

Autonomy, Solidarity, and Self-Realization: Policy Views of Dutch Service Providers

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Abstract: The popularity of autonomy and self-determination in thinking and talking about quality of life of individuals with mental retardation suggests a dominance of these concepts in the field today. Here we offer an analysis and evaluation of this view and compare it with two alternative and complementary views—solidarity and self-realization. Recent policy documents of central government and parents' organizations and recent policy documents of 22 agencies for people with mental retardation in the Netherlands are the basis of this analysis. Results suggest that proponents of these alternative views offer valuable criticisms of the dominant view. We appeal for an open discussion of various concepts and their respective strengths and weaknesses in relation to different clients and institutional contexts.

At first glance there seems to be a broad consensus in the Western world on certain ideas behind today's care for people with mental retardation. Since the United Nations Declarations on the Rights of the Mentally Disabled and on the Rights of the Handicapped, which were issued in the 1970s, it has been generally accepted that people with mental handicaps are entitled to independence. The official modern guideline on care and policy for people with mental retardation stresses that these individuals must have the same rights as do other citizens of the same age. *Emancipation* and *integration* are key terms in the today's care for people with mental retardation. Recently, the idea of equal rights has been conceptualized in terms of autonomy and *self-determination*. The stress on *autonomy* is intended to help combat the problems of paternalism that surface so easily in caring relationships.

On closer examination, however, underneath this general consensus, there is some dissent on the question of which concepts best serve the idea of equal rights. The concept of autonomy has gained dominance, but this is not

to say that it is the only concept that gives substance to the idea of equal rights. This becomes clear if one studies what service providers themselves write about their philosophy of care in their policy documents. In the Netherlands, at least, virtually all agencies for people with mental retardation have formulated their ideas of care in policy documents. In the present study we reviewed recent policy documents of 22 agencies for people with mental retardation in the Netherlands and analyzed the central normative concepts that give substance to the idea of equal rights. Our goal was to determine the extent to which there is conceptual agreement or disagreement on the concept of autonomy.

An analysis of such policy documents is just one method of gaining access to conceptual agreements or disagreements. Investigators could also interview representatives of the field or observe daily care in agencies. Policy documents, however, are well-suited to conceptual analysis because the texts themselves are necessarily conceptual. In daily practice, the connection with concepts may be more tenuous, as caregivers naturally do not say to their clients

"Please do this because it will make you a more autonomous person" (see Nass, 1996). At the same time, this example points to the limitations of an analysis of policy documents: Policy documents do not reflect daily practice or even the ideas of the people working in an agency. Therefore, in order to determine the extent to which policy is reflected in daily practice, we interviewed 15 key figures—activists, group leaders, experts, and managers—and discussed current concepts in the field of mental retardation. We also organized a group discussion with 12 managers of residential facilities. These and other interviews were discussed by Tonkens (1999) in a review of the development of care for people with mental retardation in the Netherlands over the past 50 years.

Policy documents must be understood in their political context. Service providers in the Netherlands depend on subsidies for which the national government, partly under pressure from parents' organizations, sets the conditions. In explaining their views, virtually all organization personnel refer to the policy documents of the two central and most powerful parties in the field of mental retardation: national government and the Federation of Parents' Organizations. Both have recently stressed the importance of self-determination and autonomy. As might be expected, the concept of autonomy dominates the policy documents of the service providers we studied, even if this concept was emphasized only for financial reasons. The dominance of autonomy in these texts should, therefore, not be interpreted as a sign of the prominence of autonomy in daily practice, but as no more than a reflection of its dominance in the sphere of institutional politics. One element of this policy has been the recent merger of service providers. Central government has been more or less forcing agencies to cooperate or even merge, and these mergers have resulted in a demand for the underlying principles of these new organizations to be explained. Although the service providers are not legally obligated to write a policy document, there are certainly strong expectations that they should, which are sustained by a legal obligation to formulate individual care plans for all their clients. A policy document functions as the ideological background to these plans.

