
REVIEWS

SOCIAL WORK WITH PEOPLE WITH LEARNING DIFFICULTIES. By PAUL WILLIAMS. Exeter: Learning Matters Ltd., 155 pages, 2006.

Reviewed by Aimee Lunden

PAUL WILLIAMS wrote the textbook *Social Work with People with Learning Difficulties* for social work students. Each chapter begins with an outline of the UK National Occupational Standards for Social Work which the chapter addresses. These are the standards that social workers in the UK must be taught to, although the concepts would be familiar to US social workers as well.

The author, according to the jacket of his book, “has forty years’ experience of working with people with learning difficulties ... Since 1991 he has been a lecturer in Social Work at the University of Reading where he teaches working with people with learning difficulties and anti-oppressive practice.” This book links the practice of social work with a values-based approach to supporting people with learning difficulties.

THE BOOK IS BROKEN UP into seven chapters. It begins with the question, as well as the ever changing answer, “Who are the people with learning difficulties?” Williams gives an in-depth account of how the answer to this question is not clear, and why. Although short, the chapters provide the reader with opportunities

to learn more about their topic by suggesting different activities as well as other resources, including some basic SRV texts (although one omission is that Williams fails to mention Wolfensberger’s key role in formulating Citizen Advocacy; see for example Wolfensberger & Zauha, 1973; and O’Brien & Wolfensberger, 1988).

This book is very relevant to Social Role Valorization (SRV). It adeptly introduces the ‘themes’ of SRV (Wolfensberger, 1998) to the social work student. It discusses wounds and devalued roles (chapter 5), various models of work with people with learning difficulties (chapter 1), roles (chapter 4) and the evaluation of services (chapter 5), including information about PASS (Wolfensberger & Glenn, 1975) and PASSING (Wolfensberger & Thomas, 2007).

In my opinion, this book could have a much larger target audience than just social work students. It is clear, concise and well-written. It appears to be written to workers who have some work-related exposure to people with learning difficulties, but not necessarily a lot of experience. This book could easily be used as a basic book for service workers that are not in a social work program. It has multiple exercises for the reader in each chapter that help to apply theory, as well as challenge assumptions and practice. For example, in the chapter (4) on a life-stage perspective on needs, the social work student is asked to think about valued roles for people with learning difficulties, with

an eye on basic SRV principles (described in chapter 2). This activity surely has relevance beyond the realm of social work.

A powerful message in the book for people learning to be social workers is that “We often hanker after official looking proformas and charts to guide our assessments, but in many cases the best tool is a plain sheet of paper on which a flexible amount of space can be devoted to recording information under whatever headings are felt to be necessary” (p. 77). This message is all the more necessary in that the opposite trend exists in the field of social work.

As a social worker, I was happy to read a book that challenges social workers to think about Social Role Valorization. In my own 60 credit graduate degree, it never came up once.

WHILE READING THE BOOK, I was concerned about some of Williams’ use of language. The term ‘people with learning difficulties’ is used consistently in the book. I used the phrase in this review to be consistent with the book, but that being said, the term ‘people with learning difficulties’ is one that is not often or ever used in the United States when referring to a person with mental retardation, which is who Williams is writing about. He chose the term ‘learning difficulties’ as it is how people in the self-advocacy movement in the United Kingdom prefer to be referred (p. 2). My concern with this language construct is that as social workers, we sometimes accommodate people in the name of empowerment -- and then observe as this same act of empowerment further separates people; e.g., like women who respell the word ‘womyn,’ or the chapter of a book I read in my final year of graduate school that referred to people with impairments as “disAbilities.” I find that this rift in language is not particularly helpful for encour-

aging identification with socially devalued people (Wolfensberger, 1997; Wolfensberger, 1998, pp. 2, 67).

