

3 the principle of normalization as a human management model: evolution of a definition

A reformulation of the normalization principle

Until about 1969, the term 'normalization' had never been heard by most workers in human service areas. Today, it is a captivating watchword standing for a whole new ideology of human management.

To the best of my knowledge, the concept of normalization owes its first promulgation to Bank-Mikkelsen, head of the Danish Mental Retardation Service, who phrased it in terms of his own field, as follows: 'letting the mentally retarded obtain an existence as close to the normal as possible.' Bank-Mikkelsen (1969) was instrumental in having this principle written into the 1959 Danish law governing services to the mentally retarded.

However, it was not until 1969 that the principle was systematically stated and elaborated in the literature by Nirje (1969b), who was then executive director of the Swedish Association for Retarded Children. This elaboration was contained in a chapter of the monograph *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel & Wolfensberger, 1969), sponsored by the President's Committee on Mental Retardation. This systematic description was not only the first one in English¹, but even had to be translated into Swedish in order to become the first major treatise on the topic in the Scandinavian literature. In this 1969 chapter, Nirje phrased the principle as follows: 'making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society' (p. 181).

Although the normalization principle had not yet been systematically presented in the Scandinavian literature until 1970, its significance had been widely recognized before that, and in 1967, a new, far-reaching Swedish law governing provisions and services for the mentally retarded was developed from it and became effective in 1968 (Swedish Code of Statutes, 1967 (4), dated December 15, 1967). Parts of this law were presented and discussed in the above-mentioned chapter by Nirje (1969b).

Nirje's chapter was mostly concerned with the implications of the normalization principle to the design and operation of residences for the retarded; however, the relevance of the principle beyond residential aspects, and even beyond mental retardation to deviancy and human management in general, was clearly recognized and stated. In a synthesizing chapter in the same book, Dybwad (1969) pointed to the principle as a major emergent human management concept, while also elaborating further on some of its implications to the location, design, staffing, and operation of residential services.

¹ The first major statement of the normalization principle in the British literature was contained in a three-article symposium in the December 1970 issue of the *Journal of Mental Subnormality* (Gunzberg, 1970; Nirje, 1970; Zarfes, 1970).

A reformulation of the normalization principle

For purposes of a North American audience, and for broadest adaptability to human management in general, I propose that the definition of the normalization principle can be further refined as follows: 'Utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible.'

From the proposed reformulation it is immediately apparent that the normalization principle is culture-specific, because cultures vary in their norms. For instance, normalization does not necessarily mean that human services should resemble Scandinavian services. It does mean that as much as possible, human management means should be typical of our own culture; and that a (potentially) deviant person should be enabled to emit behaviors and an appearance appropriate (normative) within that culture for persons of similar characteristics, such as age and sex. The term 'normative' is intended to have statistical rather than moral connotations, and could be equated with 'typical' or 'conventional'. The phrase 'as culturally normative as possible' implies ultimately an empirical process of determining what and how much is possible.

Since deviancy is, by definition, in the eyes of the beholder, it is only realistic to attend not only to the limitations in a person's repertoire of potential behavior, but to attend as much or even more to those characteristics and behaviors which mark a person as deviant in the sight of others. For instance, wearing a hearing aid may be a greater obstacle to finding and keeping a job than being hard of hearing (Kolstoe, 1961).

It is for this reason that the proposed reformulation implies both a process and a goal, although it does not necessarily imply a promise that a person who is being subjected to normalizing measures and processes will remain or become normal. It does imply that in as many aspects of a person's functioning as possible, the human manager will aspire to elicit and maintain behaviors and appearances that come as close to being normative as circumstances and the person's behavioral potential permit; and that great stress is placed upon the fact that some human management means will be preferable to others. Indeed, sometimes a technique of less immediate potency may be preferable to a more potent one, because the latter may reinforce the perceived deviance of the person, and may be more debilitating than normalizing in the long run.

