
that they are inadequate as they stand. The dominant
psychometric model has been severely criticised from
within the ranks of psychologists as well as from outside.
I am not suggesting that psychology cannot contribute to
an understanding of mental handicap as a social phenomenon
and consequently to a social theory. ' Indeed, I would
argue that psychologists have already made valuable
contributions - they have demonstrated that social per-
spectives of the mentally handicapped and the way that they
are handled profoundly influence cognitive, linguistic and
social development as well as self-image and individual

understandings of the world in which they live.[9]
My contention is that in order to develop a social theory
of mental handicap it is also necessary to develop a
sociological perspective, and furthermore to incorporate
insights from other social science disciplines.

.   This raises the issue of the relationship between
psychology and sociology, because I am not suggesting
that sociology can provide an adequate explanation when
psychology cannot.   Indeed, if I were to do so I would
fall into the trap of arguing for sociological reductionism.
But if psychology and sociology are not necessarily
antagonistic, are they necessarily complementary?
Do they examine and explain at different levels of social
reality - the individual and the social?   Traditionally
psychology has tended not to take account of the realities
of the social situation (although humanistic psychology
has begun to stress the need to take into account the
way that individuals understand their social situation
and in terms of methodology (ethnographic) and focus of
intent it is coming very close to micro-sociology).
Thus one of the common responses to this question is to
suggest a division of labour between the two disciplines,
each concentrating on different aspects of the problem.
Clarke and Clarke[10] have suggested, specifically with
reference to the field of mental handicap, that psychology
should be concerned with normative questions (diagnosis,
classification and treatment) while sociology should
examine technical questions (research into alternative forms
of care).   Even if we accept this as a viable proposal
it raises a number of problems because psychologists would
be working within the assumed consensus that sociologists
were in the process of questioning and this is likely to
create conflict because the sociological research is likely
to uncover and challenge the popular assumptions and
hidden arguments upon which current psychological practices
are based.   Furthermore, while the majority of psychologists
continue to argue for a positivistic methodology and the
importance of controlled experimentation, they are likely

to question the status of sociological research findings which are not based on such methodological assumptions.

The opposite view is that the differences between psychology and sociology are not merely ones of level of analysis and methodology, but that the division reflects the dominant values of society - it is an ideological division. The opposition between psychology and sociology is seen as the result of a society that stresses individualism and perpetuates the divergence between the individual and society. This divergence represents the social reality of our society and it also results in the social sciences fragmenting into specialist areas within which any attempt to understand and know the totality is abandoned. This has led some Marxist critics[11] of the social sciences to argue that they are part of bourgeois ideology, a form of mystification that helps to obscure rather than understand or explain social reality, because they cannot, as separate disciplines, grasp the totality, but merely reflect bourgeois categories of knowledge.

This criticism has some validity because it is aimed at the attempts of academics to maintain disciplinary boundaries intact in an effort to protect the purity of their disciplines. Nevertheless, different disciplines do ask different questions, the answers to which can all contribute to the understanding of social phenomena and the development of social theory. However, as I have already indicated, I do not propose to approach the ambitious path of developing a total explanation of mental handicap, but merely to demonstrate the contribution that sociology can make to our understanding of mental handicap as a social phenomenon, without committing the falacy of sociological reductionism - for we, as C.W. Mills[12] has stressed

> Do know that many personal troubles cannot be solved
> merely as troubles but must be understood in terms
> of public issues - and in terms of the problem of
> history making. Know that the human meaning of
> public issues must be revealed by relating them to

personal troubles and to the problems of the
individual life. Know that the problems of social
science, when adequately formulated, must include
both troubles and issues, both biography and
history, and the range of their intricate relations.

3.   The Development of a Sociological Perspective

'

In this section and the next one I intend firstly to
review the existing contribution made by sociology to
our understanding of mental handicap, then to suggest
what is required in a sociology of mental handicap, and
then to integrate the historical analysis developed in
Chapters 4, 5 and 6 into a more general sociological
account of mental handicap.   In Chapter 2 I reviewed the
existing sociological literature on mental handicap and
suggested why it was inadequate, arguing that it is
necessary to develop a historically informed macro-sociological
account within which micro-sociological analysis has an
important role to play.

3.1   The labelling and surplus population approaches

As I indicated in Chapter 2, sociologists have
developed two approaches to mental handicap outside of
the clinical framew rk. They have tended, however, to take over
and use uncritical1y the categorisations of mentally handicapped
people develoned by clinicians and used for administrative
rurposes - particularly the 'belief' that the mentally handicapped
can usefully be divided into two or three relatively homogeneous
and indenendent categ ries defined by intelligence/social function-
ing (alth ugh even here they may question the 'cause' of the
'low intelligence' implied in the clinical/nsychometric approaches).
At the micro-lrvel, s ciologists have begun to develop a labelling
ners ective on mental handicap[13], although much of this research
has focus ed on the mildly handicanped. At the macro-level, Farber[14]
has developed a functionalist perspective that locates
the mentally handicapped as part of the 'surplus' or
'marginal' population in advanced indus trial societies.

The micro-sociological work has tended to concentrate
on the role of the school as a screening and labelling
agency[15], and the role of stigma in the lives of mentally
handicapped people[16], although Booth[17] has examined the ways

in which parents, through interacting with their child,
build up an understanding of what mental handicap means.
This research, heavily influenced by symbolic interactionism,
has directed attention to the process of labelling individuals
as incompetent and given insight into what it means for the
individual (and indeed for his family) when he is labelled
as different - as incompetent.   It has also stressed the
relative nature of what is seen as mental handicap
(incompetence) both historically and culturally.
In particular Mercer[18] has highlighted the problem of mis-
labelling - children being categorised as retarded because
they do not conform to the culturally normative expectations
of the school system.

   The inadequacies of this perspective were also discussed,
and the ahistorical approach with its lack of attention
to power and social structure was seen as inadequate to
form the basis for a sociological perspective on mental
subnormality.   Thus the approach directed our attention
away from an endless search for the 'causes' of mental
handicap (physiological, biological, genetic or environmental)
and stressed the importance of understanding the process
by which individuals became labelled as retarded and handled
as outsiders (deviants).   However, in this perspective the
mentally handicapped (or at least the mildly handicapped)
are regarded as part of the 'underdog' population - a group
who are created by society - so we "get the impression that
people go about minding their own business and then bad
society comes along and slaps them with a stigmatizing label."[19]
This position, then, commits the fallicy of sociological
reductionism - mild subnormality is thought to be adequately
explained sociologically.   In rejecting the psychological
model it switches the 'blame' from genetic/biological/
environmental causes to the social labellers (teachers,
psychologists, doctors) and the normative expectations of
the school.   Finally it does not adequately explore the
historical and cultural context within which the action
takes place, nor the official position of the labellers,
including their role and status and the origin of their power.

   An alternative sociological approach to the labelling
perspective is to see the mentally handicapped as part
of the 'surplus' population - a group marginal to the

production needs of industrial societies. Farber[20] suggests
that such an approach overcomes the normative and
evaluative implications of regarding retarded *people*
as deviants and enables an understanding of the role and
status of mentally handicapped people in such societies.
He argues that the 'surplus' population (which comprises
the old, the sick and the poor as well as the mentally
handicapped) is functional to the maintenance of industrial
societies, and is self-perpetuating - form ing a culture
of poverty passed on from one generation to the next.
(There is some confusion as to the status of the biological/
genetic mentally handicapped who may well be part of a
surplus population but who are not integral members of a
'culture of poverty').

Farber's approach is in some ways similar to the view
dominant in the early twentieth century, that the mildly
mentally handicapped were social degenerates - part of a
group who lived at the margins of society, were parasitic
on it and were seen as posing a 'threat' to its stability.
(This resulted in the advocacy of Eugenic solutions and
life-long segregation - ideas that are by no means dead[1] -
see Chapter 5). What differentiates Farber's approach
from this one is not his description of the marginal
population but his argument that it is an inevitable and
functional feature of industrial society - functional
because a surplus labour force encourages competition
and rational efficiency, and the care of marginal groups
provides occupational roles. This approach attempts to
locate and explain the role and status of mentally handi-
capped people. Their marginal status and peripheral role
account for why they are stigmatized and tend to come low
on any priority list for public spending. Farber's
analysis parallels the Marxist argument that capitalist
societies need an underclass or reserve labour force who
are 'prepared' to take on the dirty unpleasant jobs that
nobody else wants and can easily be made 'redundant' when
their labour is not required. However, his analysis is
different in that he 'blames' the perpetuation of this

stratum on the 'culture of poverty' (socialization)
whereas Marxists argue that it is perpetuated by the
power of the ruling class and the dominant ideology in
capitalist societies.

The two theoretical positions outlined above have
not stimulated sociological research in the field of
mental handicap. This is despite the fact that the
symbolic interactionist approach has resulted in the
growth of sociological interest in other marginal/deviant
groups where previously a medical/psychological model
dominated (for example, alcoholism, mental illness and
sexual deviations). It is difficult to determine why
this is the case - although it is true that the mentally
handicapped provide research subjects that are difficult
to work with, although not necessarily more so than the
mentally ill. It could be that sociologists are
influenced by the dominant image of the retarded as a
'lost cause' or because they cannot be glorified like the
mentally ill, reformed like the alcoholic, or 'cured'
like the sick; neither can they be easily seen as
unfortunate victims like some other groups of disabled
people. Furthermore, mental handicap appears not to be
a central concern in the lives of most people (see
Chapter 7) and they are not usually thought of now as a
moral, economic or physical threat to themselves or society.

3.2 The deviancy approach and mental handicap

The dominance of a medical model of mental handicap
would tend to suggest that medical sociology (or the
sociology of health and illness, as it has more recently
become known, as sociologists in the area have attempted
to move outside of a clinical framework) should be able to
contribute to a sociology of mental handicap. Yet, as
I have indicated above and in Chapter 2, the main contri-
bution to date has been made by sociologists working within
a deviancy perspective. Interestingly, recent trends
in the sociology of health and illness have been heavily

influenced by labelling theory developed in the sociology of deviancy, and at the same time as sociologists have attempted to demedicalise conceptions of deviancy there has been a tendency to conceptualise the sick and disabled as deviants.[22]

. However, while sociologists working within a deviancy perspective researching in the area of mental handicap have concentrated on the school and psychologists as labelling agents, sociologists of health and illness have concerned themselves with medical personnel, especially doctors. The important factor that has been highlighted is the power of the doctor in diagnosing, making prognosis, and controlling treatment, especially in the case of severely and moderately handicapped people. The power and prestige of medical men is clearly demonstrated, as is their dominance over other health and welfare workers in a field where the scope for medical intervention is very limited.[23]

In the field of mental handicap sociological (and other) research has frequently taken for granted the power position of the doctor (and other professionals), his dominant role in the labelling process, and that his definition of the 'patient's' condition and prognosis shapes that of the parents.[24] Booth[25] has questioned this view and argues that the parents develop their own understanding of what mental handicap means in the process of interacting with their child. However, he does not develop this and suggest what implications it might have for the development of conflict between doctor and parents, although other sociologists have argued that the professional ideology of doctors together with their claim to be the sole arbiters of illness (mental handicap) can result in conflict.[26] Studies have suggested that in the case of the severely mentally handicapped, conflict between doctors and parents can arise as a result of faulty communication concerning the child's condition, development and prognosis. This conflict is unrelieved by the way in which parents are excluded from case conferences and discussions concerning their child (with whom they have closest contact and of

whom they take day-to-day care) because they are seen as
not having the 'appropriate expertise'.[27] At the micro-
level this research has pointed to the power of medical men
in defining and controlling the situation.   (At the macro-
social level sociologists have demonstrated how doctors
obtained this dominant position during the nineteenth
century; see Chapter 3 and section 4 below)[28]. Much of
the research carried out from within a deviancy perspective
parallels this research, in that it is informed by an
interactionist theoretical framework and examines the
labelling processes, but in this case the role and power
of teachers and psychologists, as representatives of the
school system, in labelling the mildly handicapped.