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EDITOR'S NOTE: *The following two reviews are by different reviewers but are about the same book. I am thankful to John Ford and Cheryl MacNeil for the time, interest and care they took in reviewing the book and writing up their thoughts. The issues described in the book are clearly ones they are professionally but also personally involved with.*

The reviewers have quite disparate perspectives on the same text. This is not surprising, as discussions around the field of mental disorder, which is the topic of the book, are often diverse if not divisive. I hope these reviews provide an opportunity and an incentive for our readers to reflect on the important issues raised by the reality of mental disorder and by services to mentally disordered people. As always, we welcome your comments and letters about anything published in the Journal.

MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MIS-TREATMENT OF THE MENTALLY ILL.

By ROBERT WHITAKER. Basic Books, New York, 334 pages, \$17.95, 2002.

Reviewed by John R. Ford

ROBERT WHITAKER is an award-winning medical journalist and a finalist for the 1998 Pulitzer Prize for a series on medical experimentation on the mentally ill. In *Mad In America* he has written a polemical and one-sided history of the plight of the mentally ill. Whitaker's view of our treatment of the mentally ill is summed up in the following quote from page 253, "One of the enduring staples in mad medicine has been the rise and fall of cures. Rarely has psychiatry been totally without a remedy advertised as effective. Whether it be whipping the mentally ill, bleeding them, making them

vomit, feeding them sheep thyroids, putting them in continuous baths, stunning them with shock therapies or severing their frontal lobes. All such therapies worked at one time, and then, when a new therapy came along, they were seen in a new light and their shortcomings revealed."

DIVIDING THE BOOK into four parts: The Original Bedlam (1750 to 1900), The Darkest Era (1900 to 1950), Back to Bedlam (1950 to 1990s), and Today (1990's to present), Whitaker signals his take on the misfortune of being mad in America. The author scorns physicians and pharmaceutical companies as the oppressors of the mentally ill while indicting society for allowing abuses to linger with little apparent interest. His thesis is that the medicalizing of schizophrenia has been a sad mistake broken only by the mid-nineteenth century era of "moral treatment." As mental illness came to be seen as medical in nature, physicians became the experts, establishing hospitals that were profitable for the trade but did little but abuse patients with various treatments meant only to make them passive and pliant.

In Whitaker's view, only when "moral treatment" came into vogue were patients treated humanely and cure rates were substantial. Moral treatment, grounded in Quaker principles and calling for treating one's fellow man with dignity and respect, first appeared in Philadelphia about 1810 and spread as the reformers of the time such as Dorothea Dix convinced states to open specialized hospitals for the mentally ill. Moral treatment required small institutions where kindness and respect coupled with pleasant and productive activities ruled the day. A family atmosphere existed with staff living at the institution, eating together and sharing social events with the patients. High cure and improvement rates were

reported. The professional literature of the time stressed respect for patients, good manners, positive staff-patient interaction, productive activity and dignified dress. The cruel therapies of earlier times were absent. "Moral treatment had represented a profound shift in America's attitude toward the mentally ill. For a brief shining moment the mentally ill were welcomed into the human family" (page 33).

ON A PERSONAL NOTE, the writer of this review researched the history of the Worcester, MA State Hospital at the time of the 150th anniversary of its founding (1832). While moral therapy held sway, many patients came from affluent families and appeared to spend time while at the hospital involved in the social activities of the affluent community. It appeared that some of the patients may not have suffered from severe mental illness, but neurotic or life event crises brought them to this welcoming place, thus contributing to the high cure and improvement rates reported at the time. However, as time passed the hospitals became overcrowded; alcoholics, syphilitics, criminals and patients with organic conditions and little hope of recovery were admitted, destroying the milieu that had allowed moral therapy to prosper. Soon the superintendents of the hospitals became pessimistic about cures and tended to pay more attention to the production of the farms maintained by state hospitals than to the welfare of their patients. Moral therapy's time was coming to an end.

