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Career Lines in the Area of Mental Retardation

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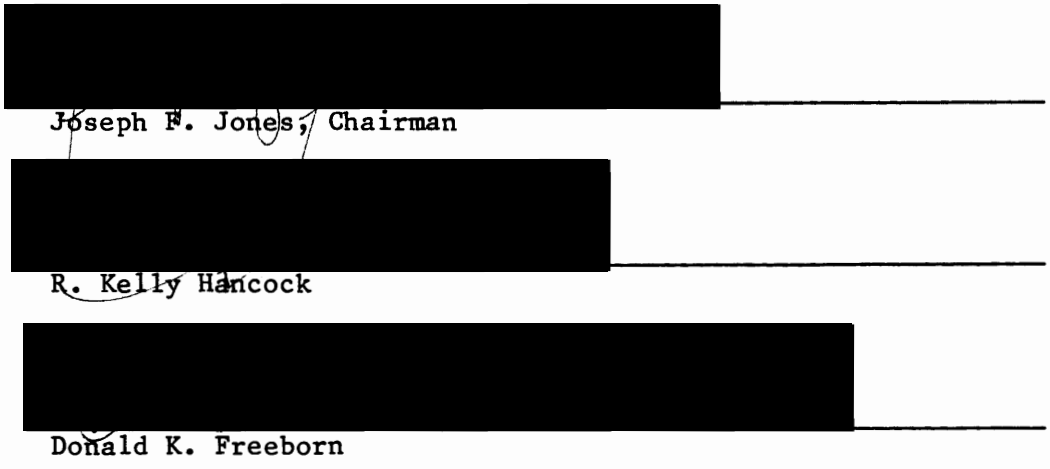

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In the past few years there has been a large growth in the number of facilities and services provided to the mentally retarded in the community, as contrasted to the institutional setting.

This thesis reviews some of the factors involved in the transition to community care for the mentally retarded as a background for an examination of the characteristics and perceptions of the persons who provide community care.

A questionnaire was employed to assess the perceptions of service and care providers relative to (1) views of mental retardation, (2) appropriate responses to the mentally retarded, and (3) perceptions

on the occupation in which the workers were employed in Washington County, Oregon in 1979.

Mental retardation is subject to social definitions which change over time. Similarly, perceptions of proper care of the mentally retarded change over time. The social movements that have affected the mentally retarded are reviewed to provide a fuller understanding of the changing philosophies of appropriate care. In this examination the process of the collective definition of a social problem was used as the orienting approach to the understanding of the current status of mental retardation as a public, rather than a private problem or issue.

How the mentally retarded are seen as fitting into the larger social structure is also examined. The mentally retarded have been characterized as part of a "surplus population" that generates a network of service providers to meet their needs. Thus, the expansion of a service industry to meet their needs is tied to other factors such as the state of the economy, the rise of a communal society with new citizenship rights, and the redistributive function of government.

It was found that the service and care providers surveyed fit the characteristics hypothesized by various previous investigations. The providers are middle-class and upper-middle-class, and see themselves as more liberal than society as a whole. Further, they believe in the philosophy of care, normalization, that generated their community-based jobs and see themselves as professionals in the field of mental retardation.

CAREER LINES IN THE AREA OF MENTAL RETARDATION

by

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CHAPTER I

WHAT IS MENTAL RETARDATION?

INTRODUCTION

Although the general thrust of this thesis is upon the burgeoning field of provision of services for one category of the population, the mentally retarded, it is necessary to lay a basis for that theme by briefly reviewing the nature of mental retardation, and the divergent responses to this condition.

The concept of mental retardation is familiar enough that most people have a common sense understanding of what is meant by the term "mentally retarded." Yet defining mental retardation beyond a common sense level is not an easy task. The problem lies in the fact that there is no objective criterion for a definition. The boundary between "retarded" and "normal" is arbitrary and subject to controversy and change, much like the definition of "mental illness."

Generally only a limited number of retarded have a biological basis for their condition. Down's Syndrome, a chromosome abnormality, is the most common example. The great majority of retarded people are defined by social criteria; Intelligence Quotient (I.Q.) testing is the most common example. Inasmuch as the American Association on Mental Deficiency's (AAMD) definition of mental retardation is

recognized as definitive in court cases, it is useful to explore the development and changes in its defining criterion.

Burton Blatt (1976:141) notes that before 1959, AAMD used an I.Q. of 75 as a cut-off point between the retarded and non-retarded. This is one and one half standard deviations from the mean on a normal distribution. This gives a prevalence rate of about 3 percent of the United States population as retarded. In 1959, the definition was changed to one standard deviation from the mean; thus an I.Q. of 80 was the cut-off point. This meant that about 16 percent of the population was potentially defined as mentally retarded. In 1973, the definition was changed to two or more standard deviations from the mean. This dropped the criterion for mental retardation to an I.Q. of 70. Blatt (1976:141) comments on the 1973 change as follows:

> It's obvious; mental retardation and emotional disturbance, and even such seemingly objective conditions as blindness and deafness, are less objective disease entities than they are administrative terms; they are metaphors more than anything else.

Although the definition may be a metaphor, there are real consequences both for those individuals directly affected and for others in society when a definition changes. For example, a recent problem at Fairview Hospital and Training Center in Oregon State, centered on the fact that some people residing there were no longer retarded under the 1973 redefinition. In my view, the subsequent release of these people, many of whom had a problem functioning alone in society, created a very real problem for the community, as well as for the individuals involved.

The AAMD (1977:vi) speaks to the problem of the 1973 redefinition when it says: ". . . that it resulted in 'de-classifying' certain individuals formerly in the Border-line Retardation group and therefore made them ineligible for needed special services."

The AAMD (1977:vii) clearly recognized that definitions are not absolutes but are relative. The preface ends with:

> Mental Retardation is a cultural concept. The definition of "mental retardation" has changed over the centuries. The consequences of designating special classes of individuals during this time has varied. The American Association on Mental Deficiency is aware that societal norms, differences in philosophy and provisions made by different societies for its members vary and change. The Committee on Terminology and Classification will continue to examine the definitions and classification of mental retardation and respond as concepts change and new data emerges.

It is fully evident that the definition of mental retardation is not only social but remarkably elastic as well.

CLASSIFICATION AND NUMBERS

Although setting a boundary between the normal and the retarded is a problem, once the line is drawn, all that fall below are "retarded." Within this range there are enormous differences, so sub-categories must be established. The difference between a mildly retarded person and a profoundly retarded one is like the difference between night and day, and the treatments and outcomes are likewise very different. The AAMD (1979:19) uses four levels of retardation: mild, moderate, severe and profound:

> MILD (sic) retardation is roughly equivalent to the educational term "educable;" moderate retardation includes those individuals who are likely to fall into the educational category of

"trainable;" the severe group includes individuals sometimes known as "dependent retarded;" individuals in the profound retardation level are among those sometimes called "life support" level.

In addition to these four categories, "borderline retarded" is a term used rather informally to designate those who fall within a few I.Q. points on either side of the boundary between normal and retarded. Generally, borderline retarded who also have physical or behavior problems are considered eligible for special services for the retarded. Jane Mercer (1973:33) calls this population the "situational retarded." She argues this group has traditionally been over-represented by members of minority groups that are culturally different. She makes the point that these people have generally been defined retarded only in the school system, not by relatives or other social groupings, and are not drawn into the specialized care and service provider networks once they escape the school situation. As adults, many of the "borderline" retarded disappear into the general population.

Understanding the concept and the problem of mental retardation includes knowing the numbers of retarded in the United States population. The AAMD (1977:431) says that based on an expected population in 1980 of 222 million: "We shall have 110,000 with IQs (sic) less than 20, and 444,000 with IQs between 20 and 50, but we shall have 6,693,940 with IQs between 50 and 70." These figures amount to approximately 3.25 percent of the total population, with the largest percentage in the educable classification.

SUMMARY

We have seen that mental retardation has been called a cultural concept and a metaphor. By whatever name, it is a social definition which has changed in the past and likely will change in the future. The I.Q. test and associated standard deviation measures are the statistical measures used to establish the various boundaries and determine the degree of mental retardation. The categories thus defined are used in school placement.

Most people once defined as mentally retarded retain that definition for life. But there are exceptions. When the definition of "retarded" changes, those previously defined as retarded may well be shifted to the normal range or conversely, previously defined "normal" individuals may become "retarded." Second, those considered situationally retarded may well leave behind the retarded label when they leave the school situation to move into normal social roles as functioning adults. Altogether, under the current definitions, we have seen that the "mentally retarded" comprise about 3.25 percent of the United States population.

While shifts such as these may be predominately statistical artifacts, they do reflect the changing politics, economics, and treatment ideologies of the day. And these definitional alterations have profound consequences both for those who are defined as retarded and those whose employment is based upon dealing with those so defined. This thesis will focus upon a particular type of consequence: "care" for the retarded. Before exploring the nature of "care" today, it is

useful to briefly examine changes in definitions and concepts of care as these are rooted in broad cultural change. This overview is the basis of the following chapter.

CHAPTER II

THE MENTALLY RETARDED'S CHANGING STATUS IN THE SOCIAL STRUCTURE

INTRODUCTION

The primary area of concern of this thesis is the care providers of the mentally retarded, those people who work in the schools, the new group homes, the new sheltered workshops, and the like. But these new and expanded facilities did not appear out of a total void. This chapter deals with the process that brought them into being. We will start with an examination of philosophies of care, addressing the following questions: What was the old philosophy? Why was it deemed no longer adequate? What new philosophy arose to challenge and replace it? What were the origins of this new philosophy?

To understand those matters one must see the problems of retardation from a social movement perspective. At least since the 1950's, the social movement aspect is important because it has guided the process of changing mental retardation to a social problem. It has demanded programs and facilities funded with public monies.

But movements change. In this case the shift was from institutionalization to deinstitutionalization as the recommended treatment strategy. This chapter is about this change and the problems arising from it.

PHILOSOPHIES OF CARE FOR THE MENTALLY RETARDED

The Old Philosophy of Care

The old preferred care system for the mentally retarded was the institution, removed from society. The institutional system was a humanistic innovation that essentially fell upon hard times. In the beginning, institutions were established as educational and training facilities that would enable its residents to function in the community. In many cases institutions provided care that was far superior to the home and community environments. But gradually they became custodial institutions. Many social factors contributed to this decline.

First, there were economic and political factors. One of the major factors in this category was unwillingness by states to expend money to build enough facilities. As the population expanded, overcrowding became common. Second, there was the rise of Social Darwinism and the accompanying Eugenics movement in the late nineteenth centure which saw the retarded as a population that needed to be eliminated to ensure the vitality of the species. An influential 1908 British Royal Commission Report gives an indication of the belief system of that time (Wofensberger, 1976:56-7):

> Many competent observers are of the opinion that if the constantly or recurring fatuous and irresponsible crimes and offenses of mentally defective persons are to be prevented, long and continuous detention is necessary.

