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Chasing Shadows: The Historical Construction of Developmental Disability

Guest editors

Tim Stainton
University of British Columbia, Vancouver, Canada

Patrick McDonagh
Concordia Unversity, Montreal, Canada

Historical study of developmental disability has until recently been a marginal activity, usually the work of people involved in the field professionally who have an interest in history but for whom it is not their main disciplinary or professional activity. While there was much of value in many of these works, there were also errors and unsupported assumptions, many of which have been reproduced in subsequent literature. This is in sharp contrast to the history of mental illness – or madness – which has, for the past forty years, been a rich vein of inquiry for professional historians, sociologists and professionals in the field. One might speculate that the lack of interest in developmental disability is a reflection of the tacit assumption that it is a relatively unproblematic concept whose history is largely limited to positive accounts of progress in care and treatment. Unlike madness, there has not been the same depth or breadth of debate on how developmental disability has been constructed or the implications of various constructions. Even the possibility that developmental disability is a social construct rather than a relatively unproblematic, empirically defined diagnostic category, is still anathema to many.

The history of developmental disability has come a long way in the past ten years. From a small handful of academic books and papers and rather more uncritical histories, there is emerging a number of lines and styles of historical inquiry. Academic historians have begun to un-

dertake detailed examinations of specific eras, institutions and personalities (see, for example, Jackson 2000; Thomson 1998; Trent 1994; Wright & Digby, 1996). In addition to this output, there has been an increased interest in various forms of representation, both historical and contemporary, from the field of cultural studies and other related disciplines (see, for example, Bogdan, 1988; McDonagh, 1998, 2000). More recently, we are seeing a very exciting development in the increasing amount of auto-biographical material giving first person accounts of the lived experience of developmental disability over the past century (e.g., Cooper, 1997; Potts & Fido, 1991). Finally, we are seeing more detailed examinations of the epistemological roots of our concepts of developmental disability (Goodey, 2001; Stainton, in press).

This research has provided an increasingly detailed picture of the history of developmental disability, but it has also brought the question "What is developmental disability?" into sharper focus. The wealth of variation amongst the plethora of rubrics that have often been uncritically assumed to be the same "thing" as that which we currently call "developmental disability" creates a fundamental problem for the historian. How does one know what constitutes the history of developmental disability if we can't identify "who" the "developmentally disabled" were historically? Would the early twentieth century British legal category of "moral imbecile" fit the current diagnostic scope? Or would the person labelled as having "fetal alcohol syndrome" today fit any pre-modern concepts of idiocy?

An example of this common conceptual conflation can be seen in the association of the mythical medieval changeling with developmental disability. Modern psychology and history frequently assumed the two to be relatively synonymous and have then interpreted the changeling myth as a mechanism for psychological adjustment to the presence of a disabled child. The epistemological equation went something like this: Changeling = developmental disability; therefore, the history of the changeling *is* the history of developmental disability. Recent research has called into question the assumptions regarding both the association

of the changeling with developmental disability and the interpretation of the myth in late modern times (Goodey & Stainton, 2001). What this example, along with those noted above, suggests is that one of the effects of an increasingly critical inquiry into the history of intellectual disability is the destabilization of the concept itself. If no historical certainty about what we are referring to exists, how do we study the history at all without ending up chasing shadows? More importantly for contemporary practice, if no definitive historical concept can be identified, do we not need to question our current conceptual models?

Although there is no definitive answer to the above questions, several general points emerge. First is a caution for both the author and reader of history to avoid trans-historical assumptions about what constitutes developmental disability. We can study a particular construct in a particular time and context, but once we move away from that frame the concept will begin to destabilize. On a more positive side, this opens up a whole new area of inquiry: the examination of the conceptual history itself, and by extension, the implications of various conceptual models for policy, practice and the moral and legal status of individuals associated with these constructs.

One of the consequences of this inherently unstable concept is the range of terms which have, and are, currently associated with it: developmental disability; intellectual disability; mental retardation; mental handicap; learning disabilities; idiocy; feeblemindedness; moron; innocent; changeling; and so on, seemly *ad infinitum.* In historical work, a further confusion is added when contemporary terms are projected onto historical periods. This practice both distorts the history, for language is often a key to meaning, and assumes that we are talking about "the same thing" throughout history, which is far from certain. Although all language is political, and often painful for people to hear, it is important that we maintain as accurate a portrayal of the language of the period in question or we both distort the historical record and imply a false trans-historical conceptual reality. Our concept of developmental disability today is not the same thing as the 19th and early 20th century

concept of idiocy or feeblemindedness. They may be related, but they cannot be substituted as synonyms. For this reason, the articles in this volume use the language appropriate to the time and context. Where developmental disability is used, it refers to what we currently understand that term to be, which may or may not be directly associated with the historical concept under examination.

The study of the interplay between the conceptualization of developmental disability and the social response to it serves as a cautionary tale for contemporary practice. It suggests that claims of an essential concept of developmental disability are perhaps unfounded. More importantly, all concepts are potentially dangerous, as many of the papers in this volume demonstrate. The focus of this volume, then, is the history of the concept of developmental disability and related concepts, as well as strategies deployed to address these ideas and the consequences of the various types of conceptualization in different times and context.

The first article, Chris Goodey's "What is Developmental Disability? The Origin and Nature of our Conceptual Models," addresses this question of concept directly, setting a critical tone for this edition in its careful analysis of the groundwork on which our modern notion of "idiocy" was constructed. In so doing, he also explicitly critiques the positivist and presentist attitudes that have long dominated thinking in the field. As he argues, we cannot find evidence of any comparable understanding of what we might recognize as developmental disability in the classical world, or even in medieval Europe. Instead, the roots of modern notions of developmental disability can be found in the religious and intellectual movements that flourished in the seventeenth century, and which found practical applications in the political writings of John Locke and his allies whose writings argued for a democratic rule based on the capacity of each individual for rational thought. The "idiot," according to the Lockean argument, is an insufficently-human exception to the rule of rational humanity.

Tim Stainton's article demonstrates Goodey's argument that our notion

of developmental disability is born of relatively recent historical processes as it challenges the notion that medieval monastaries provided shelter for "idiots" or others who may today be labelled as having intellectual disabilities. As Stainton argues in "Medieval Charitable Institutions and Intellectual Impairment," there is no evidence that any systematic means of support existed for such people. The dominant medical-psychological interpretations of intellectual disability of our era were absent in the period from 1066–1600, and, consequently, so were the validations for institutional support. Instead, Stainton argues, what support was granted to those labelled "idiots" was always secondary to poverty; that is, people known as "idiots" in their community received support only if they were also poor. There were no other frameworks in which to view this condition.

Peter Carpenter explores educational provisions, especially the newly developing system of institutions and licensing bodies, for those identified as "idiots" in his article "The Role of Victorian Women in the Care of 'Idiots' and the 'Feeble-minded.'" These institutions and licensing bodies formed an important part of the professionalization of activity and discourse around the idea of "idiocy," and as Carpenter stresses, the process of professionalization can be analyzed productively along gender lines. While Victorian projects initiated by men tended to be on the large scale, women focused their energies on more familial, cottage-industry services. Carpenter traces the history of these services, noting also their conflict with the growing authority of commissions that preferred the large-scale asylums to small teaching homes. This struggle between approaches to the support and education of people labeled as "idiots" would influence later conceptions of the notion.

In a study that nicely parallels Carpenter's analysis of the "idiocy industry" along gender lines, Murray Simpson investigates the battle between the fields of medicine and psychology over professional control of this growing domain. His analysis of this power struggle in "Medicine vs. Psychology: The Emergence of a Professional Conflict in Develomental Disability" foregrounds the process by which activity and knowledge

around the idea of "idiocy" became professionalized. One important component was the thrust to develop articulations of "mental deficiency" that would be increasingly formal and objective; indeed, without the development of apparently firm scientific criteria for defining "mental deficiency," neither professional group could have claimed authority. Alfred Binet and Théodore Simon in *Mentally Defective Children* effectively championed the importance of psychology, thereby helping to consolidate an understanding of mental deficiency as a constant psychological condition rather than an "illness," and in the process helping to establish credibility for what was then the relatively new profession of psychology. As Simpson demonstrates, "the history of the field is … a political history."

In "'Only an Almost': Helen MacMurchy, Feeble Minds and the Evidence of Literature," Patrick McDonagh explores Helen MacMurchy's analysis of literary representations of "idiocy" and "feeblemindedness" in her 1920 book *The Almosts* to promote a particular idea of feeblemindedness, and with it her eugenicist agenda of segregation and sterilization. The article investigates MacMurchy's the assumptions as she diagnoses characters and assesses the severity of their symptoms. One of the main points in MacMurchy's diagnostic criteria is an apparent "childishness" which she uses to legitimate her aggressively paternalist argument.

In "Lessons from the Past: Child Victims with Developmental Disabilities in Nazi Germany," Sally Rogow recounts the atrocities of the Nazi holocaust but with a focus on intellectually disabled victims, noting how a shift in perceptions of individuals moved Germany from being an inclusive society to one in which people were executed for their apparent deviance. As she writes, "The Nazi victimization of vulnerable people may have been unique in its organization, its mercilessness and its bureaucratic efficiency, but it serves to highlight the tragic consequences of making value judgments on human lives." But, as Rogow stresses, these value judgments also came at a time of severe social and economic upheaval; an environment difficult for most people is espe-

cially hostile to society's most vulnerable peoples, as the extreme example of Germany in the 1930s and through the Second World War demonstrates.

This collection of articles points to the processes by which we have come to believe certain things about intellectual disability, idiocy, feeble-mindedness, and a series of other terms. It also emphasizes the historical forces energizing these processes, underscoring the social construction of disability and its relationship to class, gender and power. The essays call for a shift in focus in our attempts to understand developmental disability, both in our historical analyses and in current approaches. Developmental disability, and the various other historical terms under analysis in this volume, cannot be viewed as a category utterly independent of the social, cultural, philosophical and economic forces that also influence such notions as race, class, and gender. The history of developmental disability needs to venture beyond the positivist and presentist notions that have so long dominated our thinking. The articles in this collection are each a step on that journey to a fuller understanding of what developmental disability means as a social and cultural phenomenon, each giving substance to the shadows we have been chasing.

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What is Developmental Disability? The Origin and Nature of Our Conceptual Models

C. F. Goodey
Open University
London, United Kingdom

Abstract

The basic concepts we use to describe and explain intellectual disability have specific historical roots. They cannot be found before the late seventeenth century, and their relative stability since then is due to their inseparability from the religious and political ideas that informed modern society. This history challenges theories ("positivism," "presentism") which imply that intellectual disability is and always has been the same, and that service delivery can only be improved on the basis of an institutional and philosophical status quo. The lesson for practitioners is that if we know things were radically different in the past, we know also they can be so in the future.

Every day we use concepts such as "ability," "disability," "development," "retardation," and "intelligence" as if everybody knows what we mean and as if everybody in the past would have known, however far back in history we might go. Are we justified in assuming this? There are well-researched critical histories of segregated institutions, from Samuel Gridley Howe through the long-stay hospitals examined by writers such as Wolfensberger (1976), Trent (1992), Ferguson (1995) and others. The history of educational theories, pedagogical techniques and administrative practices has been less thoroughly researched but at least it is known about, and we can read about Seguin and the feely-bag or Goddard's introduction in North America of the IQ test (Kelves, 1985).

And yet the origins of the basic concepts behind these institutions and practices, including our own, have scarcely been researched at all.

Why? One reason may be the inaccessibility of primary texts in this field. The first-hand documents produced by the administrators of the long-stay institutions, and the texts on assessment written by the first educational and developmental psychologists, are still in existence. Life is therefore relatively straightforward for the historian who wants to consult them. Primary texts about the origins of concepts, on the other hand, are harder to gather together, spread as they are across disciplines, cultures and periods, and more subject to interpretation, reinterpretation and misinterpretation.

Apart from this simple explanation for the lack of a conceptual history I would like to offer two rather more conspiratorial suggestions. First of all, to research the origins of such terms as "ability," "disability," "development" and "intelligence" is to admit that they had origins in the first place. But if these nuts and bolts of our everyday practice have origins, it also implies that there might have been or still be a culture, a time and place, where they did not exist, or where they are of no importance. Something which has identifiable origins at a certain point in history is something that may also die. If this is the case, how can we go on doing what we do now with complete confidence? Secondly, one of the deep-seated cultural beliefs of our times that things are on the whole getting better, and that we are getting better at making them better. At the very least, improvement and progress are possible. If we are always improving our services to people with an intellectual disability, what would be the point in pulling our working concepts up by the roots for inspection?[1] Thus, in both these attitudes there is a natural resistance to doing fundamental historical research that might turn out to be dangerous.

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[1] I have chosen "intellectual disability" because it is the generic term currently agreed by the international scientific community. I could have picked several other current terms, and for the last hundred years alone there have been almost a score in use. This points to the problematical character of the concept itself.

These two suggestions correspond to two related theoretical trends. The first is known to historians as "positivism," the second as "presentism" (Smith, 1988). Positivism, in our field, could be defined as a belief that the disciplines of psychology and education can produce stable scientific knowledge about the child's mind and behaviour, in the same way that physics produces stable knowledge about the laws of gravity or biology about the biochemical structure of human genes. This kind of knowledge can be proved or disproved by evidence, and once verified, it does not change. Positivism implies that intellectual disability, in the form we understand it, has always existed, whether the people living in a particular historical period recognized it or not; this way of thinking prevents us from seeing any component of that knowledge, let alone its basic concepts, as having a limited lifespan. Presentism is a view of history as improvement and progress, and more particularly as progress towards the position that the exponent of that view currently occupies. It is a circular way of using history to justify one's own practices: history marches towards the triumph of a scientific set of concepts and a particular way of doing things, and these just happen to be our own.

Thus, positivism assumes that there is a value in stable, scientific knowledge of some kind, and presentism assumes that we can be optimistic about improving things on the basis of how they are at present. There is a degree of positivist and a presentist in all of us, whether we know it or not. Without either stable knowledge or professional optimism, we are of no use to anyone. But this may lead to the feeling that it would be better not to disturb the reassurance that these approaches seem to offer. If there are fundamental terms and concepts in the history that remain uninvestigated, however, we have an intellectual duty to follow them up. Perhaps we can learn useful lessons from such an investigation.

The Classical and Medieval Periods

Historians of medicine and psychiatry always ask themselves the question: if we travelled to another culture or another time and spoke with its practitioners, would we recognize their concept of a particular con-

dition or person as being identical with our own? In fact it is easy to demonstrate that (dis)ability, development and species-specific intelligence are all concepts that can only be understood as part of a particular mind-set of the last three to four hundred years. Go back earlier and they cannot be identified. Nevertheless they have become so deeply a part of our thinking that we assume they have always been understood in similar ways in the past. An accommodating mind-set was needed before we could have a concept of people with intellectual disabilities, and I shall describe its modern beginnings in the next section.

