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1 Culture, classification and (in)competence

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This collection of essays is about the social categorisation of individuals as 'incompetent'. Juxtaposing discussions of 'incompetence' and 'competence' in different cultural settings, the contributors hope to encourage readers to question the nature and status of these notions. Although, for stylistic reasons, I will not retain the inverted commas around these and similar words throughout this chapter, they are meant to indicate their contested and problematic character. Nor is it our intention to render them less contested or problematic: quite the reverse, our aim is to provoke questions and raise creative doubts.

This enterprise builds on the small amount of work that has adopted a comparative perspective on 'mental retardation' (Dybwad 1970; Edgerton 1970; Kidd 1970; Manion and Bersani 1987; Zevenbergen 1986) and follows on the heels of a session discussing these issues at the 1994 meeting of the American Anthropological Association. It is also part of the trend that has produced a recent collection of papers offering a cross-cultural perspective on disability, in its widest sense (Ingstad and Whyte 1995). Thinking about these topics in the widest of contexts is increasingly being recognised as vital, if we are to understand them better (cf. Barnes 1996).

(In)competence

'Competence' is the capacity or potential for adequate functioning-in-context as a socialised human. It is generally taken for granted and axiomatic. In this definition, *capacities*, *potentials* and *adequacies* are to be understood as socially constructed and ascribed – and hence locally variable – rather than 'objective' attributes of persons. *Axiomatic* suggests that the competence of most individuals is not in doubt until it *is* in doubt: in the absence of evidence to the contrary, competence can be presumed, by self and others. In all local settings there are, however, those to whom the presumption of competence is not extended or from whom it has been withdrawn. That they must strive to be competent – more accurately, to

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be *seen* to be competent – is among the most telling indicators of their exclusion from the fellowship of competence. As Tim and Wendy Booth argue in Chapter 3, the presumption of *in*competence may also be axiomatic: in Britain this presumption is a powerful constraint upon people who are categorised as 'having learning difficulties'.

Categorisations of incompetence may have historical affinities with other categorisations of persons. In any local cultural context, what it means to be 'properly' human in the abstract, and the particular meaning(s) of individual human-ness, are typically the taken-for-granted bedrock upon which mutual sociality is constructed. But human-ness is socially defined and culturally variable. Doubt – or more than doubt – about the full humanity of some individuals or collectivities appears to be common. Historically, cross-culturally, and in our own backyards today, there are many instances in which individuals and collectivities have been, or are, denied their full humanity by others.

A familiar case is racism. Here members of entire social categories are defined as inhuman or as inferior humans and treated accordingly. The categorisation of persons as fundamentally incompetent has, indeed, some things in common with racism. Like 'racial' inferiority, incompetence is typically attributed or ascribed to others; it is unlikely to be self-ordained. Like 'race', it is often bound up with socio-cultural models of the body. Physical impairments, for example, have considerable impact upon socially defined 'human-ness' in some local contexts (Whyte and Ingstad 1995: 10–11; Murphy 1987). Categorisations of incompetence and 'racial' categorisations are often dimensions of hierarchical schema of human adequacy and acceptability: as sexual partners, mates, affines, colleagues, neighbours and so on.

Historically, ever more precise definitions and measurements of both incompetence and 'racial' difference were central to the burgeoning science and statistics of 'normality'. 'Racial' Otherness was equated or associated with incompetence or inadequacy, as in the typification of Down's Syndrome as 'mongolism', and in nineteenth-century ethnic classifications of mental degeneracy and idiocy (Miller 1995: 217). In the twentieth century there has been an even more consequential history of the racialisation of intelligence and competence (Fraser 1995; Herrnstein and Murray 1994; Jensen 1969). Inspired scientifically by Galton and the eugenic vision, the pursuit of 'racial' fitness was taken to the point of mass extermination (Burleigh 1991; Burleigh and Wippermann 1991). 'Racial' fitness, entangled with notions about individual incompetence, produced Nazi euthanasia programmes (Burleigh 1994). Less dramatically, in the contemporary world local political economies of (in)competence are, as Nancy Lundgren discusses in Chapter 9 with respect to Belize, located

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within wider racialised hierarchies of dependency and underdevelopment that have their roots in colonialism and empire. This may result in axiomatic presumptions of 'racial' incompetence.

