

Questions of Competence

Culture, Classification and Intellectual Disability

Intellectual disability – more commonly described as ‘mental retardation’ or ‘learning difficulties’ – is a socially constructed phenomenon that varies in important respects cross-culturally. This collection of original essays examines the classification of people as competent and incompetent in the United States, England, Wales, Greece, Greenland, Uganda and Belize. The contributors, anthropologists and sociologists, argue that it is time for a new understanding of intellectual disability. In contrast to medical and psychological models, a social model of intellectual disability emphasises the cultural and individual variability of incompetence, the intimate relationship between cultural categories of competence and incompetence, and the role of social interaction and networks in its social construction. This book is a timely and original contribution to ongoing theoretical and policy debates about disability.

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Culture, Classification and Intellectual Disability

edited by

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Contents

<i>List of contributors</i>	<i>page</i>	vii
1 Culture, classification and (in)competence RICHARD JENKINS		1
2 Mental disability in the United States: an interactionist perspective MICHAEL V. ANGROSINO		25
3 (In)competence in America in comparative perspective PATRICK J. DEVLIEGER		54
4 Risk, resilience and competence: parents with learning difficulties and their children TIM BOOTH AND WENDY BOOTH		76
5 Constructing other selves: (in)competences and the category of learning difficulties CHARLOTTE AULL DAVIES		102
6 Work, opportunity and culture: (in)competence in Greece and Wales SYLVIA VAN MAASTRICHT		125
7 Slow cookers and madmen: competence of heart and head in rural Uganda SUSAN REYNOLDS WHYTE		153
8 States and categories: indigenous models of personhood in northwest Greenland MARK NUTTALL		176
9 Learning to become (in)competent: children in Belize speak out NANCY LUNDGREN		194

10	Towards a social model of (in)competence RICHARD JENKINS	222
	<i>Bibliography</i>	230
	<i>Index</i>	246

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1 Culture, classification and (in)competence

Richard Jenkins

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

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 *incompetence* 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

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 diagnostic 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 incompetencies in which we are interested are locally understood as *definitive* characteristics of *individuals* (although

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

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):

- 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’?

- 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 to 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

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)

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

was *fit* to exercise the responsibilities of citizenship (Goodey 1995). Another argument sees it as a consequence of ‘urbanisation, literacy and a cash economy’ (Thom 1995: 251). Writing about the nineteenth century, the same author goes on to argue that:

The concept of idiocy became a stigma when it was used as technical term to isolate, to identify the non-productive or those who disturbed the peace of a working day. . . . When both handicap and criminality were lumped together under the notion of degeneracy, as they were in the very different systems of mensuration of Lombroso, Broca and Galton, the problem of being labelled an idiot became more than merely technical for those so-called defectives. (Thom 1995: 252)

These interpretations do not conflict. Theoretically one can generalise them further, by invoking Foucauldian visions of classification, confinement and control, on the one hand, and understandings of the social construction of deviance deriving from symbolic interactionism and the labelling perspective, on the other (see Cohen 1985, for a suggestive combination of this kind). They can be summarised in the evocative notion of the ‘invention of the feeble mind’ (Trent 1994).

The second trend is that *within* this period it appears that the size of the category of intellectually disabled persons has been variable over time:

A majority of the individuals shut away as ‘feeble minded’ at the height of the first wave of mass segregation, as recently as the turn of this last century, would today be ordinary citizens. (Goodey 1995: 239–40)

This variation is not trivial, and must be understood in terms of classificatory practices rather than in ‘real’ terms (Zigler and Hodapp 1986: 59–63, 90–111). At different times, more or less people, and different kinds of people, have fallen under the purview – the gaze – of the institutional and bureaucratic systems that have been developed to address the problem of incompetence. This is partly a consequence of differing levels of concern about the threat that their incompetence was believed to pose, and partly due to changing methods for identifying incompetence and variations in their use.