A policy text should be interpreted as a public policy statement on care, in which some agreement with powerful parties (such as par-

ents' organizations and national government) is inevitable. This explains why all documents adhere to some degree to the autonomy view. At first sight, there is enormous consensus on this point. If one realizes, however, that there is no denying this principle, the political background necessitates a closer reading, with a concentration on other elements present in these texts, apart from the general "lip-service" to the idea of powerful parties. In doing such an analysis, we discovered two additional lines of reasoning, pointing to other concepts. In 12 of the documents we studied, autonomy was stressed as the central concept. However, the policy documents of 10 other organizations, although adhering to autonomy, gave more weight to other aspects: 5 of them to care and 5 others to self-realization. (See Weijers and Tonkens, in press, for an analysis of the historical roots of these concepts in the Dutch care system.)

One's Own Choice

Autonomy—defined as living according to one's own rules, norms, and values—and *self-determination*—deciding for oneself what is good and worthwhile—are proclaimed as core principles in most of the Dutch policy documents. As mentioned previously, this idea is prominent in the texts of the most powerful parties in the field: national government and the national body of parents' organizations, the Federation of Parents' Organizations. In the most recent document of the Federation of Parents' Organization (1994), the following statement appears: "Freedom of choice is the central concept of this document." A 1995 document prepared by the national government contains this statement:

The intention is to put the idea of equal (civil) rights prominently to the fore. . . . The members of this government explicitly intend to make meaningful progress concerning further integration and participation of people with a handicap. The first principle in this respect is that people with a handicap should gain more freedom of choice in shaping their own lives. The intention is to reduce the dependence of handicapped people on their service-providers.

Most policy documents prepared by service providers repeat this principle (see Tonkens, 1996, for precise references). For example,

Our service, is aimed at sustaining (in so far as necessary and desirable) the process of learning to make choices and learning to cope with the responsibilities that follow from these choices. The right to self-determination is given a central place in the provision of care.

In another agency statement written in 1996, it is noted that there is "recognition of the client's right to determine his or her own course of life as much and as often as possible" and in the 1995 policy statement of yet another agency: "Most prominent in our foundation's idea of care is the individual, his uniqueness and his or her right to self-determination." In a 1994 statement it is claimed that "The life of an adult person, also one with mental retardation, is first and foremost determined by the person himself. He has the right to make his own choices." In most texts some formulation of this idea can be found, which should come as no surprise considering the dominance of central government and parents' organizations. Service providers, no matter what their religious or social background, cannot disregard the idea of autonomy, even though many agency administrators do not seem entirely happy with it. This seems to account for the fact that in most of the documents we reviewed, ideas on autonomy were phrased rather vaguely.

In analyzing precisely what these documents say about autonomy, we found it striking that the meaning of the concept of freedom of choice often remains unclear because it is not easily discernible what is to be chosen nor who is supposed to choose. As to the object of choice, choice concerns both the institutional setting and various activities of daily life (e.g., what and with whom to eat, what to wear, with whom to have sex). In order to separate these choices clearly, we call the first *institutional choice* and the second *activity choice*. Institutional choice concerns the longstanding wish of parents (parents' organizations) to choose the kinds of supports that most closely respond to the needs of their child instead of being forced to accept a standard offer. In the Netherlands today, this desire for freedom of institutional choice is widely accepted. All policy documents subscribe to the idea of institutional choice. They all state that agencies must provide the care that their clients want. This is certainly not to say that all practical obstacles to realization of this idea have been removed, but only that the idea of the right to such choice is not publicly contested. The picture is different when it comes to choice of activity, which is still the subject of debate. In both cases, it is often unclear who is to choose: the parents (or their legal representatives) or the individual with mental retardation.