Attributions of incompetence do not, of course, necessarily equate with dehumanisation. Local and cultural variability is manifold. In the area of Uganda where Susan Reynolds Whyte has done fieldwork (see Chapter 7) or in north-western Greenland (see Mark Nuttall's account in Chapter 8) it appears that 'mental' incompetence does not in any straightforward sense equate with diminished or problematic personhood. Nor, as these authors suggest, should we expect to find *one* over-arching understanding of competence in any local context: (in)competence is likely to be entangled with other domains of classifying persons.

One of these domains is age and the life course. Human infants are – by definition – unable to look after themselves and, in the first instance, they lack language. Children are typically considered as at least less competent than adults, in the sense that they are imperfectly socialised and psychosocially immature. Infants and children, however, are presumed to be on their way to competence. Older people may also be defined as less competent: they may become more physically dependent and, perhaps, communicatively and intellectually impaired. In their case, however, this is a departure from previously existing states of competence. Childhood and senility are thus states-of-being that are understood as 'normal': either a transitory pre-condition of competence, or a loss of adult competence that is a regrettable part of the scheme of things. In any local setting there may be a link between these kinds of incompetence and models of adequate human-ness, but it is not inevitable. In the United Kingdom, for example, there are some connections: in everyday understandings of the child-like innocence of people with learning difficulties, in the almost axiomatic presumption that they cannot become 'proper' adults (Jenkins 1990), and in the attribution to them by psychologists, on the basis of authoritative formal disgnostic testing, of putative 'mental ages'. In the United States the category of 'mental *retardation*' is itself suggestive of the same kind of developmental model of incompetence.

'Race'-as-incompetence and age-related incompetence are attributes of social categories rather than conditions that are specific to individuals (although they are *also* conditions of individuals, and individuals may be exempted from the presumed incompetence attaching to their categorical identification). This collection of essays, however, is primarily concerned with something else: individual incompetence that is locally understood as something other than inherently categorical, transitory or chronologically appropriate. The incompetences in which we are interested are locally understood as *definitive* characteristics of *individuals* (although

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they may also generate collective categorisations). Even in the Belizean case described by Lundgren in Chapter 9, where (in)competence is axiomatically hierarchised as a collective ethnic attribute, it still boils down to an individual matter. Not all Garinagus are incompetent, not all Creoles are competent, hence the importance in Belizean schools of testing.

The incompetences in question are also different from physical disabilities or emotional and personality disturbances. To use categories with which we as Western social scientists are comfortable, this book is about how *intellectual* or *cognitive* incompetences are understood in different local cultural settings. However, since distinctions such as intellectual-emotional or intelligence-personality do not necessarily travel well, drawing this particular heuristic boundary gets us immediately into difficulties. This issue provides our collection with one of its themes.

The first thing that a comparative perspective tells us is that intellectual incompetence does not *only* mean 'learning difficulties' or 'mental retardation'. Nor does it necessarily mean *all* of the conditions or states-of-being that these labels conventionally identify. These are classificatory categories of Western medicine and psychology, defined according to locally specific criteria. They are not 'natural' or 'real' in any sense, other than in their social construction as such. They are cultural constructs or folk models – albeit very powerful ones – and they presuppose too many important things to be analytical categories of comparative anthropological usefulness. For example, conditions such as deafness, cerebral palsy or schizophrenia – which are not defined as 'mental retardation' – might in any given cultural context be included in the category which is, locally, the closest cognate classification to 'mental retardation'. Further, whether or not there exist in any local setting categories which approximate to the North American 'retardation' or the British 'learning difficulties' is always in principle a moot point, to be resolved by investigation. The ethnography presented in subsequent chapters by Whyte (from Uganda) and Nuttall (from Greenland) makes all of these points. Thus one key question is: can we produce an analytical category of 'intellectual incompetence' – or incompetence more generally – which possesses comparative utility?