This deviancy perspective has probably, to date,
contributed most to the understanding of subnormality as
a social (and not just medical/biological) phenomenon, but
the notion that retarded people can or should be regarded
as deviants by sociologists has not gone unchallenged.
Edgerton, for example, has specifically rejected this
notion and argued that mildly retarded people are not
deviants because they do not consciously reject the
normative values of society and indeed they strive to
achieve normality - to be accpeted by 'normals' as normal.
In fact "their behaviour ... presents the very antithesis
of social deviance".[29] The controversy, then, centres
around two factors: the extent to which calling a group
deviants implies that we accept a negative image of them
and whether or not behaviour has to be motivated to be
regarded as deviant.   Sociologists who have examined
the role and status of the mentally handicapped from a
deviancy perspective aruge that while individual motivation
may be a relevant factor, so is how behaviour is perceived
and interpreted by the audience - mental handicap can
then be seen (or at least the observable behaviour of
mentally handicapped people) as a form of deviancy in the
same way as mental illness, alcoholism and disability are
- unmotivated deviancy.   (Although we might ask to what

extent at least some mentally handicapped people are able
consciously to act in certain deviant ways in order to
obtain help and support from others – Edgerton's own [30]
research material suggests that this is a possibility).
Like other forms of behaviour that are seen as deviant,
mentally handicapped people's behaviour often violates
normative expectations and is often thought to require
the attention of agents of social control (official or
unofficial). Labelled individuals have a diminished,
stigmatizing, status and sociologists (and others) cannot
ignore the fact that mental handicap constitutes one of the most
extreme possible forms of deviation from standards of behaviour
acceptable to the co munity (see Chapter 7).

As I have indicated above, interactionist sociologists
have made a major contribution to the small literature
on the sociology of mental handicap. This perspective
like the other 'New Deviancy Perspective' recognises
that deviancy does not arise unannounced, but has to be
identified, interpreted and subsequently fashioned,
and that reactions to deviant behaviour depend on the
tolerance level of the audience and the nature of beliefs
about deviancy in a community. It raises the questions of
'deviant to whom' and 'deviant from what' and when something
is said to present a social problem 'problematic to whom'.
When behaviour is said to be embarrassing, threatening or
dangerous it asks 'says who?' and 'why?'. The emphasis
is shifted from the individual and his assumed pathology,
and directed towards the society in which he lives and
especially the agents of social control. Interactionists
see the social order as a negotiated, emergent, interpretative
process in which individuals constantly confront each other
and construct their own worlds. Three exhortations arise
from this: to look at the processes involved in daily life;
to look at the meanings and symbols that evolve in any
situation; and always to view individuals as being in
interaction with others who play an important part in

shaping any encounter.   As utilized in studying deviant
behaviour it suggests: looking at deviancy as a category
which is relative to individual interpretations and
inquiring into the manner in which deviants and agents
of social control actually perceive themselves and the
world around them; moving away from the picture of the
deviant as possessing a static 'condition' and focussing
instead on the process of becoming deviant in terms of
labelling; studying the day-to-day existence of deviants;
and studying the role of reaction in shaping deviancy,
both informal and formal, publicand private.   It is not
the individual characteristics of deviants which are seen
as crucial, but the ways in which individuals/groups come
to be labelled as outsiders and handled as deviants.
The value of this approach in studying mental handicap is
that attention is not focussed on causes of behaviour
and individual pathology, but on the ways in which
individuals are selected, labelled and subsequently handled,
and the ways in which this shapes an individual's self-
perception and his future career.   In the field of mental
handicap the main empirical study is Mercer's[31] (see above
and Chapter 2) analysis of the labelling of children in
the American school system as mildly retarded.   However,
while she examines in detail the process by which children
are selected and labelled, and indicates the institutional
consequences of this process, she assumes rather than
demonstrates that being labelled retarded influences a
child's perception of self and results in a negative
self image.   (Dexter[32] does the same - but there is research
which does demonstrate that being labelled and handled as
subnormal creates a negative self image[33])

   This perspective provided an important departure in
deviancy theory, but it has been widely criticised.
In its defence, it has been pointed out that labelling
can only be understood when it is placed in a theoretical
framework which gives insights into the social processes
involved - that is, when it is placed within the larger
context of social organization and social control.

Lemert's distinction between primary and secondary deviation suggests that individuals can avoid being labelled, reject the label (Edgerton)[35] or be labelled for only part of the day (Mercer)[36]. Factors such as social class, ethnic group, family organization and behaviour can influence whether or not someone is labelled (Stein and Susser,[37] ʌ rcer)[38], and different social agencies are concerned with labelling different groups of subnormals (Mercer)[38]. Finally, labels are only a first stage; understanding what the label means is an emergent process that develops in the process of social interaction (Booth). The fruitfulness of this perspective is then that it is dynamic; it examines the process of labelling and the labellers as well as the labelled.

There are, however, a number of inadequacies and weaknesses in the approach, despite its obvious advantages over previ us a rroaches. It has been criticised for not being able to deal with t e 'causes' of deviance, although Plummer[39] has argued that this is criticising a theory for what it never intended t do. However, some labellin theorists imply that s ciety is the 'cause' of the deviant condition/behaviour. Mercer and Dexter, for example, annear to be saying that the school 'causes' mild mental handicap. While it does direct attention away from the determining constrainᵼs of biological, psychological and social forces, this sᴊg estion introduces the new determinant of social reacti n. Mild mental handicap is said t exist only in the dialogue of f rms; it does not enj y ᴐn ansolute or auton mous existence. It is i p rtant t realise that social exᴐectations do to some extent determine what is or is not an adequate level of functi nin , but it is equally vital to be alert to the possibility that this level of functioning may be 'caused' by factors other than the symb lic internalization of others' evaluations and social labelling (see section 2 above). Furthermore, by accenting the c inical/psychological system of classification into mildly and severely handicapped these theorists tend to reinforce the belief that scientific theories and systems of fact can account for and exᴐlain distinctions between people. Also, by conducting research and formulating theory on the notions of the differences between nreconceived categories and by trying to exnlain these differences

rather than pointing to the range within populations and overlapping categories they have done much to reify the c-tegories. (This is . equally true of most other sociological research in the field of mental handicap.)

Furthermore, the labelling approach remains subjective and voluntaristic. It lacks an awareness of history, and ultimately it lacks a critical position towards society, despite its apparent radicalism, because it

> fails to see that men – superiors as well as subordinates – may be powerfully constrained by institutions, by history, and indeed by biology.[40]

Interactionists emphasise the deviant and the 'problem' he presents to himself and others, but not the society within which he emerges and operates. Furthermore, there is no consideration of why the label is stigmatizing, how stigmatizing labels developed historically, or their role in social control and their relationship to the distribution of power within a society. One of the inter-actionists' most valuable contributions is that they direct attention towards agents of social control and to the process of deviancy amplification, but labelling theory and deviancy amplification are not synonymous.[41] Labelling is tied to symbolic interactionism with its insistence on the symbolic component and the ways in which societal reactions result in an increase in deviance, and to a symbolic re-ordering of self and the world. By not questioning the historical development of societal conceptions of mental handicap, or the values inherent in categorizing people as mentally handicapped, the interactionists have merely criticised school officials, doctors and other professional labellers. Thus they criticise the middle level of power without questioning societal values. Consequently they do not question why individuals are labelled as mentally handicapped, the functions of labelling some children as 'school failures' and the reasons for labelling some individuals as 'outsiders' or 'misfits'. In order to do this it is necessary to examine the ways in which deviant values are inextricably linked with social structure – that is, it is necessary to develop

a two-fold understanding of the social system to encompass
both the way it officially comprehends itself, and its
nature as it objectively exists.   Questions need to be
asked about how and why we see the world in a particuar way
and what shapes our view of reality in a class society,
with its unequal distribution of resources and power.
Interactionists share with other deviancy theorists

> ... a common flaw - they attempt to understand
> deviance apart from historically specific forms
> of political and economic organization. 42

A more fruitful approach may be that developed by structural
Marxists as an attempt to overcome the deficiencies
(outlined above) in the interactionist approach.   This
approach stresses the need to understand deviance
production as a process which involves the development
of and changes in deviant categories and images, and to
examine where these images and categories came from, and
what they reflect about the structure of priorities in
given societies.   In terms of understanding how mental
handicap became deviance, and the mildly subnormal deviant
it is necessary to examine the structural, economic and
political dimensions of the society in which these definitions
and images emerged and developed, to understand how certain
correlates of industrial/capitalist development weakened

traditional methods of coping with the mentally handicapped
and how the emergence of scientific and meritocratic
ideologies sanctioned intellectual stratification and
differential handling, and how the contraction of unskilled
jobs increased concern over the danger that the feeble-
minded were assumed to represent.   (See Chapters 4 and 5,
and section 4 below)42a

One structuralist approach that has been developed
explicitly to understand the role and status of the
mentally handicapped in industrial society is the function-
alist one (see Chapter 2 and above). Farber43 explicitly
rejects the view that the mentally handicapped are deviant
and argues that they are better regarded as incompetent
and part of the surplus population. (However, it is possible
to argue that the marginal surplus population is deviant
in that they do not participate in the major institutions

of society and consequently deviate from the norm).
This argument can be seen to parallel the Marxist argument
that capitalist societies need a surplus or reserve labour
force, to help keep the level of wages down and to provide
a group of workers who can be brought into production
and forced out as need fluctuates. Farber argues that this
surplus is an inevitable and functional feature of industrial
society, and that its members are part of a sub-cultural
group whose continued existence results from the internal
pathology of the group, but Marxists regard the problem as
arising from the social divisions necessary to maintain an
economic system based on private profit and located in the
relationship between the working class and the political
and economic structure. Integral to both these arguments
is the notion that the 'reserve' or 'surplus' population
could fill occupational slots, if sufficient jobs were
available. To what extent all mentally handicapped people
could fill occupational slots, even in routine manual work,
is debatable - some multiply handicapped severely subnormal
people obviously could not. However, as Haldane[44] suggested
as long ago as 1938, in a society offering employment for all,

slots would be found for many now considered incapable
of employment because of mental handicap. Research
in this country has demonstrated that even moderately
handicapped people can adequately perform routine manual
jobs in open employment.[45]