In the absence of proper statistical series it is impossible to be precise, but the long-term trend over this period has probably been for an expanding proportion of the population of the industrialised democracies to be classified as intellectually incompetent in various ways and to varying degrees. Some small part of this is doubtless a reflection of the increasing capacity of medicine to preserve fragile life. However, this trend also reflects something else: the gradual expansion, responding to general labour market changes, of the general category of people classified as ‘disabled’ (Oliver 1990; Stone 1985).²

A different point, and more significant for the numbers, is that many people who are today in receipt of services for the ‘mentally retarded’ or ‘people with learning difficulties’, had they lived a century or two ago would have been earning their living, albeit in precarious unskilled poverty, as relatively unremarkable members of the community. These belong to the ‘up to 75 per cent’: the modern population of ‘people with learning difficulties’ or ‘the mentally retarded’, who are so defined at least as much by their inclusion in a bureaucratised system of health and social services as by their putative disability. Their ‘equivalents’ in former times cannot in any straightforward sense be identified as ‘mentally retarded’ or as ‘having learning difficulties’.

There is, therefore, neither necessity nor even likelihood that all – or indeed any – of the ‘up to 75 per cent’ will be visible in every cultural setting. This is further support for my earlier argument: categories such as ‘learning difficulties’, ‘mental retardation’ and ‘intellectual disability’ are unstable, context-dependent, and likely to be unhelpful as analytical tools for comparative analysis, whether historical or cross-cultural. Even more dramatically, this implies that there may not even be a stable phenomenon that can be compared in these terms. All models may thus be local models.

Can it really be this problematic? This answer is yes, probably. In societies such as the UK or the USA, most people who are classified as ‘having learning difficulties’ or ‘being mentally retarded’ are people who have been assessed in childhood as less intelligent than the average – the implication being that the cognitive deficit, even if not congenital, is disruptive of ‘normal’ development – to a degree that is considered by expert opinion to be severe enough, or sufficiently troublesome to others, to require identification and intervention. This, of course, need not be a bad thing. Without diagnosis and identification, after all, how can ‘special needs’ be assessed, much less met? Fine, but we are obliged to ask whether, and to what extent, those ‘special needs’ are endogenous or are the product of categorisation and exclusion from mainstream society. The chapters which follow by Angrosino, Devlieger, Davies, and Booth and Booth deserve particular attention in this respect.

From a comparative perspective, further questions about the local specificity of (in)competence are implied by the ‘retardation as a product of urbanisation and industrialisation’ school of thought. These highlight the notions of adequate *function* that are central to classifications of (in)competence. One of them is whether small-scale societies, with simple subsistence technologies, have different thresholds of competence – or different thresholds of tolerance of incompetence – than industrialised, urban societies.

Society, technology and environment

A cross-cultural perspective upon intellectual (in)competence is elusive. Observations on the topic are scattered throughout the ethnographic literature, but there are few specialist studies. It is, therefore, impossible to generalise with any confidence about variation in the *definition* of (in)competence between cultures. We can say, however, that there is no uniformity between local cultural contexts in the *treatment* of people who are defined as incompetent. This can be seen in the chapters which follow. Neither incompetence nor intellectual disability – nor indeed disability more generally (Ingstad and Whyte 1995; Marshall 1994, 1996) – are consistent, ‘natural’ or self-evident categories. This is not to ignore the fact that, for a range of reasons, individuals differ in their intellectual and physical capacities. Nor is it to overlook the likelihood that some distinction between competence and incompetence is drawn in all societies. However, *where* the line is drawn, and what it *means*, varies enormously.

To make this point with a recent European example, it is only within the last twenty to thirty years or so that people with cerebral palsy have been removed from the ‘retarded’ or ‘learning difficulties’ categories (and, even so, their experiences of everyday interaction may not have been much improved thereby). To take another example, Islam appears to encourage a relatively high degree of tolerance of the less competent. There is an extensive and long-standing body of Islamic law which deals with their rights. This too varies, however. Thus it is incompetent men rather than women – and usually only men with property at that – who are legally protected. Nor is there a cultural consensus within Islam about nature or causation: diagnoses and treatments range from the opinions of modern scientific medicine, to attributions of *djinn* possession which entail exorcism at a shrine. There is also regional variation: while the threshold of tolerance for the incompetent may – by dint perhaps of the necessities of the desert nomad’s existence – be low among the Bedouin, this does not seem to be true, for example, in Pakistan (Miles 1992).

