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Days of Darkness Days of Hope



*The Care of Mentally
Disabled People*



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"Days of Darkness, Days of Hope" A Special Issue

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Introduction

The idea for this publication was born eight years ago when I met parents of mentally retarded children at the John E. Fogarty Center in Providence. They had incredible tales to tell. These parents told of the struggles of keeping their children at home, the battles in creating needed services, the joys of seeing their dreams materialize, and the frustration of seeing their reform movement wane. The idea for this publication was also nurtured when, eight years ago, I met persons labeled mentally retarded who had spent most of their lives at Ladd School in Exeter, Rhode Island. These persons told of being forced to leave their homes against their wills, of being incarcerated in overcrowded wards, of scrubbing floors late in the evening, of plots to escape, of learning about sex by spying on amorous attendants in the night, of episodes of courage in helping each other overcome a terrible fate.

Encouragement for an exhibition and a publication about the experiences of the mentally retarded and their families came from Dr. Frederic Weber, the resourceful and sensitive associate director of the Rhode Island Committee for the Humanities. He suggested the involvement of Dr. Joseph Bevilacqua, director of the Rhode Island Department of Mental Health, Retardation and Hospitals, who had already expressed an interest in developing a similar project in the field of mental health. Dr. Bevilacqua and photographer Salvatore Mancini both agreed that their desire to put together a photographic essay contrasting institutional and community programs for the mentally ill could be incorporated into a project about retarded people and their families. Out of these plans, "Days of Darkness, Days of Hope," a major public education project, came into being.

In the process of developing this project, including a search for the authors of these articles, I had the splendid opportunity to receive excellent advice from outstanding scholars in the fields of mental health and mental retardation. Dr. Seymour Sarason of Yale University was a very early source of strength and great inspiration. Dean Burton Blatt of Syracuse University raised important questions and suggested that historian David Rothman become involved. Drs. Gunnar and Rosemary Dybwad of Brandeis University offered countless suggestions and made numerous books and articles available to our researchers. Locally, Dr. Paul Sherlock of Rhode Island College and Dr. Robert Carl of the Rhode Island Department of Mental Health, Retardation and Hospitals were on hand for frequent consultations from the earliest stages of this project.

Mr. Albert T. Klyberg of the Rhode Island Historical Society sug-

gested that Dr. Howard Chudacoff become involved in helping to identify potential researchers from Brown University. Dr. Chudacoff did so and offered many other services. Dr. David Rothman of Columbia University offered many suggestions, and expressed his interest in helping with the entire project. Dr. Gerald Grob of Rutgers University gave me an invaluable introduction to the discipline of history and suggested the path which eventually led to two of the researchers for this project. Finally, Dr. Barbara Rosenkrantz provided contacts with her colleagues at Harvard University that directly resulted in an expansion of the areas of research.

The plight of people with mental illness has long been chronicled by Rothman, Grob, Deutsch, Rosenkrantz, and, in Rhode Island, by Jacobs Field, and Jones. We hope that this issue of *Rhode Island History* (and another special issue, devoted to similar themes, which will appear in 1982) will provide additional information that will result in a better understanding of persons with mental illness.

The plight of mentally retarded people, however, has seldom (if ever) been recorded by historians. One very distinguished social historian has said that the experiences of the mentally retarded are of little historical value. I trust that this publication will alert scholars to a wonderful source of historical study into the unconquerable strength of the human spirit.

Rhode Island History is to be congratulated for making such an overwhelming commitment to revealing this hidden history. It is fitting that the articles for these two special issues were completed during the final months of 1981—"The International Year of Disabled Persons."

JOHN T. DUFFY

Cranston, Rhode Island

"Days of Darkness, Days of Hope" is a major public education project sponsored by the Rhode Island Department of Mental Health, Retardation and Hospitals. Besides this special issue of *Rhode Island History* (and a second issue that will be published in late 1982), the project includes an exhibition with ninety photographs and text commentary, lectures, and a series of public service announcements. The project has been made possible in part by a grant from the Rhode Island Committee for the Humanities. Additional support has been provided by:

Rhode Island Development Disabilities Council

The John E. Fogarty Center—Greater Providence Association for Retarded Citizens

Blackstone Valley Association for Retarded Citizens

Cranston Association for Retarded Citizens

Northern Rhode Island Association for Retarded Citizens

Westerly-Chariho Association for Retarded Citizens

Citizens Community Foundation

Foreword

Over one hundred years ago, Dorothea Dix spoke before the Massachusetts legislature. She had visited many of what in those days were called "humane institutions" which were for people who were "different" and needed some kind of help and service from others. She described the horrors she had seen and she did this so well, so convincingly, that a movement was started to make these institutions truly humane. Over a hundred years later, and again to the Massachusetts legislature, Dr. Burton Blatt gave much the same talk. But he had the advantage that he could show pictures. It is one thing to use words to describe inhumanity. It is another thing to see the inhumanity: to capture it in a way that the human eye cannot ignore and the normal mind must ponder. What happened in the century or so between the two talks? Unfortunately, the answer is clear: every decade or so, the situations that had improved had fallen victim again to the old evils. Ten years after Dr. Blatt first visited the institutions he literally pictured in *Christmas in Purgatory*, he revisited them and again took pictures. The institutions were cleaner, there was more equipment, and there was less crowding. But one cannot escape the conclusion that these institutions contain exiles from the normal society who live lonely, unstimulated lives unbrightened by love, laughter, friendship, and sustained human warmth.

There are some people who believe that these institutions are incapable of being humane except for very short periods of time. There are many more people who believe that very few individuals need to live in these institutions but rather can live and even work in our natural communities, with or near their families. But in order to do so, they have to be seen as citizens who have rights no less than we have. The fact that they may be "different" can never be a basis for depriving individuals of their rights to live as normally as possible in their communities.

Man is an imperfect being. Man or woman, young or old, educated or not, rich or poor, wise or stupid—each needs to be reminded that what gives the most meaning to our lives, what stands up best over the course of our lives, is the feeling that we are not alone but that we are part of a dependable network of social relationships. However different people may appear, let us not forget that behind those appearances are common needs. Being imperfect, we do forget. This publication will help you remember.

SEYMOUR B. SARASON
Professor of Psychology
Yale University



*The State Almshouse, Howard,
Rhode Island. Photograph by
Salvatore Mancini.*

Three Centuries of Care of the Mentally Disabled in Rhode Island and the Nation, 1650-1950

by David A. Rochefort*

I

Recurring patterns have marked the history of the care and treatment of the mentally ill and retarded. At one end of the pendulum's swing, society has stigmatized the mentally disabled as an evil menace; at the other, it has considered them helpless victims deserving of concern and kindness. Etiological theories have also varied greatly, as mental disabilities by turns have been linked to physical disease, community disorder, and even personal immorality. Ideas about how to deliver care to the mentally disabled have also vacillated over time; the focus for such care has shifted more than once from institutions to community-based services and then back again. Contrary to the widespread notion that society advances progressively, this record is one of fits and starts, of gains won in one era only to be lost in the next.

Social and economic forces as much as medical influences have shaped this history. For example, social stratification patterns in America have determined the growth of a two-class system of mental health care for the rich and the poor, and for Anglo-Saxon and other ethnic groups.¹ Similarly, significant changes in treatment practices often have stemmed from broad religious and social reform movements that ostensibly have had little to do with physical or mental health care. Above all, the cyclical development of mental health care can be directly related to changing attitudes toward the mentally ill and retarded and to widespread beliefs concerning the underlying nature of their disability. Dr. Oliver Wendell Holmes, writing in 1861, commented on the influence that prevalent ideas and material conditions have on medical care: "The truth is, that medicine, professedly founded on observation, is as sensitive to outside influences, political, religious, philosophical, imaginative, as is the barometer to changes of atmospheric density. Theoretically it ought to go on its own straightforward inductive path, without regard to changes of government or fluctuations of public opinion. [Actually there is] a closer relation between Medical sciences and the conditions of Society and the general thought of the time, than would at first be suspected."² And so it has proved for the care and treatment of the mentally disabled.

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1. Throughout this essay, "mental health care" is used in a general sense to refer to treatment of both the mentally ill and retarded. In selecting specific language to refer to the mentally ill and retarded, I have generally adopted those terms in use during the period under discussion regardless of whether they are considered appropriate or stigmatizing today.

2. Quoted in Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Brunswick, N.J., 1964), xv.

3. Albert Deutsch, *The Mentally Ill in America*, 2d. ed. (New York, 1949), 6.

4. Quoted in *ibid.*, 12-13.

5. *Ibid.*, 18.

6. *Ibid.*, 24-25.

7. *Ibid.*, 39-54; Gerald N. Grob, *Mental Institutions in America: Social Policy to 1875* (New York, 1973), 1-34.

8. Deutsch, *Mentally Ill in America*, 332. See also Seymour B. Sarason and John Doris, *Psychological Problems in Mental Deficiency*, 4th ed. (New York, 1969), 212-214.

II

Throughout most of Western history, mental disabilities have been viewed in terms of the supernatural. This tendency peaked during the Middle Ages, when "lunacy" and "idiocy" were understood either as divine punishment or the result of involvement with evil spirits. As Albert Deutsch, author of *The Mentally Ill in America*, remarks, "Therapeutic measures in mental illness [have been] based on the prevailing theory of causes."³ Accordingly, in medieval times the primary methods of prevention and care were magic and ritual. For example, a tenth-century cure for insanity, recommended by the Reverend Oswald Cockayne in a volume entitled *Leechdoms, Wortcunning and Starcraft of Early England*, was typical of its day: "In case a man be lunatic; take a skin of mere-swine (sea-pig) or porpoise, work it into a whip, swinge the man therewith, soon he will be well. Amen."⁴ At its worst, the medieval approach to the problem of mental deviancy was less antic; it has been estimated that, between the mid-1400s and 1700, not less than 100,000 persons were executed as witches, many of whom probably suffered from some form of mental illness.⁵

Bringing with them European customs and attitudes, colonial Americans shared many Old World superstitions about mental disabilities. In the mid-1600s, the whipping post and the gallows were common punishments in cases of supposed demonic possession.⁶ But at the same time, a more benign approach was slowly coming into existence as Western society emerged from the shadow of the Middle Ages. By the late 1700s, for example, physicians were beginning to consider the relationship between insanity and a number of natural causes such as disease, excess sexual activity, and stress. And even if many citizens still related illness and handicaps to the will of God, more and more they also recognized mental disability as an economic and social problem requiring instrumental action.

In practice, the mentally disabled in America fell under the system of poor laws and received an informal, case-by-case response.⁷ The violent insane were treated like criminals and thrown into jail. Other afflicted persons, if dependent on public resources, were occasionally housed in private dwellings at the town's expense. Sometimes towns even offered financial support directly to the family of a mentally disabled person so that he might remain in his own home. Later, during the second half of the 1700s, authorities often placed the insane and feeble-minded in workhouses, houses of correction, and almshouses which were quickly spreading across the states. It is important to emphasize that during the colonial period (and even later) most Americans did not distinguish between the insane and the feeble-minded. Both fell into the category of "mental defectiveness," and, in the words of one author, treatment practices for the two groups were "inextricably bound" together.⁸ Like the insane, a feeble-minded person who provoked fear or suspicion was likely to be imprisoned or neglected.

Practices in Rhode Island illustrate these general trends. The first recorded consideration of public provision for the mentally disabled in the colony dates back to 1651 and involved Roger Williams. In a letter to the Providence town council written on January 22, 1651, Williams requested that the town assume control of the property of a Mrs. Weston and take care of this unfortunate citizen who had become a "distracted" woman:

I crave your consideration of that lamentable object Mrs. Weston, my experience of the distempers of persons elsewhere makes me confident that (although not in all things yet) in great measure she is a distracted woman. My request is that you would be pleased to take what is left of hers into your own hand, and appoint some to order it for her supply, and it may be let publike act of mercy to her necessities stand upon record amongst the merciful actes of a merciful town that hath received many mercies from Heaven, and remembers that we know not how soon our own wives may be widows and our children orphans, yea, and ourselves be deprived of all or most of our reason, before we goe from hence, except mercy from the God of mercies prevent it.⁹

Within two months the town council placed Mrs. Weston (her name at this time actually was Goodwin because of remarriage) formally into the care of six men who were given the power to sell her property in order to meet any debts associated with their responsibility.¹⁰ Evidently the woman did not receive the best of care under this arrangement, for a month later she died after wandering about alone and naked during a midnight storm.

Such personalized care, whether it proved beneficial or not, was impossible to continue as Rhode Island's towns grew in size and population. By the early 1700s, Rhode Island joined in the larger movement to establish almshouses that would house the poor and the mentally disabled. The town of Newport established the colony's first almshouse in 1723, and several other towns soon followed with their own.¹¹ In 1742, the colony passed a law giving town councils the power to assume full responsibility for the care of insane and feebleminded persons in their communities and to name guardians of their estates.¹² The effects of this law were far-reaching, for it helped to inaugurate a standard approach to the care of the mentally disabled that would persist into the 1800s.

But the practice of placing mentally disabled persons in local almshouses left much to be desired. Living conditions were ghastly in the almshouses, and little if any medical care was provided. Describing the Newport Asylum, James Nutting—an historian of Rhode Island's social welfare provisions—reports that "the poor, the sick, the blind and the insane were huddled together without attempt at classification of any sort in indiscriminate misery." Nutting also notes that "all who were sent there went with a fixed idea, well founded, that their next re-

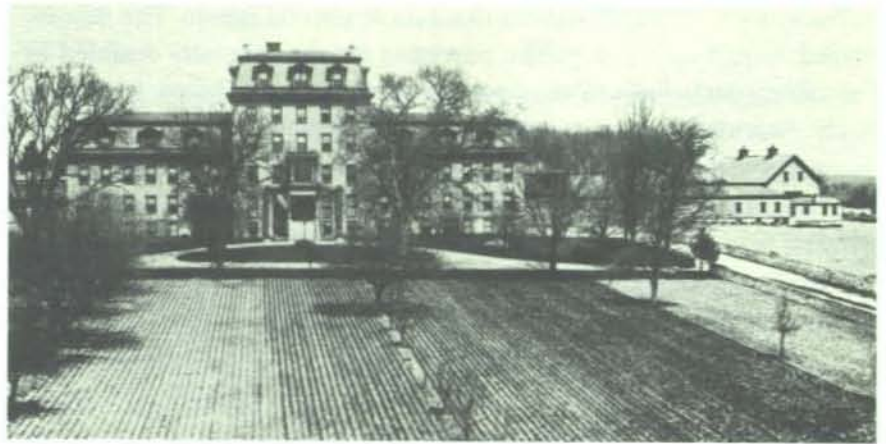
9. James Nutting, "The Poor, the Defective, and the Criminal," in Edward Field, *State of Rhode Island and Providence Plantations at the End of the Century*, 3 vols. (Boston, 1902), III, 390. I have cited the date for this letter which Bradford Swan assigns in "Roger Williams and the Insane," *Rhode Island History*, V (1946), 67. This quote follows the language of Nutting's transcription, but the reader may wish to consult Swan to read Williams's letter with the original spelling intact.

10. Swan also explains that Margaret Goodwin and Margaret Weston were the same person, a fact that Nutting confuses. Swan, "Roger Williams and the Insane," *R.I. Hist.*, V (1946), 67n.

11. Nutting, "The Poor, the Defective, and the Criminal," in Field, *State of Rhode Island*, III, 401.

12. *Ibid.*, 418.

Dexter Asylum, Providence. This institution was built in 1828 from a bequest made by Ebenezer Dexter, a wealthy Providence merchant. Courtesy of Rhode Island Historical Society Library (RHi x3 1489).



13. *Ibid.*, 401.

14. Thomas R. Hazard, *Report on the Poor and Insane in Rhode Island made to the General Assembly at Its January Session, 1851* (Providence, 1851), 97–98.