The distinction between 'elicitation' and 'establishment' of normative behavior on the one hand, and 'maintenance' on the other hand, has a number of implications. For instance, the term 'maintenance' underlines not only the importance of supporting behavior that is normative (or as normative as possible) in a person who previously behaved in a deviant (or more deviant) manner, but also the necessity of assisting some persons who have never been perceived as deviant from coming to be so perceived.

The normalization principle can be viewed as being neutral as to whether a specific deviant person or group *should* be normalized. That decision must be based on criteria and values which exist independent of the normalization principle. Here it is useful to recall that our society considers it appropriate that normalizing measures be *offered* in some circumstances, and *imposed* in others.

The normalization principle as stated is deceptively simple. Many individuals will agree to it wholeheartedly while lacking awareness of even the most immediate and major corollaries and implications. Indeed, many human managers endorse the principle readily while engaging in practices quite opposed to it – without being aware of this discordance until the implications are spelled out. Then a manager may find himself in a very painful dilemma, endorsing simultaneously a principle, as well as practices opposed to it.

In the next chapter, some of the major corollaries and implications of the normalization principle will be elaborated. The reader may find himself just as surprised by some of these as this writer was.

4 typical programmatic and architectural implications of the normalization principle

The levels and dimensions of the normalization principle

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Having stated, reformulated, and somewhat explained the normalization principle, we will now examine in more detail what it means to translate it into action. After trying unsuccessfully to differentiate between programmatic and architectural implications, I will elaborate on both of these concurrently, although additional architectural and residential implications will be covered in chapters specific to these issues. Also, the entire issue of societal integration will only be touched upon in this chapter and elaborated at length in the next one.

The levels and dimensions of the normalization principle

One can conceive of the implications of the normalization principle as falling into two dimensions and three levels of action. *Table 1*. One dimension is concerned with the structure of interactions that involve deviant or potentially deviant individuals directly, while the second dimension is concerned with the way such persons are interpreted to others. Another way of putting this is to say that both dimensions deal with the structuring of a deviant person's environment, one dimension involving the person directly, the other involving the way this person is symbolically represented in the minds of others. Of great importance to the latter are labels, concepts, stereotypes, role perceptions, and role expectancies that are applied to a person, and that often determine the circularity between his own self-concept, the way others react to him, and the way he is likely to respond.

Role perceptions and stereotypes are known to exert considerable influence on behavior. For instance, normalized and normalizing role expectations have been used with great effectiveness in treating members of the armed forces who display mental disorder (Talbot, 1969). However, only through some very recent research has the full power of the feedback loop between role expectancy and role performance been brought into sharp focus. The work of Rosenthal and Jacobson (1968), which suggests the power of role perception in the development of children, is one of the more spectacular examples. It is consistent with and explains a number of other research findings. For example, it appears quite consistent with the well-documented fact that retarded children who are placed into special classes underachieve grossly when compared to their retarded peers who are carried along in regular classes, even without any special attention.

The immediacy of contact with, or interpretation of, (deviant) individuals can be divided rather meaningfully into three levels. The first level involves individual human managers with individual (potentially) deviant persons. The second level is concerned with the immediate (primary) and intermediate social systems that act upon a person; such systems include the

(deviant) person's family, peer group, classroom, school, neighborhood, place of work, or service agency. The third level concerns itself with the larger relevant societal social systems, such as the school system of an entire province, state, or nation, the laws of the land, and the mores of a society. Below, implications in each of the six categories summarized in *Table 1* will be discussed.

TABLE 1

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

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

NORMALIZING ACTION ON THE PERSON LEVEL

The interaction dimension

On the first level of the interaction dimension (*i.e.* the person level), the normalization principle would dictate that we provide services which maximize the behavioral competence of a (deviant) person. Indeed, much of the

programming offered by human management fields and agencies would fall into this general category.