An interesting line of development in the area of
mis-labelling and the labelling of children from minority
groups and the lower working class as educationally
subnormal as a result of apparent school failure has been
made by Coard,[46] with special reference to West Indian
children in the English educational system. He argues,
using as a basis the statistics of the Inner London
Education Authority, that a large number of children from
West Indian homes are wrongly placed in E.S.N. (M) schools.
This is a result of the prejudices of (white) school teachers
and bias in assessment, especially resulting from the use
of I.Q. tests. (See Chapter 3). He argues that this
heightens the negative self-image that black children

already have as a result of living in a white society.
The mis-labelling of immigrant black children is
inextricably linked to the role that immigrants play in
British society,   (sociologists have arrived at a similar
conclusion concerning the role of immigrant/migrant labour
in Western Europe)₄   providing a reserve labour force.
Çoard suggests that immigrants came to England after
World War II for two reasons, because of the lack of
employment opportunities in their own countries due to
colonial exploitation by the British ruling class in the
past and because British society needed the services of
West Indians and other immigrant workers as a 'surplus
labour force' to do the 'dirty' jobs that native workers
were no longer willing to do.   Immigrants, Coard suggests,
perform three main tasks: they increase the supply of
unskilled labour in relation to demand, which helps to keep
wages down and profits up;   they perform many of the menial
and unwanted jobs when otherwise there would be a labour
shortage;   as an underclass they divide the working class
and dampen militancy because native workers feel that
their jobs are endangered, but on the other hand enable
native workers to move one rung up the social status ladder
from the lowest position - the immigrants provide a group
for them to look down on.   From this analysis of the role
and status of immigrants Coard argues that if immigrant
children/the children of immigrants received equal
educational opportunities then there would no longer be
a pool of cheap, mobile labour, and this would pose a
threat to the existing social order.   We can, *therefore*,
understand why "so many of our black children are being
dumped in E.S.N. schools, secondary modern schools,
the lowest streams of the comprehensive schools ..."
It is possible to expand Coard's analysis to other deprived
and minority groups in our society and the ways in which
the educational system operates to reproduce the existing
relations of production and maintain the status quo.[47]
This analysis, then, adds to our understanding of why
so many apparently biologically normal children from the
lower working class and ethnic minority homes are labelled
as E.S.N. (M).   (It is interesting to compare the ways

in which children are selected and labelled as E.S.N. in
Britain and the United States with the U.S.S.R. - see
section 5 below). It also ties in with criticisms of the
cultural biases of I.Q. tests (see chapter 2) and the way
in which the feebleminded came to be seen as a dangerous
group, a threat to civilization in the late nineteenth
and early twentieth centuries (see Chapter 5) -
the perception of the mentally handicapped developed at
that time still influences 'popular' attitudes, reactions
and behaviour to the mentally handicapped in our society
(see Chapter 7). C ard's analysis points to one fruitful line of
research that could be developed.

3.3 Requirements in a sociology of mental handicap

The main theoretical position of sociologists who
have attempted to study mental handicap, outside of the
clinical model, has been interactionist and the general
tendency has been to conceptualise mental handicap as a
form of deviancy. However, as I have indicated, the
dominant medical model of mental handicap and the power
that medical men have over the lives of mentally handicapped
people have suggested to some sociologists that a medical-
sociological framework is more appropriate; Dexter,[48] for
example, has argued that what is needed is a clinical
sociology of mental handicap. Conversely Farber,[49] within
a structural-functionalist perspective, has attempted to
analyse the role and status of the mentally handicapped by
locating them as part of the surplus population.
Sociologists working within all these perspectives/frameworks
have been concerned to understand mental handicap as a
social phenomenon, The final area of sociological concern
is the study of social policy provision for the mentally
handicapped - especially evaluating the adequacies of
existing provision.

All the research has contributed to our understanding.
Social policy research has demonstrated the inadequacies
of the existing provision in our society, although it has
tended not to question the overall framework of provision
but to examine what type of care is most appropriate within
the existing services (see Chapter 6). The interactionist
and marginal population approaches have demonstrated that

sociology can make a valuable contribution to an under-
standing of mental handicap. (See above for a critical
evaluation of these theories). The existing literature
has provided a greater insight into mental subnormality as
a social phenomenon and raised a number of interesting
and perceptive questions – including whether the mentally
handicapped can be viewed as deviants.

However, an evaluation of the sociological contribution
to date suggests that it is inadequate because of the
theoretical perspectives that inform the researchers.
Sociologists like other social scientists are concerned
with understanding and explaining social processes,
with answering how and why questions. The 'facts' that
are collected to enable answers to these questions to be
given do not 'speak for themselves'. The 'facts' have
to be structured so that they make a point, tell a coherent
story – the theories that are constructed by social
scientists are intended to do this. Although the facts
do provide constraints on theories, there is an under-
determination of theory by facts – an analysis of the facts
cannot, therefore, conclusively prove, or for that matter
disprove, a theory. I have argued that both the psycho-
logical and sociological theories developed to date are
inadequate – they either do not take adequate account of
all the relevant factors or their theoretical interpretation
is inadequate. My main criticism is not that they have
got the facts wrong, but that their interpretation/theoretical
construction is inadequate – I am criticising theories from
within a particular theoretical perspective.

Indeed within sociology (and this is equally true of
all the social sciences) there are a number of competing
paradigms or perspectives, the main divisions being
those between conflict anu consensus, and micro- and
macro-sociological theories. While some sociologists
have suggested that these are not so much antagonistic
perspectives as opposite sides of the same coin, I would
suggest that they do represent real differences,

However, a theory that can explain conflict as well as consensus and micro- as well as macro-social processes would seem to be necessary. This is not t argue for a synthesis of the competing theoretical views - such an attempt w ild be arrogant a..d probably frritless. Any attempt at fitting all the elements from the different schools int) a theoretically neat framework would result in its proponent becoming increasingly distanced from the very social reality he or she attempts to underrtand. What I want to stress is the need for a structural analysis that takes cognizance f the role of conscious- ness and agency in social and historical development and conrequently pf ur c pacit as ocial act rs to underst nd and criticise our s cial environment. W ile accepting the importance of agency it is necessary to realise that we are b rn int a society which already exists and whic has a re r less agreed distribution of roles and funct ns and in w ch the basic institutional arranrements re fixed.

While 1 d not nte d t discuss these hilosophical/ tle retical nr blems in detail, it is ercential to noint out that srcsology is in a state f 'con tant revolution', and that while abstract theoretical w rk in sociolory is divided into conoeting

paradigms, each arguing for a particular way of under-
standing society, most sociologists get on with empirical
studies of social phenomena. Nevertheless, whether
stated or left unstated all sociologists work within a
paradigm that not only structures the questions they ask,
but the conclusions they arrive at. The sociologist is
not a neutral and value-free observer, and research
findings are not undisputed 'facts' but interpreted accounts
of reality. Thus as Hindness has argued (with reference
to official statistics, but by inference to all factual
evidence), the use

> ... of social statistics for scientific purposes
> is always and necessarily a theoretical exercise
> and further that different theoretical problematics
> must produce different and sometimes contradictory
> evaluations of any given set of statistics.
> The evaluation of social statistics is never reducible
> to a purely technical evaluation. [50]

Sociologists working from within different theoretical
paradigms approach their research in different ways, use
different research methodologies and evaluate/interpret

the results within the theoretical constraints of that
paradigm. Research/analysis is not necessarily rejected
or accepted because it has been carried out within a
particular paradigm, but it is evaluated by sociologists
working from within different theoretical perspectives:
that is, research/analysis is criticised on the basis of
its theoretical underpinnings as well as its technical
merit and conclusions.

Having pointed to the inadequacies of the existing
research on the basis of its theoretical underpinnings
it is necessary to state what an adequate theory would be
like. What is necessary is a level of analysis which is
able to address itself to all aspects of experiences which
control our existence as human beings,   an approach which
rejects the view that the problem oɪ mental handicap is
the personal property of a number of pathological
individuals and their patterns of behaviour, and which
instead argues that their patterns of behaviour must
be seen in relation to society and its structures, and
to the character of that society's reactions to that
behaviour. It is essential to take as a starting point
that all human activity is essentially social behaviour,
and that all human behaviour takes place *within a social*
context, with a certain social structure and organization.
Thus theory must be adequate at the synchronic and the
dynamic levels and must be a critical theory;

> ... one which attempts to account for the sufferings
> and felt needs of the actors in a social group by
> seeing them as the results of certain structural
> conflicts and hence giving a historical account
> in quasi-causal terms of the latent contradiction
> between the sorts of needs, wants and purposes which
> the social order gives rise to and the sort of
> (inadequate) satisfaction it provides. 5]

We eed, theref re, t develo a structural account to enable a
descri tion of micro- and macro-processes, includinɡ theoretical
and ideoloɡicɑl underninnings. Phenomena must be seen as wholes or
parts of wholes; the arts can only be understood within the whole,
and the vari us narts only have meanin when they can be seen together
as a whole. We need a historically and cross-culturally informed
macro-socioloɡical account to enable us to understand why and how
the mentally handicapped are handled in our society. We need to explore

when and why mentally handicapped people become labelled
as outsiders and managed as deviants. It is necessary
to develop a critical theory which attempts to understand
mental handicap within a specific form of political, economic
and social organization - an analysis which attempts to
establish the relationship between mental handicap, social
structure and social change. This will enable us to under-
stand better the process by which mental handicap is
subjectively conceived (see Chapter 7) and mentally handi-
capped people are objectively handled (see Chapter 6).

In Chapters 4, 5 and 6 I attempted to look at changes
in perceptions and handling of mentally handicapped people
from the earliest times to the present, but concentrating
on the change from pre-industrial through industrial to
advanced industrial society. In the next section I intend
to build on this and develop the type of analysis referred
to above and show how this provides a context and theoretical
paradigm which begins to enable us to understand how and
why current policies for handling mentally handicapped
people developed as well as their role and status in
modern Western societies.

4. The Importance of History in Sociological Approaches

4.1 Introduction

Ford has perceptively asked "Why does everything go
on as normal?"[52] This is an important question and leads
us to ask why so much sociological analysis assumes
that the current situation can be studied as it is without
considering how and why that situation developed.
We consequently forget the important fact that our
perceptions of normality are conditioned by the society
in which we live, and by that society's history:

> We must remember that the investigator, whether
> a biologist, an economist or a sociologist, is
> himself a part of history and that if he ever
> forgets that he is a part of history he will
> deceive his audience and himself.[53]

We also tend to ignore the fact that there are times when
'normal' patterns are thrown into disarray and chaos, and
at these times society undergoes qualitative changes.