Beginning in the 1870s into the mid-twentieth century, physicians reasserted themselves as masters of the mental hospitals. This change coincided with the period following the Civil War when the new medical specialty of neurology developed to treat the large number of soldiers with head wounds. As the number of veterans with head wounds diminished, neurolo-

gists turned to the asylums where patients were plentiful and profitable. The neurologists decried the "non-scientific" approach of moral therapy and proclaimed schizophrenia to be a brain disease. At the same time, eugenic theory was gaining wide acceptance and the neurologists latched onto it. In an atmosphere where the mentally ill were seen as defective, worthless human beings, anything was fair game. Sterilization and lobotomy would help cure society of its defectives. "Why do we preserve these useless and harmful beings? The abnormal prevent the development of the normal. Why should society not dispose of the criminal and the insane in a more economical manner?" (Nobel Prize-winner Dr. Alexis Carrel quoted on p. 41). If patients are worthless defectives and if schizophrenia is a brain disease, then surgery is justified no matter the effect on the patient. Lobotomy and other treatments were effective as long as the patient was rendered passive and not troublesome for the staff.

With the 1950s dawned the age of the neuroleptic medications. In Whitaker's view, medications such as Thorazine and Haldol simply rendered patients passive and unmotivated, thus becoming a chemical form of lobotomy. He dismisses the development of the atypical medications in the 1990s as simply more of the same. All medications are harmful and only for the benefit of doctors and pharmaceutical firms.

WHITAKER IS CORRECT to assail the abuses that have hurt patients many times over. However, on balance, there is no balance in this book. The community movement of the present time, including Fountain House-type clubhouses, employment and residential alternatives, community treatment teams and the efforts of psychiatrists to use the lowest possible dose of medication, are not mentioned. He

presents no alternatives to present treatment except to turn us back to the era of moral treatment without medication. He views medication as the cause of mental illness, not part of an attempt to alleviate it. By ignoring the respect and partnership explicit in the clubhouse movement and other programs, he fails to see the contribution of moral therapy to the present day. As a muckraking broadside at the medical profession and the pharmaceutical industry, the book reads well. As a serious look at the current mental health system in all its strengths and weaknesses, it is lacking.

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MAD IN AMERICA: BAD SCIENCE, BAD MEDICINE, AND THE ENDURING MISTREATMENT OF THE MENTALLY ILL. By ROBERT WHITAKER. Perseus Publishing, Cambridge, MA, 334 pages, \$17.50 US/\$26.95 CAN, 2002.

Reviewed by Cheryl MacNeil

Boston Globe reporter Robert Whitaker attempts to 'right a wrong' in telling a different kind of story about psychiatric treatment in *Mad in America*. Whitaker uncovers two centuries of evidence to demonstrate how knowledge about mental illness has been manufactured to produce societal consent for the mistreatment of the mentally ill. His writings conjure up familiar images akin to Ken Kesey's

One Flew Over the Cuckoo's Nest, and his method of critical reconstruction stylistically mirrors that of linguist and war critic Noam Chomsky. Whitaker was also a highly regarded medical reporter for the *Albany Times Union* and a finalist for the Pulitzer Prize in 1998 for a series he co-wrote on harmful psychiatric research.

Mad in America examines the traditions of a mental health system where care is not simply given, but is managed and is a great source of profit. Whitaker uses a host of credible sources such as scientific journals, federal reports, scholarly bulletins and personal accounts to offer a bold institutional analysis of psychiatric mistreatment, particularly related to people diagnosed with schizophrenia. For most, this will not be a comfortable read but it is an important examination. Consumers and survivors, family and community members, and all helping professionals can benefit from reflecting on Whitaker's provoking representations.

AS A REVIEWER, I wear multiple lenses in sifting through the data presented. I have many close relationships with people who come into contact with the mental health system and have been a witness to the methods of the psychiatric establishment. I have apprenticed with Dr. Wolf Wolfensberger and his associates, spending a number of years studying and teaching the theory of Social Role Valorization (SRV). Today I am a researcher who operates within a critical theory paradigm. For me, the nature of inquiry is to critique and transform the socio-political and economic structures that constrain or exploit humankind. These are the filters I bring to my commentary.