It is important to demonstrate the gap between this mind-set and that of earlier European traditions. These days we are to some extent prepared to accept that definitions of mental illness may be relative, that they may change from one culture to another, and therefore that there is some doubt about how to interpret them when they appear in historical texts. Intellectual disability, on the other hand, seems to us be as fixed as physical disability. If we look at ancient Greek medicine and psychology we realise that we have to question this. As one might expect, accounts of physical disability are easy to match with modern ones; in Hippocrates, there are explanations of congenital dislocation of the hip, for example, based in quite a modern way on the hypothesis of events occurring in the womb (Withington, 1952). There is more dispute over the meaning of Hippocratic accounts of mental illness; it may be possible, for example, to recognize some similarities with modern accounts of manic depression and epilepsy, but this depends on our interpretation of the texts (Pigeaud, 1989). Regarding intellectual disability in any sense recognisable to us, however, in no Greek medical text there is nothing one might have a dispute about; the concept is simply absent.

Psychology as such was not at that time a discipline separate from others. Most of what we understand by it was discussed under the heading of philosophy rather than medicine (Everson, 1991). Plato in *The Republic* drew a distinction between people who could perceive the light of conceptual truth and mere *troglodytes* who were content with the

false shadows it threw on the walls of their cave. Although later commentators have made much of this famous passage, Plato intended it metaphorically, in a poetic vision of the just society. When he spoke about the everyday social realities of the time, on the other hand, the people he classified as having a condition in which learning was incurably absent (amathia) bore no resemblance to the people we perceive as being intellectually disabled today; they were fellow-philosophers with dangerous ideas, or political rulers who used their power for personal gain (Goodey, 1992). The condition had to be prevented because it led to social dysfunction (a similar justification is used by cognitive and behavioural geneticists today to justify their research). He was not drawing a satirical analogy between bad philosophers or rulers and people with an intellectual disability. He meant literally that the former were pathological; he did not acknowledge even the existence of the latter in any sense recognizable to us. He coined for himself a term that translates exactly as "learning difficulty" (dysmathia); but this referred to the illiterate. These people would in every other sense be normal and could even be good rulers, as long as they did not have anti-social appetites.

In Aristotle's case too we have a well-known example of an idea that modern readers often take to be a simple precursor of our intellectual disability. In his *Politics* he described some people as "natural slaves," seeming to justify slavery on the grounds that they were not simply captured by force but had natural characteristics that suited them to be ruled by others for their own benefit and protection (Garnsey, 1996). However, what the Greeks meant by nature is very different from what we mean; it was certainly not a scientific term in the sense that a modern biochemist would understand. People did not necessarily distinguish natural causes from social or environmental ones. Aristotle's natural slaves were simply a given part of the social fabric without whom no society could function; they might be psychologically inferior simply because they had never had the opportunity to use their brains, not because there were some innate mental characteristics preventing them from doing so (Goodey, 1999).

Without even a concept of intellectual disability, ancient writers can tell us nothing about the social roles of people we would now describe as having it. This is true of people with those conditions that might have been identifiable by physical characteristics, such as Down syndrome. Although in practice they would have had a lower survival rate, some of them must have survived in ancient societies. If so, they go unremarked by writers of the time. They do not make any appearance in the gynaecological and obstetric texts of the period. Nor may we just assume that their absence from the history has been due to the practice of infanticide. New-born infants were exposed (largely on the expectation that they would survive as foundlings) because of the poverty of the parents. Even very general physical weakness appears, from archaeological evidence, not in itself to have been a sufficient motive for exposure; there are literary references to eugenics in this sense, but no evidence that they amount to more than wishful thinking. There is certainly no evidence that infanticide was practised on children of an age at which a psychological diagnosis of intellectual disability becomes possible. This would in any case be unlikely if the ancients had no clear concept of something they might want to eliminate in this respect.

In the middle ages, classical models of psychology continued to prevail, while the separate field of medicine was dominated by the ideas of another Greek, Galen. Doctors identified a condition called "absence of mind" (amentia), but this was not something permanently embodied or innate in certain individuals; it was an organically caused illness that could happen to anyone. A shift occurred in the field of law, however, where a distinction began to be drawn between people who suffer from temporary mental incompetence and those who are born with it. Although this is more modern-looking, it was a fiscal distinction applying only to the landowning aristocracy and gentry, not a medical or psychological criterion applicable generally across the population. Guardians could be appointed for landowners who were mentally ill, on the understanding that when they had "lucid intervals" the management of their estates could be restored to them. If, on the other hand, it was decided that the heir to landed property was a "born fool," the monarch

had the right to administer the profits of the estate – a right only widely exercised later, in fact, when the Stuarts got into financial difficulties (Neugebauer, 1978, 1979, 1996). Even this only displays one half of the modern concept of intellectual disability, which is broadly conceived as both congenital and incurable. Foolishness may have been recognized in law as innate, but the culture in general did not necessarily attach incurability to innateness; "fools" might be cured providentially by God. Biological determinism was still a long way off.

We have no clear evidence for the popular perception that people with intellectual disability had a distinct social role as providers of entertainment for the aristocracy. The iconographic evidence suggests rather that some individuals were used for this purpose, but that their role overlapped with that of others whom today we would not label in this way. There are records of professional jesters who had attended university; people with short stature or curvature of the spine were also recruited as fools, and would simply have had to develop the personality that went with the job. Nor was the intellectual condition of people whom we might call disabled clearly distinguishable from that of the labouring poor, whose mental abilities were perceived to be limited and whose innate capacities for intellectual development were of no social relevance since they owned no land.

Early Modern Psychology: The Context

The matrix of the concepts we use is the seventeenth century. Before examining the reasons for this, it would be useful to summarize the mind-set that enabled the concept of intellectual disability to come about.

First of all, this period saw the growing domination of a notion of personhood that we call phenomenological, emphasizing the continuity of the individual human identity from birth to death. This would tend to imply that a condition of intellectual disability is both congenital and incurable. Simultaneous shifts in religious belief meant that there was less room for providential cure. Thus, learning difficulties were to

become the individual property of that person alone, constituting his or her identity in a much more restrictive fashion than before and inviting strict definition and labelling.

A second ingredient was the tendency to separate "mind" from "body" as a distinct, autonomous entity. This tendency, initiated by the French philosopher Descartes, was brought to a head by John Locke, whose description of the human mind in *An Essay Concerning Human Understanding* eventually came to be seen as one of the founding texts of modern psychology. Religious explanations of rationality and behaviour gave way to what was subsequently claimed to be a scientific study of the human mind, as a natural and secular realm with its own laws (albeit ones that were still seen as having been laid down initially by God). This enabled intellectual disability to be studied separately from the organic bodily influences which, according to the old Galenists, had been capable of affecting any human individual.

The third ingredient was a change in the sense of the word "nature" itself. Previously nature had been seen as a realm in which God could make on-line interventions. Once the concept of nature was secularized, it also became subject to fixed logical laws and boundaries; it became a realm in which there was no place for such interventions. Medieval thinkers had always started from the definition "man is a rational animal," but this was merely a proposition in logic; if, in the real natural world, there were some humans who contradicted the definition, this had no particular application to biological nature. Now that scientists were beginning to use logic as a way of classifying the natural world, however, the existence of exceptions to this rule about humans became an intellectual problem. People henceforth constructed as "idiots" threatened the classification of human beings as rational and themselves required classification. And so there emerged the idea of a specifically human intelligence that defined the species and belonged only within its boundaries. Although both the Greeks and their medieval successors had talked of humans as "rational," this rationality was not entirely specific to humans; it had overlapped the species boundaries between

gods, humans and sometimes even other animals. Now it became important to make the boundaries of intelligence line up with the boundaries of a particular species. It therefore became more of a problem if such specific intelligence was absent in an individual who, physically at least, appeared to belong to that species.

These three ingredients combined to become part of the new human sciences. Within early modern psychology there arose the idea of an absence or deficiency which was (a) congenital and incurable, (b) purely mental and (c) classifiable by strict laws of nature – in other words, the modern conceptual basis of intellectual disability. How and why did this come about? It is not the case that a science of psychology had always existed and was simply getting better, through changes and refinements to its conceptual framework. This concept of "idiotism" was new, and so for essential purposes was the discipline of psychology itself. Religion and politics were crucial to the process.

Religion, Politics and Intellectual Disability

Religion played an important part in the new scientific classifications of humanity. One boundary-line still familiar in the seventeenth century had been the distinction between people who were elect and those who were reprobate or unregenerate (Goodey, 2001). The greatest debate within Protestant Christianity in the early part of the century was over this question. There were orthodox Calvinists who believed that salvation was preordained before birth for a relatively small "elect" number of people and that the rest were damned, for reasons known only to God. There were others who thought that this dogma was too harsh, alienating potential converts from the Roman church. They proposed instead that everyone can be saved, as long as they have the will to do so; but to their opponents this sounded too much like Romanism. Eventually some thinkers developed a compromise position: that everyone is saved not if they have the will but if they have the capacity: that is, if they have the ability to understand what salvation means. It is in these latter texts that we first come across the word "disability" (*impotentia*)

being used to describe something internal to the individual person and the individual mind.

Thus, an initially obscure theological doctrine entered the modern mindset through popular Christian literature and sermons from 1660 onwards. At the same time, it became one of the founding principles of secular psychology. In previous explanations of human nature, the intellect was not perceived as morally neutral, since in each of us it was flawed by its association with the fallen Adam. Once some theologians had begun to propose that there was a category of people who were excused from working for their salvation by their own intellectual means because they had a morally neutral, "natural disability," then the inference could be drawn that a morally neutral realm of intellect existed and might be positively ascribed to those humans who were not thus disabled. The boundary-line between the elect and the damned phased into this distinction between able and disabled. The idea that the disability was unnatural, even threatening, quickly came to prevail over the idea of non-culpability. It is usually assumed that the eighteenth-century enlightenment replaced the harsh religious distinction with an egalitarian and universal "concept of man," but that is not quite true: the concept of man excluded the idiot, whose definition had helped bring that concept into being.

The conceptual exclusion of the idiot was matched by other beliefs drawn from theology and superstition. We think of superstition and science as opposites, and of the former giving way to the latter in this period. However, the notion that an infant born an "idiot" was a creature substituted for the real one by the devil became more, not less, popular among the proponents of psychology and the new sciences (and is still latent in the counselling given to parents of new-born disabled children that is based on anologies with bereavement). This was because the new thinkers were anxious not to pose a threat to the creationist belief that God had limited and fixed the number of species for all time. To be human is to be rational; however, by the laws of an increasingly rigorous psychology and natural history, there are some

humans who are apparently not. How to classify these creatures is then a problem. The Bible does not mention a separate sub-species between humans and other animals. Furthermore, if God had created sub-humans, it would mean that he was not good. Demonology helped to explain the problem away; that is partly why people began at this point to use the word "changeling," with its hints at the devil's paternity, in alternation with the more technical term "idiot" (Goodey & Stainton, 2001).

In England during this same period, the issue first arose in the church's pastoral practices. Theologians had always quarrelled about whether priests had the right to bar certain categories of people from communion; these included children and manifest sinners, but they also included a loose psychological category known as "the distracted." As people became less optimistic about the idea of providential cure, it became clear that some further distinction was needed between people who might recover their wits by themselves, enough to understand the meaning of holy communion, and those who never had their wits in the first place and never would, not for reasons of social class or upbringing but because of some innate and permanent mental difference. "Idiots" became the category that all parties to the dispute could agree on excluding from the sacraments, even those who formerly insisted on free admission to all. As the admission to eucharist expanded and became more inclusive, so the exceptions were even more pathologised. Churchwardens were responsible for enforcing such exclusions, and were also responsible for administering the poor law; it is probably no coincidence that at the height of these debates we also find the first call to put the "mad" in different institutions from the "idiotic," a call that was to echo through the next two centuries.

This was the background against which Locke's *Essay Concerning Human Understanding* was written a generation later, influencing the whole rise of modern psychology. The issues for him were not only religious, but political (Marshall, 1994). He conceived and wrote the *Essay* as an act of political opposition to the monarch's and bishops' claims, revived

after the English revolution, that they had a divine right to rule. The basis of their claims was that they possessed absolute principles of reason, a set of basic "common ideas" which were uniform and handed down from God and which they handed on to the rest of the population. In resisting the claim, Locke and the Dissenters laid themselves open to the accusation that they were relativists, egoistic splitters who thought that everyone could justify their beliefs in their own way. In fact Locke and the Dissenters valued uniformity of doctrine, and of church and society, just as much as their opponents. However, it would have been contradictory for them to assert both that it was they who knew the absolute principles of reason rather than the rulers whom they opposed, and that they were not splitters. To avoid this dilemma they located absolute uniformity not in the *principles* of reason, the common ideas themselves, but in the *means* by which individuals came to understand those principles. These means consisted in what we might now call a common psychological machinery, which was uniform within each individual member of the species, and which each member was morally obliged to develop by his own efforts. This provided the rationale for the idea that humans are autonomous reasoners, each possessing the mental ability to give or withdraw their consent. (In the political terms predominant in the original concept, this meant consent to be ruled by the monarch, who no longer had divine right; it became dominant after the "Glorious Revolution" of 1688–9 in England and even more pervasive in the ideas of the American Revolution.) "Idiots" were precisely those people in whom this machinery was absent or deficient.

Locke may have been a political thinker with religious roots, but he justified his view of human nature with a meticulously philosophical approach. First of all, according to Locke, autonomous reasoners are not born with the principles and ideas of absolute doctrinal truth, only with the machinery by which they will eventually be able to grasp them. He famously asserted that the infant mind is a blank slate which receives external data empirically; individuals only becomes intelligent if they possess the uniform (we would say "normal") psychological equipment mentioned above. The theory of education which he based on

this assertion implies that infants are born in a state of idiotism from which a few never or only partly escape. Neither developmental psychology nor the term "retardation" itself could exist without this specifically seventeenth-century thought; nor could particular notions such as the alleged developmental "plateau" in Down syndrome, or the idea of a so-called universal "infantile autism" which autistic adults are alone unable to escape. Secondly, Locke defined the disability of idiots by their failure to form "abstract ideas" (Goodey, 1994). The ability to form abstract ideas is what distinguishes humans from animals, according to Locke, but it is also what "idiots" lack. Anyone who has ever cast an eye over psychological assessments of children with intellectual disabilities in our schools will know how familiar this language still is. Whether or not these two moves constitute a genuine scientific advance in psychology is up to the reader to judge. What is beyond controversy is the fact that they have specific historical roots in issues much wider and more public than the specialism of psychology.

The seventeenth-century thinkers also created a more complex array of disabilities in which a specifically intellectual one might be inserted. The new picture of human abilities – newly optimistic for most individuals, newly pessimistic for our small minority – involved making a subdivision of disabilities between "mental" and "physical" which we now take for granted but which at the time seemed strange or even dangerous. Disabilities of both kinds had previously tended to be seen as "moral"; lepers and people who had physical or sensory impairments were either responsible for their own condition or had been picked out by God to illustrate Adam's fall. Early modern philosophy, emphasizing the separateness of mind and body, helped to create a dichotomy between physical and mental disability. On the whole, psychology began to exonerate physically disabled people from moral blame for their condition. With intellectual disability, on the other hand, the position was more ambiguous; in the emerging corpus of early modern psychology it was soon perceived to be dangerous, as we have seen. Locke not only hinted at demonic causes but suggested that idiots might lack souls. We live with that inheritance.

The Lessons of History

What use is this historical information to practitioners? The realization that our basic concepts have relatively recent historical roots may make us sceptical about positivist and presentist approaches; it may lead us to challenge the concepts and categories we work with on a daily basis. Sceptics can employ their knowledge that things were otherwise in the past to help us imagine that things may be otherwise in the future, that they are neither fixed for all time (positivism) nor basically sound with a mere need for tinkering (presentism). Scepticism challenges category boundaries both internally, within the genus "intellectual disability," and externally, in the relationship of that genus to "normality."