Might there be a relationship, therefore, between the treatment of incompetence and either technological complexity or subsistence pressure? In 1970 Robert Edgerton, whose ethnography of ‘mentally retarded’ people in California in the early 1960s (Edgerton 1967) remains a rare example of a study of a non-institutional setting, examined the available cross-cultural evidence (Edgerton 1970). His aim was to question the then-conventional wisdom which suggested that the ‘simpler’ the society – if only in terms of technology – the more tolerance there was likely to be for ‘simple’ people. He asked whether intellectual disabilities have become more visible and more problematic as societies

have become functionally more complex and cognitively more demanding.

Within the limits set by the small amount of evidence he could muster, Edgerton found no one pattern of tolerance or rejection of incompetence, nor any way of consistently relating either to socio-technological complexity. With respect to environmental stress and subsistence pressure, much the same was true. In some societies the incompetent are (or were) perceived as a problem, in others less so, and in yet others not at all. Take, for example, hunter-gatherers. Edgerton's summary of ethnographic accounts of the Inuit – which is supported by Nuttall's discussion later in this volume – suggests a range of responses to intellectual incompetence, from abandonment to sanctification. The Phi Tong Luang of northern Thailand, even though living on the extreme margins of subsistence, none-the-less appeared to attempt to rear all of their children. By contrast, however, the more securely affluent Chippewa and Algonkin peoples of north-eastern North America have a well-documented history of fatal intolerance towards the disabled and the incompetent.

Edgerton's was a very limited exercise, but it allowed him to reject technological or environmental *determinism* as a framework for explaining cultural variation in the understanding or treatment of those people who can be described as having intellectual disabilities. This does not, however, mean that the environment is unimportant. At least three significant environmental factors affect the *incidence* of intellectual disabilities.

First, the harsher the environment, the less likely it is that incompetent or physically disabled members of the group will survive. If mortality rates for 'normal' infants are routinely high, how much more vulnerable will a child be who is slower or more sickly than the rest? In such circumstances the issue of tolerance may simply not arise. Second, subsistence pressure can be a significant *cause* of intellectual deficits. In particular, certain kinds of malnutrition in children – for example, kwashiorkor – may produce, if allowed to persist in the medium to long term, irreversible brain damage and cognitive deficits. Malnutrition is, of course, not randomly distributed among the world's populations, so we can expect to discover variable and cumulative concentrations of pathologies of this kind.

Third, there are other environmental causes of intellectual disabilities. For example, one organic pathology which results in severe intellectual disability is congenital hypothyroidism ('cretinism') caused by an under-active maternal thyroid gland. This may be caused by iodine deficiencies in the mother during pregnancy, and is common to the point of being endemic in many areas of Asia, South and Central America and Africa

(Hetzel 1989). It has, for example, become an acute problem in Bangladesh due to the leaching of iodine from the soil by recurrent major flooding, and, hence, its disappearance from the local food chain and diet. The condition is preventable by fairly simple interventions – the adequate supply of iodated salt, for example – but, at the moment, it remains a problem of significant dimensions.

Industrial and other pollution may also cause relevant organic pathologies. One notorious example was the concentrated discharge, by the Chisso Corporation, of heavy-metal effluent into Japanese coastal waters at Minamata Bay between the early years of this century and the 1970s. This resulted in a major increase in serious impairments and brain damage, particularly in children, in the local fishing community (Michiko 1988; Smith and Smith 1975). This Japanese case suggests that among the things about which we are still ill-informed are the responses of people in small-scale communities to abrupt increases in the incidence of serious physical or intellectual impairments and their concomitant disabilities, how these responses are culturally variable, and the implications of such situations for local institutions and practices.