THERE ARE MANY STRONG connections between the findings of Whitaker's research and the theory of Social Role Valorization

(Wolfensberger, 1998; Race, 1999; Osburn, 2006). SRV theory teaches us that society judges and treats people in particular ways based on the presence or absence of certain competencies and characteristics. When people are judged to be of lesser value, they become vulnerable to losing whatever valued social roles they may have and are likely to be cast into devalued negative social roles. *Mad in America* serves as an historical case study of how this has happened to a group of people who act and speak outside the acceptable societal norms.

Whitaker's historical research begins in the mid-eighteenth century when "lunatics" and "maniacs" were segregated from the rest of society into hospitals that acted as jails to 'protect society from them.' The hospital jails were run by people who held highly valued social roles. They were "learned man" and "doctor." Over the course of history, these valued medical doctors were joined by others who were similarly awarded high social esteem and power: heads of foundations, the clergy, scientists, psychiatrists and the pharmaceutical industry. Together, they sculpted stories of brain maladies and chemical imbalances that further cast lunatics into a host of devalued roles: "Lab rat," "burden," "household pet," "defective," "malignant biological growth," and "poisonous slime."

SRV theory tells us that bad things are likely to happen to persons cast into such problematic and socially devalued roles. But one might wonder, 'How could bad things happen to people under the care of the highest learned and most socially valued citizens?' If as Whitaker claims, "treatments for the mentally ill inevitably reflect the societal and philosophical values of the day" (p. xv), then it follows that people cast into the roles of "germ plasm" and "social wastage" would be forced

to be sterilized or put to death, as happened to the mentally ill during the period of eugenics. Another finding central to *Mad in America* is that the objectification of the lunatic as a 'commodity' has been one of the most perilous social role assignments in the history of madness. Throughout Whitaker's research one question keeps arising: Do people with mental illness need doctors more than the doctors need them?

IN THIS EXPLORATION of madness, issues of power, money, imagery and role expectations are at the forefront. The most notable example is found in the competing ideologies between the moral treatment approach of the Quaker community and the biological deficiency model of the medical community. After losing one of their own under the care of the lunatic doctors, it was the Quakers who first proclaimed, "It would be the needs of the ill, and not the needs of those who managed the retreat, that would guide their care." In their moral treatment paradigm, the Quakers assumed that mental illness was a response to the "shocks of life." They placed persons with mental illness into social roles of "brethren" and "family member," and surrounded them with expectations of getting better. The imagery projected about the mentally ill was that of people who could "develop friendships, dress well and rethink their behavior." The Quakers expected people to recover and assumed that the power of recovery was within the person, not the medical profession.

This transfer of power to the person was vastly threatening to the professionals who had a stake in maintaining their biological deficiency model. And while Whitaker's research indicates that people were getting better with the care and dignity provided through a moral treatment approach, the approach was never given suffi-

cient time to demonstrate potential long term impacts. Medicine reclaimed its domain. Physicians took charge of the moral treatment asylums. And the social construction and marketing of mental illness as a biological deficiency prevailed.

It is in the history of the medical model's 'therapy' for the mentally ill where lessons about language practices are transparent. SRV teaches us to listen with a critical ear and move beyond what something is called, to defining what that means in the life of a devalued person. It is frightening to acknowledge the role that therapeutic language has played in the lives of people with mental illness. Trap doors are dropped beneath people as they are plunged into ice baths in the name of "hydrotherapy." People are strapped to a board and spun around as a condoned practice called "confusional therapy." Icepicks are plunged beneath the eyelid into the brain, people are bled to the point of fainting, drowned and brought back to life, vomiting and comas are induced, electricity is jolted into brains and numbing neuroleptics ("chemical lobotomy") are ingested. All, at one time or another, have been socially acceptable "therapeutic" practices. Whitaker's research concludes there has never been any evidence-based justification for the delivery of these 'therapies,' nor have any of these 'therapies' ever been scientifically demonstrated to be curative.