Autonomy, moreover, often appears to be

a central but vague concept in these documents. Autonomy is often connected to the ideal of self-realization or self-development, without the relationship between these ideals being explained or elaborated. In one document autonomy and self-development are initially presented as coexistent but different, but immediately after that, as somehow synonymous:

The most fundamental aim of help and care for people with mental retardation is to sustain and coach their personal development and to provide chances for them to make their own choices. . . . Personal development could be expressed as the development of the identity of a person. This does not only concern the development of skills. . . . In fact it concerns the (growth towards) an autonomous existence as a human being.

The emphasis on equality should be self-fulfilling. It is both normative and descriptive. People with mental retardation do not differ in any fundamental way from those without mental retardation—the descriptive thesis—and, therefore, they should not be treated as different—the normative thesis—with the result that both will be shown to be even more alike. The autonomy of people without mental retardation functions as the norm in this context. Clients should always have the opportunity to make their own choices, and these choices should always be respected. This principle can only be overruled in the event of danger or possible harm to the client or others. From this perspective institutional care itself is dangerous. The biggest dangers of institutional care are *dependency* and *paternalism*, as a result of the fact that the caring relationship in various institutions are unequal, with asymmetric power relations. Clients should be protected from the effects of these asymmetric power relationships. Caring, in the sense of emotional sustenance, concern, trust, and so on, is seen as problematic in this perspective. Some of the documents reviewed contained explicit statements indicating that caring should not be a task of professional caretakers but should be provided by the client's personal friends and family members. As noted in a 1994 policy statement:

It is of utmost importance that for emotional sustenance—for the desire for trust, intimacy, and love—the person with mental retardation has access to people *who are not professional caretakers!!!*

In another policy statement written in 1991, the following was found:

Company, support when they are unhappy, good advice, recreation and so on, are part of informal care in soci-

ety. It is unnecessary, even undesirable, to consider these as professional activities when it comes to people with mental retardation.

This relationship between caretaker and carereceiver was described in other policy documents as one of negotiation rather than care, thereby stressing the ideal of equality and similarity between the two parties:

The support should not be concentrated on guarding, nursing and treatment, but on negotiation. This implies that the positions of clients and care-givers are equal.

Documents in which autonomy and individual rights were stressed sometimes also emphasized individual obligations, based on the argument that rights and obligations go hand in hand:

The fundamental equivalence of people with a handicap implies, therefore, not just the recognition of rights and facilities, but also the acceptance of obligations—according to capacity.

Care and Solidarity

Contrary to the autonomy view, caring as an emotional activity, implying emotional bonds between caregiver and carereceiver, is at the heart of the solidarity view. Instead of being considered a danger to professionalism, as is the case in the liberal view, this emotionally involved way of caring is seen as real caring, as caring per se. Caring is first and foremost a question of solidarity, a matter of providing feelings of safety and belonging. In a 1995 document, this was stated in the following way:

Connectedness reaches further than the question of help. . . . [It is about] feeling secure and accepted, about allowing for feelings of trust, about noticing that others make room for you, about feeling that you belong. In short: about knowing you are safe.

In another, undated policy statement, we found the following description:

The personal relationship is the basis of the care offered. The intentional involvement of one human being towards another is characteristic of the shaping of that individual care.

These citations do not warn against emotional involvement. On the contrary—good caring is emotional involvement, which implies much more than reacting to the explicit demands of the client. It also implies giving attention and offering chances and challenges for development:

The task is not just to offer the handicapped person that which he himself says he lacks, but also to offer

care, educational and social situations, that provide opportunities or challenges for development (1996 policy statement).

Whereas this is seen as paternalistic from the viewpoint of autonomy, those defending the solidarity view are more afraid of what they see as the biggest danger of the autonomy view: neglect.

Although the concept of autonomy is based on "equality thinking," the concept of solidarity is based on "difference thinking." It presupposes a fundamental difference between people with and people without mental retardation. This difference is located in their respective positions in caring relationships: People with mental retardation are carereceivers, people without mental retardation are caretakers:

There are people whose situation calls for help. . . . There are also people who can react to that call, who can give others what they need.