15. Hazard, *Report*, 97.

moval would be to the paupers' corner of the adjacent burying ground."¹³ In 1850, an investigation of local almshouses in the state by Thomas Hazard revealed how years of public "care" had ravaged many insane persons. While Hazard noted in his report to the General Assembly recent improvement in conditions at some almshouses, stories like the following grimly described the way that many towns had been treating their mentally disabled inhabitants for generations:

I lately saw [wrote Hazard] a poor woman at the Newport Asylum, by the name of Rebecca Gibbs, who had once known better days, but had lost her reason in consequence of disappointed affection, about 30 years since; from that time she had been a charge to the town. This poor creature was, as it were, completely folded up; her lower limbs being drawn up closely to her breast, so that her knees and chin nearly or quite meet. From this position they are never relaxed. I was told by a Commissioner of the poor, who accompanied me, that this revolting deformity was solely occasioned by the poor creature having in years past, been shut up several winters in a cell, without fire, and without clothes, (for the last, as is common with maniacs, she tore from her limbs,) where she endeavored to screen herself as much as possible from the severity of the cold, by placing her body and limbs in as compact a form as she was able to, and that thus the sinews and muscles had contracted and adapted themselves to the position in which her limbs had been mechanically forced by the extremity of the weather.¹⁴

Inhumane treatment of the mentally disabled seems to have been a problem in Rhode Island towns even when insane people were not committed to almshouses. For example, Hazard reported the use of a special building in Jamestown during the early 1800s to house a man named Armstrong who was considered insane.¹⁵ The building was raised above the ground on posts and wide spaces separated the floor boards. The unfortunate Armstrong remained for nearly twenty years in this building, without fire and with little clothing or light. Located

on the highway for all passers-by to see, the structure also served as a powerful reminder to "healthy" community members of the terrible personal consequences of being a social deviant.

By the early 1800s, then, American society had largely rejected the superstitions inherited from medieval Europe in the care and treatment of the mentally disabled. Belief in demonic possession was less widespread and no longer guided community policies. Yet public provisions were generally inadequate and often cruel. The insane and feeble-minded, as we have seen, received little in the way of medical care. Although the first hospitals to treat patients with mental disabilities had been opened in the eighteenth century, first in Pennsylvania in 1752 and later in Virginia in 1773, these were isolated developments and were not really part of a larger movement.¹⁶ At the beginning of the nineteenth century, most states, including Rhode Island, still relied on local poor relief measures and a patchwork of small, indiscriminate facilities that were custodial in nature. Yet the spirit of reform that swept through America during the first half of the nineteenth century would influence a change in attitudes toward the treatment and care of the mentally disabled.

III

Social reformers in the antebellum period espoused a number of different causes and crusades such as prison reform, abolitionism, and temperance.¹⁷ Several different sources contributed to this reform impulse. America's Second Great Awakening, a religious revival that attempted to rid Christianity of its preoccupation with the Calvinistic doctrine of predestination and replace it with a more uplifting conception of man, directly supported humanitarian reform efforts. According to the new religious thought, anyone could perfect and redeem himself by having faith and by performing good works. Reform movements in the years before the Civil War also drew on a legacy of the American Revolution by reaffirming Enlightenment values of reason and social equality. But the reformers could have accomplished very little without the presence of still a third stimulus—obvious need. Americans were forced to acknowledge that their society was plagued by an array of problems and inequities. As the country's population began to shift to urban areas, the extent of poverty, mental deviancy, and crime—which all had been obscured in rural communities—now became apparent simply because more people were working and living closer together.

Within this climate of reform, mental disabilities were seen in a new light. New medical theories outlined the dimensions of the changes that were taking place. Continuing a trend that had begun in the mid-1700s, American physicians tended increasingly to view mental illness in natural terms. By the early 1800s, a large segment of the med-

16. Grob, *Mental Institutions in America*, 33–34.

17. For a discussion of this period of reform in American history and some of its causes see James Leiby, *A History of Social Welfare and Social Work in the United States* (New York, 1978), chap. 2 and 3; Walter Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America* (New York, 1974), chap. 3.

18. See Dain, *Concepts of Insanity*, chap. 3 and 4; David J. Rothman, *The Discovery of the Asylum* (Boston, 1971), chap. 5.

19. Rothman, *Discovery of the Asylum*, 125.

20. *Ibid.*, 130.

21. Ruth B. Caplan (in collaboration with Gerald Caplan), *Psychiatry and the Community in Nineteenth-Century America* (New York, 1969), 60.

22. Grob, *Mental Institutions in America*, 107. See also Helen Marshall, *Dorothea Dix: Forgotten Samaritan* (Chapel Hill, N.C., 1937); Deutsch, *Mentally Ill in America*, chap. 9.

23. Caplan, *Psychiatry and the Community*, chap. 3; Grob, *Mental Institutions in America*, 65–68, 174–186; Rothman, *Discovery of the Asylum*, chap. 6.

24. A full account appears in Fred Jacobs, "Private Care and Public Custody: Institutions for the Insane in Rhode Island, 1840–1900" (honors thesis, Brown University, 1978), 10–26. See also Jacobs, "Isaac Ray and the Profession of Psychiatry," *R.I. Hist.*, XXXVII (1979), 99–111.

ical profession subscribed to phrenological theory as a means to explain insanity.¹⁸ According to the principles of phrenology, the mind comprised several distinct faculties located in specific areas of the brain. Insanity corresponded to actual physical lesions of the brain and could thus be regarded as physical in nature. But insanity, held the phrenologists, also had an important psychological element in that it could be caused by emotional and environmental factors. In the end, phrenological theory and its offshoots united American physicians with many lay members of the community in a common concern with how intemperance, overwork, ambition, social mobility, and even political conflict were increasing the number of insane in the nation. As the historian David Rothman explains, "Psychiatric theories . . . did not reflect the unhappiness of an alienated minority but the widely shared anxiety of antebellum Americans about the social order."¹⁹

A pervasive reform impulse, a heightened awareness of the number of insane persons, and a new perception of the nature of insanity together led to the founding of a wave of mental hospitals in early nineteenth-century America. Indeed, as Rothman has put it, "A cult of asylum swept the country."²⁰ By 1861, there were forty-eight mental institutions in America: twenty-seven were established and maintained under state auspices; ten were private, corporate institutions surviving on combined private and public dollars; the remainder were a miscellany of city, county, and family-run institutions (and one federal asylum in Washington, D.C.).²¹ More than any other individual, Dorothea Dix symbolizes this era of institutional expansion. By the end of her career, Dix had helped to found or enlarge more than thirty mental hospitals in America and abroad.²²

Far from being a place of confinement and degradation, the asylum in this period sought to insulate its residents from the pressures of community life and to provide a form of active psychological therapy known as "moral treatment."²³ If environmental and emotional factors could cause mental illness, they could also cure it, so the reformers' argument ran. In this connection, the institution was seen merely as a controlled environment where humane and individualized treatment could rehabilitate and, to borrow a modern term, "resocialize" the inmates. Although it was often difficult to achieve, superintendents who practiced moral treatment aimed at creating a homelike atmosphere in their institutions. Typically, there was an organized program of education, recreation, and religious services; emphasis was also placed on close relationships between patients and staff, who were supposed to use physical restraint sparingly.

The forces that led to the founding of Rhode Island's first hospital for the insane resembled those in other states.²⁴ In the first place, community leaders shared a growing sense of the need for social reform. In the second place, Rhode Island—like other states—found it harder and harder to provide for the insane poor whose numbers increased as the state's population grew. For example, Dexter Asylum, an almshouse in

the City of Providence, had a capacity of sixty-four persons. In 1842, the Overseers of the Poor complained that it housed nearly double that amount, or 103 paupers, one-fourth of whom were considered insane.²⁵ Without doubt, similar conditions existed in several other localities in the state. Despite these similarities to circumstances in other states, the founding of Rhode Island's hospital for the insane seems also to have reflected the idiosyncratic concerns of local reformers. The abortive Dorr rebellion in 1842 sparked fears of social disorder among many Rhode Islanders, and such fears, as much as humanitarianism, may have stimulated some of the zeal for reform that was expressed in the creation of Rhode Island's first hospital for the insane.

In 1841, Nicholas Brown bequeathed \$30,000 for the purpose of establishing a hospital for the insane in Rhode Island. When it became clear that the actual cost of building such a hospital would far exceed even this generous gift, the Rhode Island legislature agreed to deliver the matter into private hands—an action consistent with the state's strong tradition of limited government. The executors of Brown's will—including Thomas Hazard, Moses Brown Ives, and John Carter Brown, who together represented some of the state's leading industrial families—then incorporated as the first trustees of the Rhode Island Asylum for the Insane and set out to raise the extra money needed for their project.

The fund-raising campaign received a tremendous boost when Cyrus Butler, a textile magnate and perhaps the richest man in New England, promised \$40,000 to the trustees on the condition that they raise a comparable amount from other sources.²⁶ By 1844, the trustees had collected more than \$50,000 in donations in addition to the combined \$70,000 from Brown and Butler. Thirty or forty large gifts made up the bulk of this sum, but there were also hundreds of one, two, and three dollar gifts, a clear sign of public backing for an insane asylum in the state. Renamed after its most generous benefactor, Butler Hospital for the Insane received its first patients in 1847.



Dr. Isaac Ray (1807–1881) was superintendent of Butler Hospital from 1847 to 1869. Courtesy of Butler Hospital.

25. Jacobs, "Private Care and Public Custody," 15.

26. There is some confusion concerning the role which Dorothea Dix may have played in the founding of Rhode Island's first insane hospital. Dix's biographer, Helen Marshall, attributes to Dix a very important part in this matter, particularly in convincing Cyrus Butler to donate \$40,000 to the project. See Marshall, *Dorothea M. Dix*, 101–102. More recent research by Jacobs, based on careful study of historical sources in Rhode Island, disputes this account. See Jacobs, "Private Care and Public Custody," 148n.



Butler Hospital, ca. 1865. Courtesy of Rhode Island Historical Society Library. (RHi X3 4121).



Thomas R. Hazard (1797–1886), a Rhode Island industrialist, presented a landmark report on the poor and insane in the state to the General Assembly in 1851. Courtesy of Rhode Island Historical Society Library (RHi x3 2384).

27. Jacobs, "Private Care and Public Custody," chap. 2; Grob, *Mental Institutions in America*, chap. 4; Jacques M. Quen, "Remarks on Doctor Isaac Ray (1807–1881)," *Rhode Island Medical Journal*, LXIII (1980), 217–219.

28. Rhode Island General Assembly, *Acts and Resolves*, 1851.

29. Hazard, *Report*, 97.

30. Deutsch, *Mentally Ill in America*, 338–340.

31. *Ibid.*, 342–343; President's Committee on Mental Retardation, *Mental Retardation: Past and Present* (Washington, D.C., 1977), 3–4. Actually, efforts in Massachusetts to educate the feeble-minded followed an earlier attempt in Connecticut, where feeble-minded children were admitted into the American Asylum for the Deaf and Dumb at Hartford, beginning in 1818.

No expense was spared either in the construction of Butler Hospital or in procuring able leadership for its operation. The hospital was an E-shaped structure with spacious dormitory rooms and recreation areas. Its size was relatively small—108 beds—in keeping with one of the principal tenets of the philosophy of moral treatment. A lovely wooded area formed its surroundings and helped to isolate it from the community. The trustees succeeded in hiring Dr. Isaac Ray, who at the time was head of the Maine Insane Hospital, to serve as the hospital's first superintendent. Ray was to become one of the most noted psychiatrists in nineteenth-century America.²⁷

Butler Hospital was actually a quasi-public resource in this period in that it performed many of the functions of a state facility. While most of its patients paid their own way, Butler also accepted a number of public patients who were supported by the cities and towns where they lived. In 1851, the State of Rhode Island also earmarked \$1,000 annually to help maintain the indigent insane at the private hospital, a decision that resulted in part from Hazard's landmark report to the state legislature in 1851, which reported more than two hundred insane persons in the state who still remained in local facilities or who were maintained by relatives and friends.²⁸ While Hazard did not recommend hospital care for all these persons, he did argue strongly in favor of such treatment for all recent cases of insanity.²⁹ Although the costs involved discouraged this practice from becoming universal, the use of Butler Hospital for public patients offered the first humane alternative in Rhode Island to the catch-all poorhouses and a general policy of neglect that the poor insane suffered at the local level.

Because of the lack of careful distinctions, many feeble-minded persons in America entered asylums for the insane during this period. At the least, this practice marked a definite improvement in conditions related to their physical and medical needs. Far more significant, however, were the large strides taken in devising special educational programs for the feeble-minded in the first half of the 1800s.

During the late 1700s and early 1800s, European researchers like Dr. Jean M. G. Itard and Dr. Édouard Séguin had been applying these new methods for stimulating the mental and physical development of feeble-minded persons.³⁰ In America, innovative treatment for this problem population first took hold in Rhode Island's neighboring state of Massachusetts, where Samuel Gridley Howe was commissioned by the legislature in 1846 to survey the problem of idiocy in the state.³¹ Already experienced with educating the blind and the deaf and interested in contemporary efforts to treat feeble-mindedness, Howe reported that there were about eight-hundred idiots in the state, most of whom, in his opinion, could benefit from education. With an appropriation from the Massachusetts legislature to support the instruction of pauper idiot children, Howe founded in 1848 the nation's first institution dedicated specifically to the care of the feeble-minded, the Massachusetts School for Idiotic Children and Youth. By 1866, similar institutions had been founded in six other states.

Progress in Rhode Island in this area was somewhat slower. During most of the 1800s, a good many feeble-minded persons were probably incarcerated with the insane in local poorhouses or received no attention at all. Still, Rhode Island recognized the important developments that were taking place in other states and attempted to take advantage by sending its own citizens for treatment, particularly to nearby Massachusetts.

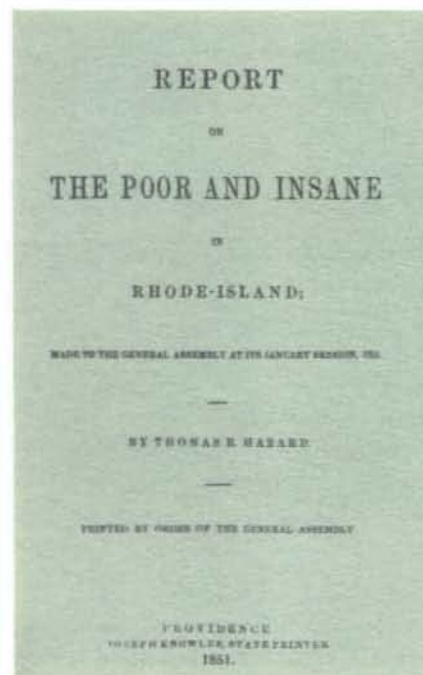
For both the insane and feeble-minded, then, an optimistic vision led to the creation during the first half of the nineteenth century of new institutions intended to remedy, or at least improve, the condition of mental disability. Under the influence of a general spirit of reform and a new, more positive image of persons with mental disabilities, treatment practices became relatively humane and individualized. Mental hospitals, in short, were generally benevolent places to be. Although proponents of moral treatment greatly exaggerated its successes, it is probable that at no time between 1650 and the mid-twentieth century was the rate of cure of serious mental illness among those admitted to mental institutions higher than in this era.³²

IV

In the second half of the nineteenth century, attitudes toward persons with mental disabilities changed again. For large segments of the professional and lay community, optimism and understanding gave way to pessimism and alienation. As a result, treatment practices deteriorated dramatically.

According to the dominant thinking of the era of moral treatment, insanity resulted largely from environmental influences over which the afflicted person had little control. By contrast, the late 1800s in America saw a new emphasis on heredity as the cause of insanity and a corresponding diminution of the importance of external factors.³³ The new etiology also sounded a related note of moralism, for medical and lay spokesmen generally held that vicious habits, like masturbation, intemperance, and lasciviousness, could aggravate latent genetic tendencies to mental disorder.³⁴ And, in state legislatures, at professional conferences, and among humanitarian groups alike, insanity increasingly was identified as a special problem of the poor.³⁵ The cumulative effect of these notions was to create in the late 1800s a widely shared image of insane persons as incurable and potentially violent. In short, they posed a serious threat to the social organism. As Ruth Caplan puts it, "Those suffering from mental disorders were no longer seen as ordinary members of the community who had been stricken by chance, but as a race apart that might corrupt the welfare of all society with its tainted blood."³⁶

Like the earlier, more benign view of the insane, this negative image also stemmed from a number of self-reinforcing ideas and events.³⁷ Most important, perhaps, was the changing composition of the popula-



Title page of Hazard's 1851 report. Courtesy of Rhode Island Historical Society Library (RHi x3 4244).