ONE OF THE BIGGEST LESSONS we can take away from *Mad in America* is the understanding that we are not value-neutral human beings and we do not make judgments nor conduct our activities outside the realm of values. I applaud Whitaker's efforts to challenge the dominant scientific paradigm and dispel the myth that scientific investigations of psychiatric issues have been neutral. The fashioning of

inquiries and treatments has consistently been backed by powerful foundations and pharmaceutical industries that have a great investment in cultivating the message that 'mental illness = broken brain.' Not only has the broken brain theory never been scientifically proven, claims Whitaker, but the activities of psychiatric investigations have produced a track record of "bad science, bad medicine, and the enduring mistreatment of the mentally ill."

I am mad about *Mad in America*. I am crazy about this book. I admire Whitaker for shining a bright light on a dark matter. Most honorable is that when Whitaker began his research, he believed in the story of progress that psychiatry had been telling the public for decades.

Understanding the nature of mental health and mental illness is an incredibly complex task. If we take the time to listen to people who have come into contact with the treatment system and elevate their voices into the discourse, as Whitaker has done, we might better understand 'what is the case' and 'what is helpful.' After reading *Mad in America*, I am left to wonder what would happen if we seriously started exploring the alternatives. What if we finally rejected the hypothesis that 'mental illness = broken brain' and rigorously examined the hypothesis that 'psychiatric institutions = repositories for our social ills'? What would happen if treatment came in the form of providing sanctuary, validation and empathy? What if we assigned the role of brethren and valued human being first and foremost to the mentally ill? What if vast resources were directed into constructing a universal narrative about recovery? What if the Quakers were on the right track?

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DO NOT GO GENTLY. By MELISSA GO-DOY (Director). Rated PG, 57 minutes, 2007.

Reviewed by Jack Pealer

TEACHERS OF Social Role Valorization (Wolfensberger, 1998) are more successful if they use examples of people who customarily endure societal devaluation but who are shown filling highly valued social roles. I stumbled on a set of such examples when I went to the world premiere of a new documentary film by a filmmaker from Cincinnati.

Do Not Go Gently (yes, I know, Dylan Thomas readers -- it ought to be "do not go gentle") by filmmaker Melissa Godoy introduces viewers to the continuing and expanding power of creativity and imagination demonstrated by people of advanced age. Godoy's aim is to confront and counter customary expectations that human imagination and creativity weaken and fail in older people. She accomplishes her aim by showing (mostly) and telling -- through

people's own voices -- the artistic stories of quilt maker Arlonzia Pettway (age 82) from Gee's Bend, Alabama; dancer and choreographer Frederic Franklin (age 92) from New York City; and composer/pianist Leo Ornstein (age 109) from Green Bay, Wisconsin.

Arlonzia Pettway has been making quilts since she was a girl. Recently, quilts that she and some of her neighbors and colleagues from rural southwest Alabama created have been exhibited in a number of North American museums. The exhibition's organizer remarks, in the film, about the similarity of the quilters' designs to paintings from highly-regarded modern painters. The quilts' designs predate the paintings, which may be why the organizer comments: "Abstraction wasn't invented in New York." In *Do Not Go Gently* we see Ms. Pettway executing her designs and listen in on her conversations with her colleagues about their work.

Leo Ornstein's public music career began nearly 100 years ago. Early in the 20th century he was renowned, in Russia and later in America, both as a pianist and as a modernist composer. He discontinued public performance in the 1920's and, with his wife (also a musician), began a music school in Philadelphia, which operated until 1953. During all those years, Ornstein continued composing. In the 1970's a music historian (who appears in *Do Not Go Gently*) found Leo Ornstein and his wife wintering in a trailer park in Texas. *Do Not Go Gently* shows Ornstein, in his 90's, working on new compositions with his wife as transcriber. The filmmaker interviews a vibrant Ornstein shortly before the composer's death at age 109, when he was living in a nursing home in Green Bay. That interview is one of the highlights of the film.