That is, there are both crucial moments and whole periods
in history when institutions and 'normality' are fundamentally
altered.   We need, therefore, to understand conflict and
change as well as normality and consensus - the objective
structure as it has historically developed as well as the
way it is currently experienced, and the ways in which
the existing situation can be changed to meet perceived needs.
While it is true that there is interest in studying patterns
of handling and social perceptions of mentally handicapped
people as they currently exist, a historical (as indeed
would a cross-cultural) analysis enables us to put this
kind of survey in a wider context.   By focussing on a
particular socio-historical context we are struck by
the fact that definitions of mental handicap apparently
change according to economic and ideological circumstances.
Also a historical awareness guards against the impression
that features of mental handicap handling are either
entirely new, or conversely are much the same as ever.
(Chapters 4, 5 and 6 demonstrate this point).   As Rex $\frac{54}{}$
a leading exponent of the view that sociology must combine
a theoretical analysis with a historically grounded approach -
has argued, the sociologist must be steeped in the social
reality which he is studying, and particularly in its
history, in order to avoid sterile theorization as an end
in itself.   Not only must theory be constructed through
a sociology informed by history, but any analysis which
purports to contribute to a sociological understanding of
social policy must be made from within a historically
grounded sociology.

In undertaking an historical analysis of the ways
in which the mentally handicapped have been handled and
conceptualized at different times in the past, we can see
how practices have changed and relate these to changes in
socio-economic structure.   As Scott has pointed out
with reference to conceptions of stigma, it is

> ... the basic principle of sociology that a
> society's core values are deeply rooted in its
> economic system; they reflect the system, and they
> change in response to changes in it.   The core
> values of societies with one type of economic
> system will therefore be different from core
> values of societies with a different type of system.

> In view of the fact that experts' conceptions of
> stigma reflect a society's core values, we are
> led to expect that the meaning of stigma that
> experts construct will systematically vary
> according to the form of the society's economic system.[55]

In undertaking an analysis of conceptions of and
responses to mentally handicapped people in pre-industrial,
industrializing, and industrial society I have sought to
demonstrate that as the socio-economic structure of society
changes, so do responses to those seen as outsiders/deviants,
including the menta ly handicapped.That is, social and economic
changes influence our definitions of mental handicap, our methods
of handling and the ways in which these are modified and changed:
what society defines as mental handicap/incompetence and how it is
handled de ends on social and historical forces and is specific to
particular s cieties at particular stages of development. Furthermore,
I have suggested that conceptions in modern Western (industrial
capitalist) societies are to some extent determined by the
ideology of this form of society. This argument has to
some extent been validated by reference to contemporary
non-industrial and industrializing societies (see
especially Chapter 2) and by the fact that responses to
the mentally handicapped changed in all Western Societies
at about the same stage in terms of their socio-economic
development and are underpinned by the same philosophical
approach to care today (see Chapter 6). However, to .
that it is capitalism and not industrialization that
shapes responses to the mentally handicapped it would be
necessary to demonstrate that perceptions of and responses
to the mentally handicapped are different in non-capitalist
industrial societies. While there is some evidence on
this available to the Western researcher, it is not conclusive
(see section 4.3 below). Nevertheless, the analysis
I undertook in chapters 4 and 5 suggested that we cannot
take for granted our society's perceptions of the mentally
handicapped - different societies do respond differently
to the same social problem. Indeed, to demonstrate this
point we need only to have shown that it has changed
historically. (However, a comparative cross-cultural
study would be necessary to demonstrate conclusively the
extent to which the socio-economic structure of a society

determines social perceptions of and methods of handling
mentally handicapped people). I have used the historical
approach in this thesis, in line with development in
sociology in other areas.

Indded, as I sh^ll dem nstr^te below, the most fruitful period
for 'dem nstrating the influence of socio-economic changes on the
handling of deviant and non-deviant populations alike is the reri d
fr m late re-c^pitalist society through to advanced capitalist
s ciety. By focu^sin on English society in the transition from
a^rarian capitalism to industrial capitalist society it is possible
to grasp mental handic^ in its historical dimension, to see that
definitions and rractices in the field of mental handicap change
across different hist ric^l ^eri ds and to und rstand the w^ys in
vhich the handlin^ of t e mentally handica^ed changes in relation
t the wider ec n mic, social, rolitical and ideological context.
Furtherm re, this a[pr ^ch enables us to situate the roblem of
th ury, to understand th t theories f mental handicap were
c nstructed ar und a logic f exrlan^tion and that theories were
ap lied in order t ex lain and sonetimes to put into oractice methods
of handlin_, in rarticul r histor'cal settir^s. The theoretical links
which have often been 'pr ved' between ethnicity and handicap,
degeneracy and handicap etc. make ^ different kind f sense and acquire
a new dimensi n of meaning when viewed in the context of nineteenth
and early twentieth century England (see Ch^pter 5). Whilc a
cr s-cultur^l study would be necessary tto provide ^ c ntrol, strong
supnort is n netheles^ ^iven by ^n analysis of this period of history.

4.2 The development of mental handicap as a social problem

In chapters 4 and 5 I argued that the available
evidence strongly suggests that it was during the course
of the nineteenth century that the mentally handicapped
became seen as a separate social problem and handled as
deviants. Up to that time those who were obviously handi-
capped and unable to support themselves economically were
either cared for by their families or warehoused in the
work houses, houses of correction or private madhouses.
Thus the mentally handicapped were an integral part of the
undifferentiated dependent population. We need to ask,
then, why they became an object of official concern and

managed as deviants only as Britain moved from pre-
industrial, pre-capitalism to industrial capitalism.
(The mentally handicapped are social deviants in that
they are part of the 'social junk'[56] - a costly but relatively
harmless group, whose very existence, because of their
inability to participate in roles supportive of capitalist
society, questions the ideology of that society - they
come to official attention when informal measures have
been exhausted or when the magnitude of the problem becomes
significant enough to create a basis for public concern).

During the nineteenth century first the severely
handicapped and then the mildly handicapped came to be
seen as a serious social problem that called into action
agents of social control and resulted in their being
handled as deviants. The 'fear' of the mentally handi-
capped grew as the number of individuals assessed and
labelled as 'feebleminded' increased with the introduction
of compulsory education, the development of social Darwinism,
and the growth of the Eugenics movement. By the turn of
the nineteenth century biological theories relating to
heredity and evolution came to play a dominant role in
determining the ways in which society viewed the problem
of mental handicap and methods of handling. (Indeed, the
conception of the mentally handicapped at this time
continues to influence public knowledge of and reaction
to mental handicap - see Chapter 7).

In the nineteenth century official and public
reactions to the mentally handicapped, especially the
'feebleminded', were conditioned by the fact that they
were seen as part of the 'dangerous classes' - a group
that threatened the stability of society. This fear
developed out of the fear of the mob that grew in late
eighteenth century England with the development of the
beginnings of the modern working class. It was argued
that there was a connection between poverty and moral
degeneracy and hence with criminal behaviour; that is,
the conditions of the poor became associated in the mind
of the authorities with the preconditions of crime.
This resulted in the production of a perceived deeper and
more serious potential danger from the lower orders -

a belief that poverty, bad habits and propensity to crime
might provoke them into riotous behaviour and escalate
into a threat to civil order itself. This led to a
declension from the poor to the criminal classes to the
'dangerous classes'. The fear grew that the 'mob' or
'sunken 10%' would contaminate the respectable working class
and create social unrest. Victorian England's image of
the poor as a dangerous residue resulted in them being
regarded as an alien class, as human refuse, outside of
civil society, a constant threat to the stability of society,
a group that needed to be constrained and controlled,
managed as deviants. Alth ugh by the end of the nineteenth century
the fear was no longer of riots and rebellion, fear remained of
the physical and mental degeneration of the race as the residuum bred
faster than the respectable classes.

When compulsory schooling was introduced, the
'feebleminded' were 'discovered' and this 'new' group
was found to come from poor, working class backgrounds -
from the social degenerate group (see Chapter 5).
New methods for identifying and justifying the handling
of this group were needed. Thus the management of the
mentally handicapped as deviant is inextricably tied to
the rise of science to a place of dominance in nineteenth
century Britain and the introduction of mass schooling
as part of the process of meeting the need for new
forms of social control in an industrial society.
(The school replaces the family and the church as the main
agent of socializing children into the norms and values
of society).

Political agitati n at the end of the eighteenth century
precipitated legal and olitical reform. It was clear that the older
forms of social control could no longer withstand the industrial
and economic change and the political challenge. Reform was the
meth d by which the new social order was constructed, and in the
process social control was strengthened and the threat of revolution
held at bay (e.g. by changes in custodial institutions, including
the workhouse, prisons and asylums). In the period up to 1850
Britain was transformed from a largely rural, basically agrarian
economy to one which was urban, industrial and based on wage-labour.

At this time the foundations of the modern British state were laid. Maj r reforms resulted in the state increasingly encroaching on social, economic and political institutions. This state intervention was accompanied by increasinf attempts to segregate and cladsify the working class into vari us categories - the respectable and the non-respectable, the industrious from the dangerous. The latter group were c icentualis·d as a major thre⁻t to the social order, and various ideological mechanisms, including charity and edueation, were utilized in an effort to moralize and regulate the behaviour, life-style and leisure activities f this gro.p.

This fear f the ⁿoor was n t new in the nineteenth century, but it took on a different dimension as social change heightened class coᶇsciousness amd the problem took on a new level of intensity.[57] Ref rns were aimed at the maintenance f order; the evolutionary and benevolent c nception f social reform is misleading.

> The history and development of social policy is in large part the history of an economically dominant class orⸯanising to become a ruling class, stamping its authority and control ver the entir⌐ s ectrum of social life. In this process ' soci 1 ref rms have layed a crucial role.[57a]

The attitude of reformers in the first part of the nineteenth century was that the idle needed t be disciplined, instilled with the habits f industry - but the need was for a particular tyⁿe of disciplined individual t work in the factories.[57b]

Studies of the introduction of mass schooling in the nineteenth century suggest that it was seen as the solution to the problem of social control, in a situation where the family was no longer able 'adequately' to socialize children.