Cosmology: culture and nature

If, with respect to cultural variation in models of (in)competence, there are no straightforward relationships between environmental factors and socio-technological complexity, what about the relationships between local models of humanity or personhood and definitions of (in)competence? Although they are present throughout this collection, these issues are explored in particular depth in the chapters by Charlotte Davies, on Wales, Susan Whyte, talking about eastern Uganda, and Mark Nuttall, in the context of north-western Greenland.

Different peoples live, to some extent, in different worlds. Ideas about the self, the nature of humanity, and the place of humans in the world, are culturally variable (Carrithers, Collins and Lukes, 1985; Jackson and Karp 1990; Morris 1994), and this has implications for our discussion. If, for example, being a ‘complete’ person is believed to be related to a metaphysical quality of individuals – what European cultures might call the soul – then much will depend upon whether people who are categorised as less-than-competent are believed to possess that quality. On the other hand, if the criteria of full humanity are more material – bodily integrity, for example – then the outlook for some incompetent or disabled people will be worse than for others. Looking at the expanses imagined by cosmologies, the conventional scientific model of a ‘mechanical universe’ has different implications for understanding incompetence than a world-view

in which the forces of motion and causality are thought of in spiritual terms. And so on.

These issues underline the usefulness, and relative shortage, of systematic evidence from a range of cultures and local contexts. Marshall's discussions of evidence from Micronesia (1994, 1996), for example, explore the local relationship between models of personhood and attributions of disability, and the inappropriateness of World Health Organisation-style Western models. In another context, Miles (1992) suggests that since Pakistani children are expected to be obedient to the will of their parents, anything other than this is regarded as a disruption of the normal *moral* order, as embodied in Allah's creation. Behavioural problems which in the UK or the USA might offer a basis for a diagnosis of intellectual disability, are thus likely to be interpreted morally, as *djinn* possession, to be dealt with by exorcism rather than educational or medical intervention.

In the absence of cross-cultural evidence we may learn from history. In the European past, even the very recent past, popular cosmology envisaged a moral universe teeming with a host of spirits, some of whom were not even clothed in the thinnest of Christian camouflage. A child of 'normal' parents who would today be diagnosed as having intellectual disabilities, might then have been identified as a 'changeling', not human at all, a poor substitute for the healthy child which had been stolen by envious fairies or trolls (Schoon Eberley 1991). The consequences of such a diagnosis could be fatal: one recommended treatment for a changeling was to drive the impostor out using fire, another was exposure to the elements. There is evidence that these harsh remedies were actually resorted to (e.g. Jenkins 1977): the abandonment of the incompetent to their fate can be attested in the nineteenth-century British Isles as well as the twentieth-century Arctic.

In other contexts, however, some incompetent persons were tolerated by Christians, even protected by the Church, as 'holy innocents' or 'sacred fools' (Billington 1984: 16–31; Scheerenberger 1983: 25ff.): intellectual deficits were interpreted as signs of spiritual grace, 'simple' states of nature that were closer to God than the immorality and corruption of culture. 'Holy innocence', as is clear from contemporary accounts, could also be understood as a state of perpetual childhood. In both cases an analogy was drawn with humanity before the Fall and the expulsion from Eden. Less benignly, of course, the historical record is also clear that the incompetent might be branded another kind of fool, and exploited for purposes of public and private entertainment.

Notions about perpetual childhood and the innocence of people with intellectual disabilities remain current. Most people, however, no longer live in a world of magical possibilities, peopled and moved by invisible

spirits. Secular and scientific rationalities coexist with and are at least as important as a multiplicity of religious world-views (in many of which the deity or deities seem to have withdrawn from the daily management of the world). The enchanted, moral universe is challenged by a model of the world derived from 'objective' statistical probability and the mechanical laws of physics and the other natural sciences.