Dancer Frederic Franklin was born in England and began to dance when he was very

young. He became a leading dancer and ballet master with Ballet Russe de Monte Carlo and a founder of both the Slavenska-Franklin Ballet and the National Ballet of Washington, D.C. He has partnered with such other dancers as Josephine Baker (1931), Maria Tallchief, Agnes de Mille, and most notably Alexandra Danilova. He has worked with most of the 20th century's leading choreographers. *Do Not Go Gently* shows Mr. Franklin at age 90 dancing the part of the Friar in Prokofiev's *Romeo and Juliet* with the Cincinnati Ballet. He is also seen coaching the premier dancers from Cincinnati. Those who came to the world premiere of *Do Not Go Gently* (March 3, 2007 at the Cincinnati Art Museum) were treated by Frederic Franklin's presence for the afternoon. He appeared onstage after the film with two of the premier dancers from the ballet and with the filmmaker Melissa Godoy. Mr. Franklin ("Freddie" to his colleagues) told stories about his career and about the process of making the film. He was, at age 92, a living lesson in Social Role Valorization.

IT'S PRETTY EASY to identify the valued social roles that this film sets before its audiences. People of advanced age are shown (not just talked about) as teachers, composers, designers, performers, sages, and elicitors of admiration from other, younger people. Adherents of Social Role Valorization will spend a few uncomfortable minutes watching what promises to be a "rhythm band" in a day-activity program for elderly people. Even this scene, though, is partially redeemed as the people, who are issued various rhythm band instruments, suddenly are energized by the drumming and all get up to dance. It's an odd but strangely compelling scene, where people's vitality violates most of the other messages in the surroundings. Clients turn into dancers.

In this brief review I've used forms of the verb "to show" often. That's because of the success of *Do Not Go Gently* at showing (as contrasted with merely talking about) people as active, imaginative, creative beings. Few "talking heads" appear in the film. Leo Ornstein composes and is a raconteur. Frederic Franklin dances. Arlonzia Pettway quilts. Donal McLaughlin, an architect older than 90 years of age, shares the design he submitted for the "9-11 Memorial" in New York City.

Do Not Go Gently is now in the final stages of preparation for its release. It will, apparently, be shown in selected theaters in North America. It also will appear on public television in the United States. As they say: check your local listings for its appearance in your area. Even if you have to wait a while to see it, *Do Not Go Gently* is worth the wait. You can learn about possible showings through the website: <http://donotgogently.com>.

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EDITOR'S NOTE: The Safeguards Letter (*a publication of Ohio Safeguards*) is an excellent resource, well worth reading. It contains thoughtful articles, stories, opinion pieces, quotes, book reviews, etc. It is available in print or by email. Contact the Editor, The Safeguards Letter, 3421 Dawn Drive, Hamilton, OH 45011 USA. jackjr158@earthlink.net. <http://www.ohiosafeguards.org/>

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Do not go gentle into that good night,

Old age should burn and rave at close of day;

Rage, rage against the dying of the light.

Dylan Thomas, 1951

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COMMON ASSETS OF MENTALLY RETARDED PEOPLE THAT ARE COMMONLY NOT ACKNOWLEDGED. By WOLF WOLFENSBERGER. *Mental Retardation*, Vol. 26, No. 2, 63-70, 1988.

Reviewed by Raymond Lemay

IN SOME OF his three- to five-day introductory Social Role Valorization (SRV) workshops, Wolfensberger has presented some twenty-two reasons why it is a good idea to implement social integration (cf., Wolfensberger, 1998, pp. 122-124). Most of these reasons are described as benefits to people who are at risk of social devaluation, including persons with mental retardation and other developmental disabilities. However, at the end, there are a few reasons that Wolfensberger highlights as being benefits to society. According to Wolfensberger, people with mental retardation have their rightful place in society: they have a contribution to make that communities and societies need. Thus, in this 1988 article, Wolfensberger presents the “strengths, virtues, gifts, capacities, prosocial dispositions, and re-

sources, here called ‘assets,’ that one can find not only in a few retarded people, but among a goodly proportion” (p. 63). It is these assets that communities do without when such individuals are excluded.