When a person evokes concern, he is not only a "receiver" but also a "giver." What then does he give? He gives us the challenge to care for him. . . . The handicapped care-receiver is valuable therefore, because he provides meaning to the life of the care-giver. (1995 document)

The value of both parties can be located in their positions in the caring process, as in the preceding citations: The one party is valuable because he or she cares, whereas the other is valuable because he or she gives the caretaker the opportunity to care, thereby giving meaning to the life of the caretaker. From this perspective, therefore, the professional caring relationship is based on differences that are not to be solved, but to be valued and cherished, because it is this difference that provides both parties with the chance to become valuable social human beings. This valuing of difference implies paternalism, and it does so overtly. Good care implies paternalism in the solidarity view, as good care acknowledges inequality and reminds caregivers of the responsibility this gives them. Consequently, this paternalism could be called overt paternalism, so as to differentiate it from more disguised and unintended forms of paternalism. Inequalities in power are not feared, and caring relationships are not seen as conflictual by nature, as is the case in the autonomy view. Not paternalism, but neglect and the alleged coldness of business-like interaction are seen here as the pitfalls of today's professional service. As noted in one of the policy statements:

Everyone, volunteer or professional alike, is, by seeing and meeting the care-receiver, called to account for what he can offer this human being. . . . The caregiving human being thereby reverts to being a human being instead of an objective professional.

Whereas "equality thinking" promotes a traditionally "male" way of caring (i.e., keeping distance), "difference thinking" values a traditionally "female" manner, in which empathy, warmth, emotional concern, and responding to demands that might not have been explicitly stated are crucial. In a collection of interviews with people (all women) who have worked as professional caregivers in the mental retardation field, most talked about their work in these terms. The following is a typical answer to the question of what good care is: "It all begins with respect for one's fellow human being; with having one's heart in the right place and with simply loving the inmates." (These attitudes would, of course, be considered paternalistic from a liberal point of view.)

In the Netherlands, the dominance of the concept of autonomy can be found mostly in the newer, nonresidential forms of care that have relatively more clients with milder forms of mental retardation. In contrast, the concept of solidarity is predominant in the older agencies, whose clients generally have more severe levels of mental retardation.

Self-Realization

In documents in which either autonomy or solidarity is stressed, self-realization is sometimes mentioned as a value, but in those texts it is subordinate to values of autonomy and care, respectively. In some documents, however, self-realization is the central value, to which other values are subordinate. What then is meant by self-realization? There are three characteristic aspects of self-realization in these texts. First, to put self-realization first in the care of individuals with mental retardation is to say that the caretaker should try to take away hindrances to and offer the person chances to develop his or her potential. Caring, as stated in one 1996 text, is about "relating to people with mental retardation in the right manner, thereby offering him opportunities for self-realization." Thinking about mental retardation, as noted in a 1995 document,

starts from the idea that being human implies becoming oneself in relation to others. For that purpose, human beings should be given room to become what they not yet are.

Second, however, self-development is just one aspect of self-realization. The other aspect has to do with being rather than with developing, with making room for what is already there rather than with striving for something more. In this sense it is implicitly founded on the humanist psychology of, for example, Abraham Maslow. Good caring, defined in one 1993 document, is "to take every human being seriously, so that total justice is done to his/her individuality." Another document, written as a sort of letter to an imaginary person with mental retardation, expresses the idea as follows:

If your true self is not taken into account . . . this often results in you behaving strangely. . . . But you also show different behavior, that belongs to you because you are who you are. . . . You are right, more room and more coaching is needed, that will make you happy.

Third, self-realization is not merely of relevance to people with mental retardation, but also to professional caretakers. The caretaker's self-realization is considered a precondition for the client's self-realization. If the agencies' atmosphere is such that caretakers feel accepted and looked after, if they feel free to be themselves and, for example, to concentrate on tasks they perform well and are happy to perform, they will in turn re-create the same atmosphere for clients. If, on the other hand, they are bullied, they will treat clients in the same manner. The concept of self-realization differs from the other two views, particularly in this last respect: The need for self-realization is what care-receivers and caretakers have in common:

Also the workers should be able to develop their own potential. . . . Every worker should have the opportunity to take part in self-realizing activities that are important both to himself and to the organization.