Internally, the study of historical change helps us to think harder about present-day categories within a supposedly generic "intellectual disability." Particular conditions wax and wane with great rapidity. Not so long ago autism did not exist as a label; Down syndrome was the nightmare in the public imagination, leading to institutionalization and to pre-natal diagnostic techniques which, it went without saying, aimed at complete eradication. Now, even with the arrival of semi-effective pre-natal diagnostic techniques, a significant minority of prospective parents reject termination for Down syndrome not necessarily for religious reasons but because the nightmare has partly receded (e.g., children are mainstreamed, act in films, etc.). Autism, meanwhile, has been "discovered" and the diagnosis is expanding every year, as is the separate specialism which informs us that people with autism live in their own separate world and thus need separate specialisms and institutions. How much of this is science and how much is just another whirl of the merry-go-round of historical and social constructions? The broad historical view allows us to see and reflect upon our everyday practices in their full context.

Externally, in the relationship between intellectual disability and normality, our historical awareness that even the basic concepts defining intellectual disability are relatively recent compels us to ask what the

difference is between them and us. If this can be called into question, then so can the practice of segregating one group from the other in separate institutions, separate service provision, "special" schools and classes.

One possible, and powerful, reaction to this by the sceptic is to say that it shows precisely how necessary the category of intellectual disability is. It came into being because modern social arrangements demand it. The knowledge that things were otherwise in the past is irrelevant. We live in the here and now. There are certain people who in this particular society, because of the way it is structured, cannot get along as equal members. Perhaps it is true that people with an intellectual disability are the arbitrary sum total of certain modern historical and social processes, that society is nevertheless real. For better or worse they live in it, and they need to be labelled in order to be helped or protected. This comes first, before any question of where help is provided, whether in the community and the mainstream of social life or in segregated settings. And if the goal is benevolent protection, then perhaps segregation is required. However, advocates of this view need to remember that by and large segregation is also status quo. Positivists and presentists therefore need to ask themselves whether the apparent common sense of their position could not be seen as a facade for vested interests or a lazy resistance to change such as mainstreaming. Nor, on the other hand, is the sceptic, whom history has taught to question the way things are, free from the obligation to face up to certain ethical dilemmas. Is it ethical to use people labelled with intellectual disabilities as experimental agents of change in a society that is often overtly or covertly hostile to them, as the guinea-pig on the end of a battering ram?

An ethical response to the two positions cannot be neutral. The answer does not lie in a strained academic objectivity, nor is there a midway or neutral position between delivering services to a segregated environment or to an ordinary one. We have to make a choice. In teaching us about what may have happened in the past, history can be a training in ethics too. In order to understand history, we normally have to try to

put ourselves in the place of others and imagine how someone in a particular period would have seen things. Perhaps we should try to extend this practice. How would we like to be treated if it were we who were being assessed? Out of everything that people with intellectual disabilities experience and dislike at the hands of others, at the top of their list are over-zealous tutelage, protection, and separation from ordinary life (Stainton, 1994). That separation has its historical origins partly in our own conceptual separations, and this is something we have the power to change radically if we wish.

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Correspondence

C. F. Goodey
1 Whitfield Road
East Ham, London UK
E6 1AS
email: CGoodey@aol.com

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Medieval Charitable Institutions and Intellectual Impairment c.1066–1600

Timothy Stainton
University of Wales Swansea, UK
and University of British Columbia, Canada

Abstract

This article examines the question of the concept of intellectual impairment in medieval Britain through a case study of early charitable institutions and their utilisation by persons with intellectual impairments. An analysis of literature on medieval charitable institutions suggests that a popular concept of intellectual impairment did exist and that some people with intellectual impairments were found in these facilities, primarily almshouses; however, this support was neither extensive nor based on any medical or psychological construction of intellectual impairment. Nor is there evidence of any specific concern with the "holy innocent." Rather, support was on the basis of poverty and was not motivated by any specific concern with intellectual impairment. The need for further research is highlighted and a suggestion is made that the dominant focus of research on medical constructions and institutions specific to intellectual impairment is misguided.

Introduction

The support of the monasteries is often cited as a key source of medieval welfare for people with intellectual impairments (Abbott & Sapsford, 1987; Scheerenberger, 1982). However, there has been little actual research into the subject to date. More critically, these largely positivist accounts assume that a concept equivalent to our modern concept of intellectual impairment existed, and that this concept lay at the basis of

early institutional support. Much of the historical literature also suggests that "disability," or more broadly the marginality of people with disabilities, stems largely from capitalist modes of production, and more specifically industrialization (Oliver, 1990; Ryan, 1987). Although there are numerous problems with this account, a general problem is a lack of research into pre-industrial concepts and social responses to intellectual impairment that might support or reject this thesis.

This article seeks to examine as a "case study" the most commonly cited example of pre-industrial support, the early hospitals and almshouses. Examining the available literature on medieval institutions in order to establish to what degree people whom today would be labeled as having an intellectual impairment were actually present in these institutions, and how and why they came to be present, helps not only to test the basic assumption that they were supported in these institutions but also the notion that a relatively fixed concept of intellectual impairment actually existed, and to examine the degree to which this was a factor in their receiving support in these institutions.

It will be argued that, although there is very limited evidence that people with an intellectual impairment were commonly supported in such institutions, such support was not provided on the basis of their disability or impairment, but rather their poverty. Finally, the paper will show that, far from a pre-industrial "golden age," marginality was then, as now, a common outcome of being perceived as having an intellectual impairment. Before we begin our specific case study, it will be useful to look briefly at whether there was any recognizable concept of intellectual disability or impairment in medieval Britain.

The Medieval Concept of Intellectual Impairment

The commonly employed term of reference in late medieval documents, "idiocy," is easily, and frequently, equated with the its later usage in nineteenth century onward. Though related, these usages are not equivalent, the earlier usage being a popular, quasi-legal term rather than

medical or psychological, with no clear definitive meaning equivalent to modern terminology. The most definitive early reference is the *Preogativa Regis* (King's Prerogative) (17 Edward. II, stat. I), thought to originate from the 13th century, which sets out the Crown's rights and responsibilities with regard to the lands of "natural fools" and "lunatics." Chapter XI states:

> The King shall have the Custody of the lands of natural fools, taking the Profits of them without Waste or Destruction, and shall find them their Necessaries, of whose Fee soever the land be holden. (2) And after the Death of such Idiots he shall render it to the right Heirs, so that such Idiots shall not aliene, nor their Heirs shall be disinherited.

In the above citation the use of both "natural fools" and "idiot" suggests the rather unspecific nature of the terms; this ambiguity is borne out by the nature of the tests for idiocy that were largely naturalistic. Fitz-Herbert's (1632) influential definition runs: "and he who shall be found to be a sot and idiot from birth, is such a person who cannot accompt or number twenty pence, nor can tell who his Father, or Mother, nor how old he is &c." One 14th century case cited by Fitz-Herbert notes that inspection showed that "she had the face and countenance of an idiot," suggesting that a popular image of an "idiot" was well established at this point. There is no suggestion that either medical or ecclesiastical opinion played a role in this process. This basic definition and means of determining idiocy would continue into the 18th century.

Current evidence also supports the view that no explicitly medical or psychological definition of "idiocy" existed until the 16th century, when a specific medical discourse began to emerge.[1] Further evidence for this view can be found in Kealey's (1981) exhaustive catalogue of physi-

[1] Paracelsus c.1493–1542, Felix Platter, c.1536–1614 Ambroise Paré c.1510–90 are the earliest credible sources with Thomas Willis c.1621–75 being the first English source.

cians in the first half of the 12th century, none of whom are cited as being concerned with this area. What remains is a popular idea with no objective conceptual criteria. The foregoing, and indeed all pre-seventeenth century history of intellectual impairment, must be viewed with this in mind.

The Rise and Fall of Medieval Charitable Institutions

Early monastic orders were characterized by a renunciation of the world and cultivation of a life of prayer. However, by 1050, some monastic orders were being formed adopting the rule of St. Augustine, which was more flexible, and some began to engage in pastoral work, caring for the sick and frail, and providing shelter and alms (Hamilton, 1986). Post-conquest (1066) Britain saw a massive growth of hospitals and other types of charitable institutions. Kealey (1981) notes that there were only seven known hospitals in the period between 400–1066, but by 1154, this number had risen to 113. Knowles and Hadcock (1971), in their exhaustive catalogue of medieval religious houses of England and Wales, cite 1,103 hospitals and charitable institutions, both secular and religious, with the vast majority being post-conquest. There were four main types of medieval institutions: leper houses; almshouses; hospices for poor wayfarers and pilgrims; and, hospitals for the sick poor (Carlin, 1989). In his study of the development of hospitals in the first half of the 12th century, Kealey (1981) notes that some 58% of these institutions were not associated with religious orders and many of those that were had little direct contact with their sponsoring orders. Guilds, municipalities and feudal lords were all involved in either supporting or independently running many of these early institutions (Knowles & Hadcock, 1971). Royal patronage was also a key factor, notably Queen Matilda, consort to Henry I (b. 1069, rgn. 1100–1135), who founded several hospitals (Kealey, 1981).

Of the institutions noted by Knowles and Hadcock (1971), almshouses were by far the most common, numbering 742. These varied in size and composition, with the majority being for men only and relatively

small in size – thirteen being a common number of inmates (Stewart-Brown, 1926). Some were restricted to Guild members or local residents, and a strict regime involving regular prayer, attending mass and the wearing of distinctive habits was usually followed (Carlin, 1989).

Hospitals explicitly for the care of the sick and infirm poor numbered only 112, according to Knowles and Hadcock (1971), and less than twenty of these were exclusively for the sick. Many explicitly excluded those deemed incurable, including "idiots," or became increasingly exclusive, with some ceasing to care for the sick altogether by the 15th century (Andrews, 1996; Carlin, 1989; Rubin, 1989). A small number provided specialist care, most famously St. Mary of Bethlehem, later known as Bedlam, which was founded in 1247. Contrary to previous suggestions (cf. Scheerenberger, 1983), it is highly unlikely that anyone with intellectual impairments was resident in Bedlam given its explicit remit and small size, and no records to support these suggestions are evident in the literature examined.

By the middle of the 14th century, hospitals significantly diminished in number (Knowles & Hadcock, 1971). The primary reason for this seems to be a decline in charitable funds to support such houses. Famine and plague had reduced the population, and the income of the patrons had seriously declined. Rubin (1989) notes that the attitude towards charity changed in this climate of labour shortages, and hospitals were seen as supporting "lazy shirkers" and helping them to avoid work. The Statute of Labourers issued in 1349 established penalties for refusing to work; it stated that any able-bodied man must work for anyone who required them and that no alms could be given to able-bodied beggars (Tuchman, 1979). Carlin adds "corrupt and crippling maladministration" to the factors contributing to the decline of these early hospitals. For example, Peter Taverner, deputy warden of St. Mary's Bethlehem, was found to have stolen everything from money out of alms boxes to chains and manacles (Carlin, 1989). After this time, many hospitals and almshouse simply disappeared or converted to other uses, such as schools. Some began to charge for their services, thereby abandoning

their care of the poor (Carlin, 1989; Rubin, 1989). Thus, well before the dissolution of the monasteries (1536–1539), medieval institutions for the poor, sick and infirm were in serious decline.

Evidence of Intellectual Impairment

Of the institutions enumerated by Knowles and Hadcock, only one makes any reference to what may be intellectual impairment. St. John the Baptist in Chester was founded in 1232 by the Earl of Chester and Richmond "for the sustentation of poor and silly persons." Carlin (1989) indicates that it provided specialized care for "the mentally handicapped"; however, this assumption seems to be based entirely on the term "silly persons," which was not a term with any exclusive association with intellectual impairment. In the only exhaustive study of St. John the Baptist, Stewart-Brown (1926) makes no mention of "silly persons," "idiots," "innocents," or "naturals" (terms generally associated with a deficit in reason) having been a particular target group for the almshouse, or even being present among the inmates (see also Harris, 1980). Although this does not preclude the presence of people with intellectual impairments, there is no hard evidence to support this contention.

St. James and St. Mary Magdalene of Chichester was founded in 1118 (Knowles & Hadcock, 1971) as a leper house, and became an almshouse in 1442. Clay notes that by the close of the 16th century, it was "occupied by a sad collection of hopeless cripples, among whom were found two idiots. A hundred years later, the bishop reported that his hospital was of small revenue and "hath only one poor person, but she a miserable idiot, in it" (Clay, 1966, p.34). The Victorian County History of Sussex also makes reference to the presence of "idiots" among the thirteen inmates, citing the hospital records for 1594 which note the presence of "John Pellard a diseased idiot, 30" and "Elizabeth Vody an idiot, 17" (Page, 1907, p. 99). Another interesting feature of the list of inmates is that along with the two "idiots" are listed five "cripples," two "maids without legs," and "Constance Cutt an impotent cripple in her loins, 15. All of honest conversation" (Page, 1907, p. 99). This list sug-

gests that disability figured strongly in the remit of this hospital, though it is not specified in any of the records examined. A final point contained in the county history is that the inmates "only left the house for the purpose of collecting alms, their income being insufficient for their maintenance; accordingly the queen in 1597 licensed William Egly as 'guider of yesd House' to collect money" (Page, 1907). This clearly infers that inmates were expected, at least in part, to pay for their care. It should be noted, however, that these records stem from the late 16th century, a time when "idiocy" was emerging as a distinct concept, and do not necessarily indicate that "idiots" were either defined or present in the facility prior to this period.

The extent to which people with intellectual impairments found support from religious and secular institutions is still unclear. However, the above does suggest that some found their way into these early institutions, but that the numbers were small. While intellectual impairments may have contributed to their poverty, it was a secondary consideration *vis a vis* their presence in these institutions. Conditions were also unlikely to have been particularly pleasant, given the strict regimes; as evidence from the medieval institutions for the insane suggest, disciplinary regimes were often harsh, with chains and shackles being commonly employed (Carlin, 1989). That no hospitals with a medical remit specifically for intellectual impairment were established, and that references to intellectual impairment are absent in the remits of lunatic asylums, suggest that there was, at this point, no medical construction of intellectual impairment. Nor is there evidence of any particular ecclesiastical concern with the "holy innocent," as has sometimes been suggested. As noted above, poverty was the primary reason for residence in these institutions; the fact that some inmates had an intellectual impairment was, the current evidence suggests, incidental.

The motives for charity cannot be reduced to a single rationale. Rahere, traditionally thought to be a jester,[3] who founded St. Bartholomew's,

[3] Kealey suggests there is no real evidence for this being the case.

did so as a result of a vision he had while undergoing a cure in Rome. Others no doubt donated out of a sense of Christian duty or public spirit, while still others did so to gain temporal reward and reputation. The primary motivation for giving, however, was the saving of one's own soul. The "seven works of mercy," an idea prevalent in the medieval mind, could, according to several medieval documents, be fulfilled by the founding of a hospital, almshouse or similar institution (Clay, 1966). By the 14th century, with economic decline and a change in attitude towards the poor noted above, we also find the more familiar motive of establishing institutions to remove the unwanted and dangerous from the streets (Rubin, 1989). Motives would change again significantly after the reformation, but that is beyond the scope of our current concern.