32. Grob, *Mental Institutions in America*, 182-185.

33. Dain, *Concepts of Insanity*, 85.

34. *Ibid.*, 111.

35. See the discussion of Edward Jarvis's report to the Massachusetts legislature (1854) in Gerald N. Grob, *The State and the Mentally Ill: A History of Worcester State Hospital in Massachusetts, 1830-1920* (Chapel Hill, N.C., 1966), 156-174.

36. Caplan, *Psychiatry and the Community*, 145.

37. *Ibid.*, 47-51; Dain, *Concepts of Insanity*, 114-144; Rothman, *Discovery of the Asylum*, 265-287.

38. *Ibid.*

39. The following discussion draws heavily on Jacobs, "Private Care and Public Custody," 67-112.

tion of patients within mental hospitals. Because of massive immigration into the United States in these years, a growing proportion of those labeled insane were foreign-born and, of course, poor. This development stimulated the prejudices of many psychiatrists, public officials, and community leaders who were likely to be native-born, Protestant, and generally well-off. In addition, as a result of commitment laws which in many places automatically sent the dangerous or unmanageable insane to the state hospital, more and more patients were the chronically disabled—senile, alcoholic, criminally insane, and so on. In a different but related way, the rise of neurology within the profession of medicine also helped to spread new views. Practitioners of this specialty favored medical care over psychological therapy and pressed for further study of the somatic basis of mental disorder. Last, by greatly overselling their own ability to effect cures, proponents of moral treatment ultimately undid themselves and contributed to a backlash of pessimism concerning the insane and their chances for recovery.

While hospitals for the insane continued to grow in number and size throughout this era, the quality of treatment within these institutions, particularly in state facilities, greatly deteriorated.³⁸ In other words, the primary *form* of care remained consistent with that in earlier years, but its *substance* was altered. Rather than humane psychological therapy, hospitals for the insane now resorted more frequently to drugs, surgery, and mechanical restraints. Clinicians became more interested in correctly diagnosing large numbers of patients than in delivering individualized care. Patients' records were brought up to date less often and with less valuable personal information. And instead of providing a haven from community pressures and conflicts, the asylum directly mirrored social divisions by determining treatment along class, ethnic, and race lines.

In the end, most state hospitals lacked the basic resources needed to deliver quality care even if this had been their central purpose. State legislatures kept operating budgets very low, few hospitals could attract and hold an adequate number of skilled attendants, and the physical plants generally were decrepit and overcrowded. The role of the superintendent tells much of the story of this dark period in the care of the mentally ill in America. While in the past he had actively involved himself in direct patient care, the hospital head in this era typically filled his time with administrative matters, such as managing the hospital's budget and raising additional funds.

Developments in the care of the mentally ill in Rhode Island during this period conformed with national trends.³⁹ In 1850, immigrants made up about one-sixth of Rhode Island's total population; by 1865, the proportion that were immigrants or the children of immigrants had climbed above one-third. Feeling the pressure of an increasing number of foreign-born in the state, Butler Hospital began in the 1850s to restrict the admission of public patients and requested further that lo-

calities remove their pauper insane from the institution. On the face of it, Superintendent Isaac Ray's professed concern that Butler Hospital direct its services to those persons it could most benefit seemed practical enough and even, in a certain sense, humane. But, as he revealed in an article published in the *North American Review* in 1856, Ray actually shared many nativistic prejudices of the era: "The Irish patients, as compared with the native are preeminently incurable. We are bound to expect, therefore, a constantly increasing accumulation of incurable cases from this quarter, a fact that must be taken into account in making provisions for future hospital accommodations."⁴⁰ By 1870, Butler accepted public patients only on occasion, primarily when they were needed to maintain high occupancy levels at the institution.

With Butler abandoning its quasi-public role, Rhode Island once again had to face the problem of providing for the poor insane. At first it responded by boarding patients in nearby facilities, such as Worcester State Hospital in Massachusetts and the Vermont Insane Hospital, but other states had their own problems with overcrowding and soon had to turn away Rhode Island residents. The Providence City Council voiced a growing sentiment in the state by recommending, in 1865, that the General Assembly consider establishing a state hospital in Rhode Island. Responding to this call, the assembly first authorized an investigation of the plight of the insane in the state and then, in 1866, appointed a special committee to "report upon the expediency of erecting a state asylum."⁴¹

In 1867, the Joint Special Committee officially recommended building a state asylum together with a state almshouse, workhouse, and house of correction at the same site—all under the supervision of a new State Board of Charities and Correction. As a model for the new state facility, the committee chose the asylum on Blackwell's Island in New York City, not *because* of the quality of care there but, rather, *in spite* of it. While the Blackwell's Island asylum had gained some infamy for its decrepit and unhealthful conditions, it nonetheless offered a compelling example of how to provide public care for the mentally ill at a cut-rate price: the New York facility spent only \$2.12 a week per patient, the lowest cost anywhere in the nation. The Rhode Island State Asylum for the Incurable Insane opened in November 1870 at its location on the Howard Farm in Cranston. To fill the new facility, the state recalled nearly all of its patients in Vermont, Massachusetts, and at Butler Hospital, and in 1884 the General Assembly passed a law shifting responsibility for all pauper insane from cities and towns to the state.⁴²

Several strands of evidence indicate that the quality of care at the State Hospital was poor, that this was indeed as depressing a place as its name suggested.⁴³ For one thing, the physical facilities were minimal, only \$22,000 having been spent on construction. The institution's capacity was 200 patients; by 1882 it was already seriously overcrowded with 282 patients. For another thing, medical care was available only



In 1844, Cyrus Butler, textile magnate and perhaps the richest man in New England, promised \$40,000 to the Trustees of the Rhode Island Asylum for the Insane on the condition that they raise a comparable amount from other sources for the construction of a new hospital for the insane. The trustees later collected over \$50,000 in donations, a clear sign of public backing for the institution. Renamed after its most generous benefactor, Butler Hospital for the Insane received its first patients in 1847. Courtesy of Butler Hospital.

40. *Ibid.*, 70.

41. Quoted in *ibid.*, 78.

42. *Ibid.*, 123.

43. *Ibid.*, 113–140; Henry A. Jones, *The Dark Days of Social Welfare at the State Institutions at Howard, Rhode Island* (Providence, 1942), 30–33.

44. Jones, *The Dark Days of Social Welfare*, 33.

45. *Ibid.*, 8.

46. The following discussion of the feeble-minded in the late nineteenth and early twentieth centuries relies heavily on Deutsch, *Mentally Ill in America*, 348-386; President's Committee on Mental Retardation, *Mental Retardation: Past and Present*, 6-16; Sarason and Doris, *Psychological Problems in Mental Deficiency*, 228-288.

on an infrequent basis: a single physician visited the asylum once a week. And, as far as the limited historical evidence from this time can show, patients apparently were subject to considerable physical abuse from attendants who, in the words of one attending physician, practiced "the arts of subduing patients without bruising or 'marking them up.' Towel strangling, rubber hose beating, and other refinements of cruelty were surreptitiously used."⁴⁴

If the founders of Rhode Island's state asylum ever seriously intended to deliver humane care there, their conception of a campus shared by several different welfare institutions was flawed from the start. Actually, this model represented little more than a sophisticated version of the eighteenth-century almshouse, with the insane (and physically ill) again being stigmatized because of their grouping with vagrants, criminals, and other ne'er-do-wells. Dr. Henry Jones, who served for thirty-four years at the state institutions at Cranston, recalled from the 1890s a startling scene of patients arriving at the facility by train:

Out upon the wet snowy platform, a handcuffed group were hustled, slipping and clanking down the slippery steps of the car. Calls and shouts from sheriffs in blue uniforms straightened up this motley crowd into a semblance of order, save one poor female, who, clanking her shackled wrist as one would a bracelet, screamed out some unintelligible language which showed she was insane.⁴⁵

Jones also recalled that excessive order and discipline marked the life of patients in the mental institution, mostly because hospital administrators attempted to emulate policies at the neighboring corrections facility, policies that were known to be well-regarded by the State Board.

Conditions were hardly better for the feeble-minded in America during these years. Like the insane, they entered a dark period in their history as negative attitudes and beliefs gave rise to harsh treatment practices. Indeed, for the feeble-minded this difficult time extended well into the 1920s, even longer than for the insane.

Many of the new beliefs regarding the feeble-minded closely resembled ideas held about the insane.⁴⁶ For example, a growing segment of the professional and lay community began to fear that idiocy could be passed directly from generation to generation as a hereditary trait. Increasingly, feeble-mindedness was identified as a cause of social maladies like crime and poverty, and many people began to believe that an excessive sexual drive impelled the feeble-minded to indulge in sexual misbehavior. Finally, in a way that directly paralleled contemporary views of insanity, there was growing pessimism in these years concerning the chances of improving the condition of feeble-mindedness through treatment. Deutsch powerfully captures the new image of mentally impaired persons that was widely shared by the end of the nineteenth century:

Séguin, Howe, and other pioneers had preached the gospel of sympathetic understanding toward the mental defective. The latter was pictured as a weaker member of the human family who had to be protected from gross abuse at the hands of society. At the turn of the century, through a swift metamorphosis, the picture was completely changed: the feeble-minded person was looked upon as a parasite on the body politic who must be mercilessly isolated or destroyed for the protection of society. For a period of two decades and more the man of science and the man on the street, with almost unanimous accord, regarded him as the most potent, if not the sole, source of all social evils. He was a sinister force threatening the very foundations of civilization itself.⁴⁷

As with the mentally ill, this changed image stemmed from diverse sources.⁴⁸ Mass immigration had much the same effect on attitudes toward the feeble-minded as it did on attitudes toward the insane. As it became clear that an increasing number of afflicted persons were of foreign parentage, stereotyped and prejudiced notions began to surface. Furthermore, the first few decades of care in training schools had yielded results that were even less positive than those in mental asylums: while not completely intransigent, the problem of feeble-mindedness evidently was not susceptible to rapid or complete remediation as some had anticipated. From the world of science came support for hereditarian theories in a revitalized, if ultimately incorrect, application of Mendelian genetics. Social researchers extended this approach in their novel genealogical studies of families like the Kallikaks and Jukes, studies which apparently confirmed that feeble-mindedness and its supposed opposite, respectable citizenship, ran in the blood. Finally, all of these developments assumed special significance in the context of Social Darwinism, a prevailing philosophy which argued that society needed to purify itself by resisting the impulse to aid the unfit in their struggle to survive—a recommendation that obviously boded ill for treatment of the insane and feeble-minded alike.

The new social attitudes and beliefs spawned a number of repressive measures. Indiana passed the first involuntary sterilization law in 1907; by 1926, twenty-two other states had followed suit.⁴⁹ By 1925, it is estimated that approximately 1,400 feeble-minded persons had been sterilized.⁵⁰ Restrictive marriage laws, also adopted in many states in the first two decades of the twentieth century, were another coercive approach to eradicating the problem of feeble-mindedness in society. Most significant, institutions for the feeble-minded multiplied in this period and gave up their educational mission in favor of a custodial one. In 1910, approximately 15,000 feeble-minded persons resided in institutions; by 1923, this number had grown to more than 40,000.⁵¹ Subsequent research has shown that the period of retention for persons admitted in the 1870s and 1880s was also much greater than those admitted twenty years earlier, in a less hostile time.⁵²

In February 1907, State Senator Thomas McKenna introduced an act

47. Deutsch, *Mentally Ill in America*, 352–353.

48. *Ibid.*, 354–362; President's Committee on Mental Retardation, *Mental Retardation: Past and Present*, 9–11; Sarason and Doris, *Psychological Problems in Mental Deficiency*, 228–275.

49. Sarason and Doris, *Psychological Problems in Mental Deficiency*, 287–288.

50. *Ibid.*, 288.

51. *Ibid.*

52. Peter L. Tyor, "'Denied the Power to Choose the Good': Sexuality and Mental Defect in American Medical Practice, 1850–1920," *Journal of Social History*, X (1977), 476.

53. *Providence Journal*, Feb. 20, 1907.

54. *Ibid.*, Feb. 22, 1907.

55. "In said school shall be maintained a school department for the instruction and education of feeble-minded persons who are within school age, or who are in the judgment of said Board capable of being benefited by school instruction; and a custodial department for the care and custody of feeble-minded persons beyond school age, or who are not capable of being benefited by school instruction."

Cited in *Ibid.*, Feb. 2, 1908.

56. *Ibid.*, Feb. 29, 1948.

57. *Ibid.*, Dec. 5, 1907.

58. *Ibid.*, Feb. 2, 1908, Feb. 29, 1948.

into the General Assembly for the establishment of a special institution for the feeble-minded in Rhode Island.⁵³ Two years earlier McKenna had been appointed to the Joint Special Committee charged with investigating the need for such a facility. To consider the bill, the Committee on Education held a special hearing before which state officials, professional group members, and humanitarian spokesmen argued strongly in favor of a Rhode Island school for feeble-minded persons.⁵⁴ A review of testimony given at this hearing reveals some of the concerns in the minds of these community leaders. Dr. Jay Perkins, representing the Society for Organizing Charity, related feeble-mindedness to the problem of crime, as did Gilbert E. Whittemore, Truant Officer of Providence. City Physician Byron Richards sounded a similar note. In the words of the *Providence Journal* reporter who covered the hearing, "He [Richards] thought the establishment of such institutions got at the root of vice and immorality." Finally, G. Alder Blumer, superintendent of Butler Hospital and a nationally recognized psychiatrist, expressed concern over the tendency of the "mentally defective" to proliferate at a higher rate than normal people. "Feeble-minded women who are loose in the community are often notoriously loose in another sense," he warned. "It is as one would expect, since there is always a marked impairment and sometimes a complete atrophy of the moral sense in feeble-minded persons." Not care but custody, then, seemed the paramount consideration in this groundswell of support for a new state facility for the feeble-minded.

The founding act for the Rhode Island School for the Feeble-minded nonetheless articulated piously the dual goals of education and custody.⁵⁵ Three adjoining farms in Exeter, the main one owned by Allen N. Hoxsie, were selected as the site for the state institution, a location that forty years later prompted a local newspaper reporter to write: "Even now Exeter School is a pretty lonely, isolated place, with the nearest community of any size 10 miles away. In those days it seemed like the end of the world."⁵⁶ The General Assembly placed the school under the joint control of the Board of Education and Board of Control and Supply, the latter being a department of management in the state. As its first superintendent, Rhode Island hired Dr. Joseph Ladd, then assistant superintendent at the Massachusetts School for the Feeble-minded at Waverley. His salary was \$2,500 a year, with living expenses for himself and his family.⁵⁷

The Rhode Island facility opened in the early part of 1908. Its beginnings truly were humble.⁵⁸ For the first fifteen months, the only facilities were a farmhouse, an adjoining barn, and a tool shed. It was decided that the school should receive a small number of students into a farm colony right away rather than attempt to reach its full capacity at once. A total of about fifteen feeble-minded persons, drawn from the state almshouse and those Rhode Island residents boarded at Waverley, composed the school's first population.

Over a period of approximately one hundred years, care of the insane

and feeble-minded in Rhode Island and the nation had undergone a radical transformation. Visions of reform and humane therapy in the early nineteenth century were largely absent by the beginning of the twentieth. In their place stood negative attitudes, fears, and a growing number of state asylums designed primarily to segregate the mentally disabled from the rest of society. In time, many of these institutions were to degenerate into places worse than even their harshest critics—there were a few—would have predicted.