The institutions existed, now the original educational function was changed to a custodial function. The two most serious indictments of

the "institution" stem from this change from education to custody. They are the "warehousing" and "dehumanization" critiques.

Although the Eugenics movement lost momentum, little change was seen in the care system for the retarded. Neither the Depression nor the World War II periods were conducive to growth or funding of these institutions. The importance of the factor of economic surplus is recognized by Wolfensberger (1976:69):

> It is noteworthy that the "new look" in retardation began in about 1950 when there was prosperity and when war-related problems, such as demobilization, reintegration of veterans, and housing shortages, were finally being solved.

By 1963, with only about 4 percent of all mentally retarded persons in institutions, a much larger percentage of money available for this population was spent on institutions as opposed to public and private programs and services (Farber, 1968:187).

In Oregon in 1963, public services for the retarded consisted of the state institutions and education classes for the educable retarded (defined as 50-80 I.Q. at that time). Even then, not all the educable retarded were served. Schools could expel those retarded who also had physical or behavioral problems, who did not "fit" into the classrooms thus defining, de facto, an educable class closest to the normal intelligence levels. At this time, mental retardation was a private problem, not a public or social problem.[1] The alternative to "nothing" for most parents of retarded children was institutional placement. Wolfensberger (1976:69) says of institutions, that since 1925 "The only major rationale left was relief for hard-pressed families . . ." This was a goal that institutions fulfilled.

The New Philosophy of Care

The new preferred care system for the mentally retarded is community-based programs, integrated into society. This is based on a concept of care called "normalization." The concept surfaced in Denmark in 1959. N. E. Bank-Mickkelsen, Director of Danish Service for the Mentally Retarded, writes (1976:242):

> The theory of mental retardation as a static and lifelong condition went well with the practice of "putting away." The new knowledge that mental retardation is a dynamic condition which can be influenced by treatment, education, and training meant a new objective for services. The 1959 Act expressed this as "to create an existence for the mentally retarded as close to normal living conditions as possible." This phrase was the basis of the theory later to be called "normalization" . . .

Bengt Nirje (1976:231), then Executive Director of the Swedish Parents' Association for Retarded Children, defines normalization as:

> The normalization principle means making available to all mentally retarded people patterns of life and conditions of everyday living which are as close as possible to the regular circumstances and ways of life of society.

Nirje (1976:231) makes an important distinction between three separate, but interdependent aspects of mental retardation. First there is the inherent disability (low I.Q.). Secondly there are the retardation traits imposed by treatment or by others. And finally there is the awareness by the individual of being retarded. To Nirje the first and last of these aspects of mental retardation are unchangeable, but the second one can be removed. Nirje (1976:231) sees the second aspect as being caused by:

> . . . possible deficiencies in the environment or the conditions of life created by society, or due to unsatisfactory attitudes of parents, personnel, or people in

> general. Institutional poverty, nonexistent or unsatisfactory education or vocational training, lack of experiences and social contacts, the problems of understanding society, etc., all add to the original handicap.

This aspect of mental retardation, it was argued, could be removed by educating the public and providing programs for the mentally retarded that integrated them into society rather than removing them to institutions.

The Bank-Mickkelsen and Nirje definitions of normalization were not well-know or published in this country until 1969. Wolfensberger (1972:24), psychologist and well-known researcher in the field of mental retardation, redefined normalization for the "North American audience" so it could be applied to the nascent system of community programs:

> 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."

This reformulation seems to lack the simplicity and elegance, not to mention the clarity, of the original definition. However, Wolfensberger was aware of cultural differences and felt that the Scandanavian model of services for the retarded simply wouldn't work here or in Canada. This is important because Wolfensberger's work is crucial in understanding the field of mental retardation. He was considered <u>the</u> authority for normalization and seemed to be a "guru-like" figure to a whole generation of service and care providers.

It should be noted that Wolfensberger's redefinition of normalization is more highly rationalized than other definitions. Wolfensberger (1972:237) says that he is "tieing normalization to sociological theory and empirical evidence." This may well serve to legitimize the concept for a well-educated audience. Unfortunately, it seems, Wolfensberger (1972:237) also borrowed ("from sociology where is has been found to have a great deal of theoretical utility") the term "deviant."

Wolfensberger (1972:13) uses the definition of deviant in his work as:

> A person can be said to be deviant if he is perceived as being significantly different from others in some aspect that is considered of relative importance, and if this difference is negatively valued. An overt and negatively valued characteristic that is associated with the deviance is called a "stigma."

In practice, this view of the mentally retarded as deviant led a generation of human management care workers to concentrate on such surface problems as the looks and behaviors of the retarded, while ignoring other important aspects of the basic problem such as socially defined "incompetence" and the social structural basis of the creation of a "surplus population," i.e., those who have no direct economic contribution to make to society.

Some professionals have taken an extremist position in objection to Wolfensberger's position, arguing that his use of the labeling perspective drawn from sociology, with that perspective's emphasis on the stigma, does a disservice to the population by the very use of the term "mentally retarded."

Wolfensberger (1972:13) recognizes the controversial nature of his position:

> Some sociologists (e.g., Farber, 1963) do not consider the terms "deviant" and "deviancy" as appropriate for some groups, such as the retarded, because to these sociologists, the definition of deviancy implies an intent to be deviant.

While this may no doubt be true of some writers, Farber appears to have been a poor choice for illustrating this point. Farber (1968:147) clearly states that, at the time he was previously writing, the retarded had long since been redefined as incompetent.

One readily apparent problem with the Wolfensberger definition is "what is culturally normative?" This question has been raised in response to issues from sexual behavior and use of alcohol to such seemingly minor issues as style of dress. It could be hypothesized that if the assumptions of normalcy that Wolfensberger uses are inaccurate or incomplete, then the programs and solutions proposed under this theory may not be effective. Recently some arguments have been raised challenging the normalization theory or approach.[2] All deal with the effects on the retarded person. One challenge has been that the philosophy has had no effect on the eradication of stigma attached to mentally retarded persons. Another challenge has been that specialized facilities, such as group homes, while appearing as normalizing, in fact intensify and maintain the identify of a person as retarded and thus do not "integrate" the person into the community at all. Other problems have been seen with programs developed under the philosophy, namely that the retarded person may be subject to more

problems and stresses in the community than in institutions or that abuses have occurred under the guise of service.

Perhaps Nirje is far closer to understanding retardation as a multi-faceted problem. With his focus on the three aspects of mental retardation, two of which cannot be changed, he points clearly to the one that may be changed through deinstitutionalization. An attempt at such a change can be documented through the utilization of a social movement approach to this issue.

MENTAL RETARDATION SERVICES AS A SOCIAL MOVEMENT

We have looked at the two different philosophies of care for the mentally retarded. Those "philosophies" helped in shifting services and treatment for the retarded. But philosophies do not change on their own accord. Bernard Farber (1968:147) provides a concise summary of the social movement aspects of the problem of community response to the mentally retarded:

> Historically, in the late nineteenth and early twentieth centuries, when mental retardation was defined primarily in terms of deviance, the social movement was in the hands of outsiders. The ferment created by these outsiders was directed toward the treatment of the large bulk of the retarded—the educable group. After 1950, with the domination of the movement by parents of the severely retarded, the concerns shifted to the medical and care problems of these severely retarded children. At the same time, retardation was generally redefined as incompetence. In the course of this redefinition, the mental retarded movement seems to have achieved respectability . . .
>
> By the 1950s middle-class parents deeply involved in providing schools and services for their severely retarded children dominated the movement.

Farber also discusses the structure of the emerging organization of parents of the retarded, the National Association for Retarded

Children, and the diversity of needs of the retarded which in his view "required an ever-expanding liaison with other agencies in the community and a constant pressure upon government" (1968:148). In Farber's view the election of President John F. Kennedy, with his history of financial support and famial involvement with retardation and with the Association, raised the organization's prestige and added support to attempts to redefine mental retardation as a public health problem, rather than an individual or family problem.

At the same time that new social movement groups were redefining retardation as incompetence and a health problem, they were also attempting to redefine retardation as a social rather than a private problem. One of the prime objectives of the parents' group was to provide community services and schools for the more severely retarded children, those in the trainable category. The parents had limited resources to meet these objectives and the cost of operating facilities was high. Soon the favored means to meet the ends sought was public funding. This may be seen also as a legitimate claim on communal society, a topic discussed in the next chapter.

PROCESS OF CHANGING MENTAL RETARDATION INTO A SOCIAL PROBLEM

Herbert Blumer (1970:298) sees social problems as "fundamentally products of a process of collective definition instead of existing independently as a set of objective social arrangements with an intrinsic makeup." Blumer (1970) further sees a five step process of collective definition; (1) the emergence of a social problem, (2) the legitimation of a social problem, (3) the mobilization of action with

regard to a social problem, (4) the formation of an official plan of action, and (5) the transformation of the official plan in its empirical implementation. We can see in the progressive move of retardation from a personal to a social problem most of these elements.

In the first step, the emergence of a social problem, one method used was to attack the institutions for the retarded. These facilities were called to public attention and shown in the worst possible light. This was primarily a media effort. Burton Blatt's book, Christmas in Purgatory (1966), described as a "photographic essay on mental retardation," was a pictorial examination of institutions and an effective mechanism for highlighting abuses that were far too common. Coupled with this "horror" approach was a positive presentation of a smaller community facility whose residents attended various community programs (Blatt, 1966:89). The latter was an attempt to graphically display the benefits of a humanistic and enlightened attitude toward the retarded.

The battle to legitimate retardation as a social problem took place in the legislative area and later in the courts. In Oregon, for example, "The Lifespan Plan" was passed by the State Legislature in 1967. This plan included diagnostic and evaluation services, education, day care centers and sheltered workshops (supervised employment sites) for the retarded. At that point, the plan was largely a concept, without funding for most services. It served, however, as legitimation for future political action and legislative funding. The late 1960's were an optimistic time. Not only would the

retarded be greatly benefitted, but the community programs would be cheaper than the institutions and save the State money.

The third stage, mobilization for action, according to Blumer's view of the development of a social problem, is a place when the "problem now becomes the object of discussion, of controversy, of differing depictions, and of diverse claims" (Blumer, 1970:303). Those opposed to the changes in the care of the mentally retarded were put on the defensive. People either believed the slogan "retarded children can be helped" or they could find no arguments to refute it.

Pragmatically, the major controversy of this stage was the debate over how to help, not whether to help. Should the trainable retarded be kept in separate buildings or integrated into existing schools? Many parents and school administrators favored the former, but were overruled by policy stands taken by the National Association for Retarded Children and other groups concerned with mental retardation, whose members were influenced by the relatively new (in this country, especially) and exciting normalization philosophy.