> Schools at once supply labour to the dominant enterprise and reinforce the racial, ethnic, sexual and class segregation of the labour force.

and

> The emergence and evolution of this educational system ...(was an) ... outgrowth of the political and economic conflict arising from this continued widening and deepening of capitalist control over production ... [58]

While it can be argued that mass schooling became necessary because of technological changes or a demand for more 'educated' workers[58a], it was also clearly a measure aimed at social control, to check delinquency, enc urage religious observance and inculcate a work discipline. (By the mid-nineteenth century children were no longer employed in factories because of protective legislation and technological c anges in the production process.[59])

The introduction of mass schooling resulted, as I have already indicated, in the discovery of the 'feebleminded' children who appeared normal, but who would not learn to conform to the educational system and consequently presented a problem. This group posed a 'threat' to the dominant ideology of the protestant ethic – a group who could not support themselves economically and were dependent on society. These children came mainly from poor homes, frequently had unemployed, alcoholic, unmarried mothers and the mentally ill or other 'degenerates' for relatives. It was also observed that this group had larger families than average and the fear grew that this group would swamp society and consequently posed a threat to civilization. By the early twentieth century it was generally accepted that this group needed to be shut away and prevented from breeding for the protection of society (see Chapter 5).

With the growth of capitalism and the challenge to religion byrational-scientific explanation there was a need to justify an inequal society, to develop an ideology that rationalized a particular kind of social relationship as natural, not on religious grounds but on scientific ones. Scientific theories replaced religion as the final arbiter of truth; that is, they were seen to provide value-free, reliable and valid accounts of the world. However, scientific theories do not develop in a vacuum, but in particular societies at certain stages of their development – that is, theories are shaped by the requirements and

constraints placed on them by the society in which
they are developed.

Britain at the end f the nineteenth century and the beginning
of the twentieth was in a state of transiti n from laissez faire to
monopoly capitalism. One consequence of this transition was the
expansion of the middle class.Mackenzie[60a] argues that eugenics
justified and sustained the position of the middle class, and
especially of the professionals[60b]. It 'proved scientifically'
that the difference betwe n the rofessi nal and the w rking
classes was due to inherited diffdrences in ability, and therefore
the divisi ns f mental and manual labour were given the force of
a natural division between different types of people. At the same
time the Eugenicists had an analysis of the practical rroblems of
Vict rian and Edward'an capitalist society; n st im ortantly, they
 ffered a practical r gramme for dealing with the situation of
chronic deprivati n and unrest anong the residuum. This group
were seen as unfit in an extreme form and were therefore a prime
t rget for eliminati n y a rogramme of eugenics. Eugenicists were
concerned with the 'fitness' of society or of the race – national
efficiency – but the fitness f a society was seen as the sum of
the fitness of the individuals comprising it. Social failure was
identified with biological unfitness, and progress was seen as
coming through the elimination of the unfit. However, the eugenicists
rejected the laissez faire attitudes of, for example, Spencer and
advocated state intervention.

In the nineteenth century the growing dominance of
science and rational explanations is seen in the way in
which medical men intervened in and gained control over
the adjudication of normality (abnormality in the case of
mental disorders – the handicapped and the ill).
The mentally handicapped were at first seen as sick and
the condition curable, but the failure to 'cure' them –
and the large increase in the numbers diagnosed, especially
after the introduction of mass schooling – necessitated
the development of alternative rational explanations
of mental handicap and for their handling as a group seen
as a threat to social stability (see Chapter 5).

By the end of the century Darwin's theory of the origin of the species and natural selection resulted in the development of scientific theories (Social Darwinism and Eugenics) that not only enabled the

'scientific' identification of the mentally handicapped but also justified policies of segregating the subnormal in order to protect society from the perceived threat of degeneracy. (The treatment of a socially dependent group, it was argued, should not be such that it would encourage others to become idlers or allow them to 'breed' and create an even larger group dependent on society). The poor and specifically the degenerates were seen to be held down by biological deficiencies, not divine ordination nor environmental/social factors, and it became seen as necessary to 'invent' scientific means of measuring 'intelligence' in order that the biologically unfit could be suitably dealt with.

The eventually successful attempts to develop intelligence tests, together with social evolutionary theories and studies of degenerate families, were used not only to justify the segregation of the mentally handicapped but as a justification for the existing patterns of social inequality, by arguing that they were the outcome of the social struggle for the survival of the 'fittest' – the inevitable working out of the 'iron law' of biology; social inequality was seen as the result of biological differences between individuals. (Intelligence tests – developed in the early twentieth century – confirmed this and provided a scientific method for screening out the most feared group – the feebleminded – see Chapter 5).

Science and scientific theories came to provide a rational explanation for 'stupidity', a justification for 'fearing' the surplus population and a means of scientifically identifying the 'feebleminded'. Once they were screened out, this group could be segregated and society protected.

It is important to point out that the Eugenics Movement was influential for a very short period - from 1900 to 1914. In terms of eugenic programmes for racial improvement its only achievement was the 1913 Mental Deficiency Act. Furthermore, while it had a large number of influential supporters, including many leading Fabians, it was not without its critics. Apart from the Fabians, who were not working class but from the professi nal middle classes[61] and perhaps concerned with protecting the interests of their own class[61a], eugenicists were o posed by socialists, right-wing conservativ s, the Catholic church and defenders of traditional individual liberties. After the First World Was, academics such as J.B.S.Haldane attacked eugenics as a paradirm case of anti-working class use f science, and the defeat of the eurenicist ideology was a prime target[61b]. The extreme rirht-wing and fascist forms taken by eug ic in the 1930' accelerated the decline in the movement's influence. However, in its time it had considerable influence on attitudes towards and icthods f handling the mentally handicapped, and elements f its ap roach can still be seen underlying current rcepti ns.

4.3 What can be learned from history

The above account suggests that the creation of mental handicap as a deviant category and of subnormal people as stigmatized (and feared) deviants is inextricably linked with changing socio-economic conditions. The perceived challenges to the hegemony of the capitalist class in the nineteenth century necessitated new methods f classifying and handling deviants. (The maintenance of hegemony by the ruling class is not inevitably based on the use or threat of force, but rather on a range of mechanisms, some objective products of the economic process and others subjective phenomena arising through the manipulation of attitudes). In this process the mentally handicapped, a socially and economically dependent group, became regarded as part of a social problem group, necessitating management as deviants. Despite apparent changes in social attitudes towards and methods of handling the mentally handicapped, the legacies of this 'fear of contamination' and regarding the mentally handicapped as 'dangerous' can still be seen in the stigma that attaches to the label 'mentally handicapped' (see Chapter 7 - indeed it may be argued that the more

severely handicapped are the ones who are 'feared' while
the mildly handicapped are considered less of a danger today -
the reverse of the situation at the turn of the century -
see Chapter 5) and the way in which the mentally handicapped
remain a 'forgotten' group in terms of economic and social
support (see Chapter 6).   The mentally handicapped are
seen not only as different, but as inferior, and they
are treated as such:

> To recognise a specific difference ... (in
> natural endowment) ... is one thing, to
> pass a general judgement of superiority or
> inferiority, still more to favour the first
> and neglect the second, is quite another.61

The mentally handicapped are created as a deviant
group not only because of their inherent characteristics
but also because of the ways in which these differences
(to the extent that they really exist) are socially
interpreted, and this interpretation appears to change
as society changes.   There appears to be a relationship
between socio-economic structure, social change and
changing social perceptions and treatment of deviant groups,
including the mentally handicapped.   Thus we can see that
in the late nineteenth and early twentieth century

> ... many of the transformation underlying the
> move towards institutionalization can be
> ... tied to the growth of the capitalist
> market system and to its impact on economic
> and social relationships. 62a

In the same way I have suggested (see Chapter 6) that
moves towards decarceration and community care in the 1960's
were not solely the outcome of humanitarianism and a
growing understanding of what mentally handicapped people
can achieve, or a result of criticism of hospitals, but
came about because it was apparently a viable alternative
with the growth of the welfare state - and it was cheaper.

A macro-historical account enables us to begin to
understand how and why social perceptions of the mentally
handicapped change as the socio-economic structure of
society changes and it is within this framework that we

can see the contribution that sociological research into
mental handicap can make.   It enables us to understand
current social perceptions of the mentally handicapped
and current methods of handling them.   Within this context
we can see the important contribution that sociological
research in the field has made - but research which
I have argued is inadequate as it stands because of its
ahistorical and consensual paradigm.   This thesis has
stressed that we can only adequately understand mental
subnormality when it is placed in a social context, and
that explanations which concentrate on the mentally
subnormal individual and his pathology are inadequate.

4.4   A comparative perspective

One main argument throughout this thesis has been
that mental handicap, especially mild mental subnormality,
has only become a social problem in industrial societies
and I have also suggested that the specific responses to
this social problem in Western industrial society is probably a
result of the capitalist socio-economic structure and
ideology of these countries.   While I am not able here
to report on extensive cross-cultural research, the
available research material (in English) would seem to
support this contention.

As far as non-Western, non-industrial countries are
concerned there is a lack of systematic research on the
problems of mental handicap.   My own analysis suggests
that there are considerable problems in distinguishing
b·tween mental handicap and mental illness in such societies,
but that the severely handicapped are recognised in all
societies.   The available anthropological evidence on
contemporary primitive societies suggests (as appears to
be the case in Western society prior to the modern period)
that responses to the obviously handicapped range from
infanticide, to leaving them to care for themselves, to
the families providing 'good' care. [*]   However, as is
the case with the mildly mentally handicapped they are not
seen to provide a large, separate social problem.
In the case of mild mental handicap many apparently go
unnoticed (it is of course difficult to determine who is

and who is not mildly mentally handicapped in the sense ·in which we use the word) although stupidity is often recognised, but the 'stupid' are not accorded special treatment.[64]

When countries begin to industrialize, however, the problem of mental subnormality becomes more acute, especially in urban areas.[65] As a society advances technologically there is less employment for the mildly retarded - mainly because of social attitudes and ideology (many mildly subnormal people could be employed on mass production jobs if attitudes changed)[66], but more importantly, retarded people find it difficult to make the social adjustment to urban living. This point is well brought out by the study undertaken in Puerto Rico[67] (see Chapter 2) which, using a quasi-experimental research design, attempted to demonstrate that industrialization (and the introduction of compulsory schooling) 'causes' the problem of mild mental subnormality. In industrializing societies the problem of severe mental retardation also grows, as with improved medical knowledge and social care more handicapped babies survive birth, handicapped people live longer, and work becomes an activity separated from the home. This necessitates the development of new methods of handling.

The difficulties with respect to evidence on non-capitalist industrial societies appear to be even more complex. As far as I am aware there is no published material in English on the social perceptions of mentally handicapped people in those countries; there is, however, some material on the education of mentally handicapped children in the Soviet Union,[68] China[69] and other Communist societies.[70] The reliability of this material as a 'true' account of the educational process is difficult to assess. It comes from two main sources: that written by academics living and working in these countries (and translated into English), and that written by those with an interest in the Soviet system, some of whom have visited these countries. Censorship and state control ensure that only what is acceptable to the authorities is published, and visitors are strictly controlled and only permitted to visit certain institutions,

which may not be representative.   It is consequently easier
to say what is the officially stated policy and the
philosophy that underlies it than to recount what happens
in practice.