However, we appear to be much more effective in shaping skills to be physically adaptive than in shaping them to be socially normative, or in shaping their *habitual* normative exercise. For instance, the normalization principle demands that a person should be taught not merely to walk, but to walk with a normal gait; that he use normal movements and normal expressive behavior patterns; that he dress like other persons his age; and that his diet be such as to assure normal weight. Too often, we may content ourselves to teach a handicapped child to walk, but we may be relatively unconcerned when the child develops a quite preventable idiosyncratic gait which elicits or reinforces a perception of deviance. We may teach a retarded young adult how to use a deodorant – but then fail to convert this skill into the adaptive habit it tends to be. Thus, we must direct much more conscious effort to this issue than we ordinarily do.

Obviously, the design of a human management-related building can have much to do with the shaping of both skills and habits of its users. For instance, buildings can make, or fail to make, developmental challenges and demands; they can elicit adaptive decision-making and enhance independence, or impose dependency. Life space should be zoned so as to encourage rather than discourage individuals from interacting in small groups at least part of the time, in contrast to space which implies interaction in large groups only, or which discourages almost all interaction. Even in the presence of other design elements which permit use of the building by the severely physically handicapped, many residential and educational human service buildings should have stairs and not merely ramps, and residential facilities generally should provide residents with access to the controls that adjust room and water temperature; turn lights on and off; open and close windows, blinds and curtains; and flush toilets. To do otherwise deprives residents of culturally normal opportunities, restricts their range of learning opportunities, and fosters non-normative dependency.

The interpretation dimension

The interaction dimension just reviewed implies that we teach a person to habitually exercise those behaviors which elicit social judgment even if they have little practical problem-solving value. These behaviors include etiquette, and may be related or attached to other normative skills of dressing, grooming, walking, talking, eating, etc.

However, there are situations where a person's public image does not (alone) depend on what he is or does, but on how those around him 'present' him. In either case, a person's image depends greatly on the actions of those who exercise 'managerial' controls over him, and therefore the manager should take steps to minimize the probabilities that the person for whom he has responsibility presents himself to the public in a fashion that is apt to lower what we might call the 'perceived deviancy threshold'. For instance, while a moderately retarded adult can be taught to dress himself habitually in a normative fashion, a moderately retarded child still has to be dressed by others, or told what to wear. A retarded adult living independently in society may indulge himself and become deviantly obese, and there may be little we can do about it. However, a mildly retarded adult in a community hostel or

supervised apartment will usually still be under agency management, and his diet can be regulated to some degree.

Similarly, where a person's appearance is less determined by himself than by the manager, it is important to attend carefully to such things as the grooming and hairstyle that we might confer upon such a person. For example, we could give a young man with Down's syndrome a 'soup bowl' haircut which accentuates his perceived deviancy in the sight of others, or a haircut which minimized the cranial and facial stigmata of mongolism. Cosmetic surgery can often eliminate or reduce a stigma, and can be as effective in enhancing a person's acceptability as teaching adaptive skills, changing his conduct, or working on his feelings. In other words, the probabilities should be minimized that a citizen can identify on sight, as being different, a person who is already deviant, or who is apt to be so labelled in the future.

Labels can be as powerful as appearances. The type of public response to the aforementioned young man with Down's syndrome will depend significantly on whether we introduce him to the public as 'Mr. Smith' or 'Joseph Smith'; somewhat condescendingly as 'Joe'; perhaps derogatorily as 'Joe, the mongoloid'; or contemptuously as 'a mongolian idiot'.

The question may be raised why it is so important to reduce the perceived deviancy of a person who may already be clearly identified as deviant. The answer is that there are degrees of deviancy, and every additional measure of deviance becomes an additional social handicap, further reducing a person's self-image, and increasing the likelihood that he will emit non-normative maladaptive behavior.