Conclusion

The evidence suggests that some people with intellectual impairments were recognized and received support from late medieval institutions. There is, however, no evidence that this support was either extensive nor particularly pleasant. It was a harsh paternalism of sorts, but, more fundamentally, it was a means of fulfilling one's duty to God and of saving one's soul. To a large extent, care for the "idiot" was valued as a means to this end, rather than as an exercise in selfless charity.

One possible explanation for the relative absence of people with intellectual impairments from early British institutions is that they were not particularly *disabled* in the medieval world, given the agrarian, labour intensive and largely illiterate nature of society. This is even more likely to have been the case after the great plagues and famines of the mid 14th century, which decimated the population and put labour at a premium (Tuchman, 1979). Although this adds some support for the thesis, noted in the introduction, that industrialization is responsible for producing the concept of disability, it does not follow that intellectual impairment did not engender other forms of marginality, and, in some cases, contribute to poverty of those popularly viewed as "idiots."

The fact that no hospitals were established specifically for intellectual impairment, and the lack of any evidence of their being treated in the general hospitals or those for the insane, supports the view that intellectual impairment was not at this point constructed as a medical or psychological problem, or indeed as any definitive concept. So while there is certainly evidence that something roughly equivalent to our concept of intellectual impairment was recognized (i.e., "idiots"), exactly what this meant in practice remains unclear. At any rate, poverty, not impairment, was clearly the primary reason for any support provided.

This economic rather than medical rationale is consistent with the *prerogativa regis,* which was concerned exclusively with the property of "idiots" (see Neugebauer, 1996). Although much more research is required before any definitive statement on the issue can be made, we can say that there is no evidence of any systematic support for those thought to have an intellectual impairment, and, further, that any support that existed was not given by virtue of their impairment but by virtue of their poverty. This would continue to be the case with the vast majority of institutional care until the beginning of the twentieth century.[4] This finding suggests that the traditional research focus on medical interest and explicit systems of support for people with intellectual impairments is misplaced; instead, a broader socio-historical focus on marginal populations is required, with poverty as a paramount consideration for the period under review here. Poverty is the great leveler, as Burton wrote in 1621: "for to be poor is to be a knave, a fool, a wretch, a wicked, an odious fellow, a common eye-sore, say poor and say all" (350).

[4] See for examples the Sidney and Beatrice Webb, 1909 on the numbers of 'defectives' in workhouses.

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Correspondence

Timothy Stainton
University of British Columbia
School of Social Work and Family Studies
2080 West Mall
University of British Columbia
Vancouver BC, Canada
V6T 1Z2
email: timst@interchange.ubc.ca

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The Role of Victorian Women in the Care of "Idiots" and the "Feebleminded"

Peter Carpenter
Kingswood CLDT
Bristol, United Kingdom

Abstract

The role of women in the innovation of care for people with learning (intellectual) disabilities in Victorian times has been underestimated. A review of the local records of the Bristol and Bath area shows that whilst no large "idiot" asylums were created, women were involved in the creation of four small schools and homes in the first 30 years of the Victorian period. In the last decades of the period, they were again involved in the creation of a series of homes that catered for the new group of the "feeble-minded." All these homes were small and appear to bear little resemblance to the "Idiot" Asylums created by male committees; rather, they were more in keeping with the idea of size espoused in the late 20th Century.

Most of the histories of the care of "idiots," "imbeciles" and the "feebleminded" in Victorian England have concentrated on the role of the workhouse (Wright, 2000) or of the large "voluntary idiot asylums" (e.g., Barrett, 1986; Gelband, 1979; Gladstone, 1996; Wright, 1993). As such, the writing has been mainly concerned with the role of men who were the governors and committee members of the large institutions, such as Andrew Reed. Otherwise the main names known are the men who authored books about people with learning disabilities, such as William Ireland, John Langdon Down (Ward, 1998), Daniel H. Tuke, William Millard and G. W. Shuttleworth. The women who are usually mentioned in histories all operated mainly in the next century: Mary Dendy, who founded the Sandlebridge Boarding Schools in 1902 and

who became a Commissioner for the Board of Control in 1913 (Jackson, 1996, 2000); Ellen Pinsent who was on the 1905 Royal Commission; and Norah Fry, who was active in the Somerset area.

Few authors have written of the role of Victorian women in the care of these people. This is probably because there are few records of these women. The homes they ran were usually small and have left little evidence of their operation, which has to be ferreted out of a wide range of records (see Carpenter, 2000b). This is to be expected, for it was difficult for women, particularly married women, to enter public life. To do so would be seen as inappropriate for a respectable woman, and an intrusion into the public domain of men (for a fuller discussion, see Lewis, 1991; Perkins, 1993). However, women did have roles in the development of care during the Victorian era. This paper illustrates this by looking at such roles in the area of Bristol and Bath in the United Kingdom. For the sake of accuracy, this paper will use the terminology of the period.

The Care of the "Idiot" and "Imbecile" 1845–1880

As well as "specialised" care, disabled paupers were looked after during this period in the community and in workhouses. A doctor, surveying the pauper "lunatics and idiots" in the community on outdoor relief in 1844 commented in his report on the ability of the mothers to care for the person and recites the mothers' comments on her child (Carpenter, 1997). But nowhere does he refer to a father, demonstrating that community care then was being provided by mothers.

The first known Victorian "home" for the care of "idiots" in England was the "Bath Idiot and Imbecile Institution" (for fuller description see Carpenter, 2000a), which commenced in April 1846 when Miss Charlotte White employed a matron to care for three "idiot" children in some rented rooms. She later related that "the general improvement in a few months was so considerable as to encourage the hope of extensive usefulness, could larger means be obtained. With this object, a Committee

of Ladies was formed and a printed Appeal circulated. These measures were so far successful that in November of the same year, the Committee were able to engage the whole house…" (White, 1854, p.1).

This institution was run by a committee of women, and most of the recorded subscriptions came from women (Carpenter, 2000a). The Lunacy Commissioners published a report of a visit to it in 1851, when they described it as containing eighteen pupils looked after by a resident matron and four teachers, as well as a small staff of domestic servants. There was a committee of management "and several benevolent ladies, members of that committee, are in the habit of almost daily attending at the house as visitors, and observing, and occasionally assisting in whatever instruction appears to be going on" (Commissioners, 1851, p.43). They also give a description of the operation of the house, with two classes of eight and five pupils being taught the properties of numbers and colours, eventually advancing to reading, writing, geography and religious instruction. They observe that "much more time and attention are given to mental than to physical cultivation; that is to say, to communicating intellectual knowledge to the pupils than to training them to habits of industry and order.…" After morning lessons and before lunch the children were taken for a one-hour walk; during out-of-school hours they amused themselves with various games and toys. The criticism of the Commissioners was that "little has been done or attempted towards rendering the instruction of the children subservient to the acquisition of useful arts or trades, such as knitting, straw-plaiting." They wanted less "mere school instruction" and more physical training, exercise and training in trades. Their complaints give the impression of the institution being run along the lines of a primary school, by women who were not impressed by the physical drill that featured so prominently in the later "voluntary idiot asylums" and reformatory schools.

However, at the time the Commissioners visited, the Whites had left Bristol, and the subscriptions were falling. It soon became effectively a private school for "idiots and imbeciles," run by a matron and managed

by a small and inactive committee. It was eventually taken over in 1887 by the men of the Bath Municipal Charity Trustees, who immediately launched an unsuccessful appeal to rebuild it as a 100-bed school (Carpenter, 2000a).

The school's founder, Miss Charlotte White, explained the motivation of the enterprise in terms of a natural need to protect children from abuse.

> The immediate cause of the experiment being tried was the knowledge that this class of children was frequently subject to the grossest ill-usage and neglect while, excepting those cases received for profit by necessitous persons, the Workhouse or Lunatic Asylum alone afforded a refuge for these unfortunates – both manifestly improper abodes for those capable of instruction. (White, 1854, p.1)

This role of protection was very much seen as a legitimate interest of women (Lewis, 1991). It is unfortunate that this enterprise lost its charitable energies with the loss of the founding woman, Charlotte White.

The next 20 years saw the creation of the five large so-called "voluntary idiot asylums": Earlswood (1853), Eastern Counties (1859), Northern Counties (1864), Western Counties (1864), and the Midland Counties (1868). John Langdon Down started his large private "idiot" asylum, Normansfield, in 1869. During this time, though, the homes that were set up for "idiots" in the Bath and Bristol area were all created and run by women and were all small (for fuller details on these see Carpenter, 2000b).

The "Idiot Home Asylum" was set up above Bath by Mrs Mercy Long, the wife of a stonemason. She and her daughters "nursed" up to six adults and children at a time in the family home, from 1858 to 1872. In 1866, the home was licensed as an "idiot" asylum after pressure from the Commissioners in Lunacy. It had a slow turnover and appears to

have provided custodial care only. It appears to have been a cottage industry, set up to provide the women in the family with a small income. It closed as a licensed asylum when the daughters moved to Greendown House, where they advertised rented apartments, but in 1876 two children and a young man appear to have been still looked after by them, as the Commissioners told them to give up either the man or the children (Commissioners, 1876).

After leaving the "Bath Idiot and Imbecile Institution," its matron, Miss Mary Short, set up her own small "School for Imbecile Children" in 1861, in Downside Lodge, Chilcompton. Though it was called a school and had a school room, it appears to have opened with adults as well as children. Again the Commissioners required a license, and so Downside Lodge was accredited in spring 1865 as a provincial licensed house. The domestic house in its acre of grounds saw few changes and by 1881 had settled to the same four ladies who stayed (with one dying in 1887) until the Lodge closed in 1917. Miss Short probably died in 1887, when the Lodge was taken over by her niece, Miss Constance Page. Constance E. Short took it over on the death of Miss Page in 1915. This home remained the smallest licensed "Idiot" Asylum in England, and lasted longer than any other known small home (56 years). The Commissioners seem to have been very pleased with it and effectively advertised it in their annual report:

> At Downside Lodge, … Miss Short receives a limited number of imbecile young ladies, upon whom she bestows the utmost kindness and attention. The House is a very comfortable one, and is pleasantly situated. The license enables Miss Short to have seven patients. At a recent visit there were only four. We are always able to commend this establishment very highly. (Commissioners, 1882, p151)

The third home, a home for "Imbecile Children," was set up by the woman who succeeded Mary Short as matron of the "Bath Idiot and Imbecile Institution," Mrs Charlotte Robins, a widow who left Bath after

only a year. She appears to have run a small home at Ivy Lodge, Cromhall, from around 1862; records show that the home was still in operation in 1871 and had closed by 1879, but a precise date of closure has not been found. She avoided licensing from the Commissioners by stipulating she catered for children only, but in 1871 her "private home for imbecile children" housed a girl aged twelve and a man aged eighteen. This combination would not have been permitted by the Commissioners, so it must be assumed that they rarely visited, if at all, after their initial visit in 1865.

All these three homes were perceived as catering for "idiots" and "imbeciles" and so came to the attention of the Commissioners in Lunacy. All appear to have been private initiatives by women to provide a living for themselves. Two women – Mary Short and Charlotte Robins – definitely had prior experience working with disabled children by being past matrons of the "Bath Idiot and Imbecile Institution"; the third woman, Mercy Long, is not known to have had experience, but may well have worked at the local workhouse. All these homes, were difficult for the Commissioners to monitor, and with the demise of the charity of the "Bath Idiot and Imbecile Institution," they argued that larger asylums were better, saying in 1865 that institutions for "idiot" children "will be most beneficial and successful if upon an adequate scale and conducted on the voluntary principle so as to enlist the sympathies and elicit the liberal contributions of the wealthy and charitable" (p 46).

There was, however, another place open prior to 1865 that cared for people who later would be called "mental defectives" or "feeble minded." Again this was an initiative led by a woman, Mary Carpenter. In 1846, she set up a Ragged School for boys in Bristol, and then in 1852 set up a Reformatory School for Boys in Kingswood near Bristol with the help of some male friends (Mills, 1977). In September 1854, with the help of her friend Lady Byron, she purchased a house in Bristol called Red Lodge (now a museum) and turned it into a girl's Reformatory School (Carpenter, 1879). This "school" moved and in 1897 changed its name to the Mary Carpenter Home [for Working Girls], "a home for the train-

ing and protection of feeble-minded girls between the ages of 10 and 25" (Wright, 1901, p.766). In 1905, it took 15 "feeble-minded" women (Royal Commission, 1908, Vol.1, question 3407), and it was later registered under the 1913 Mental Deficiency Act [1913MDA] to take "feeble-minded" women. It closed in 1919.

The Care of the "Feeble-Minded" 1880–1900

Between 1880–1900, there were no new ventures launched in the Bristol or Bath area to care for the "idiot" or "imbecile," apart possibly from the creation of the Red Cross Special School. This cause was championed by Miss Townsend, but set up under the aegis of the Bristol Education Committee, which was dominated by men. However, the 1890s saw the creation of a series of small homes that cared for "feeble-minded" women. All appear to have been championed and operated by women.

The Royal Fort was the home of the local Preventative Mission. It first appeared in the local directories of Bristol in 1878, "to rescue young girls from the influence of vicious associations; to instruct and educate them for domestic service" (Wright, 1878, p.405). There are no records of the Bristol Preventative Mission but the officers listed in the directories are all women, as were the five trustees in 1948. It housed about 20 girls. The Preventative Mission expanded its accommodation in 1893 by setting up the Chasefield Laundry Home. This "Laundry Home for feeble-minded girls" (Wright, 1899, p.722) was affiliated in 1905 to the "National Association for Promoting the Welfare of the Feeble Minded," and was described as enabling "destitute girls to remain permanently if unable to improve sufficiently for service. Age of admission 14–20; approved by the Local Government Board, 26 beds" (Royal Commission, 1908, Vol 1, p226). The Royal Fort was licensed under the 1913MDA to take young women who were mental defectives.

In 1882, Harriett Wemyss, who grew up with her sister in Painswick, Gloucestershire, opened a Training and Convalescent home and then a small home for eight children from the Alexandra Hospital for Hip Dis-

eases of London. In 1890, she started the "St Mary's Home for Working Girls Feeble in Body or Mind" (Hollingsbee, 2000). The first patron was HRH Princess Helena, and by 1905 the home held over 33 inmates, most of whom were "feeble-minded"; some, however, were "cripples." The inmates are described as "slightly [but] distinctly feeble-minded," and "quite unfit to go out into the world" (Royal Commission, 1908, Vol. 2, p.430). This home was hailed as one of the first of its kind in the country and was affiliated with the "National Association for Promoting the Welfare of the Feeble Minded." It probably was quite influential given that Wemyss was the cousin of Willoughby Hyett Dickenson – a Member of Parliament, Chairman of the National Association, and treasurer of St Mary's – who helped steer the 1913 Mental Deficiency Act through the House of Commons.