The first answer to this question is that, in order to transcend the limitations of Western diagnostic categories, it is necessary to document *local* models. There may be no better approach to this than the anthropological, specialising as it does in understanding local points of view (which is not to underestimate the difficulties involved in doing so: Geertz 1983: 55–70; Holy and Stuchlik 1983). The second answer, if we are to approach those local models with an open mind, is that we need a

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comparative approach that does not presume an ‘objective’, quantitative model of deficit (although the realities of impairment cannot be ignored either). Finally, our starting point should be ‘competence’ – culturally defined and context-dependent – no less than ‘incompetence’. A foundational assumption of any inquiry must be that notions of competence and incompetence presuppose and reciprocally entail each other. Hence the notion of (in)competence, to denote classificatory fields which necessarily encompass both competence and incompetence.

Local models

How are we to interpret and analyse the ways in which (in)competence can be understood locally? There are many different threads here, and no self-evident best way to weave them into a coherent pattern. The following are among the places from which one would have to start.

- Is (in)competence acknowledged at all in the cultural context in question?
- What are the criteria of classification and/or processes of diagnosis?
- What aetiological models are deployed to understand (in)competence?
- Is intellectual (in)competence differentiated from physical (in)competence?
- Does the general distinction between the physical and the intellectual-mental make sense in the particular local cultural context?
- Is a distinction made between emotional incompetence and intellectual deficit? This involves asking whether, and how, the former is recognised.
- Is a distinction drawn between permanent and temporary incompetence?
- Is there an explicit or implicit hierarchy of (in)competences?
- How, if at all, are physical and intellectual (in)competences integrated into an understanding of general practical (in)competence?

In fact, we must ask whether a model of (in)competence that is open-ended and sensitive to local meanings, yet capable of delineating a sufficiently distinct domain of social phenomena to permit a comparative perspective, is possible at all. This raises issues of ontology and metaphysics that are as difficult as they are ancient and ethically disturbing (e.g. Cockburn 1991; Chapman and Jones 1980; Hirst and Woolley 1982; Singer 1979).

One approach to competence which may allow us to make a start on some of these questions, is to think in terms of that which is *predictable*, *usual* or ‘*normal*’ (to introduce another troublesome word). The point of departure here is the non-deviant rather than its opposite (Jenkins 1998):

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- Is ‘normality’ – or something approximating to it – a meaningful local category?
- If so, how do locals understand and talk about ‘normality’? How does this help to constitute deviance, etc.?
- Is there a local differentiation, for example, between moral normality or deviance, and other kinds of conformity and difference?
- What is the place of sexuality and understandings of reproduction in these categorisations?
- How are incompetence or abnormality explained locally? How are they related to ideas such as ‘normality’?
- Are there specific aetiological schema for explaining specific kinds of abnormality or incompetence?

Questions about ‘normality’ inexorably lead one to think about *social control*. Considering social control as an aspect of the interactional practices and institutional constitution of everyday life prompts further questions:

- Are the incompetent recognised interactionally at all?
- If not, what happens to them?
- What difference does it make in an individual’s day-to-day life to be classified as intellectually incompetent?
- Is incompetence locally seen to be a social problem?
- Have specific institutions and practices been developed to ‘deal’ with the ‘problem’?
- What social possibilities are open to those who are classified as incompetent?
- What *must* they do or not do?
- Who classifies (in)competence or (ab)normality locally, and in what institutional settings and contexts?
- How do these issues relate to local public–private distinctions?
- What implications does (in)competence have for one’s rights and duties as a member of society?

Questions such as these lead, in turn, to a consideration of *social identity*: the ways in which collectivities and individuals are distinguished in their relations with other collectivities and individuals; the establishment, signification and organisation of relationships of similarity and difference between collectivities and individuals:

- How does (in)competence relate to concepts of social adulthood?
- To gender?
- To other dimensions of social identity, such as ethnicity or, if locally appropriate, ‘race’?
- How is ageing related to conceptions of (in)competence?
- How does intellectual incompetence affect membership of the category ‘human’?

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- What does it mean to be 'human' in the local cultural context?
- What are the implications of different *kinds* of incompetence for 'being human'?
- Does being categorised as incompetent prevent or disrupt the achievement of full person- or selfhood (however these are understood) in the local context?
- How do people who are categorised as intellectually incompetent see themselves?
- And how do they see others?