NORMALIZING ACTION ON THE LEVEL OF PRIMARY AND INTERMEDIATE SOCIAL SYSTEMS

The interaction dimension

On the level of primary and intermediate social systems in the interaction dimension, we would not work with (deviant) individuals directly, but through those social systems which act rather closely upon them. The importance and cost-efficiency of shaping social systems can not be over-emphasized. If the system is maladaptive, all the efforts of the clinicians interacting with clients on the person level can be vitiated. This has often been the case in residential institutions where the systemic structure has vastly reduced the effectiveness of dedicated workers.

In an interesting study (Rubin & Balow, 1971), it was found that of 967 children who had been tested as being essentially normal during kindergarten, 41% were classified within three years by the school system as having appreciable problems or as requiring special services. Twelve per cent had been made to repeat a grade. Phenomena such as this strongly suggest that systems often are in greater need of diagnosis, treatment, and re-shaping than the individuals they purportedly serve.

Examples of working through a social system rather than with the afflicted directly would include counselling the family of an impaired person; or performing environmental manipulations of his family social system, as we would if we helped the family obtain a home that was physically more suitable for the rearing of a handicapped child. We might help his school to start a special class into which he might fit, counsel his teacher, or prevail upon some appropriate governing body to replace (with a new and more compe-

tent director) the director of an agency that had served the person poorly in the past.

Similarly, in order to accomplish the greatest amount of normalization, both by encouraging deviant persons to imitate nondeviant ones, as well as by shaping the stereotypes held by the public of various deviant groups, deviant individuals should have maximal exposure to the nondeviant, and minimal exposure (or juxtaposition) to workers, volunteers, or other individuals who are perceived as deviant themselves by a significant proportion of the public.

In typical community life, social interaction with one's everyday contacts brings with it innumerable occasions and role expectancies that have implications to the normalization process. Unfortunately, a person identified as deviant is often further 'dehabilitated' by being deprived of these normalizing social contacts, or by being cast into social roles where he is actually expected to act deviantly.

For instance, by placing a deviant client among other deviant clients, we may reduce his social contacts with nondeviant persons. Often, we compound this problem by permitting some or even most of the staff working with a deviant group to be deviant. Thus, a common phenomenon in human management is for deviant persons to drift into employment where they work with clients who are deviant themselves. A teacher who cannot cope with regular pupils may be given a special education class; a physician who does not have a licence to practise in the community (usually because of inadequate training or skill, language problems, alcoholism, drug addiction, physical or mental problems, *etc.*) may be permitted to practise in an institution for the retarded or disordered; convicts may be placed into training or work with the mentally retarded; retarded workers may be placed as aides in homes for the aged; aged pensioners may be asked (even against their will) to become boarding home operators for convicts (*e.g. Toronto Star*, April 5 and May 8, 1972); *etc.*

Usually, human managers defend such juxtaposition practices on the grounds that the deviant worker can make a contribution by such an arrangement, that he can be habilitated by it, *etc.* However, when a person is perceived somewhat (or definitely) as a deviant 'reject' by society, and is then placed into a position where he administers services to other persons similarly perceived, it is inevitable that members of the public conclude consciously or unconsciously that the deviant individuals who are being served are of low value. For instance, a teacher who is not good enough to work with my normal child may be good enough to teach someone else's retarded child; or a retarded orderly would scare me in a general hospital, but is good enough to take care of someone else's old mother.¹ Thus, a juxtaposition of deviant workers with deviant clients devalues both of them, but particularly so the client. Inevitably, this devaluing perception will induce the public to emit behavior toward the deviant client group that is more likely to be 'dehabilitating' than normalizing.

¹ It is interesting to note the tortuous reasoning that must make up for the twisted attitudes that support the wide-spread custom of placing retarded persons as workers into nursing homes for the aged. And yet, if a retarded worker is good enough to be a competent orderly in a nursing home – as is often the case – then he is usually also good enough to work in a general hospital (*e.g. Anonymous*, 1971).