Wolfensberger tells us that, at first, people in mainstream society, particularly professionals, will doubt the possibility that individuals with mental retardation have a positive contribution to make. Part of the reason for this is the “eugenic alarm” period that so devastatingly characterized individuals with mental handicaps as not worthy of life (Wolfensberger, 1975). Moreover, individuals with intellectual handicaps have been systematically segregated away from community life (Wolfensberger, 1998, p. 18) and thus we have had very little experience of them and particularly of their qualities. Moreover, “professional practice is still preoccupied with their deficits (once called ‘inferiorities’), as exemplified by all sorts of ‘fault-finding’ problem checklists and widely used incident reports that record only negative behavior” (p. 69).

Moreover, many individuals with mental retardation experience dehumanizing and brutalizing conditions, such as those to be found in institutions, and others live lives of idleness and social isolation in so-called “community residences.” At the very least, such social contexts are not at all normative and thus inhibit the expression of many of the qualities that Wolfensberger lists in the article. By and large, the assets that individuals with handicaps are able to demonstrate require nurturing environments, for instance, loving homes.

Wolfensberger lists fifteen assets that are briefly described hereafter. Many of the assets listed come from the reality that people with mental retardation have diminished intellectual capacity, and Wolfensberger argues that this leaves room for the growth of what he calls

“heart qualities.” “This implies that mental energies and other resources are more concentrated on relationships -- sometimes for worse, but sometimes also for better” (p. 63).

1) Thus, the first asset is a focus on relationship and what Jean Vanier has called “to give life and warmth and to recognize another person and his or her needs” (p. 64).

2) Spontaneity: Wolfensberger describes this as natural and positive. However, he also suggests that there is a tendency in human services and amongst sophisticates to repress such spontaneity and even try to “normalize it out of them” (p. 64). Wolfensberger tells us that many persons with mental retardation have joy and seem to share it willingly.

3) Responsiveness: Such persons tend to “respond quickly, generously, and warmly to kindly human contact, approval, and encouragement” (p. 64). Wolfensberger tells us that this often blossoms remarkably despite the fact that many such persons have lived long histories of rejection and brutalization and “deprivations of positive affectional relationships that they open up to such relationships like a flower famished for water” (p. 64). Wolfensberger reports that “many people remark on the fact that relating to a retarded person involves their emotions more than their intellect and challenges their sensitivities” (p. 64).

4) Individuals with mental retardation see the person rather than their status or appearance. They are thus more accepting of others as they are.

5) Solicitude: “Many retarded persons have a genuine concern for things being well in the world” (p. 65).

6) Unconditional love: Love is given freely in an uncalculating way.

7) Trusting, “even when their trust is not warranted” (p. 65).

8) Unmaterialistic: “The overwhelming majority of retarded persons are poor and always will be poor. In some, this generates a possessiveness and materialism that can be pathological or a vice, but others are remarkably detached from worldly possessions” (p. 65).

9) Peacemakers: “Some retarded people have a capacity to call forth gentleness, patience, and tolerance from other people, to dissipate the anger and rage of others, and, thus, to be peacemakers” (p. 66).

10) Enjoyment: “Some retarded persons have a gift that enables them to engage in unfettered enjoyment of life’s gifts and pleasures, including the simple ones” (p. 66).

11) Honesty: Wolfensberger points out that “lying requires at least some degree of abstracting capabilities, and, therefore, retarded persons have a strong tendency to be direct and concretely honest and a concomitant low inclination -- or even ability -- to dissemble” (p. 66).

12) Linear and concrete thinking: “Retarded people apparently have a remarkable tendency to follow an issue, development, or idea in a rigorous, concrete sequentiality to its ‘logical’ conclusion” (p. 67).

13) They don’t get bored: “Many retarded persons have the capacity to engage in a single and/or simple activity for an extended period of time, far beyond when it would become boring and tedious to nonretarded persons” (p. 67).

14) Not easily sidetracked or misled.