The philosopher Ian Hacking has argued (1990) that one of the most powerful ideas in this modern cosmology, originally developed by nineteenth-century statisticians such as Galton, is 'normality'. The concept of normality does two things simultaneously: it *describes* as normal that which is most *typical* or the usual state of affairs; it then *asserts* that this is also the way things *ought* to be. The propagation of the average (and the above average) thus becomes a moral imperative. People with intellectual disabilities, from this point of view, are neither average nor normal. To revisit earlier points about the limited significance of organic pathologies in the aetiology and classification of intellectual disabilities, the statistical plotting of a normal curve of distribution for measured intelligence has probably been the single most influential factor in the definition and creation of a category of persons known as the 'mildly mentally retarded'. Before the advent of the bell-shaped curve, the category simply did not exist.

Ideas about normality were developed in nineteenth-century Europe in the context of two related ideologies. The first was a racism which asserted – on the basis of 'proof' – the inferiority of the colonised and disadvantaged peoples of the world. The second, the Eugenics movement, similarly grounded in 'evidence', aimed to improve the 'fitness' of the European population (which was often understood in terms of 'race') by discouraging the breeding of the 'unfit' and the 'inferior'. Both assumed that Europeans, particularly *Northern* Europeans, were the apex of human evolution, the normal yardstick against which the other races of humanity could be measured and found wanting.

There is little point in pouring anachronistic scorn on the ideas of an earlier time. But, as discussed earlier, those ideas were and still are consequential in the classification and treatment of intellectual incompetence. At the relatively trivial end of the spectrum, in 1866 Down characterised the syndrome which now bears his name as 'Mongolism', a reference to the eye shape which characterises the condition and a direct analogy with the 'Mongoloid race'. More significant is a well-documented and continuing predisposition in Europe and North America to label as incompetent or intellectually disabled disproportionately more black or Asian people than white Europeans (Mercer 1973; Tomlinson 1981).

Most important of all, however, was and is the dominance of a model of

'normal' humanity, legitimated by the authority of science, which claims that its criteria of adequacy and competence are 'objective' and, therefore, beyond doubt or reproach. Among the consequences for those who were labelled as 'mental retarded', 'subnormal' or 'feeble minded' were institutionalisation and seclusion. Compulsory sterilisation and abortion were routine, as was the forced breaking-up of families whose parents were deemed 'unfit'. These individual assaults and indignities may be less common, but they have not yet vanished.

At its worst, this model of human normality led to the activities of the notorious 'euthanasia' units of the German state between 1939 and 1945 (Burleigh 1991, 1994). Thousands of intellectually and physically impaired children and adults were killed. The processing of the victims – the decision whether to kill or not – was left to committees of scientific specialists: physicians, psychologists and physical anthropologists. Their professorial and scientific authority legitimated the mass murder which they directed, and many held senior academic posts in Germany until relatively recently (Müller-Hill 1988). Nor were such visions of a better world confined to Nazi Germany. As witnessed by research (e.g. Koch 1996), and by recent controversy in the press (see *The Observer*, 24 August 1997), disturbingly similar perspectives on incompetence and fitness have informed Social Democrat policy and practice with respect to compulsory sterilisation in Scandinavia until relatively recently.

Science, despite its claims to the privileged possession of universal objective knowledge, is but one cultural framework among many, albeit a powerful one. The scientific notion of 'normality' does not exist in isolation. Other cultural themes and threads are also important. Although the absence of proper comparative material makes it impossible to be certain, recent international scandals about the treatment of people with intellectual and other disabilities in Greece, Ceaușescu's Romania, China, Hong Kong, Macao and Bulgaria, indicate the interaction of modern notions of 'objective normality' with other – more 'traditional'? – cultural models of the natural and the unnatural, the human and the less-than-human.