The aim of The Sterrenberg [one of the agencies whose policy document was reviewed] is to create conditions for a good working climate for the people that work here . . . so that this climate sustains the first aim [self-realization of the inhabitants].

Good relationships form the second central value of the concept of self-realization. Whereas the concept of autonomy stresses the individual's independence, and the concept of solidarity centers around caring for the individual, the concept of self-realization emphasizes human relationships. Self-realization is only possible in the context of good human relationships because it can only come into existence through intensive contact between

caretaker and client. Becoming a human being implies becoming oneself in relation to others:

By becoming oneself we mean the right to develop and shape the potential that one has received as a human being. . . . Realizing this potential happens in situations in which one relates to other people.

If you feel secure in the company of someone, this is because you are entitled to be who you are. If that other person also feels secure in your company, that person is also allowed to be as he is. Well then, this is what we call a positive interpersonal relationship.

In this type of contact both caretaker and carereceiver are seeking to fulfill the same kind of need (instead of an entirely different need, as is supposed to be the case in the solidarity view). This is the need for self-fulfillment. This shared need for self-realization is intended to compensate for the danger of paternalism. It cannot, and is not supposed to, refute paternalism entirely. The remaining, milder form of paternalism could be called compensated paternalism, so as to differentiate it from overt paternalism.

Giving so much weight to personal relationships implies high expectations of professional caretakers. Because this sort of caring is much more than doing a job, the question arises as to whether it can be accomplished by someone with a "9 to 5" attitude. For agencies with a self-realization view, the answer is more often no than yes. Caretakers are (often explicitly) expected not to stick to their schedule of working hours and not to try and protect their private time. A clear-cut line between public and private life is hard to combine with a self-realization view of caring.

Proponents of the concept of self-realization are optimistic about people's relationships. Provided care is organized so that the self-realization of both caretakers and clients is put first, and there is no need to worry about the darker sides of human interaction. As a result of the stress on equality between individuals, for caretakers and clients alike, fear of abuse of power is not a prominent issue. This is sustained by the fact that the sort of things that are, or are not, considered to further self-realization, are left open. The same holds for the issue of who is to choose (client, parent, or caretaker). The idea of self-realization implies that this cannot be decided beforehand. The concepts of autonomy and solidarity are clearer on this point: Autonomy puts the client's view first, whereas solidarity puts the caretaker's view first.

Discussion

Dutch government policymakers tend to suggest that there is a consensus on the superiority of the autonomy view. Our analysis shows that this is not necessarily the case. The concept of autonomy is certainly dominant, but other views are also represented. However, these competing views seem to get marginalized. Responses to earlier writings and lectures in this field made us aware that, at a local level, quite a number of people have doubts about the efficacy of the dominance of autonomy and long for comparison and debate on these concepts. Many regret the impoverishment of the public debate on different views of providing care, in which only the concept of autonomy is considered politically correct and modern, and other views are often seen as old-fashioned and paternalistic. Those who still cling to them are easily pathologized: They must be afraid and overprotective.

The idea that autonomy and self-determination are necessarily of a higher value than are happiness, self-realization, or solidarity, is questionable; it is based on a false antithesis. The quality of what is provided to allow individuals with disabilities to make a choice, jointly with their families, to establish an "independent" life should be such that all involved feel it is a good place to be (see, for example, the conclusion of Raynes, Sumpton, & Flynn, 1987). To put autonomy first seems to narrow down the possibilities too much. Ironically, this is done in the name of extending potential because that is how the concept of autonomy is often defended. Now that a broader range of views on the quality of life has been promulgated in the area of mental retardation, as has a broader range of material possibilities (homes and facilities), to make those views come true, there is no need to put any value first. It would be preferable to cherish more options and a lively debate about them in which divergent views are respected and taken seriously.