The fourth stage, formation of an official plan of action, ". . . represents how the society through its official apparatus perceives the problem and intends to act toward the problem" (Blumer, 1970:304). In terms of the retardation movement the most important change has been the shift to a stress on "rights." Initially, interested groups were concerned with getting support for programs for the retarded. Those groups were grateful for what was seen as successful legislation and cooperation by officials on all levels. But by stage four, the "official plan," as expressed by legislation

and law, was not concerned with public support or gratitude, it was framed in terms of rights for the retarded. An example of this shift is seen in the right to education law (PL94-142). A lawsuit brought by the Pennsylvania Association for Retarded Citizens against the State of Pennsylvania forced the issue. The advocates won rights, such as the right to eduction and the right to appropriate treatment, and had them affirmed by the Supreme Court. Parents no longer asked for classes for the retarded. They demanded that they be established and that they be adequate and appropriate or they threatened to sue.

The fifth stage in Blumer's schema, the implementation of the official plan is the stage where the mental retardation movement is today. As Blumer (1970:304-5) says:

> . . . to assume that an official plan and its implementation in practice are the same is to fly in the face of facts . . . The implementation of the plan ushers in a new process of collective definition. It sets the stage for the formation of new lines of action on the part of those involved in the social problem and those touched by the plan.

In his outline of a "contained" social problem, Roy J. V. Pallant addresses the issue of why there should be a "new process of collective definition." Pallant argues that through the first four stages just outlined, the social problem in question had low visibility with the general public. There are little data on the results of the new community-based programs, due in part to the fact that there have not as yet been very many such new programs. What information is available is not widely circulated and that which is, is read only by those who have a special interest in it. Pallant (1979:2) also says:

> However, as the remaining institutionalized mentally handicapped residents are discharged into the normalization program, it is logical to suggest that the existence of the social problems to be discussed will no longer be esoterically contained. The present distant and thereby positive manifestation of interest by the media could in a very short time become intensive and negative and may arouse undue concern by a relatively uninformed public.

Blumer (1970:305) comments on this same issue:

> I scarcely know of any facet of the general area of social problems that is more important, less understood, and less studied than that of the unforseen and unintended restructuring of the area of a social problem that arises from the implementation of an official plan of treatment.

While the outcome of the social movement toward normalization is uncertain, there have been arguments against the normalization concept and its effect on others in society. For example, there has been newspaper publicity on neighborhood concerns when "group homes," living units for up to ten mentally retarded persons, seem to suddenly appear in a place. Some educators and parents fear that mainstreaming, i.e., placing the retarded in "normal" school settings, will lead teachers to concentrate on only a few children in the classroom and thus lower the quality of education for the rest (Landauer, 1979). Within the social problems approach outlined above, the criticisms of the normalization plans can be seen as centering around one central question: In what sense are the retarded a social problem? One answer to this question would be to deny the societal interest in the issue, to revert to the notion that the retarded were individual, or at most family problems, and essentially personal problems. But if the mentally retarded are to be regarded as a social, not a personal problem, then the issue of whether this constitutes a problem which

the larger community should help to alleviate, or one from which it should be protected remains. Essentially this is the distinction between seeing the retarded as a community health problem and seeing this population as a community threat.

DEINSTITUTIONALIZATION

We have looked at the old and new philosophies of care and the social movement that propelled a process of change to the new community-based system of care built on the concept of "normalization." But what became of the old philosophy and its manifestation, the large state institution?

Along with the concept of normalization which defined large residential facilities as inherently non-normal and dehumanizing, came the companion concept of "deinstitutionalization."

Deinstitutionalization involved three interrelated processes: (1) prevention of new admissions, (2) release of as many residents as possible, and (3) upgrading the facilities for the remaining residents with the goal of future community placement (Scheerenberger, 1976:128).

Step one, the prevention of admission, was upheld by law. Scheerenberger (1976:126-127) notes:

> The principle of deinstitutionalization pertains to the right of an individual to receive treatment and programming in the <u>least restrictive environment</u>. This concept . . . has served as the founation for federal court decisions concerning right-to-treatment and is an integral part of due process . . . for children and adolescents, the least restrictive environment implies a nurturing family setting (emphasis in original).

Translated into social policy this means that it is difficult, if not impossible, for many families to get children into

institutions. The role of the institution as "relief of hard-pressed families" has been greatly reduced. However, the move away from institutions has not been coupled with an opening of other options. In Oregon, for example, there are no group homes that will take children and adolescents, only adults are eligible. Foster home placements are scarce for the mentally retarded. Parents and others who press for institutionalization quickly discover that admission to institutions is defined in terms of the rights of the individual retarded person. Until recently no consideration of the family was allowed. The Mental Retardation News (1979:2) reports:

> . . . the U.S. Supreme Court has ruled that parents may commit their children to state institutions as long as a "neutral fact finder," usually the institution psychiatrist, approves.

This decision has created some opportunity for those desiring the "institutional" solution. Scheerenberger (1976:131-2) suggests:

> Many studies have investigated parental reasons for seeking residential placement. One consistent finding is that residential care is not sought solely for the reason of mental retardation. In some negative way, a retarded person presents problems beyond the coping ability of the family.

Scheerenberger also points to other family problems, such as mother's health and medical advice (i.e., a physician's recommendation) as legitimate reasons for placement.

While some parents have had a problem with the "prevention of admission" segment of the deinstitutionalization policy, other parents have had a problem with the "return to the community" segment. Many parents have fought the removal of their offspring from institutions. Parents, in many cases, did not want their retarded offspring returned to their care. Other parents, with offspring scheduled for transfer

to nursing homes, saw institutional care as preferable to nursing home care. In addition, some parents feared the loss of one important reason for State institutionalization, security. There is a sense of security for many in knowing that retarded offspring will be taken care of by the government after the parents are dead. With placement in private non-profit or for-profit facilities, this assurance is greatly weakened, if not totally removed.

It is unfortunate that the pressure to reduce the population size in institutions came before a comprehensive network of community services had been established. Many states, for good reason, have been accused of "dumping" residents into the community (Scheerenberger, 1976:173). The rationale for "dumping," at least by the "hard-line" normalization believers, is that institutions are so dehumanizing that anything is better. Further, the facilities and services needed in the community would not be provided without the pressure of a population already in the community in need of them. Table I (Scheerenberger, 1976:172) shows the type of placements for approximately 9,000 residents placed outside institutions between 1972-73 and 1973-74.

> The adequacy of these placements in terms of normalization and personal liberty are unknown. There is sufficient evidence, however, to indicate that all may not be right with community placements either in terms of alternative residential care or <u>less restrictive</u> settings (emphasis in original).

In conclusion, it is ironic that the third segment of the definition of deinstitutionalization (the upgrading of services and programs) may make the institution more attractive or acceptable for parents. It may well be a force that will keep institutions as part

TABLE I

COMMUNITY PLACEMENTS AS REPORTED BY 115
PUBLIC RESIDENTIAL FACILITIES

Placement	Number	Percent
Independent Living	137	1.5
Work Placement	145	1.6
Parent's (or Guardian's) Home	2,448	27.0
Other Relative's Home	261	2.9
Foster Home	1,182	13.1
Boarding Home	51	.6
Group Home	2,227	24.6
ICF Facility	501	5.5
Rest or Convalescent Home	248	2.7
Nursing Home	1,386	15.3
Intensive (Nursing) Care Facility	457	5.2
Total	9,043	100.0

of a care delivery network. But there are also other forces at work that may prevent complete closure of institutions. Gettings (1977) identifies a number of hidden impediments to deinstitutionalization. Gettings (1977:215) outlines "an increasingly heated ideological debate" in the field of mental retardation:

> One school of thought argues that recent events across the country demonstrate that maximum development occurs when the physical and programmatic environment is as near normal as possible. Therefore, all institutions, they contend, are dehumanizing and should be phased out of operation as soon as possible.
>
> On the other side of the question are those professionals and parents who see the 24-hour care institution--regardless of what it is called and how it is structured--as a necessary element in the continuum of services . . . However, incrementalists argue that there will be a continuing need for facilities which provide intensive, 24-hour care and supervision to the most severely retarded, multihandicapped children and adults.

Such apparently are the problems associated with the implementation of the "official plan." Regrettably, parents have been caught in the middle of these kinds of conflicts, as have the retarded who are central to the social problem in question.

Final Thoughts on the "Debate"

The preceding discussion has covered the normalization philosophy and its effect on collective definition of a social problem. But perhaps the positive side of the changes has been neglected. A variety of writers feel that "normalization" will bring the retarded into fuller participation in conventional society and that it may change the values of society for the better. Nirje, for example, assumes that lessening of social distance will overcome prejudice and ignorance. This kind of attitude change is certainly idealistic although the precise basis of this assumption is difficult to ascertain.

On a more specific level, Nirje (1976:240) argues that:

> A normalized setting will also help the staff who work with mentally retarded people. They will appear as social educators, helping to encourage independence, rather than as custodians. They will enjoy a higher status, which will increase their self-respect and their effectiveness. Finally, the use of the principle of normalization can help parents . . . Choice of placement will be made more freely and with an easier mind instead of being an anguished decision between the horrible and the impossible.

The concept of normalization certainly did open a new career field and, as we shall see, the people who work in the field define their work as a "profession." In this sense Nirje does seem to have been correct both in the status of workers and their feelings about the field.

Whatever the merits of these broader societal implications, one benefit is clear. The community network of services has been a real benefit for many parents. There is a large majority of parents, especially parents of children in the educable or mildly retarded range, who would never consider institutional placement. For them life is, no doubt, much easier under the new philosophy of normalization.

THE "RIGHTS" ISSUE

According to Scheerenberger (1976:65):

> Perhaps the most significant trend in the field of mental retardation during the past ten years has involved the full recognition of the rights of retarded persons.

The "rights" issue is significant enough to justify further discussion here.

Scheerenberger (1976:65) divides rights into two areas: "(1) general statement of rights issued by various organizations and (2) specific litigation." There have been questions raised relative to the issue of a general statement of rights.

> The need for these separate statements of rights in view of Constitutional guarantees for every citizen has been challenged. Fram (1974), for example wrote, "The rights guaranteed by the Constitution of the United States do not have exclusionary clauses . . . When a separate Constitution for the retarded states in part, the retarded shall have the 'same rights as other human beings' this act recognized the retarded as belonging to a separate class." Fram's observations are valid; there should be no need for a separate Bill of Rights for the retarded (Scheerenberger, 1976:70-1).

This kind of statement underscores the current conflict between general, individual rights and specific rights based on ascribed or group characteristics. It also shows the value of understanding the

concepts of a communal society and citizenship as a resource of society, aspects of the structure of society in general and an advanced industrial state specifically.

Citizenship as a resource in society according to Lenski (1966:429) "facilitates the acquisition of rewards and benefits." Communal society is a feature of the post-industrial society, according to Bell (1973:128) "in which the social unit is the community rather than the individual." Bell (1973:147) also feels that communal society "multiplies the definition of rights . . . and translates them into claims of the community."