Also, when deviant individuals work for and with other deviant persons, or when deviant persons socialize intensively and perhaps exclusively with each other, it is almost inevitable that a climate or subculture of deviancy is created which exacerbates rather than reverses the deviancy of those within this climate or subculture. Finally, at a given time, a person generally has the potential of forming a limited number of social ties and meaningful relationships. Usually, he will fill his 'relationship vacancies' with people he encounters in the social systems close to him. The likelihood of filling one's relationship needs with deviant persons is probably in direct proportion to the percentage of such persons in one's social systems. Thus, if we surround a deviant client with deviant workers, or vice versa, the chances of each group to socialize with nondeviant persons is lowered. The perceived deviance of both groups is likely to increase, and even their adaptive behavior often decreases. Far from being habilitative, the chances of habilitation for either group, especially the much larger client group, is likely to be reduced by such measures.

It follows that instead of there being mutual benefits, both groups may actually lose – if not in each specific instance, then at least in the long run of societal processes. Normalization principles would thus not only argue against the juxtaposition of deviant workers with deviant clients, but would demand that as much as possible, deviant individuals be surrounded by non-deviant ones. By the same logic, those who serve a group of deviant clients should meet at least the same standards of qualification as are applied to persons who work with comparable nondeviant groups.

Buildings should be so designed and located as to be physically integrated into the community, encourage maximal social integration of the persons served in and by them, and provide client-users with a wide range and large number of normalizing experiences. Since a neighborhood or community can only integrate a limited number of deviant persons at any one time, the size of a facility should be such as to congregate no more deviant client-users than can readily be absorbed in and by the surrounding area, services, resources, social life, *etc.* This means that hostels and other group residences have to be small, and in most cases, several residential units of small size should not be placed too close together. For instance, instead of putting two sheltered hostel-apartments for four retarded adults each in one apartment house, more integration would be achieved by placing the apartments into separate apartment houses some distance apart.

Smallness of size, in turn, dictates that residential services should be specialized² for specific types of problems and/or groups. Unlike the all-purpose institution, a small group residence is usually incapable of rendering appropriate services simultaneously to infants and the aged, the near-independent and the totally dependent, the well-behaved and the uncontrolled, the blind and the deaf, *etc.* At any rate, services for children and adults ordinarily

² The concept of 'specialization' will be encountered in several chapters of this book, and is given a meaning that differs slightly from its more common one. In the context of normalization, specialization does *not* necessarily refer to more skilled manpower use, but to more clearly identified management models and perhaps problem (but not necessarily impairment) targets. For instance, a residence operated on a child development model may actually require very little advanced manpower, and it may serve children who, despite a wide range of disabilities, have similar essential needs.

should be physically separated anyway, both in order to reduce the probability that children will imitate the deviant behavior of their elders, and because services to adults and children are generally also separated in the mainstream of society. These and certain other implications specific to the structure of residential services will be elaborated in other chapters.

Normalizing dispersal of specialized residences generally means that the location, distribution, and concentration of facilities should follow the prevailing population distribution. Thus, service facilities, and even group residences, must not only be dispersed across communities within a region, but also within specific communities. For example, one of the first comprehensive community service plans based on the normalization principle (Menolascino, Clark, & Wolfensberger, 1968, 1970) envisioned as many as fifty small, dispersed, specialized residences, hostels, and apartments for the mentally retarded of Douglas County in Nebraska (an urban area containing the city of Omaha and a population of about 400,000). By means of such a specialized dispersed system, it is planned to eliminate entirely the need for traditional institutional residences, even for the most severely impaired.

In regard to size of a facility or client group, it is important not merely to consider the ability of the surrounding social systems to absorb deviant individuals, but also the size of a grouping that tends to create clannishness, exclusiveness, and inward-centeredness. Members of small groups tend to gravitate outward and to interact with other social systems; as group size increases, this tendency diminishes. The sheer size of the group may create mutual barriers of attitudes; and a person in a large group may find too many of his social needs met too conveniently to motivate him to reach out for normalizing socialization.