Bath had its own Preventative Mission, founded by Eliza Walker:

> In January 1878 a young lady but recently arrived in Bath chanced to meet a poor girl, heard her petition for help and the name of the dwelling place. She visited her and in the same house found a young woman whom she persuaded to go into the Penitentiary, herself joining the Committee of that Institution to enable to share watching over her. As time went on she and other ladies became convinced of the need of some missionary agency to seek out and rescue girls and young children… Work commenced under the name of Bath Female Mission in April 1879… Name Changed to Bath Preventative Mission. (Bath City Archive [BCA], Accn. 341/23)

The Bath "Preventative Mission and Association for the Care of Friendless Girls" (BCA, Accn. 341/13) came to own a series of homes, including an orphan home, an industrial school for girls, and a home for unmarried mothers. It cared for "feeble-minded" girls, eventually taking over the Penitentiary and renaming it the "House of Help." "It was found that in practice, only imbecile women were taken in, and the executive

committee therefore applied to the Charity Commissioners to vary the scheme to apply only to mental defectives as they could then get payment from Local Authorities and make it pay its way" (typewritten history, Bristol Record Office, 40686/RH/F/1). The House of Help was licensed under the 1913MDA. The governing committee were all women up to the point when it merged with the Penitentiary, which had several men on its committee.

Comments

The striking feature found from examining the records of the Bristol area is that there were a series of small homes that were created to cater for "idiots" and "imbeciles," and later for the "feeble-minded." There were two clear periods of activity. In the initial period of 1845–1880, Charlotte White launched the first known English school for "idiot" children and engaged a committee of women to run it. Soon afterwards, a series of women set up small homes or residential schools as commercial enterprises to provide themselves with a living. In time this practice stopped, probably due to a series of trends. One was that the great large voluntary asylums were admitting a sizeable number of people by 1870(though most took people for only a limited period, and then the person had to apply for long term residence). Another was that the Poor Law guardians and local authorities were developing their accommodation in the workhouse and with lodging people with families (where they were cared for primarily by women). Finally, the Commissioners in Lunacy came to actively discourage these small homes, as the expense and regulations associated with licensing homes must have also discouraged the proprietors.

From the 1880s there was another flurry of activity. This was initially an interest in rescuing women, and appears in part to have come from the founding women's dissatisfaction with the systems then in place. Harriet Wemyss was active as a Poor Law guardian before she founded her home, and Eliza Walker became dissatisfied with the penitentiary before she founded her homes. The homes all seem to have quickly

realised that many of their clients were "weak minded" and developed their service in this direction.

These homes took people from the workhouses. A local guardian, Mary Clifford, describes using these homes for "feeble-minded" girls, saying

> There are not any weak-minded girls in the workhouse who have been educated in the schools or homes, because the guardians have, since 1890, sent all such to one or other of the voluntary homes opened about that time for girls … They rarely receive any but girls straight from our schools into the voluntary institutions. (Royal Commission, 1908, Vol 2, page 301 & question 16289)

Bristol and Bath may well have been unusual in the energy of the local women, as this region was famed for its level of philanthropy in the Victorian period. In the 1840s Bath was dominated by single women and by the retired officers of the East India Company (Davis & Bonsall, 1996). Miles (2001, July) has pointed out that many of the wives and daughters of the East India Company men were very active in India in founding local schools and beneficial projects, and they may well have kept this energy on return to England, willing to flaunt English convention. However, they could not flaunt convention to the point of setting up large enterprises. No Victorian woman publicly ran a large commercial enterprise – to do so would have been seen as a travesty of womanhood. It was the role of the man, as the breadwinner of the family, to make large plans, to mix with other men, and to make public appeals for funds. For any woman or committee of women in charge of a small enterprise, greatly enlarging it needed the involvement of men. Otherwise, money was raised by personal donations and by bazaars.

By the 1890s, women seem to have been involved in the local charities for women and children. An examination of the listing of "Religious and Benevolent Institutions" in Bristol for societies catering for women or children show that most of the smaller local groups list only female

committee members. Thus, the "Girls Industrial Home," the "Home of Rest," the "Preventative Mission," the "Asylum for hopeful discharged female prisoners," the "Children's Home," and the "Temporary Home for Fallen Women" all have only female officers listed. The major exception to this is "The Muller Orphanages," which were the work of one man, Muller. In contrast to the operations founded by women, this enterprise became huge, providing a home for over 2000 children on one site. In addition, the institutions for women and children that were part of greater organisations, such as the "Church of England Asylum for Poor Orphan Girls" and the temperance societies for women, also tended to have male committee members. There are a few exceptions, such as the "Bristol Female Refuge Society," the "Guardian House," which had a male committee member and did not seem to have been part of a greater organisation.

The study of the Bristol area shows that women were important in innovation in the care of disabled people. Most of the homes they created were small, and a stark contrast to the large institutions created by the male-dominated committees operating the poor law and voluntary "idiot" asylums.

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Correspondence

Dr. Peter Carpenter
Kingswood CLDT
Hanham Road
Kingswood, Bristol BS15 8PQ, UK.
email: drpetercarpenter@hotmail.com

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Medicine vs. Psychology: The Emergence of a Professional Conflict in Development Disability

Murray K. Simpson
The University of Dundee
Dundee, United Kingdom

Abstract

Over the past century there has been a competition between medicine and psychology for authority to speak of and act on developmental disability. This paper studies one particular work, Mentally Defective Children (Binet & Simon, 1914), which provides an insight into the early part of this struggle, proffering, as it does, a system for the conceptual and organizational ordering of "mental deficiency." It stakes out a claim, both discursive and professional, for psychology, restricting considerably the role and position which medicine had established. The paper highlights the need to focus on the political aspect of the history of this field.

Almost since its inception as a discipline independent of medicine or philosophy, there has been a clear and strong drive to make psychology a clinical activity, rather than a merely academic pursuit one step removed from the application of its own insights. As Leahey (1994) notes, this tendency surfaced quickly in the American Psychological Association after its foundation in 1892: "American psychology wanted to be recognized as a science…*with practical aims*" (p. 213, emphasis added). Ever since this expansion beyond the academy and the inception of professions of applied psychologists, psychology has been concerned with questions of intelligence and its abnormalities. Indeed, the "feebleminded" were one of the earliest of its objects, as both construction and target (Gelb, 1987; Karier, 1972; Rose, 1985; Sutherland, 1984).

This will to apply psychology to social problems did not, however, involve the simple question of whether the new concepts and technologies were useful and effective, but led to questions about who was competent to apply them, specifically, whether or not one required a medical training. The struggle for dominance between psychiatry and psychology should not, therefore, be seen in terms of debates about the organic against the behavioral, or physiology versus intelligence. It is about the authority to pronounce on psychology itself. It is a contest between a medical and a non-medical psychology of developmental disability.[1] Indeed the boundaries which have developed at the conceptual level have never been coterminous with the professional ones.

Relations between psychology and psychiatry are manifold and multilayered. Developmental disability represents only one area in which professional and conceptual competition has been evident. Indeed, there is scarcely any area of psychiatry's terrain that critics have not identified at one time or another as being not medical concerns. On certain occasions these contests have been epistemological in nature – over the appropriateness and adequacy of organic models to account for behavioral and psychic abnormality, for instance. Disputes around developmental disability are often presented in such terms. The medicine of developmental disability, we are led to understand, is concerned with labelling and attempting, though failing, to *cure* the "sick" body, whilst psychology places emphasis on the mutability of behaviour and its amenability to scientific pedagogy (e.g., Ryan & Thomas, 1987; Wolfensberger, 1975).

However, the professional boundaries of psychiatry and psychology have proven extremely permeable to conceptual and technological movement. Psychiatry, for instance, has freely adopted purely psychic indicators of developmental disability by means of IQ and has made substantial use of behavioral techniques. Psychology, for its part, has not been slow to study the biology of behaviour, or the physiology of the brain, and was heavily implicated in the promotion and implementa-

[1] Having made this caveat, for reasons of brevity the paper will use the term 'psychology' to refer to non-medical psychology.

tion of eugenics; it has pushed against the boundaries of not only psychiatry but even neurology. Neither has there been any inevitable or consistent relationship between institutional locus and either professional grouping or conceptual model, with both professional camps and all major theories establishing themselves in both institutional and community settings. Rather than regarding concepts, methods, and locations as inherently medical or not, we ought perhaps to say that these have all figured as elements in the tactical maneuvers between psychiatry and psychology, variously excluded and deployed, subverted, inverted and modified to suit strategic demands. The history of this field is, therefore, a political history.

Taking such a position then, it is immediately clear that this paper could not hope to tackle all of the aspects of the contest between psychiatry and psychology for authority over intellectual disability, let alone work back through the many strata which have accumulated over the past century to trace the vertical lines of its development. Adopting a far more modest aim, this paper describes one early example of this struggle for professional authority as a means of illustrating the contention that the political history of this area is at least as significant as the intellectual, as well as identifying some of the key points and tactics in psychology's struggle against psychiatry.

Alfred Binet and Théodore Simon's (1914) *Mentally Defective Children* is often overlooked or given second place to those works that actually develop concepts and methods of testing more extensively. This is understandable given that most of the interest in these authors' work is in their development of novel and enormously influential concepts and techniques for measuring intelligence. However, *Mentally Defective Children* is particularly interesting because it provides a very explicit perspective on the professional rivalries, both clinical and academic, that are of concern here. In fact, this work shows quite clearly that what was at stake in these debates was the authority to pronounce not only on matters relating to developmental disability, but on all matters pertaining to pedagogy and to the conceptual and practical ordering of the educational system. As the century progressed, of course, the rewards

would become even higher as psychology penetrated ever further into society and, consequently, the territorial disputes grew larger and more numerous (Rose, 1989).

The Assault on Medicine

The growth of psychology came at a time when the labors of nineteenth century endeavours were beginning to bear fruit. Institutions were growing significantly in size and number across Europe and North America, and the need for special and separate provision was beginning to win out, for better or worse (Ferguson, 1994; Scheerenberger, 1983). The field as a whole was also moving decisively away from its now archaic juridical orientation, a shift perhaps best signaled in the growing shift away from the antiquated terminology of "idiocy" and "imbecility." However, medicine had scarcely established itself as the accepted primary authority on the subject than it came under attack from the fledgling psychology.

Psychology did not, however, commit to an anti-pathological model. In Binet and Simon's case there is an explicit acceptance that "mental deficiency is a disease" (1914, p.13). Rather, the grounds for rejecting medical approaches and for questioning medical expertise were largely pragmatic. First of all, the alienists' concepts were imprecisely formulated and applied, and, second, in any case, there existed no means of accurately assessing them. On both these counts the techniques of mental testing gave psychology a decisive advantage, but particularly in relation to the latter. What were the aims of this pragmatism? Quite simply, it was to sort children into categories of educability and to place them accordingly: the idiot – asylum care only; the imbecile and ill-balanced – separate and specialized schooling; and, those able to benefit from normal schooling. As Binet and Simon make very apparent, the very *raison d'être* of the new theory and method of intelligence testing was to remove from the mainstream schools those unable to benefit from schooling therein and likely to hinder by deadweight (the idiot and imbecile) or disruptive behaviour (the ill-balanced) the progress of the school and the other pupils.

In Britain these pressures had already resulted in the passage of the *Elementary Education (Defective and Epileptic Children) Act* (1899), which allowed education authorities to exclude from ordinary schools those "incapable of receiving proper benefit … by reason of mental or physical defect" (Jackson, 1996). The Commission headed by Binet resulted in similar legislation in France. The French laws also specified the involvement of three professionals in the examining committee that considered the possible removal of children: the head of a special school, a physician, and the elementary school inspector. What it did not do, and this is the lacuna to which *Mentally Defective Children* is targeted, was to determine the mechanics of this decision-making. By transposing the composition of the examining committee into "three varieties of experience – that of teachers, of doctors, and of psychologists" (1914, p. 38), Binet and Simon are able to set out a manifesto for the domination of the system by psychology and psychologists, infusing it with psychological concepts and concerns, and holding it together in the crucial role of the inspector, in whom the authors invest the authority of psychology. The way in which the work defines and develops the role of the school inspector goes to the very heart of the problem and opportunity confronting what was still essentially an academic discipline, namely the lack of an autonomous clinical psychology profession.

One of the key objectives of *Mentally Defective Children*, then, was to assign roles to different professional and institutional groups and to circumscribe the areas of legitimate expertise in the production of knowledge of mental deficiency. In particular, running throughout this work are a number of direct and often vitriolic attacks on medical practice in the field of idiocy. At a most basic level, the alienists were strongly rebuked for imprecision in diagnosis. After studying admission certificates for a number of Paris asylums, Binet and Simon found no consistency among physicians assessing the degree of mental deficiency in patients, concluding that "without exaggeration [assessments]…looked as if they had been drawn by chance out of a sack" (1914, p. 76). The authors located the root of such discrepancies in the imprecision of the medical terminology, and especially the differentiation of idiocy, imbecility and feeblemindedness being based only on relative terms subject

to wide variation in interpretation: "less," "profound," "less still," etc. The quest for precision was, of course, central to the development of mental testing, mental age, and, eventually, intelligence quotient: " … the first fundamental requisite of correlation…[is]…a *precise quantitative expression*" (Spearman, 1904/1973, p. 38, emphasis in original).

The alienists were, perhaps, always vulnerable to criticism because of the lack of real headway in the physical treatment of mental deficiency. The authors regarded the tendency in medicine towards the study of etiology, pathogenetics and nosology as not directly useful in individual treatment. They argued that the study of these areas had produced little in the way of remedy, conceding, though, that it may have a prophylactic impact. Because mental deficiency was the permanent consequence of hereditarily acquired impairment (through damaged or weakened germ cells), or the result of serious illness before birth or in early childhood (e.g. Howe, 1848/1972; Ireland, 1877; Seguin, 1866; Tredgold, 1908), knowledge of etiology would not, therefore, have any direct bearing on treatment. In addition, no correspondence had been established between the location of neurological lesions and the manifestation of defect, although extent of lesion appeared to correlate with degree of impairment. The only other avenue open to the physicians, therefore, was the ameliorative treatment of symptoms by means of medico-pedagogy – an area where Binet and Simon repudiate all medical claims to expertise.

The reliance of medicine on pedagogical technology since its development by Itard, Seguin, Guggenbühl and others (Kanner, 1960; Scheerenberger, 1983) was undoubtedly a weakness. Medicine had accommodated pedagogy into its treatment armory at the beginning of the nineteenth century (see, for example, Poole, 1825), but by the end of the century, pedagogy remained almost the only treatment available to physicians attempting to treat idiocy. In the intervening century, mass education had created a hugely expanded teaching profession and psychology had become established as an autonomous academic discipline, keen to comment on subjects relevant to pedagogy and intellectual defi-

ciency. In this respect it was, perhaps, only a matter of time before some form of challenge was presented to its claims to pedagogical expertise.

Binet and Simon (1914) call medico-pedagogy to account for the remarkable claims to efficacy that had so characterized the rhetoric of the nineteenth century pioneers (e.g., "A visit", 1847). Examining returns from the school of the Salpêtrière for 117 "idiots" leaving over a four-year period, the authors found the following distribution of destinations:

improved	20
doubtful	20
deteriorated	60
dead	17

By "improved," the authors meant that the children had returned to their families, showed an improvement in their mental state and had secured some kind of occupation. The "doubtful" cases had also returned home, but there was no information about either their mental or employment status. Those who were transferred to adult asylums were recorded as having "got worse." Including the seventeen who had died, Binet and Simon suggest that the success rate for medico-pedagogy is no greater than seventeen per cent for the Salpêtrière. In the celebrated school of Bourneville in the Bicêtre, the rate of success was as low as three to four per cent. The fact that Bourneville's own establishment should show such apparently paltry results is particularly significant. Not only did Bourneville and his school enjoy international reputations, but, more specifically, they were also instrumental in continuing to disseminate the medico-pedagogical approach, imitated throughout France and abroad.