Almost everyone in the United States is a citizen and thus has individual rights as guaranteed by the Constitution. Obviously this does not mean that, in the past, everyone who lived in the United States has shared the rewards and benefits of society. Extending the full benefits of citizenship and rights to those previously excluded is a metaphor for fuller participation in the major institutions of society or "quality of life . . . now deemed desirable and possible for everyone" (Bell, 1973:127).

The new citizenship and rights are granted on group characteristics such as to blacks, women, mentally retarded, and elderly and are embodied in the laws of the land. Examples of these laws are: (1) court ordered busing to achieve integration of blacks into the educational system, (2) the quota system, ordered by the government, for hiring to ensure that women and minorities are more fully represented in the occupational sphere, and (3) the "right to education" law that brings all handicapped children into the education

system. Unfortunately, the enforcement of these kinds of laws is seen by many as threatening the individual rights of other citizens, generating conflict in society.

Both Scheerenberger and Fram are correct when they say that the retarded are protected under the Constitution, in as far as individual rights are concerned. They miss the point that the separate Bill of Rights for the retarded is a claim on the communal society for greater participation and rewards. Certainly the retarded have been treated as a separate class when specific litigation, the second of Scheerenberger's rights area, is needed to guarantee education and living situations in "the least restrictive environment."

An example of the claim on communal society nature of the various Bills of Rights is:

> The mentally retarded person has a right to proper care and physical restoration and to such education, training, habilitation and guidance as will enable him to develop his ability and potential to the fullest possible extent, no matter how severe his degree of disability. No mentally handicapped person should be deprived of such services by reason of the costs involved.

Not only is this a claim on society, it demands whatever social and economic costs necessary, going far beyond any question of individual rights.

Although "full recognition of the rights of the retarded" may be significant, it is important to understand that rights of the retarded do not hinge on any innate legal "rightness" but on an underlying economic state of surplus, the state where there are rewards and benefits enough for almost everyone in society. As the mentally retarded themselves are socially defined, so are the "rights" of the retarded as social definition.

CHAPTER III

THE POSITION OF THE MENTALLY RETARDED IN THE SOCIAL STRUCTURE

INTRODUCTION

The quality of institutions for the retarded declined considerably during the Depression and World War II. By the 1950's conditions were ripe for a new social movement for the retarded. A variety of factors, especially economic ones, played a part in the changes in this social service area. The concept of normalization, the social movement and social problem redefinition behind it needed a favorable atmosphere to flourish and succeed. Not all social movements are successful and not all attempts at amelioration of social problems are funded to the extent that mental retardation has been. This chapter explores some of the macro-level factors that affected the mentally retarded. In order to conduct this exploration, it is necessary to include the additional concepts of "redistributive function," "rights in a communal society," and "post-industrial society."

ORGANIZATIONALLY SURPLUS POPULATION IN A POST-INDUSTRIAL SOCIETY

Clinically the mentally retarded are classified individually by I.Q. level. In non-clinical settings they tend to be treated

collectively as a social problem. A sociologically relevant perspective is to see them as an organizationally surplus population, that is, a collectivity which is recognized to exist, but for which there is no recognized purpose or role. Farber (1968:13) speaks specifically of the mentally retarded when he says:

> Thus they join an amorphous group that exists but has no integral role in the social organization of the society, which could easily continue to function without this surplus population.

Michael Harrington (1962:26) speaks of a large amorphous group when he talks about the "rejects of the affluent society" and the "culture of poverty," including the retarded in this special culture.

The mentally retarded "generally fail to perform roles adequately in the basic institutions of society" (Farber, 1968:19). This includes being non-productive economically. Given that the mentally retarded have been estimated to compose 3.25 percent of the total population, this is indeed a large category of the population which is essentially non-contributing, by itself, to the national economy.

While Farber contends that society could function without this surplus population, he (1968:13) also argues that the surplus population plays several roles important in "maintaining the existing social structure."

One of the roles of surplus populations is that they "generate a series of special institutions." Farber (1968:13) explains this role:

> Organizationally surplus populations make an indirect contribution to social structure through the particular problems they create for the society. By their very incompetence and deviance, these populations require, for remediation and control, a series

> of institutions to meet the legal, welfare, health, and educational difficulties involved. As technological advances create additional segments of surplus populations, the agencies founded to meet their problems expand in size and diversity. The numbers of persons presently engaged in handling problems related to surplus populations in the United States is large enough so that there would be serious economic dislocations if all organizationally superfluous individuals were to be removed from society.

Technological advances, along with the increased complexity of society, have essentially eliminated jobs for those who have limited intelligence, are slow (not very productive), unskilled or lack coping abilities. Harrington, as well as Farber, cites technological advances as a key factor in creating surplus populations and also in explaining the agencies that are then created to meet their needs.

But these agencies are created in a rather special kind of social environment. The contention of Bell (1973) is that technological advances have shifted the focus of modern America from a "goods" producing to a "service" producing economy. He terms this new situation "post-industrial society." Bell (1973:159) writes:

> A post-industrial society . . . is increasingly a communal society wherein public mechanisms rather than the market become the allocators of goods and public choice, rather than individual demands, become the arbiter of services. A communal society by its very nature multiplies the definition of rights--the rights of children, of students, of the poor, or minorities--and translates them into claims of the community.

Service industries arise which:

> . . . deal with communal services, particularly health, education, and government. The latter has been the largest growing area since the end of World War II. The growth, in effect, has been taking place in the <u>non-profit</u> sector of society . . . More important, the non-profit sector is the major area of net new jobs, i.e., actual expansion as against replacement (Bell, 1973:146-7) (emphasis in the original).

Bell's discussion of net new jobs in health, education, and government is similar to Farber's discussion of agencies for legal, welfare, health, and educational problems.

In light of these developments, it is not surprising that the social movement for the retarded (after World War II) was able to redefine mental retardation as a health problem. The demands made on communal society on behalf of this surplus population created a whole new area of services and new jobs.

In Oregon, for example, almost all the community programs for the retarded, and the staff that go with them, are new. In Washington County alone the 1979-80 Mental Health Program budget covering the mentally retarded/developmentally disabled is over $1.5 million. This amount is to cover 1,422 clients for 10,600 service hours and does not cover such additional costs as those for the educable education programs. Certainly this money and the programs and staff that go with it can be seen as a claim on communal society. In addition there also have been changes at the State-run institutions. A pamphlet printed for the 70th anniversary of Fairview Hospital and Training Center notes a shift in client-staff ratio from 1:4.2 to 1:1.3 in nine years, much of it paid for by increases in Federal government funding. In the view of this document, "the 70's will be remembered as the decade that the human rights of the residents was (sic) addressed."

Gerhard Lenski brings in another vital factor: economic surplus. Claims on communal society would be fruitless if funds were not available to pay the claims. Lenski (1966:429) labels the governmental response to perceived legitimate claims "the redistributive function" of government.

In theory all persons and categories in a society are able to share in society largesse because of the extension of citizenship and rights to all.

According to Lenski, a focus on the redistributive function is more apt to evolve in some types of societies, with specific forms of government, than in others. According to him, the Swedish model of society, and state, is most conducive to an emphasis on the redistributive function. In his words (1966:430):

> There is also general agreement that this function is performed in varying degrees in different nations, and that it is most pronounced in countries where the Swedish pattern of political control prevails. In view of the trend toward the Swedish pattern, however, there is good reason to believe that the importance of citizenship will increase in most industrial societies in the next several decades.

Thus, the basis of the move toward normalization of the retarded and the emphasis upon the redistributive function of government had a basis in the format of the Swedish government and society, and given the societal and governmental differences it is not surprising that these concepts did not develop in the United States for at least a decade after they had found acceptance in the Scandanavian countries.

Thus far the mentally retarded have been discussed as an excellent example of (1) an organizationally surplus population and (2) a population with newly granted rights. In addition, it is a population with a new status of "full citizen in society" which needs a large number of service and care providers to ensure that these rights are implemented. These service and care providers occupy net new jobs (expansion rather than replacement) in the non-profit service area of the economy.

Bell (1973:147) hypothesizes that the people who fill these jobs will have certain distinct characteristics:

> Are there significant differences in the ethos of those engaged in the profit and non-profit sectors? There have been almost no studies in this field. Yet since the heart of the non-profit sector is health, education, and research . . . one can assume there is a core of middle-class and upper-class person who not only form a large market for culture, but whose political and social attitudes, in the main, will be more liberal than that of society as a whole.

Has the redistributive function in this care created a new career-line for the liberal, middle-class? Who really has benefitted by assigning citizenship rights to persons who have previously been excluded from the attention of society? The next chapters explore these and related questions.

CHAPTER IV

METHODOLOGY

THE RESEARCH PROBLEM

A number of issues in the area of mental retardation have been reviewed in preceding chapters. However, while not independent of the larger arena, the research presented here is concerned with the people who work in the field.

In general, it is the objective of this research to examine the backgrounds and self-perceptions of those persons who make their living by working with the officially defined mentally retarded. From the theoretical works reviewed, five general areas for investigation were derived. First, are workers in the field of mental retardation middle- and upper-middle-class people as Bell hypothesized? Second, are they more liberal than the population as a whole as Bell also hypothesized? Third, do the workers surveyed here fit Bell's hypothesis of being in an area of net new jobs? Fourth, and following from the preceding question, is this occupation seen as a profession or new professional area for middle-class people as presented by Bell and Farber? Fifth, do the workers in the field of mental retardation support the new philosophy of normalization as formulated by Nirje and Wolfensberger?

THE STUDY UNIVERSE

Washington County, Oregon is the study site. This county has a full range of services for mentally retarded persons. These services include a pre-school, public school programs for educable and trainable retarded, a sheltered workshop, activity centers, group homes, recreation programs in conjunction with Park and Recreation Districts, and specialized religious programs. Also, there is a consumer group (the Washington County Association for Retarded Citizens) and the Mentally Retarded/Developmentally Disabled Section of the County Mental Health Department, both of which work in establishing and maintaining programs for this population.

In addition, there is a large live-in facility, Good Shepard Lutheran Home, licensed as an intermediate care facility. This facility falls outside the area of community services because it is a private, non-profit living center, with admission (and population) limited. While it is characterized informally as a "mini-institution" by some, it was included in this study because Federal regulations require specialized services within the facility and many residents participate in the community service programs under the concept of "least restrictive environment." Thence, residents do not live their entire lives within the home. Therefore, the workers in this facility were included in the study population.

The study universe is composed of all people whose primary job responsibility is working in programs for the mentally retarded. Not included in the study universe were those people who perform support

services for the programs, such as secretarial or janitorial work. Also not included were those who work in church or recreation district programs whose focus is upon the general public, and therefore, only secondarily provide specialized services for the mentally retarded. Finally, those workers at Good Shepard Lutheran Home who are doing work most similar to general nursing home activities were not included in the universe.