In regard to the physical and contextual separation of age groups, strong rationales can be derived from both the interaction and interpretation dimensions.

First of all, in regard to the juxtaposition of children and adults, we must remember that many normative services for children in the mainstream of society are separate from services for adults. Furthermore, deviant adults are only rarely and in limited ways appropriate role models for children. Often this is true because today's adults did not receive the kinds of services we can offer to the children of today and tomorrow. Thus, we do not want the children to acquire some of the less adaptive characteristics of the casualties of yesteryear, but want them to be exposed as much as possible to healthy normal children of their own or similar age, or to adults who are appropriate models for their development.

Additionally, when a service for children and a service for adults are placed in close context to each other, they are often under the same administrator, and/or experience a lot of social interactions of each other's staff. A common example is a sheltered workshop in the same building and under the same management as a program for children. In such situations, the director usually will be either adult- or child-oriented, and the program toward which he lacks proper orientation suffers. If he is adult-oriented, the children's program will suffer, as it has typically to this day in psychiatry generally, which is overwhelmingly adult-centered. If he is child-oriented, the adults will be apt to be cast into children's roles. Similarly, the virtually unavoidable close interaction between the staff of the children's program

and the adult clients will tend to denormalize the adults by imposing the eternal child role upon them. As a result, the adults in such a setting will be perceived by the public to be little differentiated from children.

Finally, the optimal physical locations and juxtapositions of children's and adult services are often quite different. By selecting the same site for both, one of the services is often disadvantaged in regard to the most normalized location for its particular mission and identity.

For the sake of continuity, one of the principles relevant to the juxtaposition of aged with mature or young adults will here be drawn forward from the interpretation dimension in the next section. If we place impaired adults in a setting or grouping perceived to be specific to the aged (such as a nursing home), it is virtually inevitable that in the perception of many – if not most – observers, the younger impaired adults will be identified with the aura of hopelessness that is unfortunately imposed upon the aged ones. This means that it is much more adaptive to integrate one or a few aged persons among younger ones (in order to acquire *their* aura) than vice versa.

The underlying principle to all of the above juxtaposition issues is that any negative aura (identity, role expectancy, *etc.*) attached to a setting or a particular group will be transferred upon a minority within that setting or group. The aura can rarely be reversed by adding a valued minority to the setting or group. It is much more powerful both in terms of public perception and direct behavior modification to include a devalued person or minority in a mainstream (or even valued) majority, than to mix devalued groups with each other, or to place a valued minority with a devalued majority. One of the recurring and stronger findings of social psychology is that deviant members of a group are much more likely to change their behavior to meet the standards and norms of the group and especially its model members than the other way around (Berelson & Steiner, 1964).

The interpretation dimension

On the same level, in the dimension of interpretation, considerable thought must be given to how service facilities, and the groups of clients they serve, are named or labelled. For instance, Outwood (in Kentucky) is a very unfortunate name for an institution for the retarded. The name of a possible facility should be carefully considered so as to promote a role perception of its client-users that is nondeviant, or at least minimizes the perceived deviancy. Thus, even words such as 'retarded', 'crippled', 'handicapped', *etc.* should probably be avoided in facility names. In fact, some facilities might fare better staying unnamed altogether, perhaps being referred to informally according to the street or area in which they are located, *e.g.* the 'Harney Street Hostel', or the 'Bellevue Heights Workshop'. Similarly, the labels applied to groups of clients by an agency are very important. For instance, adults should not be referred to as 'children', 'kids', or 'inmates'; but as 'men', 'women', 'clients', 'citizens', 'trainees', 'workers', 'residents', or 'guests', as the case may be, all these latter terms lacking stigma, conveying respect, and being more normative. The term 'patient' should only be used in contexts that are unequivocally medical, and in which the various obligations and privileges of the sick role are appropriate for the persons served (Parsons & Fox, 1958).