15) Spiritual: “Retarded people have fewer intellectual barriers and, therefore, less resistance to a relationship with the divine” (p. 67).

WOLFENSBERGER points out that he is describing general virtues and qualities that are applicable to many persons with mental retardation though not necessarily to all. Moreover, many individuals might not today manifest

such qualities, but given the right conditions and life experiences, these may blossom. Indeed, he suggests certain “positive preconditions” (p. 69) which must be present for such qualities to emerge. They must have the “opportunity to function under reasonably normative life conditions” (p. 69).

Moreover, such life conditions should include the experience of “integration that includes nonretarded people in loving and friendship relationships” (p. 69). And there is a requirement for reciprocity, “the nonretarded people need to possess certain positive gifts and talents; and if they possess them, they must exercise them in the presence of, and vis-à-vis, retarded persons, something that does not always happen” (p. 69). Given the very prevailing social isolation of individuals with mental retardation, even for those living in the community (Lemay, 2006), the opportunities for reciprocal relationships and the practice of these assets is very much constrained.

Resilience

It is quite striking that what Wolfensberger seems to be describing here is another instance of resilience (Lemay & Ghazal, 2001), which is quite consistent with his descriptions of the developmental model (Wolfensberger, 1998, pp. 108-111; Lemay, 2005). On the one hand, he suggests that for these positive qualities to emerge, adversity must end, a first requirement for resilience and positive development. Moreover, if provided with more positive life conditions and experiences, a person’s developmental potential will be in a position of maximization. Thus, the potentiality for such qualities is there but they require the presence of positive life conditions and experiences to emerge. “Many retarded people today still are not afforded liberating life conditions, and many of the remainder experience them only

partially and/or for time-limited periods. Accordingly, a significant proportion of workers in our field (and in others as well) have also not had the opportunity to see the assets of retarded people sufficiently displayed or to act appropriately in light of the many positive and negative realities that such experiences reveal” (p. 69).

A Contribution to Society

This article points out the fact that the long absence of individuals with cognitive disabilities from our midst has been a tremendous loss. Such individuals living in nurturing environments, in a relationship with others, will often demonstrate qualities and virtues that will positively animate the social environment. Can there be such a thing as too much warmth, spontaneity, joy, solicitude and peacemaking? These are certainly qualities and behaviors that can enrich community life. Moreover, the vulnerability and positiveness of such individuals may call forth the best in each and every one of us, as it has the potential of gentling individuals in a society that is much too enamored with competence and material success.

Neighborhoods, groups, and other social settings that open up social space and social activities to such individuals will undoubtedly benefit; however, it is likely that such benefit will only be attained if social space is opened up deliberately and with the full knowledge of what one gains.

Conclusion

This article is a call upon human services and communities generally to open up social roles that are most appropriately and most particularly within the skill-set and attributes of individuals with mental handicaps. With this article, Wolfensberger make a moving statement about a very positive stereotype concerning in-

dividuals with cognitive disabilities. As with all stereotypes, this is a general description of a class of individuals that applies more or less to each individual, and with such a statement of stereotype comes the possibility of self-fulfilling prophecy. The realization of such a stereotype for each individual can only be viewed as a good. Thus, Wolfensberger has ascribed positive and contributory roles to individuals with mental retardation.

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Invitation to Write Book, Film and Article Reviews

From the Editor

I would like to encourage our readers to submit reviews to *The SRV Journal* of current films, books and articles. For people who are studying SRV, looking for everyday examples can help deepen one's understanding. For people who are teaching SRV, learning from and using contemporary examples from the media in one's teaching can be very instructive for audiences. For people who are implementing SRV, contemporary examples can provide fruitful ideas to learn from. Some books and articles mention SRV specifically; others do not but are still relevant to SRV. Both are good subjects for reviewing. We have written guidelines for writing book and film reviews. If you would like to get a copy of either set of guidelines, please let me know at: *Marc Tumeinski, The SRV Journal, 74 Elm Street, Worcester, MA 01609 USA; 508 752 3670; journal@srvip.org*. Thank you.