V

At this very time, a spirit of reform, called "progressivism," infused American political and social life.⁵⁹ In common with the reform movement that had appeared during the antebellum period, progressivism had roots in both religious humanitarianism and secular reform. And, like the earlier movement, progressive reform also selected diverse targets, including (among many others) the juvenile justice system, tenement house conditions, and child labor practices. The progressive era also saw a burgeoning interest in the study and attempted redress of poverty, an interest that both grew from and furthered the view that dependency did not result simply from individual shortcomings but from large-scale social and economic forces as well.

Although certain strains within progressive thought supported involuntary sterilization, marriage restrictions, and other coercive measures, the larger spirit of humanitarianism that was kindled by this reform movement served to weaken negative attitudes toward the mentally disabled. Harsh attitudes lost still more ground in the face of a number of other developments in the late nineteenth and early twentieth centuries. In the field of public health, for example, the recognition that disease was spread by germs carried in filth not only stimulated ambitious preventive efforts, but also reinforced the view that individuals could be victimized by their social environment.⁶⁰ By the late 1800s, some psychiatrists had begun to ask important questions about the relationship between environment and mental disorder.⁶¹ Other practitioners and researchers at about the same time had begun to explore the idea of an "unconscious" that contained repressed psychic material, a direction of thought that gained great momentum with Freud's visit to America in 1907.⁶² And in the early 1900s, neurologist-psychiatrist Adolph Meyer and his followers were busy promoting a new definition of insanity as a disease of social functioning which stemmed at least in part from difficulties in interpersonal relations.⁶³ In its own way, then, each of these developments in psychiatric thought seemed to lift some of the responsibility, and therefore the blame, from individuals with mental disabilities. As Daniel Clark, superintendent of the Asylum for the Insane in Toronto, Canada, philosophized in an address before the Association of Medical Superintendents of American

59. See Leiby, *A History of Social Welfare and Social Work in the United States*, 136–190; Trattner, *From Poor Law to Welfare State*, 116–190.

60. Trattner, *From Poor Law to Welfare State*, 116–135.

61. Caplan, *Psychiatry and the Community*, 247–262.

62. *Ibid.*, 266–268.

63. David Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980), 302–309.

64. Caplan, *Psychiatry and the Community*, 251.

65. *Ibid.*, 263–292; Rothman, *Conscience and Convenience*, 298–323.

66. Rothman, *Conscience and Convenience*, 1–13, 324–375.

Institutions for the Insane in 1892: "Man is ruled by the external influences, from the thralldom of which there is no manumission, being, as Emerson would say, in 'the hands of the cherubim of destiny.'"⁶⁴

The first half of the twentieth century marked an ambivalent period in the treatment of the insane. On the one hand, new positive attitudes and images stimulated important developments in treatment practices and in attempts to produce a community-based system. On the other hand, deeply-ingrained negative views did not disappear all at once, and the custodial institution—with all of its inadequacies and inhumanities—remained at the center of care of the mentally ill in America.

On the national level, new approaches for treating insanity in this period ranged from the innocuous and mildly ridiculous to the truly innovative.⁶⁵ In the former categories belong such treatments as music therapy and "photochromatic therapy" (which exposed patients to sunlight filtered through colored glass). More serious developments included family care programs for boarding out patients, and a "cottage system" which placed less disturbed patients in small structures around the hospital grounds. But without doubt the most important advance in the care of the mentally ill in the early twentieth century was the development of a national mental hygiene movement, a broad-based effort to reform asylum conditions, improve aftercare services, and create new preventive programs.

The problem was, however, that none of the new mental health services that sprang up in this period became sufficiently widespread to make a real difference, and certainly none threatened the dominant position of the custodial state institutions.⁶⁶ For example, psychopathic hospitals and outpatient clinics—both strongly supported by the mental hygiene movement—were new treatment centers intended, respectively, to provide short-term inpatient care and ambulatory psychiatric care to people with relatively mild emotional problems. In fact, only a small number of psychopathic hospitals actually were established and those that did come into existence often ended up serving as way-stations for patients admitted to the state hospital. The same was true

Interior of the male "barracks" at the State Hospital for the Insane, 1913. Courtesy of the Providence Journal Company.



with outpatient clinics. Only a few ever developed into active treatment centers open to the community for more than a token number of hours. All the while, the custodial mental hospitals continued to grow, in spite of chronic problems with overcrowding and understaffing. From 1800 to 1940, the number of persons within state mental hospitals increased nearly five times as fast as the general population.⁶⁷

Care of the insane in Rhode Island in this period revealed the same ambivalence—positive growth in some areas, stagnation in others. Administrators and state officials, for instance, instituted a number of changes at the state asylum in an attempt to transform this facility from one of custody into one of treatment, a transformation which they tried to signify by a change of labels as well—from the State Asylum for the Incurable Insane (1870), to the State Hospital for the Insane (1897), to the State Hospital for Mental Diseases (1922).⁶⁸ At the turn of the century, after agitation by members of the medical profession in the state, the General Assembly removed official control of the State Hospital from lay to medical hands. During the period from about 1910 to 1930, administrators introduced a number of special treatments including hydrotherapy, physiotherapy, and occupational therapy. In these same years, the physical plant of the state facility was improved somewhat with the addition of several new buildings and recreation areas.

Rhode Island also had an active mental hygiene movement.⁶⁹ An official chapter of the National Committee for Mental Hygiene first met in the state in 1916. Subsequently, it focused on improving commitment laws, community education, and urging the development of a more comprehensive system of services for persons with emotional problems. The first mental hygiene clinic in the state opened in 1916 on Thayer Street in Providence. Although personnel shortages caused by World War I forced it to close shortly thereafter, other clinics followed in several areas of the state in the next three decades. Another important service appeared in 1928, when Providence city officials, with the backing of the General Assembly, approved the establishment of a psychopathic ward at the Providence City Hospital. And, in 1931, the Emma Pendleton Bradley Hospital was dedicated, a private facility in Rhode Island that provided specialized psychiatric care for emotionally disturbed children.

But care of the mentally ill in Rhode Island in these years had another, darker side that, in many ways, overshadowed the benefits of new services and programs. For example, an episode reported in the *Providence Journal* in February 1923 did much to suggest the seriousness of the problem of patient abuse at the State Hospital.⁷⁰ The news item involved James Keezer, an eighty-two-year-old man from Newport who had apparently succumbed to pneumonia. When an autopsy revealed that the deceased actually had seven broken ribs and a punctured lung (which had caused the pneumonia), hospital administrators admitted discharging two attendants twelve days earlier for "fail[ing] to handle Keezer without resorting to force." This incident is notable not

67. *Ibid.*, 374.

68. *Ibid.*, 336. In addition to the names which were applied to Rhode Island's state institution in 1897 and 1922, Rothman also cites the name which was first considered for the public asylum at the time of its founding, the Rhode Island Asylum for the Pauper Incurable Insane (1869).

69. This paragraph is based upon information presented in Sarah M. Saklad, "Psychiatry in Rhode Island," *R.I. Med. Jour.*, LXIII (1980), 207-216.

70. *Providence Journal*, Feb. 3, 1923.

71. *Ibid.*, Mar. 6, 1930.

72. *Ibid.*

73. Saklad, "Psychiatry in Rhode Island," *R.I. Med. Jour.*, LXIII (1980), 212.

74. Deutsch, *Mentally Ill in America*, 348-386; President's Committee on Mental Retardation, *Mental Retardation: Past and Present*, 9-41.

75. President's Committee on Mental Retardation, *Mental Retardation: Past and Present*, 15.

only because of the age of the victim and the brutal beating he suffered, but also because of the behavior of hospital officials: only the fact that a death was involved brought this event into the open and resulted in the pressing of criminal charges. Ironically, Keezer had been hospitalized because of a delusional psychosis that led him to believe someone would kill him.

Patients at the state facility were subject to other kinds of health risks as well. In 1930, the State Public Welfare Commission reported to the General Assembly a death rate at the State Hospital that was excessive even for institutions of its kind.⁷¹ In the previous year, there were 220 deaths, or 9.5 percent of the total population at the hospital. Of these deaths, an abnormally high number were tuberculosis cases, and this same disease was a contributing cause in virtually every death. The commission concluded that the problem stemmed from overcrowding and the "lack of a suitably equipped building in which patients may receive proper medical and surgical attention."

Even aside from the medical problems which it exacerbated, nothing spoke as powerfully to the deficiencies of the State Hospital as chronic overcrowding. Cited in every report on conditions at the state institution, this problem underscored the inadequacy of existing facilities and the central role that the State Hospital played within Rhode Island's system of care for the mentally ill. A brief statistical summary tells the story. In 1930, capacity at the state hospital was 1,460; its patients numbered 1,943.⁷² Following an expansion program, in 1940 capacity rose to 1,800. But by then there were 3,200 patients.⁷³ In short, the increase in patients at the state hospital did not merely keep pace with additions of new beds, it far exceeded them. In just a decade, overcrowding went from approximately 33 percent to 90 percent above capacity.

The same basic theme is apparent in the treatment of feeble-minded persons in America between 1900 and 1950. There were significant advances in delivering care, to be sure, but the custodial institution continued to dominate.⁷⁴ Positive developments included a renewed interest in educating the feeble-minded; the eventual discrediting of simple hereditarian theory to explain the incidence of feeble-mindedness; the development of special education classes in public schools; the beginning of organization among the parents of children with special needs; and a new definition of feeble-mindedness (or mental retardation as it was called by the end of this era) in terms of a person's capacity for social functioning. On the negative side were the lingering force of a menacing image of retarded persons and a strongly established pattern of custodial institutional care. In 1925, there were approximately 40,000 residents in public and private institutions for the retarded, a ratio of .34 persons per 1,000 population. By 1950, the number of residents had grown nearly fivefold to 190,000, or nearly .9 persons per 1,000 population.⁷⁵

Concerning one type of new service for the feeble-minded, Rhode Island led the nation. In December 1896, at a fire station on Burnside



Patients relaxing on the State Hospital grounds, ca. 1915. Courtesy of the Providence Journal Company.

Street, the Providence School Department began the first special class for the higher-grade feeble-minded within a public school system. An initial class of about fifteen children expanded to include about fifty feeble-minded students in 1903 who met in three classes in different areas of the city. As with similar developments that soon followed in other states, special education classes in Rhode Island grew out of "contrary roots of compassion and intolerance."⁷⁶ In its annual report, the Providence School Department explained: "Our teachers in the regular schools found so much relief when disorderly pupils were transferred to the disciplinary schools, that they were not slow to request the removal of the backward or mentally deficient children, who were receiving comparatively little benefit in their schools, to the same school for special instruction."⁷⁷

The founding of the Rhode Island School for the Feeble-minded in 1908 also brought about some positive changes in the treatment of the feeble-minded in the state. While the primary motive behind this development may have been a desire to protect the community from a fearful menace, for many persons who were removed from the state almshouse and, particularly, local welfare institutions, establishment of the state facility marked a real improvement in conditions. Over the course of the first few decades after its founding, the state institution improved to some extent both its physical capacities and programs so that, by 1948, the Exeter School—as it was then called—had more than twelve buildings and approximately 120 employees, and it prided itself on a parole program for placing its charges back into the community.⁷⁸ Even more hopeful, however, was the gradual shift in attitudes toward the feeble-minded in this period, a shift that Dr. Joseph Ladd summarized in an interview in 1948. Reflecting on forty years of service as head of Rhode Island's state facility for the feeble-minded, Ladd commented: "In the old days people believed that the mentally deficient should be kept out of circulation and incarcerated in institutions as cheaply as possible. Now we've come to realize—some of us, at any

76. *Ibid.*, 16.

77. *Report of the School Committee, 1896–1897*, Providence, Rhode Island; *Records of the School Committee, 1899–1903*, Providence, Rhode Island, June 29, 1900, 96.

78. *Providence Journal*, Feb. 29, 1948.

79. *Ibid.*

80. *Ibid.*, Feb. 2, 1917.

81. *Ibid.*, Mar. 21, 1923.

rate—that cheap institutional care is the most expensive in the long run because the more effectively you can train the feeble-minded and teach them some simple trades, the sooner you can send them back into the community. We have also learned that institutions should only be used as a last resort."⁷⁹

But ideals were hardly ever realities. In fact, as with the mentally ill, care of the feeble-minded in Rhode Island in the first half of this century centered primarily around a state institution afflicted with many serious problems. For example, in 1917 a conflict erupted between the Board of Control and Supply and the Board of Education, the two state agencies that shared control of the school for the feeble-minded.⁸⁰ A report from the latter agency complained that the Board of Control and Supply was interested only in cost-saving measures, not quality of care, in making decisions for the state facility. In the same report, the State Board of Education also drew special attention to staffing problems at the state school and revealed that two attendants employed during the previous summer apparently had been insane. In 1923, Dr. Arthur Ruggles, superintendent of Butler Hospital, added to this criticism of the Exeter School in a speech before the Lions Club at the Biltmore Hotel in Providence. In addition to reciting a litany of problems that plagued the state facility—fire hazards, improper medical care, a long list of persons waiting to be admitted—he characterized the Exeter School as “a great stigma” on the State of Rhode Island.⁸¹

In 1928, a special legislative commission investigated the Rhode Island Public Welfare Commission and the institutions it controlled.

*Aerial view of the State Hospital for Mental Diseases, 1964.
Courtesy of the Providence
Journal Company.*



After a comprehensive study of the conditions there, the commission issued a stinging indictment of the Exeter School. Some of the problems it detailed had been noted before: there was a serious shortage of attendants, and the school lacked a hospital building to isolate residents with contagious diseases. In addition, the commission's report aired some further deficiencies. It found the dining rooms inadequate and the diet poor, the superintendent needed at least two assistant physicians to help him provide medical care and special training, and the social service department succeeded much better in placing female inmates who were ready for parole than males. In the most crucial matter, the report found that, contrary to one of its founding goals, little education actually went on in the state "school." "An impartial survey of the history and present condition of this institution has convinced the members of this commission that at no time during the twenty-one years of its existence, has it approximated the purpose for which it was established," the authors of the report wrote. "It was established for the purpose of providing special training for the feeble-minded; it has been from the beginning and is at the present time a custodial institution providing little else than food and shelter for its inmates at smallest possible cost."⁸²

An appraisal of care of the retarded in Rhode Island in this period would be incomplete, however, without a brief summary of statistics related to overcrowding at the Exeter School. Already in 1915, less than ten years after its founding, Superintendent Ladd commented in an address before the Rhode Island Medical Society that his school was crowded and could not admit more students until enlarged.⁸³ Twenty-five years later, in 1941, 746 inmates occupied space for 505, and Ladd observed at the time that overcrowding kept the school from training and returning to the community many higher-grade feebleminded persons.⁸⁴ Finally, in 1944, a newspaper story reported that fifty inmates at the state school were forced to sleep on the floor because 876 students were enrolled in an institution whose capacity was only 565.⁸⁵

By 1950 the system of mental health care stood poised at the beginning of a new era. Forces that were shortly to lead to "deinstitutionalization" and attempts to establish community services for the mentally ill and retarded already were visible both in Rhode Island and the nation. Scandalous exposes of the conditions within institutions were becoming more frequent and more pointed; a movement among the parents of mentally retarded children had begun; and many mental hospitals had introduced new tranquilizing drugs with the result that their censuses were to decline for the first time in history. But this was also a system constrained by its past. The mentally ill occupied every other hospital bed in the United States, and a hundred years of history had solidified (some would say "calcified") state institutions for the mentally ill and retarded.⁸⁶ This was the ambivalent legacy which three hundred years of mental health care left to reformers and policymakers in the 1950s.

82. Quoted in *ibid.*, Dec. 30, 1928.

83. *Ibid.*, Mar. 3, 1915.

84. *Ibid.*, Nov. 3, 1941.

85. *Ibid.*, Apr. 21, 1944.

86. Mike Gorman, *Every Other Bed* (Cleveland, 1956), 24.

VI

It is instructive to reflect on those issues in the delivery of mental health care which have been most persistent and most difficult for more than three hundred years. Each may be phrased as a question. What are the causes of mental disability and to what treatments will it respond? How can a dual system of care for the rich and the poor be abolished? What is the proper role of the hospital or other large institution in caring for persons with mental disabilities? Are community services a realistic alternative to state institutions or merely a necessary complement? Finally, how can a sufficient number of skilled and caring people be attracted to work in delivering care to the mentally ill and retarded?