Even the symbols surrounding a potentially devalued person or group

should be carefully considered. These symbols may be both transmitted and received unconsciously, but nevertheless tend to suggest or perpetuate social perceptions. When cattle prods are used to train the retarded or severely disturbed, a conscious or unconscious perception of the trainees as 'dumb cattle' is apt to be reinforced. Even well-intended symbols can be ill-chosen, as in the song 'Hi, Look Us Over' (from the film of the same title on the Canadian Special Olympics), in which the retarded invite the public to 'put us in clover, not behind a fence'.

An implication of particular poignancy is that contrary to common belief, a staff-to-client ratio that is any higher than necessary is undesirable. A high staff ratio can imply an interpretation of the client as being more deviant than he is, and can thus be denormalizing under certain circumstances. This is also one of the reasons why service facilities (especially residences) should 'specialize'. We should group clients so that each group can be served with the minimum feasible number of restrictions and personnel.

In many instances, a normalizing measure falls into both dimensions of the person level, or into both the person and primary-intermediate level of the interaction dimension. In consequence, a measure may serve the function of shaping a normative skill while simultaneously creating a normative role perception in an observer which, in turn, elicits additional normative behavior from the deviant client in a beneficial circularity. Some examples of management with such dual impact follow.

Normalization means living in a bisexual world. This has differing implications in different service settings. In children's programs, it means that men as well as women should be involved. For adults, especially in residential services, it usually means that the building and the social structure should produce at least as much mingling of sexes as in a hotel. There are only a few contexts — many of these in adolescence — where activities are normally sex-segregated.

The daily routine of clients as well as client groups should be so structured as to be analogous to that of comparable nondeviant persons of the same age.

A physically or mentally handicapped adult, even if severely impaired, should be engaged as much as possible in work that is culturally normative in type, quantity, and setting. Even if conducted in sheltered settings, work should be culturally typical adult work, rather than involving activities commonly associated with children, with play, with recreation, or with leisure; and sheltered workshops should resemble industry.

An important aspect of normalization is to apply health, safety, comfort, and similar standards to human management facilities and programs as they are applied to comparable settings for other citizens. This has implications primarily to residential facilities, such as institutions; and even more particularly to publicly operated services which, in many jurisdictions, may and do operate below the standards prescribed by law and/or regulation for private facilities. However, it also has implications to clinics and other settings. For instance, reception and waiting areas should be as comfortable, attractive, and private as typical citizens might encounter in comparable community services.

Also, in regard to physical facilities, thought must be given to the 'building perception', *i.e.* the way the physical facility is likely to be perceived by the public. The external appearance or context of a building, even if it is perfect in terms of internal arrangements, can exert a detrimental effect upon citizens' response to the persons associated with this building. For instance, a building that looks like a prison or that was recently used by disturbed individuals is apt to elicit associations not conducive to integration of subsequent client-users of the building. Positive or negative associations affect not only outside observers, but also those who work with the client who is being perceived.

Architecture speaks a powerful language, and can shout out loud interpretations of the client-users of buildings. For instance, putting a drain in the middle of a living room floor (as in some institutions) interprets the person who lives in such a room as an animal who must be 'kept' and cleaned as in a zoo. A non-enclosed toilet says that its user has no human feelings of modesty. Bars on the windows, or even an isolated location of a building, suggest that the building's inhabitants are a menace to society. However, since group residences in particular imply an agency context, and since buildings generally interpret their users almost invariably in a social-systemic rather than individual context, the architectural implications on the person level are virtually indistinguishable from those on the level of primary and intermediate social system.