These scandals also suggest another angle on these issues. To judge from the content and presentation of the stories which have emerged in the British press over the past few years, the harsh treatment of people with intellectual and other disabilities may be becoming a marker of difference in popular discourse, a visible index of 'Otherness', 'underdevelopment' and cultural distance. It is something that 'they' do (conveniently forgetting, of course, a long and relatively recent history of scandals in Britain and elsewhere: cf. Ryan and Thomas 1987).

The relationship between ideas about culture and nature offers one key

to a better understanding of cross-cultural variation in the treatment of the incompetent. Two variations on this theme may, in different ways and with differing degrees of significance, be relevant. Deeply rooted in human experience, the first concerns the difference between humans (cultural) and animals (natural). Classification, however, is never that simple. There are always anomalies. Domesticated animals, or children prior to socialisation, may each be anomalous, depending upon the culture concerned. So may children with obvious birth defects, or children who fail to thrive or become competent adults. What matters is how the anomaly is resolved: classifying or re-classifying the child as animal or human, part of nature or culture, is one option. The ‘changeling’, for example, is a representative of the natural world. Anomaly can also be handled differently, however, by sanctification, as in the case of the ‘holy innocent’. However it is achieved, upon the resolution of the classificatory problem depends the subsequent treatment of the individual concerned.

The second theme is more recent and returns us to ideas about normality. Here the distinction is between the natural (normal) and the unnatural (abnormal or deviant). Here, by the classificatory logic of statistical frequency – and, indeed, by the classificatory logics of transformation and inversion which are so familiar from structuralism – *culture*, being typical for humans, becomes part of human *nature*. Thus incompetence in things cultural – the inability to learn language, etc. – may be interpreted as an indication of an unnatural and inferior humanity. Although not an animal, the person with intellectual disabilities may be classified as sub-human, an unnatural monstrosity.

The two classificatory themes are not the same. Nor do they deal necessarily with similar issues (although each has a bearing on the boundary between humanity and the rest of the cosmos). However, each allows the classification of individuals who are categorised as incompetent as something less/other than human. In conjunction they are a powerful means of social exclusion, even to the point of extermination.

Contesting classifications

The classificatory boundary between culture and nature occurs in one form or another in *all* cultures. While it may permit the derogation of incompetent individuals as less than human, it does not demand it. Other cultural themes may be of considerable significance in protecting or positively valorising the incompetent. The most obvious, perhaps, is *religion*, the discourse about the sacred (exemplified in the earlier reference to ‘holy innocence’). Religion may or may not be relevant, but it is important to consider questions such as:

- Does local religion categorise the incompetent as equal to or inferior to their competent brethren?
- Does local religion privilege incompetent people, theologically or otherwise?
- How does this relate to notions of human essence, such as ‘the soul’ (a question which refers back to the discussion of humanity and personhood)?
- Is a distinction drawn locally between spiritual essence and intellect?
- Where appropriate, what is the relationship between local religion(s) and more universalistic religions such as Christianity or Islam?

Religion – even different versions of the same religion – may either negate or support dehumanising classifications; religions differ widely in this respect. Hindu and Buddhist theologies of reincarnation understand the human–animal distinction as one point on a continuum of ascent towards the eventual dissolution of individuality. This does not, however, *dictate* the benign treatment of the incompetent. Incompetence or intellectual disability may, for example, be interpreted as a penal aspect of the soul’s *karma*. Nonetheless, such evidence as there is (Sen 1992) suggests that there are relatively high levels of public tolerance for people with intellectual disabilities in, for example, India.

Of necessity, religions interpret the relationship between culture and nature. It is somewhat artificial therefore to distinguish religion too sharply from other discourses on the culture–nature theme. However, religions – particularly universalistic religions – may also draw another boundary: between the believer and the unbeliever, the saved and the damned. In respect of both of these boundaries, religion is an important influence upon the classification and treatment of ‘proper’ human beings.