These are infinitely more complex questions than is suggested by posing them so baldly. The last two, in particular, raise epistemological questions about communication with people who may, for example, possess few communicative skills and have cognitive impairments. These questions are thorny enough if the researcher is working in a culture where s/he has a native linguistic competence (e.g. Atkinson 1988; Atkinson and Williams 1990; Booth 1996; Booth and Booth 1996; Flynn 1986). For anthropologists, working as they often are on cultural and linguistic *terra infirma* (if not utterly *incognito*), they are posed even more sharply.

Thinking about social identity entails asking *who* identifies individuals as competent or incompetent? Localities are – in ways which are complex and often contradictory – components of wider arenas of communication, decision-making, resource/penalty allocation, and identification. In the modern world, the attribution of (in)competence is unlikely be a purely local matter. Indigenous or local models may be at odds with external or metropolitan models, over response and treatment as well as classification and diagnosis. As Nuttall's discussion of Greenland in Chapter 8 illustrates, metropolitan models – particularly in-so-far as they are Western scientific bio-medical models, bound up with the organisational practices of the state – are likely to be consequential in different ways, and to different degrees, than local models or indigenous knowledge. Taking a different tack, Lundgren, in Chapter 9, discusses the damaging internalisation of metropolitan models in the ex-colonial periphery. She also suggests, however, that in a place like Belize, where the majority of the population can be said to fall short of metropolitan ideals of competence, some of the *extremes* of incompetence may be less visible. But in all respects, power is an issue that is never far away.

'Mental retardation' and 'learning difficulties'?

To talk about Western bio-medicine, and the state, in the context of (in)competence, is to talk about classificatory categories such as *mental retardation* in North America, and *learning difficulties* or *learning disabilities* in the United Kingdom. Although these might appear to be

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straightforward diagnostic categories, they are, in fact, difficult notions to grasp with clarity or precision. There is not even consensus about appropriate terminology; for example, 'learning disabilities' means something quite different in the United States than it does in the United Kingdom (Murphy 1992).

A consistent feature of campaigns in Western societies on behalf of people who are classified in this way has been successive changes in terminology. In the United Kingdom this has involved progressive shifts of nomenclature: from 'idiocy', to 'feeble-mindedness', to 'mental subnormality', to 'mental handicap', to 'learning difficulties', and finally, on the part of the Department of Health, to 'learning disabilities'. In the United States, by the same process:

> *defectives* became *mental defectives*, *imbeciles* became *high-grade* and *low-grade imbeciles*, *moron* became the *higher-functioning mentally-retarded*. More recently *the mentally retarded* have become *mentally retarded persons* and now *persons with mental retardation* and, in some circles, *persons with developmental disabilities* or *persons specially challenged.* (Trent 1994: 5, italics in the original)

The politics of correctness here are integral to strategies aimed at enhancing the individual worth and social value of the people concerned, in their own eyes and in the eyes of others, and improving their care. However, categorical ambiguity of this kind might also indicate unease about the nature – the social and ontological status – of the people concerned. It is difficult not to agree with Trent's further observation:

> In this process, essence has been apparently liberated from existence, being from descriptions of it. Behind these awkward new phrases, however, the gaze we turn on those we label mentally retarded continues to be informed by the long history of condescension, suspicion and exclusion. That history is unavoidably manifest in the words we now find offensive. . . . While our contemporary phrases appear more benign, too often we use them to hide from the offense in ways that the old terms did not permit. (*ibid.*)

The more recent labels are not more accurately descriptive: everyone, for example, has *some* learning difficulties, however trivial. They are not necessarily less stigmatising either – the polarity of *any* category can be subverted. Nor is the fact that 'learning difficulties', for example, appears to command most assent at the moment among those working in the field in the United Kingdom sufficient to dictate its use. Other categories have their advocates, and the strength of support for particular labels among the labelled is a matter of assertion rather than evidence. For the purposes of thinking comparatively, these categories that are so locally specific are unlikely to prove helpful.