As a contribution to this debate, we list some of the strengths and weaknesses of these three concepts. The strength of autonomy lies in its offering a vocabulary for a powerful campaign against belittlement and paternalism and for taking people with mental retardation seriously without reservation. This fits in with thinking on equality in general, but this would be an even greater strength if some problems still attached to the concept of autonomy were

to be solved. The first problem with the concept of autonomy is concern that the question of whether choosing is only a right or also an obligation remains. What if a person does not *want* to choose, albeit temporarily and related to particular topics? One could argue that the concept of autonomy often stresses that people with mental retardation do not only have rights, but also obligations, as is often emphasized in the documents. However, what these obligations should be is never mentioned; only the rights are discussed in the texts.

Second, caregivers have noted that "free choices" are easily manipulated by caregivers, including those who do not intend to manipulate. Even though the concept of autonomy aims at fighting paternalism, the problem of paternalism is hard to extinguish and can easily return in a disguised form. Caregivers find that they have quite a lot of influence on the free choices of their clients, for example by the way they present the choices and their consequences. Third, people we interviewed noted a relationship between the stress on autonomy and the duplication of bureaucracy in caring work. The stress on autonomy is meant to extinguish paternalism by formalizing caring procedures in order to make them controllable, which in turn results in a lot of paperwork. Managers noticed that good administrators are not necessarily good caregivers, which can create a problem when it comes to selecting candidates for caring jobs. Finally, the concept of autonomy does not provide a vocabulary for the emotional aspects of the caring relationship because these are transferred from the professional to the personal sphere. The caretaker is merely assigned to the role of merchant, not to a role of a person who cares about the client and has feelings about providing care.

The concept of solidarity has three strong points. First, proponents of solidarity try to emphasize the value of people with mental retardation, whether or not they adhere to standards that are derived from the lives of the dominant group, in this case, standards of autonomy. Second, solidarity presents a positive view of caring relationships, namely, that caring relationships have their own logic; they differ from other kinds of relationships, such as those in the market or the courtroom. Therefore, there is no use in translating the logic of the one sphere to the other. Third, the concept of solidarity seems to have a greater appeal to

caretakers, at least those with a long-term commitment.

However, this view is also not free of problems. First, it does not make room for notions of inequality, powerlessness, and power abuse that are so prominent in the lives of many people with mental retardation. Caring relationships are, without exception, presented as harmonious, peaceful relationships that nobody could object to and in which no conflicts occur if only all strive for the good. Second, contrary to the autonomy view, people with mental retardation are mainly defined as objects of care, not as co-citizens. As such, their value as human beings is stressed, but this does not seem to counteract their inferior position in society.

The strength of the concept of self-realization, for its part, can be found first in the idea that people with mental retardation should be seen as valuable individuals, of equal value to people without mental retardation, no matter whether or not they conform to ideals of autonomy and self-determination. Another point in favor of the concept of self-realization is the fact that self-realization is a vague but rather optimistic concept. It implies that something valuable and worth developing is present in everyone. However, what self-realization should mean exactly, as well as who is to judge that, is deliberately left open. This is all to be discovered through human relationships.

These strengths are also linked to the weaknesses of the self-realization view, however. The centrality of relationships in the self-realization view puts considerable stress on relationships. Contrary to the autonomy view that tends to give a lot of weight to formalizing care and, consequently, to paperwork, the concept of self-realization gives much credence to personal relationships. However, because the quality of relationships is not easily manageable, the idea of self-realization is vulnerable. It may also be hard to reconcile this view with the conditions of professional caring today, such as defined work schedules and the ability to separate working hours from private time. Second, the vagueness of self-realization as a concept, and the vagueness about who is to determine what it might be, also has a darker side: The danger of paternalism is not restrained as well as it is in the autonomy view. Paternalism as such is not refuted, only *overt* paternalism is refuted while the idea of *compensated* paternalism holds.