For these reasons, Binet and Simon reject the existing forms of medical examination for including too much that is not of direct relevance, overcomplicating the examination to no advantage. In their proposed alternative scheme for examination all questions pertaining to cephalometry, past medical history and heredity are relegated to an optional

section. The obligatory section contains only such information as is directly relevant for schooling – signs of additional medical conditions, sensory and motor impairments, epilepsy, and so forth.

In addition, *Mentally Defective Children* casts doubt on whether the usual methods for the collection of etiological information by doctors will in fact contribute to a more scientific understanding of mental deficiency. The non-systematic collection of data in the form of case notes, the dominant approach in medicine, introduced uncontrollable variables and was at odds with the statistical approach of the psychologists. There is a latent epistemological confrontation in *Mentally Defective Children* between the experimental approach proposed and the "empiricism" of medicine. For psychology, a more systematic approach to data collection was the key to understanding the role of factors like heredity, alcoholism, insanity, poverty and other social ills in the genesis of mental deficiency. "Scientific work can be done in no other way. When it is done otherwise, it is worth nothing" (Binet & Simon, 1914, p. 114).

Despite beginning the discussion of the position of medicine with an acknowledgement of the "important role" of the doctor, Binet and Simon set out to hem in that role and exclude physicians from areas in which they had hitherto been active. Nonetheless, the authors lament the tendency of some physicians to neglect their role in "collaborating actively in the important work of the teacher" (1914, p. 87). Indeed, there is an underlying tension, carefully managed, in the utilization of psychological testing within a still essentially pathological model, between understating and over-stating the differences between the defective and the normal child – two tendencies that the authors eschew with equal vigor. The role of the psychologist rests, at this point precariously, between these two poles, the one making the education of mentally defective children a purely pedagogical matter for the schoolmaster, and the other leading to medical domination.

The two broad roles to be played by medicine, then, were, first, the reception and care of those deemed ineducable due to the severity of

their intellectual deficit, and, second, the identification of those not suited for special education by reason of not being "true" defectives, or having complicating medical conditions. In both cases, it was to act on the boundaries of mental defect, indeed to assist in constituting those very boundaries, but in neither instance was it to play a direct part in the assessment of intellectual capacity. With respect to the first of these roles, *Mentally Defective Children* continued the generally accepted dictum of the special schools, that only those likely to benefit from the instruction therein be admitted. However, it also signaled far more specific criteria and greater pessimism about the capacity of "idiots," and even "imbeciles," to benefit. Medicine was to continue its domination of the institutions for the "social waste," which were to give up any hope of educating their inmates.

What is striking about this proposed remit for medicine is that it not only attempts to push physicians out of the realm of education, but also consigns them to a very orthodox *medical* role; a psychiatrist is not required to perform these functions. The thrust of the discussion of medicine is to assign the physical-pathological dimension of mental deficiency to the doctor and the psychic-pathology to the psychologist. Significantly, however, the examination by the doctor comes *after* the initial identification of abnormality by the teachers and the systematic examination of suspect cases by the school inspector.

"Psychologizing" the System

In the period since 1945, psychology has been increasingly successful in its struggle with medicine over developmental disability to the point where it enjoys a near hegemonic domination of the conceptual field and substantial control over the service complex. Trent (1994) provides illustrative evidence in the control of the *American Journal of Mental Deficiency/Retardation* since 1948, when the last physician, Edward Humphries, occupied the post of Senior Editor. Similarly, the American Association on Mental Retardation goes so far as to state unambiguously that "Mental retardation…is not a medical disorder…Nor is it a

mental disorder" (Luckasson et al., 1992, p.9). Paradoxically, perhaps, this success was achieved in no small measure through the critique of one psychological approach, intelligence testing, by another, learning theory (McConkey, 1997).

Mentally Defective Children, then, provides us with some clear insights into one of the earliest challenges from psychology against its medical counterpart for the control of mental deficiency. This occurred in spite of the wholesale adoption of intelligence testing models by medicine that would come, and the fact that future challenges would come from radically different schools of psychology. The lines of this conflict were established at levels of both knowledge and practice.

At the level of professional and institutional practice, Binet and Simon empowered the school inspector with the authority of their psychology, opening the way to the creation of a new clinical profession, and assigning a pivotal position in the proposed machinery of the mental deficiency – education nexus. The inspector was to be the technology by which all parts of the system would be scrutinized; practices reviewed; information gathered, collated and analyzed; objectives set and evaluated; professional and institutional autonomy reined in; and the movement of children between sectors controlled. The physician, by contrast and despite being more firmly established in the role, was almost completely relegated from all aspects of the assessment of mental deficiency and in the theory and practice of pedagogy.

The psychological strategy is not limited to a professional level, however. In addition to positioning the inspector at the heart (or, rather, the eyes) of the complex, the principles of psychological epistemology were also diffused throughout. As noted, for instance, the accumulation of empirical data from clinical cases, which typified medicine, was criticized severely for its inexactitude, subjective variation, and lack of rigor. In its place were substituted precise quantitative measurement of individual difference, the formulation of quantifiable objectives for the various parts of the schooling system, and the systematic gathering of data for the evaluation of methods against these targets. The psychological

approach was also to be based, not merely on observation, but on experiment. The systematization of psychology was to be achieved by making the structures, tools and procedures of assessment uniform throughout the education system. This allowed, first, for the more scrupulous monitoring and regulation of those involved in administering the tests and, second, for the production of standardized output data.

Thus the "psychologization" of the field was not accomplished in the elimination of other systems, methods or professions. Neither were these other elements to be restructured or reconstituted along psychological lines. Instead, the tactic was to construct a regulatory framework within the existing and emerging systems of provision so that the complex itself became disciplined to the discursive rules of psychology. This disciplining of the system was evident in the way in which *Mentally Defective Children* set out clear and quantifiable objectives for the evaluation of all services for mental defectives. The other key component of the disciplinary framework was the establishment of means by which this evaluation could occur. Here the role of the inspector would be pivotal.

Conclusion

It needs scarcely to be pointed out that *Mentally Defective Children* does not constitute a description of mental deficiency in the second decade of the twentieth century. It is more a manifesto and program of reform, reflecting only one side of the conflict this paper alludes to.

The success of the psychological strategy was not uniform. The complete domination of the institutional complex by medicine, which was formalized in the United Kingdom by the *National Health Service Act* (1948), was not matched in North America, where much greater variation occurred. At the school level, psychology made significant inroads everywhere, though without achieving the complete subjection of teaching to psychology. In addition, and as already noted, psychology eventually won the upper hand through its own reorientation towards behaviorism.

Nonetheless, the entry of psychology into the field produced a number of lasting and very significant legacies. Among these was to make the social competence aspect of definitions (adaptive behaviour) more conceptually rigorous, reflecting the influence of evolutionary theories on psychology (Murphy, 1949), and to give it increasing conceptual significance as the century progressed (Heber, 1959; Luckasson et al., 1992). More importantly, and with enormous practical and conceptual significance, was the massive enlargement of the category of "mental deficiency" over "idiocy" and "imbecility." In the United States, the new threshold category of "moron" was estimated by Fred Kuhlmann to exist in a ratio of 12:3:1 to the "imbecile" and "idiot" respectively (Scheerenberger, 1983). Goddard (1910/1976), mapping the Binet–Simon intelligence tests onto the old classification scheme, identified the old thresholds of "idiocy" and "imbecility" as being mental ages at full development of two or less, and three to seven respectively. This stopped a full five years short of the newly drawn "moron" category, which encompassed a mental age of eight to twelve.

The effects of this move require far more space than could be accorded here, but two points are worthy of note. First, despite the use that would be made of the "moron" designation as a technology of social control (Gelb, 1987; Thomson, 1998; Trent, 1994), the new category was not created for the control of delinquency and deviance in society, at least not in the first instance. It was, rather, born out of an educational imperative, the need to remove from the classroom those not amenable to normal schooling (Sutherland, 1981). Second, the expanded category of abnormality dramatically alters the prevalence of clinical diagnosis among those so identified. Taken at the higher threshold, the very large majority of persons we now think of as developmentally disabled do not have any identifiable pathological condition; the lower the threshold is drawn, the more the balance shifts towards the existence of clinical pathology. Needless to say, the outcome of such movement undoubtedly affected the claims to legitimacy of medicine over psychology. Over the course of the twentieth century, it helped tip the balance in favour of psychology and against medicine.

To conclude, the main point being made here is that the development of the knowledge of developmental disability cannot be divorced from the politics of its development and application. The complex of knowledge and practice constituting developmental disability continues to be subject to conflicts that cannot be reduced easily to the interests of people with developmental disabilities themselves. Indeed, the very people caught in the shifting nexus of developmental disability have figured very little in the medico-psychological conflict. At one level, the centrality of arguments about effectiveness of treatment methods is obviously related to some notion of the interests of mentally defective children, and, indeed, this thesis certainly does not point towards an interpretation of events based on naked, or perhaps even conscious, professional ambition. At the same time, however, we also must question the extent to which these discourses actually constituted those interests, and thus what it meant to be "mentally defective." In addition, whilst these questions may be pursued historically, their significance is not confined to history, since it is in the machinations of professional power of this kind that developmental disability is rendered knowable and amenable to intervention.

The opportunities for people with developmental disabilities to exert influence on this power-knowledge complex appear somewhat mixed. On the one hand, the multiplicity of the system suggests that resistance has to be mounted on a number of fronts and against very different sets of tactics; the possibilities for subjection are numerous. On the other hand, it does suggest that we need to avoid thinking and talking in terms of *a* system – a singular, monolithic entity, pushing downwards with all its considerable weight on those caught helplessly beneath it. Developmental disability is far more like a constantly shifting and plural complex of competing forces and interests, opening up the possibility of resistance in the interstices of conceptual confusion and ambiguity, and in the unresolved contests of the powerful.

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Correspondence

Dr. Murray K. Simpson
Department of Social Work
Gardyne Road Campus
The University of Dundee
Dundee DD5 1NY, United Kingdom
email: m.k.simpson@dundee.ac.uk

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"Only an Almost": Helen MacMurchy, Feeble Minds, and the Evidence of Literature

Patrick McDonagh
Concordia University
Montreal, Canada

Abstract

Helen MacMurchy's 1920 book *The Almosts: A Study of the Feeble-Minded* examines literary representations of "feeble-mindedness" ostensibly to place before her readership the image of the feeble-minded individual and to foreground his or her needs. MacMurchy uses literary evidence to naturalize the concept of feeble-mindedness, and to argue that those identified as "feeble-minded" require assistance in order to survive, which should come in the form of state-supported asylums. Further, she argues that for the continued health of the nation and the race, people identified as "feeble-minded" should be sterilized. This article asserts literature can tell us significant things about intellectual disability, but not in the way that MacMurchy believes; instead of simply rendering lifelike characters from whom we can learn the truth about disabilities, literature can tell us how the idea of intellectual disability – or idiocy, or feeblemindedness – is constructed within a society. It also provides evidence for the symbolic and often ideological functions of these ideas. MacMurchy's commentaries on literary characters underscore her own beliefs, and reproduce the conflicts of her times about what constituted a "feeble mind" and how such a mind was to be dealt with.

"Sometimes the poet sees more than the scientist, even when the scientific man is playing at his own game," writes Dr. Helen MacMurchy at the beginning of her book *The Almosts: A Study of the Feeble-Minded*. "The novelist can give a few points to the sociologist, and the dramatist

to the settlement worker. Had the voter and the legislator studied with a little more attention the works of William Shakespeare and Walter Scott, we might have come sooner to some of the alleged discoveries of the twentieth century" (1920, p. 1). *The Almosts*, published in 1920, uses literature – from the renowned to the obscure – to illustrate the characteristics of the "feeble-minded." In literary representations, MacMurchy found a means to consolidate a particular idea of "feeble-minded" people and promote segregation and eugenics as solutions to the social problems she credited to this group.

This article examines how MacMurchy uses literary representations to reinforce the socio-medical category known as "feeble-minded," and also touches upon the role of literary and other cultural representations in the construction and articulation of the idea of idiocy, feeble-mindedness, intellectual disability and comparable notions. Intellectual disability, notwithstanding whatever physiological or sociological reality it may have, is also a social construction, often vaguely defined, but, as this article will argue, with an unacknowledged load of symbolic and ideological baggage. How do the historically linked ideas of idiocy, feeble-mindedness, and intellectual disability work in the symbolic economy of a society? That is, what meaning, what purpose, do they serve when articulated in a particular way by a society? Literary and other artistic works are important points of analysis for examining the often contradictory ideological uses of the concepts of intellectual disability and related notions, and for illuminating the tensions inherent in these concepts. They can also highlight the very contextual nature of the definitions we use to isolate and contain the qualities associated with these terms.

The Threatening Feeble Mind

By the time she published *The Almosts*, MacMurchy (1862–1953) was a respected commentator on what was commonly characterized as the "social problem" of feeble-mindedness caused by "their relation to crime, pauperism, intemperance, the social evil [prostitution], incompetency,

and disease" (Goddard, 1914, p. 19). She had received her medical degree from the University of Toronto in 1901, and was the first woman appointed to the resident staff of the Toronto General Hospital. After a brief spell of general practice, she moved into public service (McConnachie, 1983). There, as Angus McLaren (1990) noted, "Helen MacMurchy probably did more than any other individual in Canada in the first third of the twentieth century to alert the public to the dangers posed in public health" (p. 30). From 1905 to 1916, she was the Inspector of the Feeble-Minded in Ontario, during which time she produced a series of reports articulating what she perceived as the risks society ran by not addressing the threat of the feeble-minded (Simmons, 1982). From 1915 to 1920, she was Inspector of Auxiliary Classes for the Ontario Department of Education, and from 1920 to her retirement in 1934, she was the first chief of the division of Maternal and Child Welfare in the Department of Health. McLaren (1990) observed that she "was motivated more by the threat disease posed the 'race' than by empathy for the individual. Her humanitarianism, manifested in her support for a number of badly needed health reforms, was always held in check by her conviction that innate biological inequality could never be overcome" (p. 30). She was a vigorous advocate of state control over those labelled "feeble-minded," from her early reports to her later work, *Sterilization? Birth Control?*, in which she posed the question: "How long is it possible for any nation to last when the normal stream of national life is polluted at its source by feeble-minded who increase in double or treble the ratio of the normal?" (MacMurchy, 1934, p. 36).

In holding these positions, MacMurchy was following a line of thought that identified the feeble-minded as a threat to social order, because of their reputed higher involvement in crime and other "anti-social" activities, and to national or racial health, because their alleged higher levels of reproduction threatened the racial gene pool with degeneracy (and the maintenance of racial standards was a key concern for many eugenicists). In 1883, Francis Galton coined the term "eugenics" to describe strategies for improving the health of the "race." "Negative eugenics" sought to eliminate those traits considered unhealthy and

degenerate, while "positive eugenics" tried to encourage those traits thought to be desirable. Although MacMurchy's work encompassed both positive and negative eugenics, her writings on feeblemindedness are explicitly connected with the latter. As Thomson (1998) noted of the United Kingdom, "In the first decade of the twentieth century, the rather diffuse debate over degeneration found a sharper focus, as mental defectives became defined as the central eugenic threat facing the nation" (p. 20). At the same time in the United States, Henry Herbert Goddard, from whom MacMurchy drew much of her data and inspiration, sought to demonstrate in numerous writings that the health of the community and the nation relied upon the segregation and sterilization of the "feeble-minded," who were responsible for crime, racial degeneration, a growing population of substandard citizens, and a general strain on social efficiency (Goddard 1912, 1914, 1916, 1920).