Most of the available material is on the Soviet Union's [71]
methods of handling mentally handicapped children, and
the philosophy underlying diagnosis and handling.
A short article on China' seems to suggest that the country
still tends not to regard mentally handicapped children
as a problem - the severely handicapped are excluded from
schooling and left to stay at home while the mildly
retarded are handled in the 'normal' schools.   The
authors of the report suggest that this is because China
is still a developing country and has not yet reached
the stage of development where subnormality is seen and
responded to as a social problem.   This is not, however,
the case in the Soviet Union, [73] where special provision is
made for all those diagnosed as mentally handicapped.

In the Soviet Union the mentally handicapped are
divided into three groups/categories - the severely retarded
(idiots), the moderately retarded (imbeciles) and the
mildly retarded (debiles).   (Most of the available
information is on the diagnosing and handling of the latter
group as the emphasis has been on education and the
educational system).   The major influences on the selection
and education of mildly retarded children has been the
research and writings of Soviet psychologists, especially
the work of Vygotsky and Luria (see Chapter 3).
Soviet philosophy does not accept genetic (intelligence)
determinants or cultural causation of mental handicap;
all mental handicap is assumed to be due to C.N.S. damage,
and consequently mental handicap is seen as a purely
physiological condition.   Intelligence tests are officially
banned in Russia because they are thought (because of
their cultural bias) to discriminate against peasants and
the working class in favour of the culturally advantaged;
diagnosis is, therefore, based solely on neurophysiological
evidence.   Great care is taken not to mis-diagnose
children as mildly subnormal on the basis of poor school

work and level of current attainment - the emphasis is
placed on whether or not the child appears to be capable
of learning in the normal classroom and every effort is
made (including individualised learning programmes) to
help the slow-learning child in the normal school before
he is sent to a defectologist. (It is worth noting that
the prevalence rate for Educational Subnormality is
much lower than in the West; for example, 1% compared
with 3% in the United States[74]). When a child has been
diagnosed as mildly mentally handicapped he is sent
to a special school - the emphasis is placed on preparing
the child for a useful work career by the age of eighteen
years, and it is claimed that the majority of mildly and
moderately mentally handicapped children obtain open
employment on leaving school. (In Britain the vast
majority of moderately retarded and some mildly retarded
school leavers go to Adult Training Centres).

It is possible to glean some understanding of attitudes
towards the mildly retarded from the way in which they are
handled in the educational system. As is the case in
Britain, they go to special schools, but in Russia these
schools are usually boarding ones that care for the health
and recreational needs of the child as well as the educational
ones. The staff-pupil ratio is low and teachers of the
mentally handicapped are held in high esteem, as they have
a longer training than teachers of 'normal' children and
command a considerably higher salary.

Official policy in the Soviet Union is, then, that
mentally handicapped children are given all the care and
help they need and every effort is made to enable them to
develop to their full potential and take on adult social
roles. Special emphasis is placed on correct diagnosis,
intelligence tests are rejected because they are seen to
be culturally biassed, and every effort is made not to
mis-diagnose a child. However, the extent to which this
theory is put into practice is an unknown, nor is it
possible to determine social perceptions of the mentally
handicapped or official attitudes, reactions, behaviour
towards them. Nonetheless this analysis does suggest,

as does the historical analysis, that we cannot take for granted our society's perceptions of and methods of handling the mentally handicapped.

4.5 Conclusion

In this section I have argued that, within a historically (and cross-culturally) informed macro-framework, sociology can make an important contribution to our understanding of mental handicap.   This framework enables us to understand that social definitions and understanding of mental handicap, and responses to those who are seen as different/incompetent, cannot be taken for granted but are conditioned by the socio-economic and ideological framework within which they are perceived and interpreted. Within this framework we can see the contribution that micro-sociological, psychological and other social science disciplines can make to a social theory of mental handicap, and this will be the subject of my final section.

5. Requirements in a Social Theory

5.1 Introduction

Up to now in this chapter I have concentrated on summarising my criticisms of the dominant medical and psychometric models of mental handicap and demonstrating what an historically informed macro-sociological approach can contribute to an understanding of mental handicap as a social phenomenon. Indeed, with the exception of chapter 7 this has been the main concern of the thesis. In this final section I will broaden the analysis in order to demonstrate the contribution that can be made by micro-sociological/psychological perspectives as well as the other social science disciplines to a social theory of mental handicap. (It is also important to bear in mind that biological constraints on behaviour cannot be entirely written off, and that medical and clinical perspectives on mental handicap are of extreme important in terms of finding ways of preventing mental handicap, and also of developing programmes that will enable mentally handicapped people to develop their full potential). Finally, I will suggest possible future directions for sociological research in the field of mental handicap.

An argument that we should develop a social theory is not a plea for multi-disciplinary research, but a recognition that all the social science disciplines can make a contribution to our understanding of social phenomena. It is, however, necessary to recognise that interests and 'perceived' requirements in an account/understanding do vary between (and within) social science disciplines, and that different social science disciplines take certain aspects of social reality for granted (psychologists, for example, assume the structure of society, and sociologists the unique individual) and concentrate on others. A fully social theory can take nothing for granted; it must take into account all the relevant factors, from biological to social constraints including individual, social, economic

and political factors.   In this way it will be designed to
build a total picture within which specialist research
can play a vital role, but without which we fail to
conceptualize the totality of what mental handicap means
as a social phenomenon as well as a biological/medical
condition.

5.2   Going Beyond a Macro-Sociological Theory.

In Chapters 4, 5 and 6 I examined the ways in which
social perceptions of mental handicap and ways of handling
the subnormal have changed as societies have changed.
In Chapters 5 and 6 I have also pointed out the important
ways in which scientific factors interact with social/
political/economic factors ro influence social policy
towards the mentally handicapped. Thus in order to under-
stand current patterns of handling mentally handicapped
people, we need research into the history of science,
as well as the politics and economics of social policy.

In Table 12 I illustrate the interaction between
scientific research findings, social policy and economic/
political factors in determining methods of handling the
mentally handicapped in the last two hundred years.
I am not suggesting a simple causal relationship, but
rather one of circular causality; nor am I suggesting that
scientific research findings directly determine the form
of social policy. (A number of alternative ways of dealing
with the problem are always available given the acceptance
of research findings).   However, there is a definite
relationship between the production of knowledge, social
policy and the economic/political climate, and the interaction
of these three factors does seem to determine methods of
handling. The way in which knowledge is produced, validated,
distributed and changed is interpenetrated by social/political/
economic phenomena; that is, science does not develop
independently of other developments in society.
However, in order for a scientific 'discovery' to be
recognised it must be taken up and used. At any given time

	Scientific research (diagnosis and prognosis) ←→	Social policy (handling deviants) ←→	Economics/ politics (a allocation of scarce resources; b political and economic philosophy)
	↑↓	Philosophies of treatment and handling ↓	
	Models of mental Handicap ↓		
Early 19th century	Sensationalism (only S.S.N. discernable; 'curably sick') ←→	Treatment in ←→ private institutions if able to pay; other- wise left with families or in workhouse	Laissez Faire capitalism (Fear of riot and revolution)
Mid/late 19th century	Social Darwinism and Eugenics ↓		Growth of professional middle class
	M.H. (esp. feebleminded) as social menaces ←→	Incarceration ←→ to protect society	Minimum provision out of public funds Monopoly capitalism
Early 20th century	IQ tests developed to ascertain feebleminded, who are gradually becoming seen as 'incurably sick' ←―	Hospitali- zation	(Boer War - concern with national efficiency)
Post-World War II	Psychological and ←→ sociological theories gradually move towards M.H. as 'developing people'	Community care and normalization	Equal opportunity . Welfare state. (Period of relative affluence, followed by depression)

there are a number of competing scientific explanations,
and policy-makers can choose between them in determining
what course to take. Thus in the late nineteenth century
some medical men were advocating community care, but
policy-makers 'listened' to those who advocated incarceration
as the best method of handling social problem groups, including
the mentally handicapped. It is also possible that
scientists and politicians are reacting to the same
situation. Thus in the late nineteenth century the
growth of the Eugenics and Testing movements were at
least partly a response to the 'discovery' of the feeble-
minded with the introduction of compulsory schooling.
The government were also faced with the problem of handling
this group of children who could not be coped with in the
normal school in a situation where traditional methods of
social control were no longer appropriate.   In
deciding what areas to research into, scientists are
influenced by two factors: the likelihood of funding
(certain projects - especially those involving issues of
current concern - are more likely to be funded by others)
and the possibility that the research findings will be
taken up and used. Finally economic/political factors
will influence what alternative policies are realistically
open to decision-makers.

The constraints of economic/political factors are
illustrated by current policies in the area of mental
handicap. (I have discussed this in Chapter 6, and in
Chapter 7 I have indicated that community attitudes play
an important role here). In Table 13 I summarise the
ways in which the concepts of 'normalization' and
'community care' can be (and have been) used to justify
quite different methods of handling. The ideas of
community care and normalization grew out of psychological/
sociological research findings in the period immediately
following World War II, when the Welfare State ideology
of equality of opportunity was developing (see Table 12).
At this time the main method of handling the mentally

Table 13:   Normalization and community care

Normalization   —   —   Community care

Individual   Social   Leave in   Discharge   Establish
  level   ↳ level   own family   from   community care
                                                hospital   programme

Make the   Change the   Use 'normal'   Establish
individual   environment   services in   additional
'normal'   in which the   the community   services and
              individual   facilities for
              lives   the M.H.

Normalize environment[1]   Integrated communit
                                                service for the
                                                mentally handicappe

Integration in main-
stream of society[2]

Services and facilities provided
enabling the M.H. to lead as near
a normal life as is compatible
with their degree of handicap

                    and

Community 'educated' to react and
behave towards the M.H. as
ordinary citizens.

Notes: 1.   This does not necessarily mean living in the
              community; it could result in 'normalizing'
              the institutional environment.

         2.   This is not inevitably seen as the outcome
              (see note 1).

handicapped was by incarceration in large, isolated
hospitals, but by the 1970's governments in Britain, the
United States and Western Europe were apparently accepting
the notion of community care and making plans to implement it.
In Britain this coincided with a period of economic
recession, and community care has tended to be implemented,
in such a manner that it enables a reduction in expenditure.
Spending on the large hospitals is reduced, but additional
facilities are not provided in the community and the
main burden of care falls on 'Mum' and the rest of the
family when this is possible.   (In the case of mildly
subnormal adults, who tend to be socially incompetent,
they are likely to become destitute and exchange one
unsatisfactory institutional setting for a different but
equally unsatisfactory one).

       While a historically informed macro-sociological
account enables us to understand more fully current social
policy in the field of mental handicap, we need also
to consider political and economic factors (and indeed,
as I shall argue below, to work at the micro- as well as
the macro- level).   This approach can also be utilized
to provide greater understanding of other social phenomena.