A series of longstanding questions, then, awaited the new era of mental health care which began in the 1950s. The response has been a community-based system which combines some genuinely new ideas with others having a long tradition within reform circles in the mental health field. The experience of the past quarter century tells us that, in practice, community programs for the mentally ill and retarded have met some challenges better than others. But only time will show which of today's approaches will still be found useful tomorrow. If the past is an accurate prologue, change will be the rule and the cycles will continue. More definitive knowledge, more effective services that are based on this knowledge, and an increase of public resources for mental health care—only these fortuitous developments could make it otherwise.

Mental Retardation, State Policy, and the Ladd School, 1908–1970

by Eric C. Schneider*

I

In the early twentieth century, Social Darwinism magnified fears of the socially deviant. Darwin's dictum of the survival of the fittest assured middle- and upper-class Anglo-Saxons of their elect status. But, ironically, natural law was being controverted; the fit reproduced slowly, giving rise to fears of race suicide, while the unfit seemed to propagate without end. Social science encouraged this prejudice as a series of studies including *The Kallikak Family* (1912), *The Hill Folks* (1912), *The Pineys* (1913), *The Jukes in 1915* (1915) and *The Family of Sam Sixty* (1916), which purported to prove that crime, destitution, illegitimacy, and feeble-mindedness were intertwined and hereditary phenomena. The newly developed Binet-Simon tests, which were given to prison and poorhouse populations, confirmed the belief that inherent mental defectiveness caused most crime and poverty.¹

Those most influenced by hereditarian doctrine were the professionals who came into contact with the medically and socially deviant. Physicians, wardens, social workers, and sociologists led the chorus of those who proclaimed that inheritance was destiny. The pages of the *Proceedings* of the National Conference on Charities and Corrections were filled with expressions of concern over the problems posed by the mentally deficient. Dr. Walter Fernald, the leading American student of mental deficiency, proclaimed in 1893 that the more able feeble-minded were destined to become "vagrants, drunkards, and thieves" if they remained in the community, while scientific study had shown that large proportions of criminals, drunks, and prostitutes "are really congenital imbeciles." Opinions such as these led to demands that the mentally retarded be permanently quarantined from the rest of society.²

The pessimism of asylum superintendents, such as Fernald, was shaped by the history of their institutions. Schools for the retarded, begun in the mid-nineteenth century, were intended to train their youthful inmates to become self-sufficient members of society. By the 1870s, however, it had already become apparent that most institutions were simply custodial. Some inmates ceased to improve upon reaching puberty, while others retrogressed; even those who appeared able to support themselves stayed, since they provided cheap help for the institution and parents were often unwilling to have them removed.³

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1. See Richard Hofstadter, *Social Darwinism in American Thought* (Boston, 1955); Mark H. Haller, *Eugenics: Hereditarian Attitudes in American Thought* (New Brunswick, N.J., 1963); Donald F. Pickens, *Eugenics and the Progressives* (Nashville, 1968); Rudolph Vecoli, "Sterilization: A Progressive Measure?" *Wisconsin Magazine of History*, XLIII (1960), 190–203.

2. Walter E. Fernald, "The History of the Treatment of the Feeble-Minded," National Conference of Charities and Correction, *Proceedings* (1893), 22 (hereafter cited as NCCC, *Procs.*); Peter Lawrence Tyor, "Segregation or Surgery: The Mentally Retarded in America, 1850–1920" (doctoral dissertation, Northwestern University, 1972), 149.

3. Tyor, "Segregation or Surgery," 68–76; Albert Deutsch, *The Mentally Ill in America* (New York, 1946), 346–347.



*Rhode Island School for the Feeble-Minded, ca. 1916.
Courtesy of Rhode Island
Department of Mental Health,
Retardation and Hospitals.*

4. Walter E. Fernald, "Care of the Feeble-Minded," *NCCC, Procs.* (1904), 387-388.

5. *Ibid.*, 382-383.

6. Henry A. Jones, *The Dark Days of Social Welfare at the State Institutions at Howard, Rhode Island* (n.p., 1942), 35-40; *Report of the State Board of Education*, 1908, 35.

7. Rhode Island School for the Feeble-Minded, *Annual Report, 1910*, 5-7, hereafter cited as RISFM, *AR*.

The superintendents translated custodialism into a benefit for both society and the inmate. Fernald, for example, thought that only a few could leave the schools and lead "useful, harmless lives," and that even then feebleminded persons did not become "desirable members of a modern American community."⁴ The belief that the institution was the ideal place for the retarded followed both from the notion that few could survive outside the institution without harming themselves or the community and from the fear that keeping the retarded at home produced an intolerable strain on the family. Anxiety over a retarded child's care worried mothers "into nervous breakdown, or insanity, or an untimely grave," sent fathers searching after drink, drove sons into gangs, and pushed daughters into the streets. Studies that linked mental defect to crime and pauperism only reinforced the superintendents' warnings that the institutionalization of the mentally retarded was in the best interest of all.⁵

II

Prior to the establishment of the Rhode Island School for the Feeble-Minded in 1907, mentally retarded persons in the state were cared for in a variety of settings. Obviously some remained at home with parents or relatives. Those whose families were unwilling or unable to keep them were usually sent to the almshouse, which contained a miscellaneous collection of the unwanted poor, the elderly, the chronically ill, mothers of illegitimate children, and the retarded. Some were sent to the State Hospital for the Insane, while others, who were convicted of offenses, landed in the state reformatories or jailhouses. Rhode Island also provided for some of its mentally retarded out of state. In 1908 for example, the State Board of Education had thirty-seven mentally retarded persons under its care, thirteen in the Connecticut School for Imbeciles, five in Hospital Cottages at Baldwinville, Massachusetts, seventeen at the Massachusetts School for the Feeble-Minded, and two at the Pennsylvania Training School for Feeble-Minded Children.⁶

In 1907 Rhode Island built its own state institution. A state school relieved both the almshouse and the hospital for the insane of an unsuitable burden; in both institutions the lack of any planning or training for the mentally deficient condemned a retarded inmate to perpetual dependence upon public charity. The legislature established a "farm colony" as recommended by a committee of the State Board of Education, which had visited state institutions in Pennsylvania and Massachusetts. Walter Fernald, superintendent of the Massachusetts School for the Feeble-Minded, had persuaded the committee that farm labor and residence in small cottages was better for the retarded than life in larger congregate units. Undoubtedly the state legislature was pleased with a plan in which patient labor defrayed some of the costs of operation.⁷

While recognizing that much of the institution's work would be custodial, the legislature also established a "school department" for trainable mentally retarded children of school age. It was hoped that they could eventually become somewhat self-sufficient and contribute to the cost of their upkeep. In addition, families who could afford it were required to pay something toward the support of a retarded relative—the full charge was \$800 per year, but many in the institution were publicly supported.⁸

Admission to the school for the feebleminded occurred in two ways. For voluntary admissions, the parents or guardians of a mentally deficient person had to write and request admission. All requests had to be accompanied by certificates from two doctors stating that the subject was a proper candidate for admission. For commitment, a complaint was made to a justice or clerk of a district court that a person was feebleminded and required restraint for his or her own welfare, or for the public's welfare. The justice or clerk would then issue a warrant for the person's arrest and set a date for a hearing on the complaint. Until the hearing, the person, who was in essence "accused" of retardation, could go free on bond or be detained at the School for the Feeble-Minded. If the court determined that the complaint was true, it could then order the person committed to the School for the Feeble-Minded until the State Board of Education proved that such restraint was no longer necessary. As in any civil or criminal case, the defendant had the right to appeal.⁹

The State Board of Education, which received jurisdiction over the school, apparently attempted to involve Rhode Island citizens in the institution. Fifty people attended a session, presided over by the governor, to discuss the needs and help plan the objectives of the school. But whatever the intent of the Board of Education, in practice the forces of economy and ideology combined to limit the possibility of citizen participation in the school's affairs. The desire for a peaceful rural setting for the "farm colony" and the availability and cost of land led to the purchase of three farms and five hundred acres far from the state's population centers, at Exeter, Rhode Island.¹⁰

The School for the Feeble-Minded opened in January 1908 when Dr. Joseph Ladd, a protégé of Walter Fernald and formerly his assistant at the Massachusetts School for the Feeble-Minded, arrived with eight "boys" to begin work on the farmhouses that formed the nucleus of the new institution. The plan was to house sixty male inmates by the autumn of 1908 and to erect a girls' dormitory by the spring of 1909. Work of the dormitories began in the summer of 1908; the first inmates did much of the grading, excavating, and installing of sewers for the new buildings, in addition to tending the crops that provided much of their food. The male section opened in early 1909, and the first inmates sent were transferred from the out-of-state public institutions. In an ominous portent, the dormitory was full on April 1, 1909, and a waiting list was established. Meanwhile, appropriations for the construc-

8. *The Exeter School* [n.p., n.d.].

9. *Rhode Island Acts and Resolves*, 1907, Chapter 1470, 90-92.

10. RISFM, AR, 1910, 5-7.

11. RISFM, *AR*, 1910, 8-10; *AR*, 1911, 6-7. The female dormitory did not open until 1913.

12. *Providence Journal*, Nov. 13, 1932.

tion of the female wing were not made until 1910, and even after construction was completed in the following summer the building remained unoccupied for lack of funds. Thus from its inception the school was plagued by an insufficient physical plant and the lack of adequate funds.¹¹

The remote location of the school and the lack of funds combined to make conditions in the early years of the institution resemble those in a frontier community. In bad weather, especially in the winter, the roads were nearly impassable and the school largely cut off from the outside. Ladd recalled having to take a sled and horses to town in order to get supplies, which then had to be stretched as far as possible. "There were days," he wrote, "when the food was portioned out very sparingly, after they had been snowbound for many days and it was impossible to get supplies through." The old farmhouses that served as the institution's first units were difficult to heat, and there were times "when the wood stoves served inadequately to warm the building on bitter cold nights." During the first year, Ladd, his wife, and infant daughter all lived in one room, while the inmates and two attendants lived in the rest of the farmhouse, and they all ate "from the same kettle."¹²

As the institution became better established, more emphasis was placed on formal training. Education for the retarded in the nineteenth century focused on having them perform progressively complex physical tasks; gymnastic exercises and sensory motor drills were used to prepare patients for vocational training. The therapy at the School for the Feeble-Minded was essentially similar. Ladd noted that the "surest and quickest" and, in some cases, the only way, "to quicken the mental activity" of the retarded was through physical exercise. Gymnastics and folk dancing for the women were among the more pleasurable lessons the inmates learned. Women were also trained to wait on tables, sweep, dust, make beds, scrub floors, wash windows, do laundry, cook, and sew. Men learned carpentry, shoe repairing, painting, and solder-

Inmates at the Exeter School on their daily walk, November 1941. Because of the lack of staff, this was the only exercise they were allowed. Courtesy of Rhode Island Department of Mental Health, Retardation and Hospitals.



ing. Under the supervision of the carpenter, the men made in one year 236 pairs of shoes, 4 tables, 8 ironing tables, 32 boxes, 5 cabinets, 16 clotheshorses, and 276 clothes hangers. Meanwhile, the women made an extraordinary number of aprons, dresses, overalls, shirts, napkins, bed pads, and even 165 Christmas stockings. Thus, the day-to-day operation of the institution and the desire for economy fit well with traditional ideas on training the retarded.¹³

Restrictive visiting procedures tended to keep the school hidden from public view. Rules for visitors, enacted in 1915, stipulated that an inmate could receive company on Thursday and Saturday afternoons from 1:00 to 5:00 P.M., which made visiting difficult for working parents. An inmate could receive only one visit per month, and no visitors were allowed on Sundays or holidays. Only if advance notice were given would a resident be ready for a visit.¹⁴

Such regulations were really unnecessary in the first two decades of the school's history, as its location served as an effective barrier to parental intrusion. Parents who wished to follow their child's case had to rely on correspondence with the superintendent. For example, F1 was admitted to the school in 1912 because she had atrophied legs as well as signs of mental deficiency. Her father had been injured at work and the mother was too ill to care for the girl, leaving the School for the Feeble-Minded as their only recourse. The mother recovered, but kept the girl at the institution, and exhibited her concern for her daughter in a series of touching letters. "I am very anxious to know," she wrote Dr. Ladd, "how [F1] is getting along. Please write me if she cries much and whether she takes the food you give her and if she sleeps well at night. Please answer me as quick as possible as I am very anxious to know." Ladd replied with a description of the girl's progress, health, and prognosis. Apparently the family was too poor to take the girl home and unable to visit her. The mother wrote frequently and Ladd replied when he could, always assuring the woman of her child's health and well-being, until the girl's sudden death during the 1918 influenza epidemic.¹⁵

Ladd referred to the menace of the feeble-minded in his reports, perhaps as a way of inducing the legislature to appropriate more money for the school. In the first full report in 1910, Ladd divided the mentally deficient into five categories: the idiot, the low-, middle-, and high-grade imbecile, and the feeble-minded. Intelligence ranged among these groups "from that seen in the profound idiot, who shows practically no more signs of mentality than a plant, to that shown by the feeble-minded boy or girl upon the question of whose mental deficit even experts may disagree." The "moral imbecile" made up a more able—and more dangerous—group. Ladd believed the moral imbeciles combined a minimum of mental defect with a maximum lack of moral restraint: "Doubtless many habitual criminals, petty thieves and the like, and many sexual offenders belong to this class. In fact, most of the girls of this class come to the institution with a history of promiscuous sexual relations, and many of the boys after one or more attempts at rape." In



Joseph H. Ladd (1876-1974) is the person most closely identified with institutional care for retarded people in Rhode Island. He was the first superintendent of the Rhode Island School for the Feeble-Minded. From National Cyclopaedia of American Biography.

13. RISFM, AR, 1913, 12-14.

14. RISFM, AR, 1915, 5-6.

15. Case of F1, Ladd Center Files, Exeter, Rhode Island.

Joseph H. Ladd

Joseph H. Ladd (1876-1974) is the person most closely identified with institutional care for the retarded in Rhode Island. He was the first superintendent of the institution which now bears his name, and he spent nearly his entire adult life at the school in Exeter. Ladd assumed his post at the newly created Rhode Island School for the Feeble-Minded after receiving a doctor of medicine degree at Dartmouth in 1900 and then serving an eight-year apprenticeship to Walter Fernald. He shared Fernald's belief that many of the feebleminded constituted a threat to society and needed to be institutionalized. Ladd later retreated from this position and affirmed instead the desirability of training the retarded to lead productive lives in a community setting. Ladd remained, however, a staunch advocate of sterilization. He declared in 1948 that "many states have already passed sterilization laws for eugenic purposes and I hope Rhode Island won't stay behind much longer." Ladd believed sterilization made the return of the retarded to the community feasible, for it solved the problem of their propagation, which was one of the most basic components of the "menace of the feebleminded" myth.¹

Ladd's beliefs must be understood in the context of their time. Ladd retained the hope shared by many in the progressive era that social problems could be solved through the application of science. Institutional care and training dealt with the current generation's mentally retarded; sterilization claimed to ensure that a future generation would not face the problem. The Exeter School was molded by Ladd's personality and ideology during the forty-eight years of his superintendency. Appropriately, the school was named after him in 1958, two years after his retirement at the age of seventy-nine. If Ladd's beliefs and his institution seem outmoded today, it is because the society that shaped them has moved beyond the progressive consensus, which demanded that persons labeled as mentally retarded be segregated or sterilized.

1. *Providence Journal*, Feb. 29, 1948.