This, then, is the critical perspective informing MacMurchy's interpretations of characters in literary texts. The strategy of literary analysis she employs in *The Almosts* is rudimentary at best. It consists of a largely chronological overview of"feeble-minded" or "idiot" characters, with long quotations from writers such as Sir Walter Scott, Charles Dickens, George MacDonald, and Charles Reade.

These passages, punctuated by MacMurchy's commentary, are drawn almost exclusively from the nineteenth and early twentieth century, although she refers to the Fool in *King Lear* and expends several paragraphs on John Bunyan's character Mr. Feeble-Mind from *Pilgrim's Progress* – who, she determines, is not feeble-minded, but merely "infirm and irresolute, undecided and easily depressed" (p. 6). The emphasis on nineteenth century literature is telling. The literature of previous eras contains characters who are presented as "idiots," but there is no discernable anxiety around "idiocy" as a social problem. It has become almost a commonplace to note that disability becomes of interest to western society after the industrial revolution, and that pre-industrial society, which asked different things of its members, had considerably different understandings of impairment (Gleeson, 1999; Oliver,

1990). Literary representations certainly indicate changes in the social understanding and interpretation of "idiocy," especially in the second half of the nineteenth century. The same period saw a growing body of works addressing the often-joined issues of urban decline and racial degeneration, such as W. R. Greg's "On the Failure of 'Natural Selection' in the Case of Man" (1868), James Cantlie's *Degeneration Amongst Londoners* (1885/1985) and J. Milner Fothergill's *The Town Dweller: His Needs and Wants* (1889/1985).

Mental Deficiency in the Novel

In *The Almosts*, MacMurchy works to define the truth about "feeble-mindedness," while noting that most representations are flawed in some ways. Thus, she designate Smike, in Dickens' (1839/1978) *Nicholas Nickleby*, as feeble-minded, noting that "In none of Dickens's works is there a more instructive picture of a mentally defective boy" (p. 60). Smike's employment at Dotheboys Hall, she writes, reminds us "of the fact so well known to those who have the care of the feeble-minded – they can earn their living in an institution," although she also optimistically observes that to find an institution as horrendous as the boarding school in the novel is, due to the enlightenment of the twentieth century, "not possible now" (p. 62–3). She concludes her assessment of Smike by stating that it is "in some ways the greatest study of a mental defective in English literature. And the greatest lesson for us is that it is our duty to protect feeble-minded persons from being exploited and cruelly treated" (p. 78–9). She identifies errors in the portrayal, however; when Dickens presents Smike's deathbed description of his vision of a heavenly Eden, MacMurchy rejoins, "Pathetic and beautiful as the skill of the great writer has made this picture, who shall say that it is wholly without foundation? Yet truth compels us to add that such regard to the future and to the organization of human life and its innermost meaning, is all but unknown to the mental defective" (p. 78).

Occasionally, MacMurchy draws practical lessons from representations. For example, she closes her summary of George MacDonald's short tale

"Malcolm," in which the title character experiences a special communion with the natural world, with the observation that "farm colony life for mentally defective persons is intended to give them the maximum of freedom and development" (p. 129).

Diagnosing Barnaby Rudge

The works of Charles Dickens provide the most fertile source of MacMurchy's material. Chapter II, The Mental Defectives of Dickens, comprises 70 of 178 pages contained in *The Almosts*. One of the most significant of these works is *Barnaby Rudge*, perhaps the only major Victorian novel to have an intellectually disabled title character. It tells the story of the 1780 Gordon Riots, which began as a protest calling for the repeal of the 1778 Roman Catholic relief act. Barnaby, labelled an "idiot" by the novel's other characters, and "the most famous of Dickens's feeble-minded people" by MacMurchy (p. 41), is at the centre of the violence, and exemplifies what the literary critic Myron Magnet calls the "moral idiocy" of the rioters. He is a sympathetic character, though, devoted to his mother but clearly in need of governance. However, Barnaby's father is a murderer; he had killed his employer, and then, bloodied from the deed, appeared before his pregnant wife, causing her to faint and sending her into labour. Barnaby's intellectual disability is thus causally linked to his father's crime – at least in the symbolic economy of the novel. There is some evidence that Dickens thought this to be the etiology of intellectual disability in the real world; in 1853, he wrote that idiocy was "generally associated with mental suffering, fright or anxiety, or with a latent want of power, in the mother" (Dickens & Wells, 1853/1968, p. 499).

MacMurchy begins her critique of Dickens by directing the reader's attention to the discredited "maternal fright" theory endorsed in the novel. She goes on, though, to stress that Dickens has properly rendered Barnaby's "child-like" nature. Dickens (1841/1973) describes Mrs. Rudge reminiscing about her son's infancy, when he was "old and elfin-like in face, but very dear to her, gazing on her with a wild and vacant eye";

even as an adult, Barnaby's "childhood" is "complete and lasting" (p. 250). He is "a relying, loving child to [Mary Rudge] – never growing old or cold at heart, but needing … care and duty in his manly strength as in his cradle-time" (p. 195). MacMurchy responds enthusiastically to this aspect of the representation:

> Do we remember how happy we were in childhood? We could not be made unhappy, largely because we could not understand the griefs and burdens of our elders. And the feeble-minded have been well called 'permanent children.' We can always make them happy. They never grow too old for simple childish enjoyments. They cannot be acquainted with grief except in a childish way. They can always make themselves happy if we let them. (pp. 47–48)

The "childishness" of the "feeble-minded" is critical to MacMurchy's argument, and we will return later to this point.

When Dickens is writing *Barnaby Rudge* and, for that matter, when Robert Zemeckis (1994) is filming *Forrest Gump*, they expect to find readers who will understand the uses to which they put the image, the "idea" of intellectual disability. How, then, would Barnaby become meaningful to Dickens' readers? Why, for instance, is Barnaby "child-like"?

The 1830s and 1840s, the period of *Barnaby Rudge*'s composition and publication, saw the publication of more than thirty books espousing paternalism, as well as an "endless outpouring of novels, pamphlets, and articles that championed the same principles," observes historian David Roberts (1979, p. 25). As the term suggests, paternalism posits a parent-child relationship between different levels of society. The governing classes existed – in an ideal case – as a benevolent father to those beneath them, to whom they had certain responsibilities, such as ensuring that their tenants and labourers were sheltered, fed, and capable of meeting their needs. In return, the lower classes owed respect and deference, as well as labour, to their superiors in station.

The disruption of traditional paternalist structures of relations between the social ranks – due to the industrial revolution, among other things – stimulated a search for a sound theoretical basis for a new, revitalized paternalism. The Gordon Riots in *Barnaby Rudge* provide a parallel to the Chartist threats of the 1830s and 1840s, a series or working-class uprisings (Brantlinger 1969; Butt & Tillotson 1957; Magnet 1985; Rice 1983), which Dickens saw as being the lamentable result of poor governance on the part of the paternalist leaders of the British state. Roberts (1979) suggests that the attempt to develop a new paternalism was characterized by the oft-reiterated claim that the upper classes bore a responsibility to assist the weak. "The paternal government intervened," he observes, "not so much to maximize happiness or for reasons of private right or public honour, but where the weak and helpless of Her Majesty's children needed protection" (p. 191). This group, not surprisingly, included those labelled idiots, but also the sick, the deserving poor, and the orphaned. All of these groups could be constructed as "children" according to this model.

The association of Barnaby with the Chartist movement implies a broad social program in which society would continue to be run by benevolent paternalists, which, increasingly for Dickens, meant government intervention. The association of Barnaby with the rioters and, by extension, with chartist dissidents suggests that, for Dickens, they are, like Barnaby, in need of a loving but strong hand to guide them. Barnaby acts not only as an "idiot" character but also as a political metaphor. Interestingly, Dickens' belief that an "idiot" like Barnaby could live a happy and productive life as a member of the community, and could be taught greater responsibility, foreshadows the philanthropic asylum movement that began toward the end of the 1840s, with the goal of educating and returning to the community people labelled as "idiots."

This faith in the "educability" of idiots does not convince MacMurchy, who is critical of the notion. "On the whole," she writes, "the character of Barnaby Rudge, though presenting many interesting features, can hardly be said to be Dickens's greatest success in the portrayal of feeble-

minded persons. It is too much influenced by the thought of the time. The author shows himself here rather abreast of the current opinion in his time about mental defectives. But in many of his other feeble-minded characters, he shows himself far ahead of such opinion" (p. 60).

MacMurchy reads Barnaby as a character removed from his literary context, seeing his role in the novel's drama but not considering the symbolic and ideological uses to which Dickens puts this character. Nor does she consider the comparable symbolic and ideological uses performed by the idea of feeble-mindedness in social narratives.

Representation and Society

MacMurchy notes that Barnaby is "not idiotic, but of a higher grade, when we consider his doings in the political troubles which form the center of interest in the latter part of the book" (p. 45). Many other works that consider Barnaby's idiocy are, like MacMurchy's, also of the "diagnostic case study" genre. Leonard Manheim (1972) has argued that Dickens got it wrong in calling Barnaby an "idiot" and that he is in fact schizophrenic. Sir Russell Brain (1960), however, claims that Barnaby is a fine specimen of a mentally defective character. Thelma Grove (1987), with the advantage of additional work carried out in the field of clinical psychology over the years, is able to proclaim Barnaby "the first autistic hero in English literature" (p. 147). All of these criticisms assume the stable, transcendent reality of "schizophrenia," "mental deficiency," and "autism"; they reify these categories while failing to consider the discursive construction of intellectual disability, its predecessors, and related conditions.

The concept of "feeble-mindedness" did not exist when Dickens was writing. MacMurchy's argument rests on the assumption that, because he was a "great writer," Dickens perceived the true nature of feeble-mindedness even though social scientists had not yet defined such a category. However, it seems more likely that MacMurchy's own inclinations and beliefs guided her assessments of characters. It is worthwhile

to recall the genesis of the idea of "feeblemindedness" as an attempt to create a category of diagnosis that captures those who could otherwise pass as normal. These "almost normal" people were the greatest threat to social order and national health because they travelled and reproduced freely, without the constraints placed on individuals more easily identified as "idiots."

Recall MacMurchy's endorsement of Smike as Dickens' best example of a "feeble-minded" person. Dickens, unlike MacMurchy, seems to credit the abuse and neglect Smike experiences as the cause of his physical and intellectual frailty – Smike's condition is not innate but rather a consequence of his environment. Further, as the illegitimate and abandoned son of the novel's villain, Ralph Nickleby, Smike serves important symbolic functions which are as significant to his portrayal as any attempt on Dickens' part to create a "realistic" figure. So while MacMurchy identifies Smike as a "feeble-minded" character, it isn't entirely certain that Dickens would agree.

Interestingly, MacMurchy spends a good portion of the book discussing characters that she then claims are not feeble-minded. Indeed, the title "the almosts" comes from a passage describing Quasimodo in *Notre-Dame de Paris*: "Quasimodo … n'était guère qu'un *à peu près*" (Hugo, 1832/1961, p. 176). But after rendering this in English as "only an almost" (p. 117), she goes on to assert that although many readers believe Quasimodo to be "mentally defective … it is not so"; rather, his vigour, agility, courage, self-control and inhibition are "powers … not possessed by persons who are mentally defective" (p. 116). Still, despite his disqualification from the ranks of the feeble-minded, she continues describing him for the next seven pages. Similarly, Jo in *Bleak House* is proclaimed "not mentally defective (p. 93), and Sloppy in *Our Mutual Friend* is diagnosed as "probably normal" (p. 79). Sir Gibbie, in George MacDonald's story of the same name, is characterized as "singularly gifted and attractive" (p. 130). Of Donatello in Hawthorne's *The Marble Faun*, she hesitates by noting that mature readers will experience "too many doubts as to whether such a person as Donatello could

ever have lived" (p. 145); however, she notes that "This fanciful story, while it does not add another to the mentally defective characters in literature, is interesting as an indication of people's ideas on this subject" (p. 149). These long expositions on characters she diagnoses as "normal" are necessary in order to draw a boundary between the normal and the deficient, to set criteria that will define the feeble mind.

MacMurchy's divisions point to a specific notion of what constitutes a "feeble mind"; if we distill the primary similarities from her examples, a "feeble mind" is one that must be governed and lead. Smike relies on Nicholas Nickleby for help; thus he is feeble-minded. Barnaby Rudge is led by his mother, by various less honourable characters, and eventually by the benevolent patriarch Gabriel Varden; thus he must also be feeble-minded. An apparent independence of thought and action, on the other hand, denotes the able-minded – such as Jo, Sloppy, and Quasimodo.

Reconstructing the "feeble-minded" as children enables MacMurchy and others to argue more effectively for segregation and sterilization. Children, after all, are not allowed to wander freely or to have sex, at least not in the well-regulated family that MacMurchy imagines as a model for the state (notably, MacMurchy also wrote a series called *The Little Blue Books* on the proper means to raise a healthy family – part of her contribution to "positive eugenics"). As wayward children, the "feeble-minded" can be rounded up and sterilized with some justification, as they are clearly not capable of acting in their own best interests and require paternal authority in order to be happy and safe. Such, at least, is the thrust of argument. (Interestingly, Goddard employs much the same strategy in his writings, consistently referring to those he labels "feeble-minded" as "children," regardless of their chronological years).

MacMurchy's divisions are also drawn along conventional lines observed by eugenicists, who believed that the "fittest" should prosper, even if demographics suggested they were endangered. Hence the dismay by MacMurchy and other eugenicists at the infuriating fecundity of the

feeble-minded. Hence also MacMurchy's (1916/17) insistence that only the "fit" have the right to head families: "It is a great public duty to see that as the nations rests upon the home for its foundation, so those who can never make or help to make a home, are not permitted, because of our selfish hearts and slack hands, to debase the national life and to degrade the glory of the national character" (p. 63). This paternalism remains a dominant force in both perceptions and treatment of people labelled as having intellectual disabilities. Indeed, much of the current anxiety around recent movements such as those supporting Individualized Funding can be traced to this paternalist perspective.

As MacMurchy notes in her conclusion to *The Almosts*, "We must make a happy and permanent home for [the feeble-minded] during their lives. The only Permanent Parent is the State" (p. 178). It is, she asserts, a question of duty. MacMurchy's argument, at least in Ontario, was never fully accepted. Segregation was adopted, but not sterilization. While the 1920 *Report on the Care and Control of the Mentally Defective and Feebleminded in Ontario* accepted that this population was indeed a "state problem" (p. 7), it also warned against the exaggeration of this problem (p. 11) and, contra MacMurchy, offered the prospect that "an appreciable portion of that class can be, by care and attention at the proper time, made reasonably fit to support themselves or to earn something toward their own livelihood and support, whether at large or in an institution" (p. 16).

But the report also entrenched a paternalist legacy that lives on in the dominant attitudes towards and responses to people labelled as having intellectual disabilities. The social narrative, those stories we use to explain the way society operates, continue to place people labelled as having intellectual disabilities in positions subject to charity and control. We need to question what function this paternalist narrative serves in any attempt to form a new, integrated place in our communities for people labelled as having intellectual disabilities. The success of community living and participation depends in large part upon our abilities to analyze the discursive history of disability, and to articulate new discourses.