NORMALIZING ACTION ON THE SOCIETAL LEVEL

The interaction dimension

On the societal level of the interaction dimension, we might work to change the entire school system of a province, state, or even nation, rather than merely changing one class or one school. For instance, many authorities have stated that our present school system unconsciously encourages teenagers from lower-class and disadvantaged backgrounds to drop out. To change such practices, we may have to change laws, perhaps reform teacher training institutions, revise funding and taxing patterns and priorities, *etc.*

The interpretation dimension

Perhaps the major challenge in the interpretational dimension of the societal level is to achieve a redefinition of deviancy, and to foster greater acceptance of some behaviors or characteristics considered deviant today. Normalization can be enhanced by encouraging currently normative citizens to broaden the range of what they consider to be normative. To cite a simple example: to wear a business suit to an important reception or social affair would probably have been perceived as deviant behavior in the past; however, if a number of prominent individuals or a significant minority of persons wore business suits or other more casual attire to such events, such behavior would no longer be considered deviant. Thus, citizens in the mainstream of a culture can do much toward the eradication of harmless deviancy by adopting habits and lifestyles which are somewhat more tolerant and casual than some of those of the past, many of which have been entirely due to historical accident and convention, and are entirely neutral from a moral viewpoint.

Teaching, exhortation, demonstration, and life-style modelling may be

necessary to convince the public that deviancy is of our own making, and is often harmless. We should work for greater acceptance of differentness of modes of grooming, dressing, speaking; of skin color, race, religious and national origin; of appearance, age, sex, intelligence, and education. Also encouraged should be greater acceptance of the physically and sensory handicapped, the epileptic, the emotionally disordered, and perhaps the sexually unorthodox. Here, it is important to recall that societal response to deviancy tends to be general, rather than specific to a particular deviance. By furthering societal acceptance for one type of differentness, we are also and indirectly gaining increased acceptance for a group in which we have a particular personal or professional interest.

Concluding comments on the normalization principle

There are, of course, innumerable other implications from the clinical level to the level of large social systems. The examples given here represent only a selected and arbitrary sampling. However, they underline that many major and minor practices that are currently accepted and not found objectionable by proponents of other human management systems are, in fact, quite inconsistent with the principle of normalization.

The normalization principle has powerful theoretical force vis-a-vis other human management systems, and despite its late emergence, considerable empirical evidence – primarily from social psychology and related fields – can be marshalled in support of it. However, upon first superficial exposure to the principle, one may well ask how it differs from a number of other approaches.

The difference lies in the simplicity, parsimony, and comprehensiveness of the principle. It subsumes many current human management theories and measures – but goes beyond them in stipulating other measures that have been neglected so far. And the principle is easily understood once one has opened one's mind to it.

There are some persons who react to the normalization principle with indifference. I view such reaction as being due either to lack of understanding of the principle, defensiveness about being associated with practices which violate the principle, or attempts to project an air of blasé sophistication. It should, however, be obvious already that even some enlightened human management systems, such as the 'therapeutic milieu', have either been fragmentary in their conceptualization, or have failed to incorporate features which clearly flow from the normalization principle.

Perhaps in no other human management aspect is the above point brought out more clearly than in regard to the corollary of integration of the deviant with the nondeviant. While the strongest arguments for integration can be made on the intermediate level of the interaction dimension of the normalization schema, considerations derived from other levels and dimensions appear to provide additional support for integration practices. Our typical past failures to implement such integration imaginatively, systematically, and aggressively is proof of the fact that we have not really either conceptualized or embraced an ideology of normalization. Thus, the blasé sophisticate's claim that normalization is merely a new name for old beliefs and practices, or for existing systems, is patently false.

I firmly believe that the normalization principle, simple and uncompli-

cated as it is, is the human management principle that is most consistent with our socio-political ideals and current psycho-social theory and research on deviancy, role performance, and other social processes. I further believe that the normalization principle is so self-evidently valid as well as 'right' that it may well become universally accepted in all areas of human management.

This chapter is intended to translate the principle into some specifics, and to summarize certain major implications. Some of these implications require additional and more detailed treatments, especially as provided in the next three chapters.