Universalistic religions such as Christianity and Islam, which view all souls as, in theory, prospective candidates for conversion and salvation, might be thought to be benign by definition. Unfortunately this is not so. To take fundamentalist Protestantism as an example, much depends upon whether people with intellectual disabilities are deemed by a particular sect to be capable of being ‘born again’. One may also encounter the belief, inspired by the Second Commandment of the Old Testament, that the birth of a child with intellectual disabilities is a punishment for the sins of the parents or grandparents.

Religious salvation is generally a matter for the hereafter. Secular movements and ideologies may, however, seek salvation in the here-and-now. One characteristic variation upon this cultural theme is, in varying ways, concerned with the achievement of greater *equality*, however that may be defined. A relatively modern ideology, developing alongside the idea of normality, the pursuit of equality can be understood as an expres-

sion of the celebration of the *average* which is one – and only one – of normality's central themes. Two obvious possibilities here are socialism, on the one hand, and variants on the liberal advocacy of universal human rights, on the other. There may be others. There is certainly a range of questions to be asked:

- How do universalistic notions of human equality articulate with individual variability with respect to (in)competence?
- Are there specific political discourses in the local context about, for example, disability rights?
- What are the consequences, for people who are categorised as intellectually incompetent, of various formal national or international specifications of civil and human rights?
- How do such matters reflect local–national relationships, or insider–outsider themes?
- What have been the local effects of wider changes such as political and administrative ‘modernisation’, and developments in the delivery of medical and other services?

And so on. Although equality is conceptually linked to the idea of the average or the norm, it is necessarily concerned with more than the middle reaches of the social spectrum. One of the most influential models of social and economic equality implies that as many people as possible should at least be included economically within the bottom reaches of the ‘average’ lifestyle; that there is a minimum ‘normal’ level of access to social provision and goods to which everyone is entitled. A different but no less important understanding of equality is political or constitutional, the extension of the rights of citizenship to all. This has implications for participation and inclusion in the political process, and full equality before the law.

As with religion, however, doctrines of equality do not – as the flourishing of slavery in post-Independence America demonstrated – necessitate that all men and women will be treated as equals. The deciding factor is eligibility: *who* qualifies for inclusion in equality. But notions of equality, however they are framed, necessarily encourage struggles to extend the criteria of inclusion. This can be seen most clearly in recent years in the campaigns of the Disability Rights movements in the United States and Europe (Oliver 1990), and in the various attempts by legislatures to put some of those rights, at least, on to a more secure legal footing (Doyle 1995). Political discourses of equality also offer an image of a normal way of life, which could – should – be accessible to all, and imply some redistribution, thus legitimating the participation of the excluded in the wider prosperity of society.

In all of these respects, the politics of equality have inspired the modern

philosophy of care known as ‘normalisation’ (Wolfensberger 1972). This promotes independent living for people with intellectual or other disabilities, in ordinary community settings wherever possible, and their participation – once again as far as possible – in culturally normative behaviours and activities. Ideologies of earthly equality do not, however, necessarily solve the problems faced by people with intellectual disabilities. They may, in fact, be re-shaped into a new kind of benign oppression: the tyranny of normalisation may be as powerful as the opportunities offered by egalitarianism (Brown and Smith 1989; Chappell 1992). As Wolfensberger himself made clear, normalisation is, at least in part, explicitly ideological; what is moot is whether or not one accepts his notion of the ‘good ideology’ (1972: 9). The important questions in this respect are:

- Who defines what is ‘normal’?
- In whose interests?
- Where does the promotion of normalisation become the persecution (behaviour modification) of non-conformity?
- What happens if people with intellectual disabilities do not want to live independent lives in the community?
- What happens if they do not want to conform to locally normatively-valued patterns of behaviour?

These questions suggest the possibility of a sting in equality’s tail: relatively equal access to valued goods and conditions of life may be implicitly conditional upon fitting in to a ‘normal’ lifestyle or way of life. With respect to the USA and the UK, the chapters by Devlieger and Davies suggest that, according to the dictates of normalising ideologies in local practice, the price of acceptance for people whose being-in-the-world challenges our classificatory boundaries may be the surrender of the independence – to be non-criminally deviant, eccentric, heterodox, non-conformist, or whatever – that is actually definitive of ‘normal’ adulthood in Western democracies.