So, throughout the rest of this discussion I will avoid categories such as 'mental retardation' or 'learning difficulties', other than to place them in inverted commas as categories of everyday local use. However, terminology is sometimes necessary. I have reluctantly chosen to accept the argument of Hattersley *et al.* that the best term, for the conditions and states-of-being that are called 'mental retardation' or 'learning difficulties', is 'intellectual disability':

> 'Intellectual' is a more accurate description than 'mental', which is a term associated with psychiatry rather than learning; 'disability' directs attention to the need *to enable* the person by whatever means are possible, recognising that impaired movement, vision, hearing and speech commonly compound the learning difficulties further. (Hattersley *et al*. 1987: 3–4)

Since it has not passed into widespread use, this expression has the virtue in this context of not yet being particularly locally or culturally specific. So, where necessary, I shall talk about *intellectual disability*. Other contributors, however, talk about 'learning difficulties'and 'mental retardation' and I have not intervened in this respect.

A general definition of intellectual disability might stress social and cognitive incompetence: difficulties experienced by an individual in doing things as well as most other people in the appropriate cultural context. In use, however, the concept clearly means more than this. In contemporary Western industrial societies, a clinical diagnosis of 'mental retardation' or 'learning difficulties' will typically draw upon three criteria:

- a measured IQ below a particular (arbitrary) score;
- the identification of the condition during early childhood;
- 'behavioural' problems.

The latter criterion is increasingly being questioned by professional opinion (although where there is no organic pathology it is the most likely reason for *referral*). The first two criteria, however, are professionally consensual and, in increasingly elaborated versions with respect to tested intelligence, relatively well-established over time (Miller 1995: 213).

There is less consensus with respect to *aetiology*. Clinical conventional wisdom suggests that in only 25–30 per cent of cases so diagnosed is intellectual disability associated with an identifiable organic pathology; Zigler and Hodapp (1986: 51–4), arguing at the same time for a slightly lower overall prevalence rate than is generally accepted, suggest that the figure is closer to 50 per cent. The rest – between a half and three-quarters of the category in question – attract a variety of labels, of which the United States has, perhaps, been most productive:

> retardation due to sociocultural factors, familial retardation, retardation due to environmental deprivation, nonorganic retardation, and cultural-familial deprivation. (Zigler and Hodapp 1986: 8)

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In other words, the bulk of the category consists of people who have been categorised as significantly less bright than the general population average, without there being any clear diagnosis or understanding of the reasons for their incompetence.

Talking about aetiology raises issues that are fundamental to the comparative enterprise. The identifiable organic pathologies – Down's Syndrome, iodine deficiency, lead poisoning, Fragile X syndrome, and so on – have in common the fact that they are, albeit in differing degrees, definitively embodied. They are more or less visible. In the archaeological record individuals with hydrocephalus or Down's Syndrome are as pathologically identifiable as modern individuals with the same conditions (Brothwell 1960; Cronk 1993; Murphy and McNeill 1993: 126–7, 129; see also the case referred to by Nuttall in Chapter 8). An individual with a condition of this sort in one cultural context is, in some senses – *although in some senses only* – 'the same' as a person with the same condition in any other cultural context. In any and every cultural setting it is possible to identify a population presenting the symptoms of the organic pathologies or impairments that are intellectually disabling. However, how those symptoms are understood locally, and how the individuals concerned are treated, is culturally and contextually variable. The pathologies are not in themselves determinate; but they do exist and they can be discovered.

But, what about the up to 75 per cent – in Britain or the USA – who are less visible? How are people such as these cross-culturally visible? Do such people exist at all in other cultural settings? One comparative approach to these issues is historical.[1] We encounter an immediate problem, however. As Berrios argues (1995: 225, 233), most historical accounts of the topic treat the modern point of view as by definition superior to that of past generations, and the past as 'a preparation for the present'. This may simply be a general problem in the writing of history, but it highlights a serious difficulty with respect to our particular area of inquiry. The question of appropriate categories is the tip of an epistemological iceberg: it is not merely that talking about 'learning difficulties' or 'mental retardation' with respect to earlier periods is anachronistic – it certainly is – but that the *categories* of people that these words denote did not exist in, say, the nineteenth century.

To put this another way, the last two centuries or so in Western industrialised states have witnessed two connected trends. In the first, the criteria for identifying – or, if you prefer, socially constructing – intellectual disability, have become more broadly based and inclusive as they have become ever more sophisticated. One interpretation links this to the expansion of the notion of citizenship following the American and French revolutions, and its subsequent definition by exclusion, by defining who