5.3   The Integration of Experience

       In constructing macro- accounts of social phenomena
it is all too easy to forget that individuals are as
important as social structures.   Ultimately one is
concerned with mentally handicapped people, the members of
their families, their relatives, those involved in helping
roles, and the people living in the community, as well as
the people who make decisions affecting the lives of the
mentally handicapped and their families.   Individuals

.

are shaped by society, but they also have ideas, feelings
and reactions, and they can in turn influence that
society - they are not totally determined by it.
Thus I have argued in Chapters 6 and 7 that the attitudes
and reactions of community members to the mentally handi-
capped (influenced as they are by social factors) do
influence the policy decisions made by decision-makers.
We need to go beyond this and try to understand not only
how individuals and communities feel about and react to
mental handicap (as an abstract concept) and mentally
handicapped people but also how mentally handicapped
people and their families understand and react to their
situation.

In Chapter 7 I have reported on three small ethnographic
studies which illustrate the type of micro-sociological
research that could make a contribution at this level.
I have argued that abstract studies of attitudes do not
enable us to understand how people react to and behave
towards mentally handicapped people. We need not only
to understand why people react in the way that they do, but
also how the behaviour of others is understood by mentally
handicapped people and their families. My main conclusion
was that it appears not to be central or salient in the
lives of most people, but that when a community is faced
with a group of mentally handicapped residents there tends
to be considerable adverse reaction, justified by
reference to stereotyped images, influenced by outdated
views of the 'dangers' presented by mentally handicapped
people. (It was also interesting to find that many of
these (mis)conceptions were also shared even by those who
were prepared to act as voluntary helpers in a hostel).
The families of mentally handicapped people generally
tended to feel that they were stigmatized, as was the
mentally handicapped member, not only by strangers, but
also by relatives, friends and many of the professionals
they came into contact with. (Experiences did vary,
however, and it may be that parents' own reactions to mental

handicap influence the way they experience the reactions/
behaviour of others).

The possible contribution of micro-sociology and
human potential psychology can also include trying to
understand what it is like to be mentally handicapped
in our society.   A small start has been made in this
direction.   The Participation Conferences[75] have given
a voice to mentally handicapped people, and enabled them to
express their views. Bogdan and Taylor[76] have constructed
a life history of 'Ed', a mildly subnormal man, and
Heshusius[77] has reported on an ethnographic study of how
labelled mentally handicapped people experience their
lives in a hostel.   All of these reports give us a
greater insight into what it is like to be labelled and
handled as retarded in our society and have clearly
demonstrated that it is possible for mentally handicapped
people to have views on how their lives should be
structured and that they have 'human feeling'.   Mentally
handicapped people are seen as feeling, understanding,
reacting human beings, not machines or animals who are
acted on and do not have 'real human feelings'.

However, while research at the micro-level (socio-
logical and psychological) is a vital element of any social
theory, it is imperative that we do <u>not</u> forget that this
takes place within a social context, a society with a
history that influences its organisation and structure.
As Marx has said, 'Men make history, but not in
circumstances of their own making'.[78]

5.4   Future Directions

Mental handicap has been neglected as an area of
study until very recently, and still is in sociology,
social psychology, anthropology and the other social
science disciplines. Most research has been concerned
with discovering the biological 'causes' of the mentally
handicapped (to find ways of preventing some types),
refining diagnostic tools and comparing normals and sub-
normals matched for chronological or mental age.

More recently some effort has been made to find new (better) methods of helping mentally handicapped people to develop to their full potential.   All this research effort is essential and needs to be expanded, but so does more social research.   Indeed, without a framework the meaning and the ways that research findings are utilized are difficult to understand.   An example of this is prevention of Down's Syndrome;   this condition could be almost eliminated if all pregnant women were screened by amniocentesis and karyotyping, but there are financial and ethical constraints that need to be taken into account.

Social research needs to be undertaken in a number of areas.   There is an obvious need for more cross-cultural research, especially into social reactions and behaviour towards the mentally handicapped in contemporary non-industrial societies, and non-capitalist industrial societies.   However, at the present time I see the main need to be more micro-studies expanding on the types of ethnographic research reported on in Chapter 7 - research into what it is like to have to care for a mentally handicapped child, to be labelled mentally handicapped or to be confronted with mentally handicapped people living in one's neighbourhood.   This type of research is made imperative given current social policy in the area. However, it must be borne in mind that social policy is influenced by political and economic factors as well as 'scientific' research findings, and all these factors underlie the present set of policies.   Finally, the purpose of such research (which is itself influenced by political/economic factors as well as the social values of the researcher) is not necessarily to promote social change, or influence social policy, but to give insight and under-standing to both those in the situation and those outside.

1: Craft and Craft, 1978   2: Ryan, 1976

3: Birch et al, 1970

4: E.G. Rutter has argued that relatively low levels of lead
pollution, such as those found in inner city areas, can cause
I.Q. to drop by as much as 5 points. This would result in a
two-fold increase in the incidence of mental handicap, given current
cut-off points. (Quoted in Tucker, 1980).

5: Haldane, 1938   6: See, e.g., Doyal, 197

7: See Chapter 3 and, e.g., Mittler, 1 74; Locke, 1978.

8: See also Tomlinson, 1981, and Mercer, 1973.

9: See, e.g., Clarke and Clarke, 1973, 1978; Mittler, 1979; Bogdan
and Taylor, 1976; Tizard, 1964.

10: Clarke and Clarke, 1973a.

11: See, e.g., Adorno, 1967; Hurst, 1972.

12: Mills, 1958 P248 (Penguin ed 1970)

13: Dexter, 1956a, 1 63, 1964; Mercer, 1972, 1973; Booth, 1978;
Edgert n, 1967.

14: Farber, 1978

15: De xter, 1956a, 1967, 1964; Mercer, 1973.

16: Edgerton, 1967   17: Booth, 1978

18: Mercer, 1 73   19: Akers, 1967

20: Farber, 1 6 , 1968a   21: Eugenics Society

22: F r a r vi f th trend see Stacey, 1978

23: F r a arental view of the d minant power of doctors in the
field f mental handicap see MacCorm ck, 1978.

24: J.G. Vosey, 1975   25: Booth, 1978

26: E.C. Bl or and H robin, 1975 27: E.C. MacCormack, 1978

2 : See also, e.g., Scull, 19 5, 1977, 1979; Parry and Parry, 1976.

29: Edgerton, 1 67 P209

30: Edgerton (1967) describes the ways in which the mentally
retarded are able t manipulate people to obtain help in
coping with the demands of everyday life.

31: Mercer, 1973   32: Dexter, 1964

33: E.G. Edgerton, 1967   34: Lemert, 1967

35: Edgerton, 1967

36: Mercer, 1973

37: Stein and Susser, 1960

38: Mercer, 1973

39: Plum er, 1979

40: Gouldner, 1968 *P11*

41: For a m re d tailed ccc unt see Pearson, 1975.

2: Spitjer , 1975 *P639*

42a: ,See Tomlins n, 1981, for a very recent attempt to develop such
    a persnective with respect to the mildly educationally subnormal.

43: Farber, 19

44: Haldane, 1938

45: Tizard, 1 64

46: Coard, 1971. (This analysis applies specifically to children
    from We t Indian ackgrounds. Asian children do not annear to
    have the same problem.)

47: See, e.g., B wles nd Gintes, 1976; Sharp and Green, 1976.

48: Dexter, 1964.

49: Farber, 1968

50: H ndness, 1 74 *P47*

51: Fay, 1975 *P96*

52: F rd, 1975

53: Haldane, 1938 *P182*

54: Rex, 1c 3

55: Scott, 1970 *P273*

56: See Spitzer, 197 , f r a fuller devel pment of this erspective.

57: H bsbavn, 1968

57a: Jones and Novak, 1 80 *Ps150-51*

7b: Thompson, 1968

58: Bowles and Gintes, 1976 *P234*

58a: See Johnson, 1976

59: Simon, 1960

60: It is interesting to note in this c ntext that the inheritance
    of intelligence was n t universally accepted in nformed circles.
    S iles (1859) did research concerning the origins of eminent men
    which came to dontrary conclusions from Galton's, and J.S.Mill
    (1873) maintained that
        I have long felt that the prevailing tendency to regard
        all the marked distincti ns of human character as innate,
        and in the main indelible, and to ignore the indisputable
         roof that by far the greater nart of these differences..
        are such as not only might but naturally would be
        nr duced y differences in circumstance s, is one of the
         chief hindrances to the rational treatment of great social
        ouestions and one of the chief stumbling blocks to human
        improvement.

60a: Mackenzie, 1976, 1 78

60b: F rre l, 1 70. The rofessional middle class constituted the
        verwhelmin aj rity f the membership f the Eu enics Education
        Soci ty.

61: Hobsbawn, 196

61.a: See Mackenzie, 1978

61b: Wers k y, 1972

62: Tawney, 1931 *P49*

62a: Scull, 1977 p24

63: Edgerton, 1970

64: Abliz/-Miranda et al, 1966

65: Dybwald, 19'0; Ablizu-Miranda et al, 1966

6E: Tizard, 1964

67: Ablizu-Miranda et al, 1966

68: See Kety, 1962; Sutton, 1980

6o: See Robinson, 1978

70: FG Cjeijel et al 1980

71: See Sutton, 1930

7 : Robinson, 1 78

73: Sutton, 1980

74: Kety, 1962

74a: Leach and Wing, 1930

75: C.M.H. 1973

76: Bogdan and Taylor, 1976

77: Heshusius, 1981

78: Marx, 1844

7.: Stein, Sus r and Gut rman, 1977

 O: Open U 'v rsity, 19 2.

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At the time of the interview all but one family were still involved in some kind of treatment for their child. Being unable to predict whether their child would require further hospital treatment or when the end point for their child's rehabilitation would be reached seemed to generate hope in some parents regarding the future appearance of their child's scar. Other parents remained more cautious. This depended on how the situation was appraised and continued to be appraised by individual parents. (See Section 4.3 for further discussion of hope and caution).

A related sub-theme was identified in connection with parents' difficulties in coming to terms with the uncertainty regarding their child's condition. Families expressed **fears for the future** almost exclusively surrounding the issue of their child's scars and the possibility that they could be stigmatised or become self-conscious. This was viewed as inevitable by some parents, although others remained more hopeful.

Harriet's mother expressed her concerns for her daughter when she got older but remained hopeful that this could be tackled:

> *M: well my main concern is how is she going to react when she is getting older cause she will, she will be marked and when she is a teenager it will cause her problems. She is never going to be comfortable wearing little shoe string tops and stuff like that. But it is how we bring her up, to be able to deal with that.* (Text unit 470)

Predictions for when children were likely to be affected varied between families.