16. Joseph H. Ladd, "The Feeble Minded," in *RISFM, AR*, 1910, 17, 18, 20-21. See also *AR*, 1915, 18. For the association of sexual license with mental defect in women see Peter L. Tyor, "Denied the Power to Choose the Good: Sexuality and Mental Defect in American Medical Practice, 1850-1920," *Journal of Social History*, IV (1977), 472-489; and Eric C. Schneider, "In the Web of Class: Youth, Class, and Culture in Boston, 1840-1940" (doctoral dissertation, Boston University, 1980), 237-241.

case anyone doubted that society required protection "against the poor, weak, feeble-minded child," Ladd gave an example of a case in which a feebleminded girl was left at home while her mother worked "and nearly a hundred cases of venereal disease infection were found distinctly traceable, directly or indirectly, to this one source." If this was intended to make the legislature more generous, it failed.¹⁶

The emphasis on the institution's role as a school naturally declined as it became filled with patients identified as deviant. When inmates' families objected to the term "feebleminded" in the school's name—undoubtedly because of the unsavory connotations the term had acquired—the name was officially changed in 1917 to the Exeter School. But such cosmetic changes could not hide developments there. Patients long kept at the state infirmary were transferred to Exeter, while

court commitments began to make up an increasingly large proportion of referrals. By 1921 Exeter officials complained about the overemphasis made on custodialism, noting that many people believed that the only appropriate cases were those who were unimprovable. An investigation by the National Committee for Mental Hygiene in 1923 led to charges that the Exeter School was a school in name only, that it denied admission because of overcrowding to many who applied, and that it provided little training for those already there. The committee found that "at least 50 males and 126 females should be receiving vocational training. Idiots should have habit formation training. All inmates should be taught to take care of themselves properly."¹⁷ A shortage of staff led not only to the collapse of the training program, but also to the inability even to supervise the inmates properly. As a result, some of the "high grade" residents were placed in charge of some of the wards. The institution made, the committee concluded, "a poor impression for one that has been in existence for fifteen years." In the words of Dr. Arthur Ruggles of the Butler Hospital, "Once established, it [the Exeter School] has apparently been forgotten."¹⁸

In 1922 the Exeter School began a parole program for its inmates. Parole was a necessary response to overcrowding—in 1923 an institution designed for 240 housed 378, and many of the dayrooms and the halls were filled with extra beds. Since the most able were the ones who were placed out, parole furthered the school's transformation into a custodial institution. The departure of the "higher grade" inmates also affected institutional upkeep, since these residents had shared with the staff much responsibility for maintaining the institution. Ladd found "the result is that, instead of its being difficult to find work for the patients to do to keep them busy, it is very difficult to get the work of the institution done."¹⁹

Parole became a possibility because fear of the feeble-minded had largely receded after World War I. Social scientists had begun to refute the earlier notion that prisons contained a disproportionate number of mental defectives, while eugenicists' simplistic theories of heredity were also being challenged. Important for the decline of the myth of the feeble-minded was the publication of the results of the U.S. Army's alpha and beta tests. The alpha (for the literate) and the beta (for the illiterate) intelligence tests were designed in 1917 for use on draftees. After the war it became known that nearly half of the two million soldiers examined (48 percent of the whites and 89 percent of blacks) had a mental age of thirteen years or less, which placed them in the feeble-minded range. It became obvious that these "scientific" measures of intelligence were in fact culturally biased, and some questioned whether or not intelligence was a measurable entity that existed apart from culture. The uncertainty surrounding the measuring of intelligence, the collapse of the equation of criminality with feeble-mindedness, and the gradual recession of eugenicist thought all helped make the parole of more able patients from the Exeter School an acceptable policy.²⁰

Conditions in the Exeter School were not improved either by in-

17. Penal and Charitable Commission, *Annual Report*, 1917, 4 (hereafter cited as PCC, AR), PCC, AR, 1921, 17; *Providence Journal*, Apr. 13, 1923.

18. National Committee for Mental Hygiene, "Rhode Island Mental Hygiene Survey," 1923, 27; *Providence Journal*, Mar. 21, 1923.

19. PCC, AR, 1922, 8; Public Welfare Commission, *Annual Report*, 1923, 11, 8.

20. Joel Spring, "Psychologists and the War: The Meaning of Intelligence in the Alpha and Beta Test," *History of Education Quarterly*, XII (1972), 3-14; Haller, *Eugenics*, chap. 8; *Providence Journal*, Nov. 13, 1932.

21. *Providence Journal*, Dec. 30, 1928.

creased tolerance for the retarded in the community or by commission reports and exposes. The first development only accentuated the distinctiveness of those still institutionalized, while the commission reports rarely motivated the legislature to appropriate more funds to improve the physical plant or hire more staff. Newspaper stories appeared periodically exposing institutional conditions, but the similarity in these reports over time suggests that little changed. The history of the Exeter School essentially alternates between neglect and scandal.

Another investigation of Exeter in 1928 led to charges that the school was simply a "dumping ground." Three cottages for male inmates were wooden, "antiquated and unfit for . . . use." The basement of one was used as the paint shop and was filled with inflammable materials, and the endemic overcrowding meant that another basement served as a dormitory. No provisions for recreation or entertainment existed in these cottages, and the inmates, when they were not working, just sat around in the dormitories. "When one recollects," said the investigators, "that the dormitories are overcrowded with beds and that only an occasional chair or bench is found in them one can easily understand the tedium they must suffer, and the oppressiveness such an environment must breed." Two hundred inmates lived in the school building in which there were only two or three settees for them to sit on. The institution, which contained 430 residents, had no hospital facilities and only a small room for minor medical treatment. In their conclusion, the investigators issued a sharp condemnation of the institution: "At no time during the twenty-one years of its existence, has it approximated the purpose for which it was established. It was established for the purpose of providing special training for the feeble-minded; it has been from the beginning and is at the present time a custodial institution providing little else than food and shelter for its inmates at smallest possible cost."²¹

The investigators misread their history in part, for the legislature intended the school to have a custodial wing. Within the first decade of Exeter's founding, however, the custodial function had overwhelmed the training one, as the myth of the feebleminded's menace encouraged the use of the school for purposes of incarceration. As noted above, a parole system restored the more able inmates to the community during the 1920s as fear of the retarded receded. However, custodial cases had gradually accumulated, and the parsimony of the state legislature meant the institution was unable to revive its function as a training school. Furthermore, the increase in the patient population outstripped the building of facilities, as relatives and communities rid themselves of an unwanted social problem. By 1928, Exeter was indeed a warehouse for society's refuse.

Revelations about the Exeter School in the 1950s were quite similar to the findings made by earlier investigators. In 1956 Selig Greenberg began a series of newspaper articles that revealed the low budget, the understaffing, and the overcrowding that was the usual state of affairs

Who Was Sent to Exeter?

It was sometimes quite difficult to categorize persons as mentally retarded even after the development of IQ tests. Before IQ tests, measures of defectiveness were frequently behavioral; for example, promiscuity in a woman was used as evidence of mental defect, as was evidence of disobedience or aggressive behavior in school or in some other institutional setting. Similarly, persons who were unable to support themselves and who seemed confused or "slow" could also be sent to an institution for the retarded. Two examples help to clarify how difficult it was to categorize persons as mentally retarded.

GK was born in 1881 and in September 1899 was admitted to the local almshouse. He was temperate, able to read and write, and had supported himself as a laborer, but in 1899 he was unemployed and local authorities thought he was feeble-minded. GK was transferred to the Rhode Island School for the Feeble-Minded in February 1908 shortly after it opened. GK had apparently become accustomed to institutional life during his eight years at the almshouse, but nonetheless at Exeter he soon became a valued worker. He drove the school's delivery truck and his record mentioned that he did his job "better than any man we have ever been able to hire." Despite his ability, GK remained at Exeter because, his record noted, he had only known institutional life, disliked taking orders, and resented having to deviate from his daily routine. Thus, institutionalization became its own justification, and GK drove the school's truck until his death at age forty-five in 1926.¹

DB, on the other hand, was the type of violent offender thought of when people discussed the menace of the feeble-minded. Committed to Exeter at the age of fourteen in 1933, DB escaped twelve times before being convicted of a criminal offense and sentenced to the State Reformatory in 1937. After serving his one-year sentence, DB was freed in 1938. Six months later he was again committed to Exeter, the court record noting that he was "insane." Several more escapes, during which he committed a number of crimes, led to a sentence to the Men's Reformatory. In 1942, DB received his parole, but the following spring he was arrested again, this time for arson.

DB's record listed his IQ as 39, but he was repeatedly able to outwit authorities and to escape confinement. The investigation that followed this notorious case revealed administrative incompetence and confusion. For several months DB was listed as committed to two different institutions, while at other times he was totally without supervision. After his last arrest he was committed to the State Prison, and the investigating committee recommended that he be transferred to the State Hospital for Mental Diseases. DB's ability to escape and commit crime was aided by the state's inability to decide if he was insane, feeble-minded, or simply a criminal.²

It is questionable whether either GK or DB belonged in the Exeter School. Yet both were considered feeble-minded according to imprecise or behavioral measures of intelligence, and there were few alternatives available.

1. Case of GK, Ladd Center Files, Exeter, R.I.

2. Case of DB in *Report of State Commission on Public Welfare Institutions*, 1943, 85-104.

22. Selig Greenberg, "The Forgotten Two Percent," *Providence Journal*, Mar. 11, 1956.

23. Selig Greenberg, "Exeter Penalties Aim to 'Shame' the Unruly," *Evening Bulletin*, Mar. 13, 1956.

24. Department of Public Welfare, *Annual Report, 1957*, 171 (hereafter cited as DPW, AR); DPW, AR, 1958, 173-174.

at the school. Statistics on inmate longevity in the institution showed the custodial nature of care. Of 874 inmates, 541 had been there ten years or longer, 283 for twenty years or longer, and 113 for thirty years or more.²² Abuse of patients also made the news. Greenberg discovered that unruly inmates were locked in the detention room, occasionally for several months at a time. There they had their clothes removed, wore nightdresses, and slept on mattresses on the floor. Residents claimed their diet in detention consisted only of bread, soup, and cocoa, though Ladd disputed the charge. Other inmates scrubbed the floors and stairs late into the night, while disruptive high-grade residents were punished by being transferred into the dormitories of the severely retarded for several weeks, where they endured various humiliations, including eating the ground-up gruel served at meals.²³

In response to charges such as these, the Exeter School attempted to revive its training program. Residents were classified according to three groups: educable, trainable, and custodial. The administration's intention was to bring the most capable up to a fifth-grade academic level, while training the second group to perform simple institutional tasks and bringing them to the kindergarten level of achievement. For the first time, classes were started for the severely retarded, those with IQs below 20. In 1958 an evening school enrolled 150 students, all over sixteen years of age, and provided lessons in academic subjects, music, woodworking, sewing, and square dancing, as well as in learning how to fill out a job application or how to seek assistance in doing so. These changes, however, did little to quiet criticism of the institution.²⁴

Amidst this growing controversy, Dr. Ladd, already well over the state's retirement age, resigned on June 1, 1956. His retirement came after forty-nine years as superintendent of an institution that was, for better or for worse, almost exclusively identified with him. Charges of patient neglect, abuse (an attendant had been convicted of manslaughter

Residents working at the Exeter School laundry, 1956. Courtesy of Providence Journal Company.



ter), and filthy conditions surfaced repeatedly in the 1950s, and led to another state probe in 1958. Although the majority report exonerated the administration (then headed by Dr. John Smith) of accusations of mismanaging funds and allowing unsanitary conditions and patient abuse, the scandals of the 1950s were not adequately explained either to the public or to residents' families. Suspicion clouded Ladd's last years at the institution, and the new administration largely inherited its problems. The renaming of the Exeter School as the Ladd School in 1958 (on the same day that the majority report was issued) was appropriately symbolic. But while dignitaries gathered to honor Ladd, the parents' association assailed the majority report; the "true conditions," they claimed, "have been submerged by an avalanche of words."²⁵

III

In 1964 Dr. Robert Kugel, in an interview with the *Providence Journal*, suggested that at least half of the retarded youngsters under the age of nineteen who resided at Ladd could be placed in foster families. He told reporters that "retarded children are better off in a home-like atmosphere to which they adjust than they are in a state institution." The trend in state care since the 1920s had been to place the most promising. The state adopted home placement only reluctantly, because paid staff had to be hired to perform many of the tasks formerly done by the ing. The state adopted home placement only reluctantly, because paid staff had to be hired to perform many of the tasks formerly done by the high-grade patients, who were the most likely to be paroled. Despite this economic loss, Ladd encouraged placement, commenting that "we've come to realize . . . that cheap institutional care is the most expensive in the long run because the more effectively you can train the feeble-minded and teach them some simple trades, the sooner you can send them back into the community." He suggested that the institution should be a place of last resort and that children be placed in foster families. Ladd focused his attention on the institution he directed and not on the creation of new policy, however, and the state continued to focus on taking higher grade patients out of the institution. While Kugel also framed his discussion with the *Providence Journal* in terms of taking patients out of the school, it was a first step in the reconsideration of state policy for the retarded. Kugel advanced the idea of foster care as a keystone of state policy and as a replacement for institutionalization. Foster family and group-home care would become a rallying cry, as others, especially parents, began to challenge the hegemony of the institution.²⁶

25. *Providence Journal*, Nov. 5, 1955, Nov. 6, 1955; DPW, AR, 1956, 148; *Providence Journal*, Jan. 18, 1958, Jan. 22, 1958, Feb. 4, 1958, Mar. 14, 1958, Mar. 18, 1958; Andrew J. Loiselle, "Preliminary Report of the Advisory Commission to Investigate the Exeter School" (typescript, 1958, Rhode Island State Library). For the parents' reaction see *Providence Journal*, Mar. 16, 1958. Of course twenty years later Smith would be replaced as superintendent during a similar scandal over conditions.

26. *Providence Journal*, June 9, 1964. On overcrowding and placement see *Providence Journal*, Nov. 20, 1937. On Ladd see *Providence Journal*, Feb. 29, 1948. For the resistance of superintendents to the development of parole programs see David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (Boston, 1980), 362.



Tangible results of the value of vocational training programs for retarded students, sponsored by the Parents' Council. Courtesy of the Providence Journal Company.

The Parents Council for Retarded Children and Social Change in Rhode Island, 1951–1970

by Barbara Bair*

"No doubt many of you can recall, as I can, when the retarded child was each family's private—often even its secret—problem. Individually, every parent tried his best to solve the problem. Doctor after doctor was called upon, institution after institution was tried, until at last hope sunk into desperate resignation. There was only one ending to that private, secret road: failure. It has been little more than a decade that a newer way has been tried on a nationwide scale—the way of cooperation, the way of banding together. Instead of the intermittent pushes of an individual parent against the hard wall of prejudice and apathy, there is now the mighty push of millions. And the wall is crumbling."

—CONGRESSMAN JOHN E. FOGARTY, 1961

In the 1950s and early 1960s the options open to the parents of a retarded child in Rhode Island were few. Professionals would almost inevitably recommend that the parents institutionalize their retarded son or daughter. For parents who could afford it, institutionalization meant bringing their child to a private school especially geared to the handicapped. For most parents, however, it meant bringing their child to Exeter (Ladd) School. Many parents chose to keep their children at home instead. Cared for within the family, these youngsters faced life in a society where no organized educational, recreational, or vocational opportunities existed for them. In 1963, John Fogarty, Congressman from Rhode Island, stated that such a "system of care could better be called our system of 'don't care.' And it is among the millions of retarded who remain in our communities . . . that our 'don't care' system has been most vicious."¹ The Parents Council for Retarded Children was organized in reaction to this constrained social environment. In the decades following the council's first meeting in Providence in 1951, parent activists worked together to broaden the options available for their own children and for all retarded people in the state.

For the parents who founded the Parents Council, frustration with the quality of services available for their children had begun with their

* Ms. Bair is a Teaching Fellow in American Civilization at Brown University. She wishes to acknowledge the assistance of staff members at the Archives Office of the Philips Memorial Library, Providence College, where the Fogarty Papers are housed. She would also like to thank James Maher, Helen Turner, Evelyn Trudeau, Jack Kavanaugh, Nathan Sklar, Milton Ferris, and Dr. Zigfried Pueschel, all of whom kindly agreed to be interviewed by the author.

1. John Edward Fogarty, "Educating the Mentally Retarded Child for Living," *Address at the Institute in the Psychology and Education of the Educable Mentally Retarded Child* (Boston, 1963), FS Box 12a F8. The Fogarty Papers have been indexed by Matthew Smith and are part of the special collections at Providence College. Further citations from the Fogarty files will be given according to the Smith Index.