QUESTIONNAIRE DEVELOPMENT

In order to establish a basis for comparison, a questionnaire was developed following the National Opinion Research Center's General Social Survey of 1975 and 1977 (NORC). These questions, and the associated available data, allowed for a national base line that could then be used to assess Bell's (1973) assertion that workers in the field of mental retardation (MR Workers) could be expected to be "more liberal than society as a whole" and they are "middle-class and upper-middle-class."

Furthermore, utilizing the NORC data allows for comparisons between the study population responses and the responses from a national population sample. Data from these studies are used throughout this report in an attempt to ascertain a variety of dimensions of the views of the occupants of positions in the emerging field of "mental retardation worker."

Given the interest in self-perceptions of the workers in the area, a series of questions on job satisfaction and mental retardation service work as a profession were adapted from a study done by Wager,

et al. (n.d.). Central to the thrust of the research is the degree of support given to the concept of normalization for the retarded vs. institutionalization of these persons. Thus, a number of questions were developed to tap the degree of suport of the philosophy of normalization among those employed in the field.

As a pre-test, the questionnaire was discussed with staff members of the Multnomah Association for Retarded Citizens (who would not be in the study group) as representative of the population to whom the survey would be administered. As a result, some questions were rewritten, some were deleted, and the format of the questionnaire was rearranged.

QUESTIONNAIRE ADMINISTRATION

Questionnaires were distributed to potential respondents in two ways. Private and public agencies distributed the questionnaire and cover letter to their employees. School district personnel received the questionniare and cover letter by mail. One follow-up reminder by postcard was distributed in the same manner. All agencies determined the number of employees they felt fit the description of the appropriate study universe. Since agencies are bound by confidentiality restrictions, limited access to names and addresses of the respondents was available.

A total of 146 questionnaires were distributed. A total of 86 completed questionnaires were returned, for a return rate of 59 percent. Of the 86 questionnaires returned, 39 (45.3 percent) were from school district personnel and 47 (54.7 percent) were from public or private agency personnel.

LIMITATIONS

Several limitations of this research are undoubtedly already apparent. Lack of control of the distribution of the questionnaires meant that others decided whether recipients fit the criteria for inclusion in the study universe.

Another problem was reaching school district personnel during the summer months. A replication done during the school year would probably have resulted in a larger total return rate for this group.

The demographic nature of Washington County doubtless needs to be considered in assessing the data reported here. The Washington County Mental Health Plan (1979:1-5) reports that Washington County is "predominately rural" with the bulk of the population concentrated in the Tualatin Valley. The population is "overwhelmingly Caucasian." Further:

> The median family income of $20,448 in 1977 was highest in any county in Oregon. More than one-third (35.6 percent) of employed males are in high status occupations and the County's unemployment rate of 5.9 percent in 1977 was sixth lowest in the state (Washington County Mental Health Plan, 1979:15).

It is impossible to know what, if any effect, these factors have on the results obtained.

Finally a word of caution on the topic of generalization should be added. Washington County is representative of the range of community programs available statewide. All its programs were begun during the last twelve years under the double prods of the concept of normalization and the impact of the Association for Retarded Citizens, but there are factors which make Washington County unique. Programs

for the retarded were started in this county earlier than in other areas. (The effect of two factors, (1) the presence and impact of Good Shepard Lutheran Home on community programs and (2) the presence and impact of peripheral programs, such as recreation, sponsored by community agencies, is not addressed here.) The nature of Washington County as a middle-class suburban area, if seen as a desirable place to work, could hypothetically lead to a self-selection process and competition for jobs that would produce a higher percentage of workers with the very set of characteristics that are being measured.

Comparative studies could lead to a clarification of the issues of the reactions to the mentally retarded and the self-identifications of those persons who provide service and care for the mentally retarded population.

CHAPTER V

FINDINGS

INTRODUCTION

As mentioned earlier in the discussion of methodology, the data obtained from the Mental Retardation workers in Washington County were compared with the data available from the National Opinion Research Center surveys. Given the non-representative nature of the MR workers who responded (as noted in the previous limitations discussion) elaborate statistical procedures are not appropriate. Rather than engaging in an unwarranted methodological enterprise, it seems more to the point to simply report, and interpret, the percentage differences. This chapter presents those data which bear upon the arguments developed in previous chapters.

SOCIAL CLASS

Daniel Bell hypothesized that workers in the new non-profit area would be middle-class and upper-middle-class persons. An examination of this is possible by comparing the responses of the care providers in Washington County that were surveyed (MR Workers) with the National Opinion Research Center(NORC) data.

Subjective Social Class

The questionnaire item on subjective social class is not directly comparable to the NORC data because of differences in categories. Further, the Bell hypothesis uses the terms "middle-class and upper-middle-class." Nevertheless, indirect comparison can be made and is shown in Table II and Table III. The question posed was: "If you were asked to use one of these names for your social class, which would you use?"

TABLE II

SOCIAL CLASS OF MR WORKERS

Social Class	MR Workers
Lower	0.0%
Working	9.3
Lower Middle	8.1
Middle	52.3
Upper Middle	25.6
Lower Upper	0.0
Upper	0.0
N/A	4.7
	100.0

TABLE III

SOCIAL CLASS OF GENERAL POPULATION

Social Class	NORC Sample
Lower	4.4%
Working	49.0
Middle	42.7
Upper	3.9
	100.0

In the group of workers surveyed, 77.9 percent saw themselves as middle- or upper-middle-class persons. As a comparison to the national sample, all categories of middle-class indicated by the respondents can be collapsed to show a total of 86 percent middle-class as compared to 42.7 percent in the NORC data. Thus, it is apparent that the MR workers responding saw themselves, as a population, to be more in the middle-class than does the general population, thus supporting Bell's hypothesis.

Father's Occupation and Status

Questions were framed to measure the type of social class the respondents came from, as opposed to where they currently saw themselves.

The NORC data lists father's (or father's substitute) occupation and these are coded on both occupation and prestige scores. Questions asked of the MR workers were: "who was the principal bread-winner in your family?" and asked for "the usual occupation of the principal bread-winner in your family." The principal bread-winner was: mother 9.3 percent and father 90.7 percent.[4] In comparing the data, the results may be slightly biased because "mother's" occupation was included in the MR workers group, but not in the NORC sample. All occupations were coded following the NORC scales, both for occupation and prestige. The results are shown in Table IV and Table V.

TABLE IV

OCCUPATION STATUS OF FATHERS OF MR WORKERS AND THE GENERAL POPULATION

Occupation	MR Workers	NORC	Diff.
Professional, Technical & Kindred	22.1%	6.4%	+15.7%
Managers & Administrators (Except Farm)	24.4	12.7	+11.7
Sales Workers	8.1	3.2	+ 4.9
Clerical & Kindred Workers	5.8	3.0	+ 2.8
Craftsman & Kindred Workers	16.3	25.1	- 8.8
Operatives	3.5	19.7	-16.2
Laborers (Except Farm)	4.7	6.2	- 1.5
Farmers & Farm Managers	10.5	20.4	- 9.9
Service Workers (Except Private House)	3.5	3.4	+ .1
Parent Didn't Work	1.2	----	+ 1.2
	100.1	100.1	

TABLE V

OCCUPATIONAL PRESTIGE RANKINGS OF FATHERS OF MR WORKERS AND THE GENERAL POPULATION

Prestige Rank*	MR Workers	NORC	Diff.
89-70	4.7%	2.3%	+ 2.4
69-50	38.3	15.7	+ 22.6
49-30	46.6	59.7	- 13.1
29-10	10.5	22.2	- 11.7
	100.1	99.9	

*The larger the number, the higher the prestige.

Again, both Table III and Table V show support of the Bell hypothesis that the new service workers will be disproportionately from the middle and upper-middle-class.

Another way to approach the social class question is to pose the question: "Thinking about the time you were 16 years old, compared

with American families in general then, would you say your family income was far below average, below average, average, above average, far above average?" This was done with both the NORC sample and the MR workers. The results are shown in Table VI. On this measure as well the Bell hypothesis of the social class origins of the new service workers is supported, for the MR service and care providers see themselves as coming from families with more than average incomes.

TABLE VI

FAMILY INCOME OF MR WORKERS AND THE GENERAL POPULATION, AS ESTIMATED BY RECALL

Estimated Family Income	MR Workers	NORC	Diff.
Far Below Average	7.0%	8.2%	- 1.2
Below Average	24.4	24.1	+ .3
Average	37.2	51.6	-14.4
Above Average	29.1	13.3	+15.8
Far Above Average	2.3	1.8	+ .5
DK/NA		1.0	
	100.0	100.0	

Summary

In addition to workers in the field of mental retardation seeing themselves as middle-class and upper-middle-class (77.9 percent), it would appear that they also feel they come from this class background. Respondents' fathers who were in the professional or managerial occupations totaled 46.5 percent, compared to a total of 27.4 percent for the general population sample. The survey group also showed fathers' prestige scores in the upper half of the scale 43 percent to 18 percent for the general population sample. The subjective question of

income at age 16 reinforces the previous objective measures of occupation and prestige. The respondents remembered family incomes that were "above average and far above average" for a total of 31.4 percent as compared with the general population sample combined totals of 15.1 percent. The Bell hypothesis of class status would appear to be clearly supported by the responses from mental retardation workers in Washington County.

LIBERAL ATTITUDES

Daniel Bell hypothesized that workers in the new non-profit area would be more liberal politically and socially than the population as a whole. A comparison of responses of the service and care providers in Washington County with national survey data provides an assessment of this hypothesis.

Subjective Political Liberalism

The mental retardation workers were asked to place themselves in a range of political views that people might hold. The answers and the comparison with the general population sample are shown in Table VII.

Collapsing the preceding table into three categories perhaps shows more clearly the difference between the workers in the mental retardation field and the population as a whole. The results are shown in Table VIII.

Clearly reflected in Table VIII is the more liberal self-identification of the MR workers respondents as compared with the general population sample.

TABLE VII

POLITICAL ORIENTATION OF MR WORKERS
AND THE GENERAL POPULATION

Political Category	MR Workers	NORC	Diff.
Extremely Liberal	8.1%	2.4%	+ 5.7
Liberal	31.4	11.0	+20.4
Slightly Liberal	27.9	14.0	+13.9
Moderate, Middle of Road	11.6	36.9	-25.3
Slightly Conservative	9.3	16.4	- 7.1
Conservative	7.0	11.7	- 4.7
Extremely Conservative	0.0	2.5	- 2.5
N/A	4.7	5.0	
	100.0	99.9	

TABLE VIII

POLITICAL ORIENTATION OF MR WORKERS AND THE GENERAL POPULATION
IN THREE CATEGORIES

Political Category	MR Workers	NORC	Diff.
Liberal Range	67.4%	27.4%	+40.0
Middle of the Road	11.6	36.9	-25.3
Conservative Range	16.3	30.6	-14.3
N/A	4.7	5.0	
	100.0	99.9	

Subjective Social Liberalism

Social liberalism is a fairly complex issue. Therefore, in order to assess this world view, 15 questions from the 1977 NORC material were asked of the MR workers to try to ensure that an adequate and comprehensive measure of social attitude would be obtained. Questions included dealt with both social problems and national issues. It may be argued that the national issue questions

could be included in political orientation. However, even assuming an overlap between political and general social orientation, the range of questions is intended to tap a general liberalism dimension.