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Correspondence

Patrick McDonagh
6037 Hutchison Street
Montreal, QC, Canada
H2V 4B7
email: patmc@cam.org

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Lessons from the Past: Child Victims with Developmental Disabilities in Nazi Germany

Sally Rogow
University of British Columbia
Vancouver, Canada

Abstract

This article outlines the extermination policy in Nazi Germany of people with developmental disabilities and demonstrates the consequences of negative social attitudes and social constructs that view disability as "defects" and "hopeless cases," and people with disabilities as a "burden on society." There are important lessons to be learned from the experience in Nazi Germany. Disregard of the humanity of people with disabilities and the separation of science from human and moral concerns makes victims of defenseless and dependent people. The article demonstrates the fragility of social institutions in the face of social chaos and economic constraints, and highlights the importance of an informed and caring community in protecting the rights of all citizens.

Social institutions, schools and treatment programs reflect the values of society and its perceptions of people with disabilities. When people with disabilities are not seen as individuals, when they are denied access to their communities and are treated as medical categories or labels, they are made vulnerable to all forms of abuse and neglect. Nowhere is this made more explicit than in the experience of children and adults with disabilities in Nazi Germany.

In Hitler's Germany, people who were blind, deaf, physically and/or developmentally disabled were viewed as a "burden" to society, "useless eaters" who posed a threat to the health of the nation. The fact that this took place in a country where rehabilitative education and integration

into the community were pioneered illustrates how fragile social institutions can be in the face of social chaos and disregard of human and moral concerns.

At a time when children with even mild mental handicaps were routinely isolated in large sterile institutions in Britain and North America, they were kept with their families, exposed to the world, and lived and worked in the community in Germany (Safford & Safford, 1996). More than a thousand community day schools (Hilfschule) operated in German towns and cities to enable them to "lead rewarding lives" (Becker, 1985, p. 91). The community-based guidance and treatment centres for children with emotional and behaviour problems became a model for Europe and America (Safford & Safford, 1996). However, the pioneering efforts of German educators, psychologists and social workers came to an abrupt halt soon after Hitler came to power in 1933.

Within a very short time, the Nazi government transformed schools and treatment programs from places of learning, healing and rehabilitation to work camps, prisons and execution chambers (Aly, 1994; Burleigh, 1994; Friedlander,1994; Peukert,1987). The number of community day schools was sharply reduced, and those that remained became training centres for streetsweepers, domestic workers and garbage collectors (Becker, 1985). No one with a mental handicap was allowed to live or work in the community without first submitting to sterilization (Burleigh, 1994).

People with disabilities, once they were seen as a threat to the health of the nation, were forcibly removed from society, placed in institutions, and finally became victims of the Nazi "killing" programs. Disabilities were seen only as "hereditary illnesses" to be eradicated by isolation and murder, as Ernst Rudin's 1934 commentary demonstrates:

> The results of our science had earlier attracted much attention (both support and opposition) in national and international circles. Nevertheless, it will always remain the

> undying, historic achievement of Adolf Hitler and his followers that they dared to take the first trail blazing and decisive steps towards such brilliant race-hygienic achievement in and for the German people. In so doing, they went beyond the boundaries of purely scientific knowledge. He and his followers were concerned with putting into practice the theories and advances of Nordic race conceptions … the fight against parasitic alien races such as Jews and Gypsies … and preventing the breeding of those with hereditary diseases and those of inferior stock. (Ernst Rudin, 1934, *The Archive of Racial and Social Biology* cited in Frei, 1993, p. 122)

A great deal of government effort and attention was directed at the destruction of schools and services. Hitler appointed all-powerful special authorities that were responsible only to him. Genetic Health courts were created to enforce Nazi health laws, and physicians were required to register every child with a disability; indeed, the failure to report was punishable (Burleigh, 1994). Traditional local government agencies were circumvented and ignored, which caused constant conflict between administrative agencies and led to increasing chaos and rivalry, as well as a growing reliance on extreme measures (Peukert, 1987).

Aly (1994) noted that removal from the community offered huge financial benefits as well as absolute control of people with disabilities. Rationalized by Nazi racial science and "eugenics," the destruction of schools, treatment centres and family support services was highly profitable. The funds that supported rehabilitative education and treatment were diverted to the building of new children's hospitals and free medical services (Aly, 1994). Dr. Ernst Wentzler, one of the chief architects of the children's killing program, built his modern children's clinic in Berlin with funds appropriated from Catholic Sisters who looked after children with developmental disabilities; funds were also taken from welfare agencies, health insurance, guardianship courts, municipalities, and private charities (Aly, 1994).

Removal From the Community

Compulsory registration of people with disabilities paved the way for forced institutionalization, which was achieved with a combination of health regulations and government deceit and duplicity. Families were forced to place their children in institutions by government appointed public health authorities. Deprived of family allowances and fearing loss of all services, many parents believed their children would be better served in an institution than at home without treatment. The regulation that banned children with any type of disability from receiving medical treatment in ordinary pediatric hospitals (even for ordinary illnesses) forced parents whose children needed medical care to place them in institutions, where they were told their children would receive the most advanced and expert therapy on open wards (Heimansberg & Schmidt, 1993).

As soon as they placed their child in an institution, parents discovered they had no control over their child's life nor any choice about the institution to which their child was to be sent. Many children were placed in institutions so far from their homes that parental visits were extremely difficult, if not impossible. Some institutions discouraged parent visits altogether.

Parents who refused to commit their children were threatened with loss of guardianship rights (Burleigh, 1994). Single mothers who refused to part with their children found themselves assigned to contractual labour, which forced them to surrender their children (Freidlander, 1994).

After their children were placed in an institution, many parents became alarmed and suspicious. They received reports that exaggerated the degree of their child's disability and contradicted the reports they had been given by their family doctors. Children who were speaking and playing independently at home were described as incapable of speech and "severely feebleminded" (Burleigh, 1994). Parents who were able

to visit the institutions were often shocked and alarmed when they saw their children's emaciated bodies. Children who had been active and healthy became listless and their arms and legs were often covered in bruises. In response to their complaints, parents were told their child was refusing to eat or was hurting him or herself (Friedlander, 1994). Efforts to bring children home proved useless; parents were stonewalled and threatened with legal actions.

All private and most religious institutions and residential schools were closed and hundreds of children were transferred to the large institutions without parent permission or consultation. The only religious schools that remained in operation were located in remote rural areas. When children were transferred, their parents only received official form letters telling them their child was in transit and was being sent to an unnamed institution (Burleigh, 1994).

Children who were wards of agencies were transferred without the knowledge of the wardship courts, which found themselves without power and jurisdiction. Chaos and confusion shattered whatever child protection had existed. As the war progressed, government authorities insisted that child welfare administrators transfer children whom they considered "unsuccessful cases" out of the welfare system into state institutions and work camps (Peukert, 1987). Children with disabilities under five years of age were sent directly to state institutions.

The only young people who avoided institutionalization were those who were mildly disabled and able to pass state intelligence tests. These students were forced to submit to sterilization and were required to perform long hours of arduous labour. Those who did not pass the tests or could not perform the labour were considered "feebleminded" and were transferred to institutions. Nurses and attendants at the institutions observed that many newly arriving children spoke fluently and could read and write, but this did not prevent them from being described as "hopeless cases" (Aly, 1994).

Life In the Institutions

With the doubling and tripling of child populations in the institutions, standards of care rapidly deteriorated, and state inspections were perfunctory or suspended entirely (Burleigh, 1994; Friedlander, 1994). There were not enough beds, and newly admitted children slept on unhygienic straw mattresses and were rarely given therapy or treatment (Burleigh, 1994). Shortages of wheelchairs kept children unable to walk in their beds or on mats on the floor (Friedlander, 1994). There was so little food that in some institutions the kitchen workers brought food from their homes (Burleigh, 1994).

Professional nurses were dismissed and their places taken by former domestic or farm workers, recruited from the ranks of unemployed members of the SA, Nazi women groups or the League of German Maidens, who had little understanding of the children in their care and simply followed orders (Burleigh, 1994). The emotional toll on the children was enormous; fear, resistance and rebellion were silenced with drugs, electric shocks, and beatings.

In 1939, a few days after war was declared, Hitler issued a decree that gave physicians the authority to murder the children in their care. The decree was issued after the war began to minimize the effects of public and church protest (Kogon, Langbein & Rue, 1993).

The Euthanasia Programs

"Euthanasia" or "mercy death" was the euphemism for murder. Other terms, such as "disinfection" and "special handling" (Sonderbehandlung), were also used (Aly, 1993). Two separate Euthanasia programs were developed, one for children and one for adults (which included children as young as three years). The programs were designed, developed and administered by physicians in great secrecy. The Chancellory of the Fuhrer (the Kdf, or Kanzlei des Fuhrer) appointed the physicians who operated the child program under the name of a fictitious organization,

the "Reich Committee for the Scientific Registration of Severe Hereditary Ailments" (Burleigh, 1994; Friedlander, 1994).

Despite the secrecy of the operations, strenuous efforts were made to convince the German public of the necessity of killing "useless" people. Hitler ordered the making of propaganda films, such as the film "*Victims of the Past,*" which made use of special lighting effects that portrayed people with disabilities as grotesque monsters who were surviving at the expense of healthy people. The film was shown all over Germany (Doino, 1995). Tours of the institutions were arranged for members of the SA, SS, Hitler Youth and League of German Maidens who came to see "freak" shows (Aly, 1994; Burleigh, 1994). More than 20,000 visitors came to one institution where the director lectured about the necessity of killing disabled children for the "good of the nation" (Burleigh, 1994).

Killing children and young people with disabilities brought career advancement, university posts, extra bonuses as well as avoidance of military service to the physicians who supervised the twenty-two pediatric killing wards and the gas chambers built in psychiatric hospitals. Nurses also received extra supplementary payments (Burleigh, 1994). Eager to meet quotas, the physicians ignored their own guidelines and made random, arbitrary choices (Aly, 1994; Burleigh, 1994). Parents were never informed that their child was dying until death was imminent or the child was already dead (Burleigh, 1994). Most of these young ambitious physicians in charge of the killing operations had little experience or knowledge of the children in their care, but they were given almost complete authority over the selection of child victims.

Poison and starvation were the main methods of killing on the pediatric wards. These deaths were neither merciful nor painless; death by starvation is long, drawn-out and painful, and child victims suffered pneumonia and other debilitating illnesses before their deaths (Burleigh, 1994). Infants were routinely murdered. Ernst Wentzler murdered hundreds of babies in his Berlin clinic (Aly, 1994).

Victims of the Adult Euthanasia program were killed in the gas chambers that were first built at designated institutions. The victims of the adult program were selected from questionnaires that directors of hospitals and institutions were required to file on every patient (Burleigh, 1994). A few directors tried to protect their patients by not filling out the forms, but this proved futile. When the Reich committee did not receive completed questionnaires, they sent medical students and secretaries to complete and collect the questionnaires. The patients selected for euthanasia (including children) were taken by bus to transit institutions for temporary stays before being transported to the killing institutions.

Despite the curtain of secrecy, many people knew that people were being murdered in the institutions. People who lived near the institutions saw the steady arrival of the buses and could see the steady streams of strange smelling smoke pouring out of the chimneys (Freidlander, 1994). Everyone who lived or worked in the institutions knew about the killings, even the children. One nurse reported:

> Everyone talked about it, even the children talked about it. They were all afraid to go to the hospital. They were fearful that they would not come back. It was a general rumor. The children played a coffin game. We were astonished that the children understood. (Friedlander, 1994, p.170)

Hitler responded to the parent and public protests by tightening secrecy; his 1941 edict banned public protest, making it punishable. Also in 1941, the gas chambers were dismantled and reassembled at Belze, Maidenek and Treblinka; the killing operations were driven into deeper secrecy and the killings continued as "wild euthanasia" (Burleigh, 1994). Many killing ward physicians were sent to supervise the slaughter in the death camps (Friedlander, 1994). In addition, the Nazis extended their extermination policies to the countries they occupied. Children in Austria, Poland and other conquered nations did not escape the euthanasia programs; only in Holland did physicians act unanimously in

refusing to cooperate (Cranford, 1992). In total, more than a quarter of a million children and adults were victims of the Nazi killing programs.

After the war, virtual silence surrounded the genocide of children and adults with disabilities. Most of the physicians and nurses who played major roles in the killing euthanasia programs continued in their positions as if nothing unusual had taken place. However, court records and the accounts of parents and guardians tell the story. After the war, thousands of cases were brought before the German courts, providing documentation of the enormity of the crimes (Burleigh, 1994).

The nurses, physicians, teachers, and social workers who were trusted with the care of children and adults were perpetrators of these crimes. It was they who implemented the policies of the Nazi government. Perpetrators availed themselves of the opportunities and accommodated themselves psychologically to the destruction of people's lives (McFarland-Icke, 1999). One of the fundamental requirements of the program was that it be discreet. The belief that the killings should take place in normal institutional surroundings made them part of the institutional structure, and the deaths were made to appear to be "natural deaths." McFarland-Icke (1999) attempts to explain the complicity of the nursing staff by arguing that institutional environments discouraged identification with the victims; he also suggests that the staff's desire for normalcy and emotional security may have enabled them to wilfully ignore the great contradictions between the role of nursing and their participation in the killing operations. The nurses who complied convinced themselves that the killing was justified. Psychological distancing from the victims was encouraged and maintained, and perpetrators simply saw "hopeless" cases, not human beings.

Those who managed to avoid complicity had strong convictions and found ways to circumvent the bureaucracy. A few hospital administrators and public health physicians tried to protect their patients. Professor Walter Creutz, a public health official, together with a few of his colleagues managed to save lives by labelling patients fit for work, re-

leasing them to their families or hiding them in the woods on days that the transport buses were scheduled (Gallagher, 1990). Between 3,000 to 4,000 lives were saved by these physicians (Kogon, et al, 1993).

The genocide of people with disabilities that took place in Nazi Germany has not received the attention it deserves as part of the Holocaust. The gas chambers were first developed in psychiatric hospitals and institutions that housed children and adults with disabilities. Isolation, segregation, and the identification of people only through their disability denied vulnerable people access to their communities and permitted the social distancing that encourages mistreatment.

The Nazi victimization of vulnerable people may have been unique in its organization, its mercilessness and its bureaucratic efficiency, but it serves to highlight the tragic consequences of making value judgments on the worth of human lives. It should also be remembered that a major motive for the destruction of school and treatment programs were economic. The funds derived from the closing of schools and treatment programs paid for Nazi social and medical programs. The killing programs enabled the emptying of hospitals that were later converted to take care of wounded soldiers. These motives were hidden beneath the so-called scientific rationalization for extermination. The Nazi experience speaks of the fragility of social institutions and the way that economic concerns too often shape the way that social policies are implemented.

Exclusion from mainstream society fosters social distancing and encourages thinking about people with disabilities as "cases" to be treated, rather than as individual human beings. There are dangers inherent in separating science from human and moral concerns and considering the needs of people with disabilities as separate and apart from general social concerns. Social distancing permits people with disabilities to be viewed as "cases" rather than as full human beings who belong to their families and communities. As the history of people with disabilities in the Nazi regime demonstrates, the consequences of this process can be horrific.

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Correspondence

Sally Rogow
#309–638 West 45th Avenue
Vancouver, BC, V5Z 4R8
email: srogow@interchange.ubc.ca