2. Nathan Sklar, Hamden, Connecticut, Interview, Aug. 31, 1981.

3. Milton Ferris, Wakefield, Rhode Island, Interview, Sept. 14, 1981.

4. Evelyn Trudeau, Warwick, Rhode Island, Interview, Sept. 9, 1981.

5. Helen Turner, Newport, Rhode Island, Interview, Sept. 24, 1981.

efforts to get advice and explanations from medical professionals. For most, early diagnostic experiences were characterized by poor communication between doctor and client. This lack of meaningful interchange of information was coupled with most professionals' limited knowledge about the etiology and therapeutic treatment of retardation. As one professional summed up his colleagues' feelings: "the attitude on the part of professionals [in the 1950s] was that there was nothing to be *done*. It was seen as an institutional problem, period."² Such attitudes were partially the result of the lack of training concerning mental retardation given in most American medical schools. In the 1950s, mental retardation—like death or old age—was virtually dismissed as an irreversible or minimally treatable condition. The focus in teaching and training was on the curable and reversible, the acute condition and not the chronic. The emphasis was also on the development of technical, not psychosocial, skills and understandings. Thus the field of mental retardation was avoided as an area of medical failure, full of uncertainties and limited possibilities for professional intervention.

Because of prevailing attitudes about the nature of retardation and the resulting lack of interest and expertise, many parents of retarded children in Rhode Island spent years taking their young children from one practitioner to another, seeking explanations for the slowness of their children's development. Many of the parents who became activists had experiences with physicians who knew that mental retardation was the cause of the children's slow adaptation, but who chose to withhold this information from the parents rather than speak straightforwardly about a condition they felt unable to cure or unprepared to describe in an optimistic way. As one parent recalled, he and his wife "had a retarded child for almost three years before we knew he was retarded. We knew something was wrong, but nobody seemed able to tell you, or to pinpoint it, and we went to some of the best pediatricians. They probably had an idea but didn't want to be the one to tell you."³ Another parent remembered that the physician who delivered her son had recognized that the baby was retarded but continually reassured her to the contrary. "It turned out long afterward," she said, "that he didn't want to alarm us. It was easier for him to say 'just go along,' 'just wait,' and hope we would find out some other way what was wrong."⁴ The couple was eventually given a straight diagnosis—two years and three doctors later.

A mother in Newport went through a similar cycle of worry, consultation, and lack of answers. Although she had been aware of her son's slowness from the first few days after his birth, she was not told he was retarded until he was over three years of age. In recalling her feelings when the practitioner finally told her frankly about her child's disability, she said that she "was *so relieved* to know there was an answer. Actually knowing he was retarded was not upsetting to me—it was . . . the fear, the guessing and still not knowing what was wrong that was bad. I didn't mind, as long as I knew there was a *reason*."⁵

The attitudes of physicians, and thus the kind of information given to the parents of retarded children, was shaped by other factors besides inadequate training. Physicians who had learned little information about retardation in medical school tended to share the popular prejudices and misconceptions about retarded people that were prevalent in the population at large. One such misconception was the old idea, popularized at the turn of the century by Henry Goddard and other Social Darwinists, that retardation was somehow associated with degeneracy or a low income, and thus it was the parents' way of life or socioeconomic standing that was to blame for the child's condition. This class bias was perpetuated by professional attitudes in the 1950s and played an important role in determining the nature of the membership of the initial Parents Council. As one early parent activist remembers, the council members "were mostly nonprofessional people. Parents from different walks of life who had a problem. At that time there were not many professional people coming out admitting they had a retarded child in the family. They were the worst of anybody about admitting it, you know, sort of 'here I am a doctor, or in college, or a university, and I have a retarded child?.' Their attitude was [that] this was unheard of, maybe with a *mill* worker [or some other working class parent] you might expect this, but not [with] a professional."⁶

Some physician reactions to mothers seeking an initial diagnosis for their child were shaped not only by prejudices about retardation and myths about class status, but also by stereotypes about women. Several mothers had the experience of having their concerns dismissed as "hysteria," "overprotection," or implications of failure in the duties of motherhood. When asked to describe the early years of their sons' lives, two women recounted the reactions of doctors during their visits. One remembered that one of the physicians she consulted "seemed to think I had babied him, spoiled him. He thought [the boy] was spoiled rather than slow. If anything it was just the opposite, because we treated him as a normal child." In a visit to another practitioner she was accused of the opposite kind of mismanagement. The physician said to her, "Is *this* the first thing you ever did about this child?" She was incredulous. "Here we'd been taking him to doctors all along . . . and then this doctor talks to me as if our son was the way he was because I'd neglected him."⁷ A third type of reaction was neither an assumption of smothering or neglect but of nervous excitability. As another mother remembers, her baby was noticeably "not right. My mother looked at him, looked at me, and said: 'You better get the doctor over here.' Well, I had called him before and told him we were having so much trouble getting him to eat. He'd said 'Oh, just another overanxious mother' and put my call aside."⁸ These reactions on the part of the practitioners had more to do with their views of the clients presenting the complaints than with the actual retarded children themselves.

A major part of professional attitudes also originated in the general emphasis put on intervention during medical training. Thus choices

6. Milton Ferris, Interview, Sept. 14, 1981.

7. Evelyn Trudeau, Interview, Sept. 9, 1981.

8. Helen Turner, Interview, Sept. 24, 1981.

9. Bernard Farber, *Mental Retardation: Its Social Context and Social Consequences* (Boston, 1968). See also Stanley P. Davies and Katharine Ecob, *The Mentally Retarded in Society* (New York, 1959).

10. Helen Turner, Interview, Sept. 24, 1981.

about communicating information to parents were based not only on popular assumptions and on a desire to preserve authority, but on a sense of hopelessness, a feeling that with retardation there was nothing to be "done." Sociologist Bernard Farber has used the idea of "surplus" populations to describe this kind of fatalistic view of retarded people. Within this framework retarded citizens, like the ill, the disfigured, the aged, the poor, or racial minorities, are perceived as marginal, and therefore expendable, people.⁹ One parent activist recalls encountering this sort of attitude throughout her retarded son's lifetime (1943-1978). For example, when her son was young she read an article in a magazine "about a woman in Chicago who'd taken in these children no one thought could learn. She took them in and taught them practical things like how to cross a street, how to go to the store." Excited by the optimistic tone of the article, and by the possibilities it suggested for her own son, she decided to discuss it with her physician. After hearing what the article was about, he said "They shouldn't be allowed to print stuff like that." He felt such attitudes raised false hopes in what he considered to be impossible circumstances. Years later, when her son was dying in a Rhode Island hospital, nurses tried to comfort her with the "consolation" that his death would be the "best thing" for everyone involved. She had a different view of his impending death because she had a different view of the value of his life. She remembered that after he died a nurse said to her: "We're going to put you up for sainthood." Rejecting the negative view of her son implicit in such a statement, she replied that "No . . . he was the saint, but nobody knew it." She explained the difference between her own view of her son and the ideas about his lack of social worth which were accepted by others: "He was like part of me, the *best* part of me . . . he had so much feeling. There was *so much* more there than people realized by just looking at him. . . . What they didn't seem to grasp was that I *loved* [him] and they can't really understand that. They only think about intellect and forget that love is the strongest force in the world."¹⁰

It was this sort of exasperation with professional attitudes and with the resulting lack of services available for retarded people which led to the formation of the Parents Council in 1951. The establishment of the council was the beginning of the development of a large resource network operating on behalf of retarded citizens in Rhode Island. The term "network" refers to a variety of people who recognize that they share common needs and goals, and who decide to work together to make changes they believe are necessary. The creation of a network is a two-fold process. First, it entails the recognition of limited resources. In the case of the parents network, this meant recognition of the lack of services, funds, knowledge, and training which existed in the area of retardation. Secondly, the creation of a network involves the redefinition of traditional roles on the part of those who become active participants. The formation of a network is a way of "breaking out from the confines of the stance of being passive recipients of what others think these

groups [in this instance, retarded individuals and their families] are and need."¹¹

Why did this process of personal redefinition and deliberate organization for social change occur when it did in Rhode Island history? The activism which led to the formation of the Parents Council in 1951 was actually the result of incremental changes that had begun during the war years. Some of those changes were ideological. The racial assumptions and sterilization and extermination policies of Adolf Hitler caused many people to regard pre-war theories about retardation—theories which were based on similar eugenic interpretations—with new horror. The mass destruction and personal tragedy of the war itself also caused many to re-evaluate their ideas about the basic value structure and purposes of society, and to make a commitment to support humanistic causes.

Besides raising important ideological questions about the nature of human life, the war experience also created a social environment in which ordinary citizens were encouraged to step outside traditional roles. Some of the men who served in the armed forces occupied positions which called for responsibility and decision-making. They were not eager to relinquish these attitudes after the war's end. As one Rhode Island veteran has explained, one of the reasons the parents network began in the post-war years was because "many of us had been in the service, and we came home, and we just weren't ready to take some of the pat answers we used to get before."¹² A process of personal redefinition also occurred for many people who did not serve in the armed forces. Some women, for example, were hired and trained for skilled blue-collar jobs, positions which were alternatives to more conventional housework and pink-collar service jobs usually occupied by women. Women who entered the wage-work force in the war years were also more likely to join a union. Union activity helped men and women alike to develop organizational skills and to have the experience of working collectively to gain reforms on their own behalf.

The parents network in Rhode Island began with a number of informal encounters which made key people aware of the need for an association for parents of retarded people in the state. Evelyn Trudeau, an activist in the network since its inception, remembers one encounter which typifies the sort of exchanges which led to the formation of the Parents Council. Three friends, all young mothers of retarded children and all future activists, had exhausted available resources in their search for services for their children. After inquiring at several facilities they went to speak to Nathan Sklar, then director of Jewish Family and Children's Services in Providence. Sklar had served as a psychiatric social worker in World War II, worked in a mental hygiene clinic after the war, and was involved in organizing services for the retarded in New Jersey before he came to Rhode Island in 1950. The three young women Mrs. Trudeau remembered were among other frustrated parents who had come to speak to Sklar about their concern for their retarded chil-

11. Seymour Sarason and Elizabeth Lorentz, *The Challenge of the Resource Exchange Network* (San Francisco, 1979), 227, 5. See also Alfred Katz, *Parents of the Handicapped* (Springfield, Ill., 1961).

12. Milton Ferris, Interview, Sept. 14, 1981.

13. Nathan Sklar, Interview, Aug. 31, 1981. See also *Providence Evening Bulletin*, Sept. 1951.

14. Evelyn Trudeau, Interview, Sept. 9, 1981.

15. Gunnar Dybwad is quoted from an interview cited in Robert Meyers, *Like Normal People* (New York, 1978), 118.

dren and the lack of resources available to them. Sklar drew on his knowledge of procedures in New Jersey, where a parents group had already been organized. At his urging, an article appeared in the *Providence Evening Bulletin* announcing a meeting to be held on October 24, 1951, for parents who were interested in sharing experiences and working for change. Over one hundred parents arrived at the first meeting, which took place at the Biltmore Hotel in Providence.¹³ Few of those who came were acquainted with other people at the meeting, and most of them had dealt with the decisions about the care of their children alone. The parents network became a way for them to overcome their prior feelings of isolation and to receive strength and support from others living in situations similar to their own. Evelyn Trudeau has described those early days of communication, support, and positive action:

None of us knew each other before, and no one had known where to turn. With our boy we had had no one to talk to. We had no idea of anyone with a similar problem—that was one of the main things that got us together, was just to be able to talk to somebody who understood and shared your problem. And that's how we got started. We knew there had to be someplace, somebody, who could help these kids, and we were going to see to it that they got that help. . . . first we got our initial meeting, then we found who were the doers, then we started meshing. We got a board together, we were able to make decisions, delegate, and get action.¹⁴

This kind of post-war organization and action was not limited to the State of Rhode Island. As Gunnar Dybwad, past executive director of the National Association for Retarded Citizens, has said: "Things began happening in the late 1940s and 1950s in the Scandinavian countries, in America, England, Belgium, and elsewhere. Why? Perhaps because by comparison with what we had seen in the war, we started putting greater value on human life, on human rights."¹⁵ In the United States in the late 1940s several advocacy groups had been formed, many by women in response to the exclusion of their retarded children from public schools. These groups sprang up around the country, notably in New Jersey, Massachusetts, New York, Washington, and Minnesota. The Minnesota group was atypical in that it included many professionals who were also active in the American Association on Mental Deficiency. In the 1950s that organization was progressive, advocating retarded children's rights to diagnosis, care, and training, and endorsing the idea that such services should be provided by public funding when private funds were not available. In the fall of 1950, the Minnesota parents association organized a national convention in Minneapolis. Representatives from twenty-three parents groups attended the conference and voted to confederate their organizations into a nationwide association. Originally called the National Association of Parents and Friends of Mentally Retarded Children, the name of the

organization was changed to the National Association for Retarded Children in 1952 (and later, as the original founders' "children" became adults, to the National Association for Retarded Citizens, in 1973). In future years, this national network became an enormous lobbying force behind federal legislation and appropriations for retarded people.¹⁶

In Rhode Island, in the first year following the initial meeting of the council (1951-1952), a series of lectures, films, and tours were arranged. This was done in a conscious effort on the part of the parents to educate themselves about the causes and treatment of retardation so that, armed with facts, they could plan reformatory action. Speakers invited to lecture at meetings included leaders from the national association, the director of a progressive school for retarded students, and specialists from Boston and elsewhere. Discussion groups were held, funds were raised, and contacts were made with other volunteer organizations. The parents began immediately to push for school and recreational services for their children, to meet with state officials, and to begin scrutiny of Exeter School as a first step in recommending changes there.

By the end of its first year (November 1952), the council voted to become officially affiliated with the National Association for Retarded Children. Throughout the 1950s and early 1960s other parents groups were organized independently in areas outside of Providence. These other groups also became affiliated with the national association. In June 1962 these various groups became affiliated as a state association with several local chapters. By 1968 the state association, the Rhode Island Association for Retarded Citizens, included ten regional chapters with almost a thousand family memberships.

Most of the organizers of the initial council remained strong activists in the parents movement through the years. Some of them became major forces in the regional chapters which were organized around the state. While personalities and styles differed greatly, these early organizers shared certain attributes. Some of these attributes were directly related to the nature of the networking process itself: parents approached the issue of retardation through group action and by sharing knowledge with other parents, a situation very different from the parents' earlier experiences as individuals dealing with professionals on a one-to-one basis. The viability of the networking process was dependent upon the active participation of parents and the successful coordination of their efforts. Both of these necessary elements were taken care of by organizers, people within the network who could see the connections between various members' ideas and interests and who could motivate parents to become active in the association. Such good coordination of action helped to maintain the egalitarian, give-and-take character of the network. One long-time participant has described the energizing results of the early organization as "mass activity" where "everyone was rushing off doing what they could. It was almost as if we had fifteen presidents, not one."¹⁷

16. See Laura Blossfield, "Letter to the Editor," *Bergen Evening Record* (Bergen, New Jersey), Oct. 13, 1946. See also Mildred Thomson, *Prologue: A Minnesota Study of Mental Retardation* (Minneapolis, 1963).

17. Milton Ferris, Interview, Sept. 14, 1981.

J. Arthur Trudeau (1912–1966), standing, a former executive with a transportation company and a self-employed businessman, was a charismatic leader in the Parents' Council. Trudeau is pictured reminiscing about the contributions of Congressman John E. Fogarty, seated, in the field of mental retardation at a dinner honoring the congressman in 1965. Courtesy of Mrs. J. Arthur Trudeau.