The data shown in Table IX indicate that the MR workers in general respond with a more socially liberal view of how to deal with a variety of problems than did a national sample of respondents, as was predicted by the Bell hypothesis.

Summary

The data examined thus far support the Bell hypothesis that workers in the new non-profit area would be more liberal politically and socially than the population as a whole. The workers in the area of mental retardation in Washington County placed themselves heavily in the liberal range of political orientation, while the national sample was distributed relatively evenly among the three categories.

The workers in the area of mental retardation also differed from the national sample on almost all the social attitude questions and in the direction of more liberal. The exceptions are the questions of too little money spent on the "rising crime rate" and "drug addiction" where the survey population's responses are close to the views of the national sample.

With more liberal social attitudes and self-identification as more politically liberal, overall the mental retardation workers show a profile of a group that could easily support such liberal notions as a statement of rights for the retarded and the concept of normalization.

TABLE IX

SOCIAL ORIENTATION OF MR WORKERS AND THE GENERAL POPULATION

Social Issue*	MR Workers	NORC	Diff.
Courts do not deal harshly enough with criminals	37.2%	82.9%	+45.7**
Favor the death penalty for murder	26.7	66.8	+40.1**
Oppose required Bible/prayer in public schools	74.4	33.3	+41.1
Right to suicide if has an incurable disease	68.6	37.8	+30.8
Right to suicide if has gone bankrupt	20.9	6.8	+14.1
Right to suicide if has dishonored family	19.8	7.5	+12.3
Right to suicide if tired of living and ready to die	27.9	13.2	+14.7
Too little money spent on protecting environment	70.9	47.3	+23.6
Too little money spent on nation's health	73.3	55.6	+17.7
Too little money spent on big city problems	48.8	40.2	+ 8.6
Too little money spent on rising crime rate	64.0	65.5	+ 1.5
Too little money spent on drug addiction	48.8	54.8	- 6.0
Too little money spent on nation's education system	72.1	47.5	+24.6
Too little money spent on condition of Blacks	36.0	25.0	+11.0
Too little money spent on Welfare	22.1	12.3	+ 9.8

* These questions correspond to questions 1, 3, 5, 14-17, and 19-26 on pages 5 and 6 of the questionnaire, Appendix A.

** The wording of the first two questions results in a positive response indicating a conservative viewpoint and a negative response as a more liberal viewpoint. The reverse is true for the rest of the questions. The plus percentage difference shows a more liberal social orientation.

It could be argued that the more liberal political and social attitudes may be the result of the higher educational levels of this population,[3] however this was not the question posed. It would be interesting to explore the possibility that those workers in the area of communal services are more liberal than workers of comparable education levels, in, for example, business administration or engineering, where orientation and training rather than education itself might be a factor. One might speculate on the differences of perceived social desirability, as well.

MENTAL RETARDATION AS AN AREA OF NET NEW JOBS

Bell saw the non-profit sector as an area of new new jobs. Farber saw an increase in size and diversity in agencies for surplus populations. Common sense indicates that if group homes, sheltered workshops, and other programs for the mentally retarded are new programs, they would provide jobs that had not existed before.

One approach to these issues is to examine the age of the workers in the field, how many years they have worked with the mentally retarded, and how many previous jobs they have held, and then to see if this information supports the concept of a new job area.

Age and sex of the survey population is shown in Table X. From these data it does appear that the field of mental retardation workers is a new occupational area, given the relatively youthful nature of the respondents.

The question was asked "How many years have you worked in the area of Mental Retardation?" The results, with the cumulative

TABLE X

AGE AND SEX OF MR WORKERS

Age	Male		Female		Totals	
18-21	1.2%	(1)	5.8%	(5)	7.0%	(6)
22-25	5.8	(5)	7.0	(6)	12.8	(11)
26-29	7.0	(6)	20.9	(18)	27.9	(24)
30-33	4.7	(4)	15.1	(13)	19.8	(17)
34-37	2.3	(2)	7.0	(6)	9.3	(8)
38-42	2.3	(2)	7.0	(6)	9.3	(8)
43-47	1.2	(1)	5.8	(5)	7.0	(6)
52-Over	2.3	(2)	4.7	(4)	7.0	(6)
	26.8	(23)	73.3	(63)	100.1	(86)

frequencies, are shown in Table XI. Fairly clearly reflected in these data is the "new job" nature of the area of mental retardation work, that is, over one-third of the workers had been in the field three years or less and over half had been in this line of work for four years or less.

TABLE XI

NUMBER OF YEARS IN THE AREA OF MENTAL RETARDATION

Years	Number	Cumulative Frequency	Years	Number	Cumulative Frequency
1	10	11.8%	9	1	83.6%
2	12	25.9	10	7	90.6
3	11	38.8	11	1	91.8
4	12	52.9	12	1	92.9
5	9	63.5	14	3	96.5
6	3	67.1	15	1	97.6
7	8	76.5	19	1	98.8
8	5	82.4	N/A	1	100.0

Another approach to the "newness of the field" issue was to ask: "How many full time jobs did you have before you started working in the field of mental retardation?" The results, with cumulative frequencies, are shown in Table XII. Once again the newness of the field is shown by these data. Almost half of the respondents had had only one other job prior to the current one, and three-fourths had held three or fewer previous positions, suggesting an expansion into a new sector.

TABLE XII

NUMBER OF JOBS PRIOR TO WORK IN MENTAL RETARDATION

Jobs	Number	Cumulative Frequency	Jobs	Number	Cumulative Frequency
0	18	20.9%	4	5	83.7%
1	19	43.0	5	6	90.7
2	17	62.8	6+	8	100.0
3	13	77.9			

Summary

All these findings are consistent with Bell's hypothesis of net new jobs in an expanding area of work and Farber's concept of expanding agencies. The workers are young, early in their career field, and have either started there or switched relatively early into the area of mental retardation.

With community programs and trainable education classes being new in the last 12 years, "old-timers" in the field of mental retardation would not be expected. Table XI shows approximately 91 percent working in the field ten years or less; with over half (53

percent) in the field four years or less. Table XII shows a surprising 21 percent having their first full-time job in the mental retardation field. The age range of the mental retardation workers was from 18 to 60 years old; modal age was 28 years; and the mean age was 32.5 years. Table X shows the largest group of workers (46.5 percent) fall in the age range between 26 and 33 years of age. It would be interesting to do another study of this nature after another 12 years to see if the workers will "age" within the field of work, or be replaced by other, younger workers.

PROFESSIONALISM

Nirje speaks of the effect of normalization on the people who work with mentally retarded persons, that they will appear as social educators rather than custodians and will enjoy a higher status which will increase their self-respect and their effectiveness. The implication seems to be an increase in prestige for those in a field which has had a negative image.

Farber, with his emphasis on increase in agencies to meet needs of an organizationally surplus population, and Bell, with his net new job approach, omit the status or prestige question entirely. The emphasis is on the workers themselves as middle-class white-collar people, rather than people who reflect or are tied to the stigma of the mentally retarded.

But how the workers themselves see their jobs in terms of status and class is a question which can be addressed by asking whether or not the people who work in the area of mental retardation see this as a profession.

Within a strict sociological definition, it would be hard to argue that mental retardation care and service is a profession. There are no specific academic or training programs for workers in the field of mental retardation. There are no standards or licensing procedures to qualify for this work (aside from those who work in the public education area). Many of the people working in the field could be expected to identify themselves as teachers, who are working in an area of specialization. Finally, there are a wide variety of academic degrees held by workers in the mental retardation field, some in specific occupational areas outside of education.

It might be expected from these factors that workers in the field would not see mental retardation as a profession or would be ambivalent in their feelings.

To test this prediction, two measures were used. First, a measure of the area of college degrees of the survey population was employed, and second the subjective feelings of the respondents on the question of their occupation being a profession was probed.

Of the total of 86 respondents, 66 had college degrees. The academic area of these degrees is shown in Table XIII.

TABLE XIII

ACADEMIC AREA OF COLLEGE DEGREES OF MR WORKERS

Degree	Percent	Number
Education/Special Ed.	47.0%	31
Social Science	28.8	19
Business	1.5	1
Specific Occupational	18.2	12
Other	4.5	3
	100.0	66

Given the newness of the occupational area it was hypothesized that the workers would show a great deal of ambivalence and uncertainty about whether they were or were not working in an occupation that would qualify as a profession.

In order to assess this hypothesis, three questions were used in an attempt to elicit, not only attitudes about the work as a profession, but also the certainty that the workers felt about the professional nature of the work. These questions were: "In general do you think of work in the field of mental retardation as a profession?"; "How strongly do you feel about this?"; and "How difficult is it for you to decide whether or not work in the area of mental retardation is a profession?" The results are presented in Table XIV in the form of polar opposites, i.e., the strongest feelings of yes and no are at either end, with ambivalent respondents in the middle.

Summary

The results do not support the hypothesis. In spite of the variety of college degrees and the large percentage of educational degrees that would supposedly identify the holders as members of the educational profession, the respondents labeled the area of mental retardation as a profession. A total of 86 percent of the respondents felt this area was a profession and felt very strongly or strongly about it; as compared to 3.6 percent who felt it was not a profession and felt very strongly or strongly about it. The expected ambivalence and uncertainty was evidenced only by the remaining 10 percent.

TABLE XIV

HOW MR WORKERS FEEL ABOUT AREA AS A PROFESSION

Degree of Difficulty	Yes, A Profession Feel Very Strongly	Yes, A Profession Feel Strongly	Yes, a Profession Feel Not Very Strongly	Yes, A Profession Feel Not At All Strongly	NA	No, Not a Profession Feel Not Very All Strongly	No, Not a Profession Feel Not Very Strongly	No, Not a Profession Feel Feel Strongly	No, Not a Profession Feel Very Strongly
Not at all Difficult	49.4%	12.9%	0.0	0.0	0.0	1.2%	0.0	0.0	2.4%
Not Very Difficult	3.5	16.5	3.5	0.0	0.0	0.0	2.4	0.0	1.2
Difficult	1.2	2.4	0.0	0.0	2.4	0.0	0.0	1.2	0.0
Very Difficult	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	54.1	31.8	3.5	0.0	2.4	1.2	2.4	1.2	3.6

PHILOSOPHY OF CARE FOR THE MENTALLY RETARDED

Another issue the data reported here can address is the normalization concept as outlined by Nirje and Wolfensberger. It would be assumed that workers in the mental retardation field would feel a strong degree of support for community programs and facilities for the retarded. It could likewise be assumed that the workers in the field would be opposed to institutionalization. Tied to the question of institutionalization is the question of ideological debate that Gettings addressed. All three issues will be discussed in this section.