To what extent do these concepts of au-

tonomy, self-realization, and solidarity conflict with each other and to what extent are they complementary? Autonomy and solidarity mirror each other in most respects. To begin with, they represent opposite views on caring and paternalism. Although proponents of autonomy are very concerned about paternalism and abuse of power, those favoring solidarity are not. Yet although advocates of solidarity emphasize caring as an activity in its own right, those who support autonomy do not. Self-realization is somewhere in between these two poles.

Second, these concepts represent opposing views on the relationship between people with and those without handicaps in a broader sense. At the heart of this matter lies a question that is always at stake when thinking about the relationships between different groups in society: To what degree and in what respect are various groups seen as different and/or equal? If a dominated group is considered equal, who defines the basis of this equality? If a group is somehow defined as different but equivalent, how can this equivalence be defined and valued? These questions can also be discerned in the functioning of different concepts in the field of mental retardation because the autonomy view is implicitly based on equality-thinking, whereas the concept of solidarity is based on difference-thinking. The concept of solidarity presupposes a fundamental difference between people with and those without mental retardation. This difference is manifested in their respective positions in caring relationships: Whereas people with mental retardation are carereceivers, people without mental retardation are caretakers.

Consistent with difference-thinking in general, the dissimilarities between people with and those without disabilities does not need to be a problem at all, provided that both parties are seen as unequal but equivalent. The value of both parties can be found in their positions in the caring process: The one party is valuable because he or she cares, whereas the other is valuable because he or she gives the caretaker the opportunity to care, thereby giving meaning to the life of the caretaker. From this perspective, therefore, the professional caring relationship is based on differences that are not to be solved but, rather, to be valued and cherished. In the autonomy view, based as it is on equality-thinking, the supposed lives of people without mental retardation function as the norm. Differences in autonomy between people

with and those without mental retardation should, first and foremost, be treated as a sign of a lack of equal treatment of, and equal opportunities for, the former. In this view equality should be the solution to the problem of relationships between these two groups. The norm of equality is implicitly based on the lives of people without mental retardation: People with mental retardation should have the opportunity to become more autonomous, like the majority of people without mental retardation.

Regarding the issue of equality versus difference, the concept of self-realization is somewhere between autonomy and solidarity. On the one hand, consistent with equality-thinking, the concept of self-realization stresses the similarities between people with and those without mental retardation. On the other hand, it does not locate these similarities in characteristics or behavior—as difference thinking does—but, rather, in need—the need to realize oneself. However, what self-realization is supposed to mean is deliberately left open.

Such questions about equality and difference have been thoroughly studied with regard to homosexuality, ethnicity, and gender. The equality position is a good argument against discrimination, but it implicitly puts the norms (ways of life, traditions, behavior) of the dominant group (whites, heterosexuals, men) as the general norm, to which the nondominant group should adjust. This adjustment then functions as a precondition of equality. However, difference-thinking suffers from the opposite problem. By claiming difference but equivalence for some nondominant group, proponents legitimize different (discriminatory) treatment for different groups, and their claim of equivalence is not very powerful in the face of the dominance of the other group.

These concepts conflict with one another in the sense that they presuppose and give substance to different and conflicting caring interactions. They conflict in particular situations. However, they are complementary on a more abstract level. It is very possible to adhere to all three, with the realization that one may have to choose in particular situations. In other words, it is all very well to favor autonomy, self-realization, and security, but these ideals are not always reconcilable. If, for example, a client wants something that is not good for her according to caregivers, a choice must be made between autonomy, self-realization, and safety.

The same is true if a client is asked about her preferences, and caregivers cannot find out what she wants. In all these cases, it is important to realize that it is not just the ideals themselves that are weighed but also, and maybe even more so, their disadvantages. So the question is not just whether in a particular case autonomy is to be preferred over solidarity and self-realization, but even more whether the danger of neglect is to be preferred over the dangers of overt and compensated paternalism.

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