> *M: Doesn't bother him ... I'm worried what it'll be like when he gets to mingle with other kids*
> *F: When he gets to school - when he has swimming lessons at school that's what I worry about.* (Text units 443-444)

Three parents observed that their children had already been exposed to experiences during which they could have felt stigmatised. Of the eight parents who expressed these fears for the future, all felt that the current age of their children protected them from the negative impact of stigma and predicted that they would experience difficulties as they got older. Karen's mother felt the future was going to be particularly difficult for her child as she had an identical twin sister:

> *M: I have been thinking, yes, how she's going to be you know. Like she's going to see S***** [sister], is it going to be all right? There's not a mark on S*****. I think it's going to get harder as she grows up. I think it's easier now because she doesn't understand as much, she's only four, but when she starts school and you know things like that, I think its going to be, its going to get worse I think...* (Text unit 623)

2.2 Perception that accident and related events have had a negative impact on family

Parents described the difficulties of dividing their time between the injured child and the rest of their family. Parents of six of the seven families who had more than one child at home described their worries about the impact the experience had had on their other children. To a varying degree they expressed their difficulties with separation from their other children and trying to ensure their well-being whilst their sibling was in hospital. This appeared to be a threat regardless of whether they perceived their family or partners as offering support in terms of caring for the rest of their family.

> *M: Yes I'd say it was they had been affected not just Karen you know. Cos, like I'd been away and coming back and F**** the baby she's quite close to me, err, how can I say, she's mummy's girl she doesn't do much with her father, with me, you know and she felt, I used to come home. I used to be so tired, I used to try and do the best I could with them you know, but it affected them, you know. Cos my mum used to say, err, they've been ok today, when I used to phone. They have been a bit quiet and I think it affected them as well you know.*
> (Text unit 345)

This mother was also concerned for her husband's well-being as she felt unable to offer him sufficient support.

2.3 Others' responses perceived as a threat to well-being

Parents readily identified the reactions of other people as unhelpful or distressing. Three related sub-themes emerged - perceptions that others were **blaming** or **evaluating** them, and **comments or actions that were unhelpful.**

Appraising family or medical professionals' reactions as **blaming** them for the accident or **evaluating** them as parents was a source of concern for several participants. John's mother recalled:

> *M: M*** [ambulance driver] went up and felt the water and he come back and he made a comment I didn't quite catch what he said he just went and tutted and I thought you know what do you want me to do you know I didn't throw him in it or anything.*
> (Text unit 130)

Three parents also believed that their child may currently blame them or would blame them in the future for the experiences they had gone through. For example, Karen's mother described her daughter wanting her mother to remove her scar:

All parents also described **comments and reactions that were unhelpful**. These varied from people being too sympathetic, becoming upset themselves or being insensitive to parents' feelings or needs. For example, Harriet's mother recalled her feelings when she returned to work, where she had only been employed for a week before the accident:

> *M: But it's quite a big place where I am working and nobody asked, nobody knew about it which was another thing*
> *I: Mmhm*
> *M: Once I got into work I found it really strange because if it had been where I was working previously everybody would have known about it.* (Text units 335-337)
> *M: And I don't know which was worse the complete indifference because nobody knew or everybody been overly concerned for me 'cause if they had been overly concerned I would probably have spent all day skryking (sic)* (crying). (Text unit 339)

2.4 Healthcare professionals perceived as failing

Eight families considered that some aspect of the service they had received from healthcare professionals was worthy of criticism and exacerbated the levels of distress they were experiencing. Parents' descriptions of professionals suggested that overall they had a mixed opinion. However, clear cut distinctions were made by seven parents between those staff whom they felt to be non-supportive or who behaved in a manner that upset them and those who they found to be helpful. Parents placed these health service staff in mutually exclusive categories, distinguishing between those who they felt were protective and those who were not. The intensity and nature of the criticism levelled at services varied. Four parents described how difficult they found it when they perceived themselves to have been "fobbed off", not listened to or felt that information they had requested had not been forthcoming. Three participants also considered that staff behaviour, such as offering parents a choice over medical decisions, was handing over too much control to parents. The manner in which they were spoken to by medical staff was also criticised by some parents.

Elizabeth's mother recalled:

M:... and they were sort of going away and coming back and in the end they said, well we'll put some cold stuff ... No one seemed to want to take control of the situation. They were all running around and didn't know what to do. It seemed like I was having to cope with me, her and take control which I wasn't particularly happy with. (Text unit 74)

Table 6b - Stability of coping strategies over time

Super-ordinate theme 4:Coping strategies	More intense during event/hospitalisation	More intense after discharge/now
4.1 Distancing self from emotions generated by accident and its consequences		
Cut off from emotions/'auto -pilot'	✓	
Disbelief	✓	
Using humour/euphemisms avoiding emotive language		✓
Explaining away impact on child.	✓	✓
Normalising child's reaction	✓	✓
Avoiding accident reminders		✓
4.2 Overcoming difficulties/regaining control		
Using 'practical' coping	✓	✓
Belief in own resources or developing strengths	✓	✓
Monitor child's medical care/question professionals	✓	✓
Beliefs about ensuring child's safety		✓
4.3 Maintenance of hope		
Gaining hope from healing signs	✓	✓
Gaining hope from child's "strength"	✓	
Beliefs in recovery	✓	
Caution		✓
Social comparison	✓	✓
4.4 Managing blame/guilt		
Attributing the accident to a unique set of circumstances		✓
No one to blame/concluding the event was an accident		✓
Avoiding blame discussions		✓
Making up for the accident to child	✓	✓
4.5 Making sense of and justifying own reactions		
Normalising the event		✓
Justifying		✓
Normalising their own reactions		✓
4.6 Systemic management strategies		
Allocation of roles	✓	✓
Being strong for their child or partner	✓	
Polarised views		✓

Family interventions have been suggested as important by both proponents of PTSD models of parental adjustment and the stress-resiliency models. Interventions aimed at facilitating coping skills have been trialed for parents of children with leukemia and although helpful at the time of diagnosis, were not related to subsequent parental adjustment (Kupst and Schulman, 1988). In line with Le Doux et al. (1998), the current study suggests that more systemically oriented family therapy interventions may be more appropriate. Coping strategies described by parents that involved or affected other family members included being allocated a role, not discussing the event, being strong on someone else's behalf and adopting polarised views regarding key issues. Whilst it is not suggested that these are generally pathological, for some parents the use of these strategies was detrimental to their well-being. The issues identified therefore do not appear to be around coping skills per se but are associated with open communication and the development of a mutually satisfactory response to the event. Therefore, proposals by Figley (1989) for systemic working with traumatised families may be useful to consider. These include: allowing each family member to tell their story of the event and encouraging others to hear them; reframing ideas about the event or problem such as blame; developing a family consensus about the event; shifting attention from the identified patient to consider "individual's healing theories" and identifying alternative family and individual coping strategies if necessary.

Finally, the commonly adopted strategy of parents distancing themselves from the emotions generated by the accident and its consequences, may affect both the depth and pace of therapeutic interventions offered. In addition, the importance of strategies that allowed parents to remain hopeful, may interfere with therapists who wish to help parents 'accept' the potential injury consequences. Other authors have suggested cognitive restructuring so that parents gain more realistic expectations about their child's recovery (e.g. Holaday & McPhearson, 1997), but the current study implies that these interventions should be approached with caution. When parents reflected on the interview process, they acknowledged that even if they had wanted to have such a conversation when their child was in hospital, it would have been difficult to do so practically. In addition, they suggested that intervention from a mental health professional might be viewed as suggesting that they were not coping and prevent them from accessing such a service. Low key interventions from known medical staff or facilitated groups, aimed perhaps at normalising some of the parents' reactions, may prove at least initially, to be more appropriate.

Our ref: R/E/16/99

7 July 1999

Dear

RE: APPLICATION R/E/16/99: THE IMPACT ON PARENTAL WELL BEING OF CARING FOR A PRE-
       SCHOOL CHILD WHO HAS BEEN ACCIDENTALLY BURNED: A PHENOMENOLOGICAL
       INVESTIGATION OF PARENTS EXPERIENCES OF THE HOSPITALISATION
       AND AFTER CARE OF A CHILD WHO HAS BEEN BURNED

Thank you for submitting the above protocol which will be considered at the next meeting of the
Paediatric Research Ethics Committee on Thursday 15th July 1999 at 4.40 pm in the **Boardroom,**
NHS Trust.

You are invited to attend to answer any specific questions raised.

Please contact the above extension to confirm your attendance.

Thank you.

Yours sincerely

Chairman
Paediatric Research Ethics Committee

Our ref: 1r/e/16/99

16 July 1999

Dear

RE: APPLICATION R/E/16/99:   THE IMPACT ON PARENTAL WELL BEING OF CARING FOR A PRE-SCHOOL CHILD WHO HAS BEEN ACCIDENTALLY BURNED: A PHENOMENOLOGICAL INVESTIGATION OF PARENTS; EXPERIENCES OF THE HOSPITALISATION AND AFTER CARE OF A CHILD WHO HAS BEEN BURNED

Thank you for attending the 15th July meeting of the Paediatric Research Ethics Committee.

As you are aware the Committee requested a minor amendment to the consent form and copies of the letters of support from   Consultant Clinical Psychologist and   , Consultant Burns & Plastic Surgeon.

The Committee are happy to approval this study and look forward to receiving the revised consent form and letters of support.

We wish you well with this study.

Yours sincerely

Chairman
Paediatric Research Ethics Committee

Appendix 2 -Recruitment criteria for Burns Unit staff

- How had did your child behave after the accident at home/nursery/other people's houses? What did you make this?

Discharge from hospital ward and rehabilitation:

- How did you feel when .... was discharged from hospital ? What were you most concerned about ?
- What was the experience like for the rest of your family?
- How long do you think it will take ....to recover? What do you think will help?
- What was/is the experience of attending the clinic/ follow-up appointments like?
- What type of treatment /burn care were you involved in after your child was discharged from the ward? Was anybody else involved in this treatment ?How did this effect you and your family? How did you cope?
- How did you feel when ....went to school /nursery after the injury?

Impact on parent

- Do you feel you have changed since the injury? How?
- What affect as the burn had on you as a parent?
- What affect has the injury had on your approach to parenting....?
- How if at all has this changed since the injury

Coping / Support

- How do you feel you coped at the time of the injury /accident ? How do you feel you coped whilst ...... was in hospital / when he/she came home ? How do you feel you are coping now? What did you find most difficult?
- What helps you cope? What has been most helpful? What methods do you use? Have you used these methods before? How useful have these methods been?
- Overall how has .... being burned effected you family?
- What helps your family cope?
- What type of support (if at all) have you received? Who has supported you? What type of support have you found most helpful?
- How often has the accident/injury been talked about since it occurred? With whom do these discussions occur?

Expectations for the future

- What concerns do you have about the future?
- How do you think the burn will effect your child in the future?
- How do you think the burn injury will effect you and your family in the future?

Reflections on interview

FINALLY – How have you found doing this interview?
When would you have preferred to have this conversation?

End interview: Thank participant for their co-operation and remind them that will be contacted once more. Discuss contact numbers if upset or feel upset when researcher leaves.