The normalization concept is predicated on a community based system and adherents of this approach disclaim the institution as "dehumanizing." Questions were asked that attempted to measure the respondents' feelings both on community facilities and institutions. Out of the information obtained on the question of institutionalization, inferences were drawn to support the Gettings argument of an ideological division in the field of mental retardation over the necessity of some form of institution.

Community Care

The questions asked of the survey respondents were: "In general how do you feel about the mentally retarded utilizing community placements and facilities (as opposed to institutions)?" and "In general how do you think people in this county feel about the mentally retarded utilizing community placements and facilities (as opposed to state institutions)?" The results are shown in Table XV.

TABLE XV

DEGREE OF SUPPORT FOR COMMUNITY FACILITIES: MR WORKERS' VIEWS AND MR WORKERS' PERCEPTIONS OF COMMUNITY ATTITUDES

Degree of Support	MR Workers	Community	Diff.
Very Supportive	79.1%	5.8%	+73.3
Supportive	17.4	44.2	-26.8
Neutral	3.5	27.9	-24.4
Not Supportive	0.0	17.4	-17.4
Not at all Supportive	0.0	1.2	- 1.2
N/A		3.6	----
	100.0	100.0	

It appears that the persons who are working in the field of mental retardation see themselves overwhelmingly supportive of community facilities for the retarded, while seeing the general community as being less enthusiastic, but nevertheless, supportive of such facilities.

Institutions

Clearly it is in the self interest of persons who are working with the mentally retarded in the community to keep the retarded out of the institution. In order to assess the strength of this interest, an open-ended question "Under what special circumstances would you favor admission of a mentally retarded child or adult to a state institution?"[5] was included in the questionnaire.

Responses to this question were sorted into five categories: none, external factors, individual characteristics, and other considerations. Presented in Table XVI are the percentages endorsing each of the five categories, and the percentages separately for school and other agency personnel.

TABLE XVI

SPECIAL CIRCUMSTANCES FOR INSTITUTIONALIZATION, BY PERCENT AND PLACE OF EMPLOYMENT

Reasons	Totals	School	Agency	Diff.
None	10%	6%	14%	- 8
External Factors	28	19	34	- 15
Individual Characteristics	46	50	43	+ 7
Family Concerns	10	19	2	+ 17
Other Considerations	6	6	7	- 1
	100	100	100	

Persons employed in schools appear to give greater weight to family concerns, while agency staff put more emphasis upon external factors (such as lack of community services) in recommending institutionalization of the retarded.

However, place of employment is not independent of background characteristics of the workers. That is, school district personnel tend to have education degrees, work in the larger context of the school system, and deal with retarded people under 21 years of age. Agency personnel, in contrast, have more of a variety of advanced degrees, work in the context of the community, and deal with many more of the adult retarded.

The question specifically asked for the circumstances under which the MR worker would see institutionalization as an appropriate method of care for the retarded. The 10 percent who responded "none" are, of course, those who most clearly support the "pure" normalization concept.

"External factors" was the response of 28 percent of the respondents and can be characterized by the terms "lack of community

services" and "last resort." The problem here is seen as resting in the community or incapable parents, not with the retarded person.

"Individual characteristics" was the response of 46 percent of the survey population and is characterized by the terms "severe or profoundly retarded" and "dangerous to self or others." The problem here is seen as resting in the condition or behavior of the retarded person. Those offering this response envision an institutional population composed of those retarded who cannot be trained, those with severe medical problems and those who must be removed from society because they present a danger.

"Family concerns" was given by 10 percent of the respondents as a reason for institutionalization, not a factor given much consideration by many of the major writers in the field. The responses fit the reasons that parents give for institutionalizing their retarded offspring and are included in Scheerenberger's discussion of family management problems. The fact that professionals in the field give these same reasons makes the family the unit of concern and transcends issues of individual rights and lack of community facilities. The answers in this category can be illustrated by the answer "When the person becomes too disruptive, for any reason, to his family's life - their structure as a family is most important."

The last category, "other considerations," was the response of 6 percent of the mental retardation workers surveyed. The answers in this category fall outside ideological boundries, but bring in factors that are not usually given serious consideration. These factors include short-term programs such as respite care and training for

individual needs, lack of safety in the community (the retarded as potential "victims"), and fear of leaving the institution. Another answer given was "being with people like themselves," a phrase that is severely criticized by most professionals in this field as a justification for hiding away stigmatized people; yet the phrase could also be interpreted as "peer group relationships" and also encompasses and answers the criticism of "stress in the community" engendered by community programs. The answer "if they wanted to go" may seem frivolous at first glance, but I am aware of a case where admission to Oregon's Fairview Hospital and Training Center was the choice of the individual, based on valid reasons.

In line with Getting's argument of an ideological division in the field of mental retardation between those who feel that all institutions should be phased out and those who see a continued need for some kind of 24-hour care facility, it would seem that the "none" and "external factors" categories fall into the community only ideology, and that the "individual characteristics" falls into the continued need (for institutions) ideology. This leaves "family concerns" and "other considerations" outside of the ideological debate altogether. Although it would seem that "family concerns" would be included in the argument for institutions, the argument is centered on needs of the retarded, not their families, so in this context it is excluded. Given these definitions, the above data can be collapsed into a trichotomy. Table XVII shows the result of this approach.

Not only are there differences between the school district and public and private agency personnel, there are differences within the

TABLE XVII

IDEOLOGICAL DIVISION BETWEEN SCHOOL AND AGENCY PERSONNEL

Ideology	School		Agency	
Community Only	25%	(9)	48%	(23)
Continued Need	50	(18)	43	(20)
Outside Ideology	25	(9)	9	(4)
	100	(36)	100	(47)

school and agency categories. Although the institution may be "left-over" from an old philosophy of care, at least for the present it seems to be perceived to fill a need.

Summary

As was hypothesized, the workers in the field of mental retardation are very supportive of community facilities for dealing with the mentally retarded. As Table XV shows, 79 percent listed "very supportive" as their choice of response. The combined categories "supportive" and "very supportive" included 96.5 percent of the survey population, yet they perceived that the community response in the same two categories would only be 50 percent. These results indicate a perception of a difference of philosophy between those in the field of mental retardation and the rest of the community. It is important to note that this is not necessarily how community members might actually respond if they (and not the professionals in the field) were asked the same question.

In line with the normalization theory, it was assumed the workers in the field would be opposed to institutions, so the 10 percent

response of "none" as a rationale for institutionalization is not surprising. The 28 percent responding with "external factors" is likely a recognition that community programs are not at a stage where they can meet all needs. What is surprising is the 46 percent endorsement of the view that some individual's needs could best be met in institutions; that there was something about the individual that justified institutional care.

Although only speculative, this does seem to support the Getting's concept of an ideological division among workers in the field, as does Table XVII even though the division may not be apparent, either to the workers or the general public.

CONCLUSION

An "ideal type" of a service or care provider in the field of mental retardation would show a young, middle or upper-middle-class person who comes from a family of the same class status. This person would also be well-educated, more liberal politically and socially than the general population, and recently embarked upon a career line the person likes to think of as a profession.

This profile of a worker in the field of mental retardation would seem to lend credence to Bell's description of the probable characteristics of workers in new job areas, although the field of mental retardation is but a small segment of the whole spectrum of health, education and government jobs that he sees developing in the communal service area in the post-industrial society.

The development of new programs for the mentally retarded in the last 12 years not only fits Bell's concept of net new jobs, but also Farber's idea of an increase in the size and diversity of agencies to meet the needs of an organizationally surplus population. The agencies responsible for mental retardation have established new areas of service in activity centers, sheltered workshops, group homes, and public education for the trainable retarded. These are services for the mentally retarded that did not exist in the past.

An important and often overlooked factor in understanding the net new jobs and increase in size and diversity of agencies in the field of mental retardation is the social movement process. Within the structural framework of communal society and the redistributive functions of government, the social movement was the instrument that made successful demands for services and funding. There are many segments of the organizationally surplus population; there are many demands on communal society; and there are many failed or just not very successful social movements. The social movement for the mentally retarded was very successful. It not only generated a system of community services that required service and care providers, it was responsible for the public law that says that all children have a right to education. This law affects all physically or mentally handicapped children, not just the mentally retarded, and creates a demand for special education teachers.

In answer to the question "Has the redistributive function in this case created a new career-line for the liberal, middle-class," on the basis of this research the answer would have to be "yes."

The answer to the question "Who really has benefitted by assigning citizenship rights to persons who have previously been excluded from the attention of society?" is not answered so easily. Certainly the result of these new rights, the net new jobs and expansion of agencies, has benefitted the service and care providers who now work in the area of mental retardation. They are the clear beneficiaries.

On the basis of this research, the benefits for the mentally retarded themselves are not so clear. Although the mentally retarded were not the objects of this study, one could speculate that to the extent that the service and care providers believe in the philosophy underlying the community care system and see themselves as professionals in the field, the mentally retarded that they serve are also beneficiaries. One might speculate also that the concept of deinstitutionalization, with the upgrading of programs and services, would also benefit those who reside in institutions, though perhaps to a lesser degree.

It also seems clear that both community programs and institutional care are considered appropriate services for the mentally retarded at this time. However, this research seems to indicate that this is an area of divisiveness in the field of mental retardation and thus an area that may be subject to redefinition in the future.

Although parent's groups were early champions of services and rights for the mentally retarded, one could speculate that the service and care providers comprise a new, powerful advocate group for the retarded, both to protect and expand their own career line and to protect the rights of the mentally retarded as a group.

NOTES

1. C. Wright Mills (1959:8-13) defines "the personal troubles of milieu" and the "public issues of social structure" which sound similar to the distinction made here but actually have a different meaning. The terms "private problem" and "public problem" relate to the process of "collective definition" to change one to the other in the Blumerian sense.

2. Since normalization is a dominant belief system, serious challenges are few and are located at the fringes of the literature, i.e., mainly unpublished. Most criticisms of facilities (other than institutions) see the solution to the problems as accountability, better evaluation and monitoring, and most of all, more money. See Brown and Guard (1979), "The Treatment Milieu for Retarded Persons in Nursing Homes"; Pallant (1979), "Social Problems Associated with the 'Normalization' of the Mentally Handicapped; and Rhoades (1975), "A Sociological Challenge to Normalization as Applied to Community Alternative Residential Facilities."

3. Kelly and Chamblis (1966:382) make this point, "Education it turns out, is the best predicator of political attitudes . . ." They also point out (1966:381) that: "Political liberalism is not a unidimensional phenomenon. Persons who are liberal on some issues may be conservative on others. In general, the higher the social class standing the greater the liberalism on civil rights, civil liberties and internationalism scales, and the greater the conservatism on welfare issues" (emphasis in the original). For the purposes of this study, liberalism, both political and social, is treated as if it is unidimensional.