And there is yet a further twist to these complexities. Angrosino argues in Chapter 2 that in a liberal capitalist democracy such as the United States the dominant normative themes of independence and self-sufficiency are still, despite decades of high unemployment, powerfully expressed in the notion of ‘earning your own living’. Accepting the label of ‘disability’ is one of the few ways in which an individual can achieve an honourable exemption from the responsibility to ‘pay your own way’ (cf. Wadel 1973). As Deborah Stone has put it: ‘Disability accounts for a substantial proportion of income redistribution and, in much smaller measure, for the distribution of some fundamental privileges and duties of citizenship’ (1985: 4).

A similar theme can also be traced in van Maastricht's account of a day centre for 'people with learning difficulties' in Wales in Chapter 6. Despite the public importance of a progressive rhetoric rooted in normalisation, 'created dependency' was the – doubtless unintended – consequence of their insulation from the harsh realities of a world governed by the market, via their categorisation as 'disabled', as vulnerable individuals.

Finally, another aspect of contested classification is worth considering: the relationship in any cultural context between local folk models of (in)competence and the Western medico-psychological model(s) which have achieved a degree of global hegemony. This suggests a final short list of questions:

- How is the conflict between the different models and understandings, where it exists, expressed?
- What are its consequences for people who are categorised as incompetent?
- How does this relate to relationships between local administration and government and external sources of policy and funding or resources?

These questions are not only relevant with respect to marked cultural diversity or Otherness (from a Western perspective). Even within the settings that are their source, Europe and North America, Western scientific medico-psychological models are likely to have local folk competitors and vernacular variants. This has become more marked with the recent proliferation of alternative therapies.

Nor should the competitive global variety in scientific models be underestimated. The role of the psychological and medical establishments in the mass extermination of intellectually disabled people in Nazi Germany has already been alluded to and is relevant in this context. Between 1920 and 1989, Soviet and Western medical and psychological orthodoxies diverged in many ways, intellectual disability among them (Thom 1995: 257). Today, much work remains to be done before we understand better Chinese medical science and psychology, in this field no less than in others. To return to an earlier point, all models are local models.

In this introductory chapter I have explored some of the matters which arise when one tries to think about (in)competence from a comparative perspective. Doing so has entailed asking questions which permit us to move away from the axiomatic dominance of the Western medico-psychological model, towards a framework within which the socio-cultural construction of the phenomenon can be appreciated alongside the presence of intellectually impairing pathologies. And it is, in the strongest

possible sense, the social *construction* of (in)competence, not just cultural variation in *responses* to impairment, that I am talking about. This is the most robust thread which unites all of the contributions. It is as central to Nancy Lundgren's discussion of the routine incompetence of 'normal' schoolchildren in Belize, as it is to the discussions of the experiences and situation of people who are categorised as being 'mentally retarded' or as having 'learning difficulties'.

The chapters which follow were not in any simple fashion commissioned to exemplify the issues, or operationalise the questions, that I have set out above. Each chapter will touch on some of them, as appropriate, but the authors were encouraged to pursue their own intellectual agendas. This is still a relatively new field of inquiry, with nothing to be gained from channelling our endeavours too tightly. In that spirit, this collection is presented as an encouragement to the further research and debate that will help us to move beyond present ethnocentric, and somewhat unimaginative, conventional understandings of (in)competence.

Notes

- 1 In addition to the texts cited, Scheerenberger (1983), Ryan and Thomas (1987: 11–29, 85–116), and Atkinson, Jackson and Walmsley (1997) offer further perspectives on the history of intellectual incompetence and disability. Rosen, Clark and Kivitz (1976) is a useful selection of late nineteenth- and twentieth-century documentary sources.
- 2 This brief reference glosses over Oliver's important argument about the role of capitalism in the medicalisation and individualisation of disability as a socially constructed category.