4. Survey questions by necessity have to be general and never cover all contingencies. However, the question "Who was the principal bread-winner in your family?" elicited nine responses of "both father and mother equally," which was 10.5 percent of the respondents. There were also three responses of "father then mother" and two responses of "both parents work but am listing the parent with the highest or most stable income." I think there is some indication that this question (and others like it) that assume there is one consistent principal bread-winner may not accurately reflect the reality of society today. Most responses were coded on the father's occupation for this study.

5. An underlying assumption of this question is that the professionals in this field would, in line with the normalization concept, be opposed to institutionalization. This assumption was strengthened during the pre-test, when it was suggested that the phrase "even though you may oppose institutionalization" that prefaced the question was a double-negative and not necessary for understanding the question, and the phrase was removed.

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APPENDIX A

SURVEY LETTER AND QUESTIONNAIRE

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SURVEY LETTER AND QUESTIONNAIRE

Dear Respondent:

I am asking for your help in my attempts to find out about the people in Washington County who work with children and adults who are mentally retarded. Some speculation but little research has been done on the characteristics of those of you who work in this important area. This study is a major part of my work for the Master of Science degree in Sociology at Portland State University. The thesis topic is "Career Lines in the Area of Mental Retardation," and will cover not only characteristics of workers in the area, but also change in the number of workers over the past twelve years and changes in the philosophy of care and services that has made this development possible.

The questionnaire has three parts: about how you see your work; about yourself and your background; and about the way you think about some issues in society.

This survey is meant to be anonymous, and there is no way that I or anyone else can identify any individual. If you have questions please call me at home (648-3328) or call my thesis sponsor Dr. Joseph F. Jones at Portland State University (229-3926). If you are interested in the results, please call and I will be happy to share them with you when the analysis is completed.

I would appreciate your cooperation and time in filling out the questionnaire as completely as possible and returning it to me by _____ 1979.

Thank you very much for your assistance.

Sincerely yours,

Charlotte Ballard

ABOUT YOUR WORK SATISFACTION AND EXPECTATIONS

IN ORDER TO UNDERSTAND THE WAY IN WHICH PEOPLE WHO WORK IN THE AREA OF MENTAL RETARDATION SEE THEIR JOBS AND THEIR SATISFACTIONS, WE WOULD LIKE YOU TO ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR JOB AND THE SERVICE AREA IN WHICH YOU WORK.

*****

1. On the whole, how satisfied are you with the work you do--would you say that you are:

1_____very satisfied
2_____moderately satisfied
3_____a little dissatisfied
4_____very dissatisfied

In general, how satisfied are you with the recognition and support you receive in your work from:

2. The personnel who most closely examines your work.

1_____very satisfied
2_____moderately satisfied
3_____a little dissatisfied
4_____very dissatisfied

3. Parents of mentally retarded people.

1_____very satisfied
2_____moderately satisfied
3_____a little dissatisfied
4_____very dissatisfied

4. The community in general.

1_____very satisfied
2_____moderately satisfied
3_____a little dissatisfied
4_____very dissatisfied

5. In general how satisfied are you with your opportunities to utilize specialized skills in your work?

1_____very satisfied
2_____moderately satisfied
3_____a little dissatisfied
4_____very dissatisfied

6a. In general do you think of work in the field of mental retardation as a profession?

1_____yes
2_____no

6b. How strongly do you feel about this?

1_____very strongly
2_____strongly
3_____not very strongly
4_____not at all strongly

7. How difficult is it for you to decide whether or not work in the area of mental retardation is a profession?

1_____very difficult
2_____difficult
3_____not very difficult
4_____not at all difficult

8. How many years have you worked in the area of mental retardation?

_____

9. Is there any occupation--either in or outside the mental retardation field--you would seriously like to have, other than the one you have now?

1_____yes If yes, which one (please be as specific as possible)?
2_____no _____

10. In general, how do you think people in this county feel about the mentally retarded utilizing community placements and facilities (as opposed to state institutions)?

1_____very supportive
2_____supportive
3_____neutral
4_____not supportive
5_____not at all supportive

11. In general, how do <u>you</u> feel about the mentally retarded utilizing community placements and facilities (as opposed to state institutions)?

1_____very supportive
2_____supportive
3_____neutral
4_____not supportive
5_____not at all supportive

12. Under what special circumstances would you favor admission of a mentally retarded child or adult to a state institution?

_____

_____

13. Do you have any opinions, concerns or feelings that you would like to express about your job or the area of mental retardation in general? Here is your chance._____

_____

_____

ABOUT YOURSELF

NEXT, WE WOULD LIKE TO KNOW SOMETHING ABOUT YOUR PERSONAL BACKGROUND. IN MANY AREAS QUESTIONS SUCH AS THESE HAVE BEEN USEFUL IN HELPING TO UNDERSTAND THE WAYS IN WHICH PEOPLE SEE THEIR JOBS AND JOB SETTINGS. SOME OF THESE QUESTIONS HAVE BEEN ASKED IN A NATIONAL SAMPLE, WHICH WILL MAKE POSSIBLE SOME COMPARISONS OF PERSONS IN JOBS LIKE YOURS WITH THE GENERAL POPULATION.

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1. During the time you were growing up who was the principal bread-winner in your family?_____

   Describe the usual occupation of the principal bread-winner during the time you were growing up.

   Job Title:_____

   Main Duties:_____

   In what kind of agency, firm, or concern does (did) the principal bread-winner work and what did they do/make?

   _____

2. Thinking about the time when you were 16 years old, compared with American families in general then, would you say your family income was:

   1_____far below average
   2_____below average
   3_____average
   4_____above average
   5_____far above average

3. What is the highest grade in school (<u>not</u> including schooling such as business college, technical or vocational training) that you completed and got credit for? _____

4. Do you have any college degrees?

   1_____yes If yes, what degrees and in what field?
   2_____no _____

5. How many full time jobs did you have before you started working in the field of mental retardation?_____

6. In what year were you born?_____

7. Are you female_____ or male_____?

8. If you were asked to use one of these names for your social class, which would you use?

1_____lower class
2_____working class
3_____lower middle class
4_____middle class
5_____upper middle class
6_____lower upper class
7_____upper class

9. We hear a lot of talk these days about liberals and conservatives. Following is a range of political views that people might hold. Where would you place yourself on this list?

1_____extremely liberal
2_____liberal
3_____slightly liberal
4_____moderate, middle of the road
5_____slightly conservative
6_____conservative
7_____extremely conservative

How many and what kind of organizations do you belong to? Listed below are 16 kinds of organizations (including other). If you answer "yes" please specify also "how many."

		1 Yes	2 No	3 How Many
10.	Fraternal Groups	(____)	(____)	(____)
11.	Service Clubs	(____)	(____)	(____)
12.	Veterans Groups	(____)	(____)	(____)
13.	Political Clubs	(____)	(____)	(____)
14.	Labor Unions	(____)	(____)	(____)
15.	Sports Groups	(____)	(____)	(____)
16.	Youth Groups	(____)	(____)	(____)
17.	School Service Clubs	(____)	(____)	(____)
18.	Hobby or Garden Groups	(____)	(____)	(____)
19.	School Fraternities or Sororities	(____)	(____)	(____)
20.	Nationality Groups	(____)	(____)	(____)
21.	Farm Organizations	(____)	(____)	(____)
22.	Literary/Art/Discussion/Study Groups	(____)	(____)	(____)
23.	Professional or Academic Societies	(____)	(____)	(____)
24.	Church Affiliated Groups	(____)	(____)	(____)
25.	Any other groups	(____)	(____)	(____)

26. Are you employed by:

1_____a school district
2_____a public agency
3_____a private agency
4_____not employed, a volunteer

GENERAL SOCIAL ATTITUDES

FOR THE PURPOSES OF THIS STUDY, AND TO LEARN MORE ABOUT THIS IMPORTANT AREA, WE WOULD LIKE TO COMPARE THE SOCIAL ATTITUDES OF PERSONS WORKING IN THE AREA OF MENTAL RETARDATION WITH THE SOCIAL ATTITUDES OF A NATIONAL SURVEY OF THE GENERAL POPULATION. THE FOLLOWING QUESTIONS HAVE BEEN ASKED OF A SAMPLE OF THE UNITED STATES POPULATION; YOUR ANSWERS TO THEM WILL BE VERY USEFUL TO US.

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1. In general, do you think the courts in this metropolitan area deal too harshly or not harshly enough with criminals?

   1_____too harshly
   2_____not harshly enough
   3_____don't know

2. Do you think the use of marijuana should be made legal or not?

   1_____should
   2_____should not
   3_____don't know

3. Do you favor or oppose the death penalty for persons convicted of murder?

   1_____favor
   2_____oppose
   3_____don't know

4. Would you favor or oppose a law which would require a person to obtain a police permit before he or she could buy a gun?

   1_____favor
   2_____oppose
   3_____don't know

5. The United State Supreme Court has ruled that no state or local government may require the reading of the Lord's Prayer or Bible verses in public schools. What are your views on this--do you approve or disapprove of the court ruling?

   1_____approve
   2_____disapprove
   3_____don't know

6. Should divorce in this country be easier or more difficult to obtain than it is now?

   1_____easier
   2_____more difficut
   3_____don't know

Below are listed some of the major social institutions in this country. As far as the people running these institutions are concerned, would you say that you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?

		1 Great Deal	2 Only Some	3 Hardly Any
7.	Banks and financial institutions	(____)	(____)	(____)
8.	Major companies	(____)	(____)	(____)
9.	Organized religion	(____)	(____)	(____)
10.	Education	(____)	(____)	(____)
11.	U.S. Supreme Court	(____)	(____)	(____)
12.	Scientific Community	(____)	(____)	(____)
13.	Congress	(____)	(____)	(____)

Do you think a person has the right to end his or her own life if this person:

		1 Yes	2 No	3 Don't Know
14.	Has an incurable disease	(____)	(____)	(____)
15.	Has gone bankrupt	(____)	(____)	(____)
16.	Has dishonored his/her family	(____)	(____)	(____)
17.	Is tired of living and ready to die	(____)	(____)	(____)

18. Thinking about all the different kinds of governments in the world today, which of these statements comes closest to how you feel about communism as a form of government?

1_____It's the worst kind of all
2_____It's bad, but no worse than some others
3_____It's all right for some countries
4_____It's a good form of government

We are faced with many problems in this country, none of which can be solved easily or inexpensively. I'm going to list some of these problems and for each one, I'd like you to tell me whether you think we're spending too much money on it, too little money or about the right amount.

		1 Too Much	2 Too Little	3 About Right
19.	Improving & protecting the environment	(____)	(____)	(____)
20.	Improving & protecting the nations' health	(____)	(____)	(____)
21.	Solving the problems of the big cities	(____)	(____)	(____)
22.	Halting the rising crime rate	(____)	(____)	(____)
23.	Dealing with drug addiction	(____)	(____)	(____)
24.	Improving the nation's education system	(____)	(____)	(____)
25.	Improving the condition of Blacks	(____)	(____)	(____)
26.	Welfare	(____)	(____)	(____)

Thank you again for your help.