Some of these early organizers had similar backgrounds, where friendship ties were formed and leadership and organizational experience was gained. Milton Ferris, the first elected president of the council (1952) and later a leader in the South County chapter, had been active in the Machinist Union at Brown and Sharpe Company in the 1930s. During those union days he became acquainted with John E. Fogarty, who was active in the Bricklayers Union. Fogarty, who gave up bricklaying and union work when he was elected to Congress in 1941 (a position he retained until his death in 1967), had known J. Arthur Trudeau during their high school years at La Salle Academy. Trudeau, like Ferris, was active in the parents network since its beginning, and became a leader in the Warwick chapter in the 1960s. Like the others, he also had organizing experience as a member of the Firemen's Union.

The friendship of Arthur Trudeau and John Fogarty had positive consequences for retarded people which reached far beyond the confines of the State of Rhode Island. As a result of his humanitarianism and the strong ties that developed between Trudeau and himself, Congressman Fogarty became an avid champion of retarded citizens' needs and rights throughout his long career in Congress. As chairman of the House Appropriations Committee he acted to bring about a major shift in the federal policy on retardation. Under his guidance retardation policy be-

came a public health issue, and thus an issue of social and national, rather than individual and private, responsibility.

Congressman Fogarty was first invited to a Parents Council meeting in 1954. He attended the meeting and became reacquainted with his old classmate, Arthur Trudeau. The two soon "became inseparable."¹⁸ Each Saturday Fogarty would return to Rhode Island from Washington D.C.; while he was home, he would keep a standing lunch date with Trudeau and his son, Kenneth Trudeau, who is retarded. Thus Fogarty became an important part of the Rhode Island parents network, taking ideas formulated locally and translating them into federal policy. In his speeches, John Fogarty rarely took personal credit for the social changes his legislation had been able to bring about. Instead, he carefully credited the Parents Council, and Arthur Trudeau in particular, for keeping him aware and making him care as deeply as he did. In 1966, the congressman gave a speech about advances in the field of retardation, many of which had been made due to his influence, and reminisced about the early days of the Parents Council. "I remember as though it were yesterday" he began, "that my long-time friend, the late J. Arthur Trudeau . . . gave me my first real insight into the hell-on-earth that so recently represented existence for mentally retarded children." He went on to say:

In 1954, I was asked to address a small organization in Rhode Island composed of the parents of mentally retarded children. I didn't know much about mental deficiency, so I listened more than I talked. I had heard the familiar statistics about there being five million mental defectives in the country and three hundred more born each day to American families, but I had never before looked into the eyes of parents to whom these children had been born. They told me of the hopelessness of the treatment outlook, of the difficulties of getting these children into any kind of school, of the tragic air of rejection and defeatism which seemed to engulf all professional and public discussion of the plight of these children.¹⁹

Enlightened by contact with parent activists, the congressman set out to reverse public policies that had maintained these negative circumstances for retarded people for so many years. He personally introduced (or managed the appropriations for) several legislative acts which made the changes in attitudes and the kinds of services the members of the parents organization sought realities. His legislative influence resulted in the creation of clinics, sheltered workshops, special education classes, and special education training; the liberalization of actively discriminatory immigration laws; and the funding of major medical research into the causes (and thus the means of prevention) of retardation.

J. Arthur Trudeau's own career within the parents network is illustrative of the kind of coordinating and motivating skills that made the parent organizations successful vehicles of social change. Like John

18. Evelyn Trudeau, Interview, Sept. 9, 1981.

19. John E. Fogarty, "Speech to New Hampshire Council for Retarded Children," Concord, New Hampshire, November 1966, FS Box 15f, F 34; and "Progress Toward Mental Health: A Joint Responsibility," *Address to the National Governor's Conference on Mental Health* (Chicago, 1961), FS Box 10d, F 16.

20. Evelyn Trudeau, Interview, Sept. 9, 1981.

21. Jack Kavanaugh, Wakefield, Rhode Island, Interview, Sept. 4, 1981.

Fogarty, Trudeau had a knack for winning minds by first winning hearts. His wife, Evelyn Trudeau, herself an activist in the network, has described his seemingly omniscient and omnipresent skills as an organizer. She recalls that her husband "was just the go-getter, and the fund-raiser, the contact between people in offices that needed to be linked together, he would open the door, he was everywhere, he was into everything. He was just a born leader . . . he had that charisma, you know."²⁰ Jack Kavanaugh, current director of the La Plante Center (a sheltered workshop in South County) was first drawn into the parents movement by Trudeau. At that time (the early 1960s) the Warwick chapter, which Trudeau had largely led and organized, was trying to begin construction of a sheltered workshop. (The workshop would eventually be completed after Trudeau's death in the mid-1960s and named the Trudeau Center in his honor.) A feeling of depression had descended upon the group because they had just learned that federal funds from the Hill-Burton Act, which they had expected to use for construction, could not be used for building the center after all. Kavanaugh remembers the situation and Arthur Trudeau's ability to spur the despondent into action. As he recalls: "Arthur Trudeau did the best job of rallying shattered morale that I've ever seen. Arthur energized us into the responsibility of raising the money in the community, through our own efforts. And Arthur's rallying cry—he was the only person I've ever known who could say 'I have every confidence' and make it sound like he had an absolute ironclad guarantee—Arthur said 'I have *every* confidence we *can* do this!'; and stirring in our seats we said 'Right, Arthur!'—little knowing we were about to change our entire lives."²¹

While male organizers tended to be those elected to formal office, female organizers also existed in the parents network, usually in less of a limelight. Notable exceptions to this rule are Elizabeth Boggs and Eunice Kennedy Shriver, both highly visible major leaders in the national retardation-advocacy network. On the local level the majority of members of regional chapters were women. However, few of these women are listed as officers or directors on organizational letterheads through the years. Within the parents organization women tended to be designated as the "doers," while men tended to become the "directors." One woman, who had been active since the first formation of the council in 1951, described this tendency. She remembered that when it came to electing officers, "then you got into that male chauvinist idea that only a man can be president, only a man can be a boss—you know—it was usually a female who would end up having to be the secretary or treasurer." In her opinion, "there were probably some of the women who would have been better qualified to take on as president or something like that, but back in those days women supposedly 'couldn't' do anything like that."²²

The fact that women were not generally represented in official positions of authority does not accurately portray their actual strength or impact within the movement. More important, women formed the

base of grassroots activism. The Parents Council's first elected president, Milton Ferris, described the membership of the early parents organization as "mixed, both husbands and wives, with a leaning toward the women." He went on to stress that "all through this whole movement they were—the women were—the driving force. You'd get a few people who had experience on their side and could provide a good impetus there, such as myself . . . and Arthur Trudeau, he was a spark-plug. But mainly, there were the women. Through time the husbands would drop out, . . . but the women, they were the real doers."²³ This tendency was not exclusive to voluntary action on behalf of retarded people. Most voluntary associations, whatever their focus, are maintained by women activists, who are more likely to participate and more likely to sustain their membership than men.²⁴ A 1968 study of the Providence chapter of the Association for Retarded Children found that "the average member is a white female between forty-six and sixty-five years of age. She is a married housewife, who sometimes works [for wages, outside the home]. She is Catholic, votes Democratic, and is a high school graduate. Her family income is between \$5,000 and \$10,000."²⁵

The process of role redefinition, the shift from passive to active roles and from personal to group action, is basic to participation in a network. For women who became active in the parents network this process was not so much an actual redefinition as an extension of conventional "female" roles—those of mother, teacher, home manager, or nurse. For many of them, participation in their local chapters grew out of the fact that their retarded child was considered to be their personal responsibility. As one woman activist has explained: "I was very fortunate. My husband and I shared the situation. In very many of the cases [of families with a retarded child] it was different, because the father would refuse to accept the situation, he saw it as a reflection on him. In a good many families the father just ignored it, and anything that was done was done by the mother. She had to take care of the child all day long, but also had to take over any other chores, things that needed to be done. She also would have trouble getting free to come to meetings because the husband took no responsibility."²⁶ Most women with retarded children relied on their own personal networks for support. They turned to mothers, sisters, sister-in-law, and women friends and neighbors for the advice, aid and skills needed to deal with their situation. Unlike most male members of the parents organization who had gained their organizing skills from the wage-work, military, or political realms, women who became organizers acted from experience gained within their family and personal support networks.

Arthur Trudeau's work in the Warwick chapter and his association with Congressman Fogarty is representative of the first style of organizing. The contributions of Helen Turner, who was active in the Newport chapter in the 1950s and 1960s, are illustrative of the second sort of orientation. Dissatisfied with the level of education being given

22. Evelyn Trudeau, Interview, Sept. 9, 1981.

23. Milton Ferris, Interview, Sept. 14, 1981.

24. See Ethel Miller Adams, *A Study of Volunteers in Five Community Areas* (Philadelphia, 1964) and W. G. Mather, "Income and Social Participation," *American Sociological Review*, VI (1941). See also Herta Loeser, *Women, Work and Volunteering* (Boston, 1974).

25. Robert Segal, *Mental Retardation and Social Action: A Study of the Associations for Retarded Children as a Force for Social Change* (Springfield, Ill., 1970), 24.

26. Evelyn Trudeau, Interview, Sept. 9, 1981. See also Renee Portray, "Impact of the Mentally Retarded Child on the Family" in International League of Societies for the Mentally Handicapped, *Session on Mental Retardation* (Washington D.C., 1966), 3-22.

27. Helen Turner, Interview, Sept. 24, 1981.

28. Milton Ferris, Interview, Sept. 14, 1981.

to retarded children at Newport's Friendship Street School, Mrs. Turner visited a preschool class that had been started in Pawtucket. Inspired to improve conditions in her own town, she returned to Newport and found some classrooms owned by the local school department that were not currently being used. She then organized a new school in those classrooms. When she recalled the process of organization of the new school, she remembered that the first step was to see the vacant rooms and get official permission to use them. The rooms "were perfect, you know, real classrooms. Of course, if I had gone—I'm just *nobody*, you know, just an ordinary housewife—but Jim Maher, who's really the guiding light who's put the chapter where it is today, called in. He called the Housing Authority and got permission to use the building." The second step was to assemble the necessary staff. Mrs. Turner "found a couple of certified teachers who were home with small children and talked them into coming in with our kids." After recruiting these mothers, she turned to another untapped segment of female support. "For volunteers," she went "over to the War College and set up a table to get Navy wives to volunteer, and they did." She felt that "those women were so wonderful . . . if a child needed changing these women changed them, if a child got sick, they cleaned up after them. We had one woman I will never forget. She was great. She had a degree in Speech and she came to me and volunteered to come in twice a week. She came and set up materials to use with the kids to help them with their speech."²⁷ Helen Turner had organized a school by recruiting women whose interpersonal skills, learned in caring for their families or in pursuance of their careers, were crucial to its successful operation.

The bottom-up, or grassroots, changes brought about by organizers like Trudeau or Mrs. Turner, and many others in the parents network, were significant. As one activist has noted, the parents organization "became stronger and stronger and stronger. The more power they were able to exert, the more volunteer people could shape professional peoples' viewpoints."²⁸ The changes in attitudes which were brought about through organizational efforts were also translated into services. A diagnostic clinic was opened, recreational programs were funded, scout troops and camps were begun, sheltered workshops were put into operation, and special classes were developed. The process of redefinition that started with the roles of the parents themselves also encompassed the roles played by retarded people, and spread "upward" to professionals and public officials. While parents who had been passive and doubtful became active and knowledgeable, retarded people who had been isolated and dependent developed greater social skills and feelings of worth. Likewise, teachers who had no interest in teaching retarded students before activism forced changes in educational policy became trained in special education. Researchers who had not considered retardation as a topic became experts in the field. And physicians who had



once had nothing but institutionalization to recommend found themselves with greater options to consider.

The parents movement influenced local politics as well. The successful passage of bond issues for services for the retarded, and the legislative establishment of the Office of Mental Retardation are examples of the influence of the parents network on state policy. Association members would organize in support of a bond issue, make telephone calls, contact newspapers, and make use of television interviews, bumper stickers and advertisements. They would also demonstrate the size of their interpersonal network at the polls. The influence of the network went beyond the actual members of the parent organizations. One organizer explained the political significance of this fact:

You're talking about almost a thousand members. Now you're talking about families, and the influence these families have with

Nursery school program initiated and operated by the Parents' Council. The Council also established and funded model classes for moderately retarded children and adolescents at the Windmill Street School in Providence in 1954. Courtesy of the Providence Journal Company.

29. *Ibid.*

30. Segal, *Mental Retardation*, chap. 9.

31. James Maher, Newport, Rhode Island, Interview, Sept. 10, 1981.

grandparents, with brothers, sisters. So you're talking about quite a deal. Because the friends and neighbors near a retarded child were very interested in the child too. So we could probably multiply ourselves by twenty . . . when it came time for a vote we'd have whole darn neighborhoods on our side, people who knew the families, had been feeling something for them, wanted to help. Everytime we had a referendum for the retarded in the State of Rhode Island, ever since we formed in 1951, there were more votes, more people voted on those issues for the mentally retarded than any other issue on the ballot.²⁹

Fear of future cutbacks lay behind the fight for permanent establishment of the Office of Mental Retardation in 1967. Other questions, such as which department should administer Ladd School and whether the Office of Mental Retardation should have a separate budget and power to administer bond money, were also at issue. Again, interpersonal connections and grassroots action had a good deal to do with the success of the association's point of view. The bill supporting the permanency of the Office of Mental Retardation, H-1838, was sponsored by Representative John Hogan, brother-in-law of George Gunther, then president of the Rhode Island Association for Retarded Children. With the pressure from calls and letters from members of the parents groups, and support from key members in the House and Senate, the bill was passed by the legislature, but vetoed by the governor. However, support for the legislation was strong enough that the veto was overridden and the bill became law on the last day of the legislative session in spring of 1967.³⁰

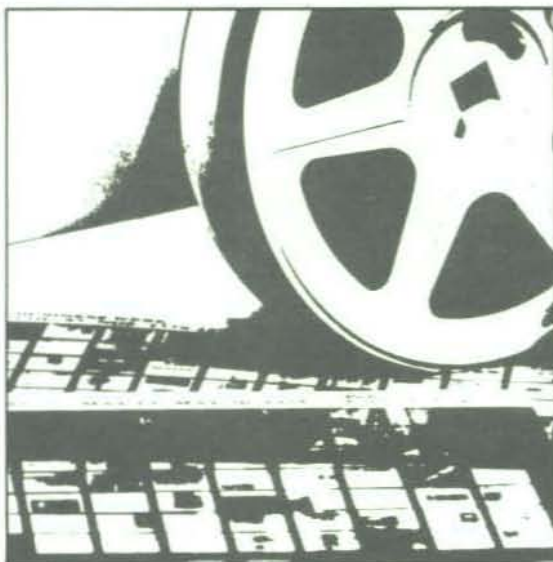
Ironically, the successful fulfillment of short-term goals resulted in the demise of parent activism and the end of the cohesiveness of the original parents network. One reason for this demise was the failure of new parents to join the movement or to see the need for group advocacy. Those parents, whose retarded children were born in the 1970s, had services available to them that the parents of retarded children who were born in the 1940s and 1950s had created. James Maher, a leader in the parents movement in Newport, has summed up this ironic state of affairs by saying that "the energy and enthusiasm of thirty years ago came from trying to make something when you had nothing."³¹ Once "something" existed, notably sheltered workshops and special education classes in public schools, the motivation for activism was lost.

By the 1970s, the parent organizations were characterized by many dues-paying but nonparticipating members, and a small core of veteran activists. Factional lines deepened and old mainstay volunteers became disillusioned as interpersonal networks were superseded by new business-like facilities with paid staffs. The process of role redefinition so central to the organization of the parents network was reversed, and informal future-oriented, grassroots activism gave way to formal bureaucracies engaged in the provision of day-to-day services.

However, the essential issues behind the rise of parent activism in the 1950s have not been changed. At bottom, the formation of the parents' network raised important questions about dominant social values and strengths of individual lives, both of the parents involved and of the retarded people they knew and loved. It was an example of social changes that are possible through collective action. It was also a statement about toleration and respect for differences among people—a working illustration of the type of humanism which John Fogarty once called "a kind of 'selfish unselfishness.'"³²

32. John E. Fogarty, "Speech to the 15th World Health Assembly," Geneva, Switzerland, May 15, 1962, FS Box 10a F5.

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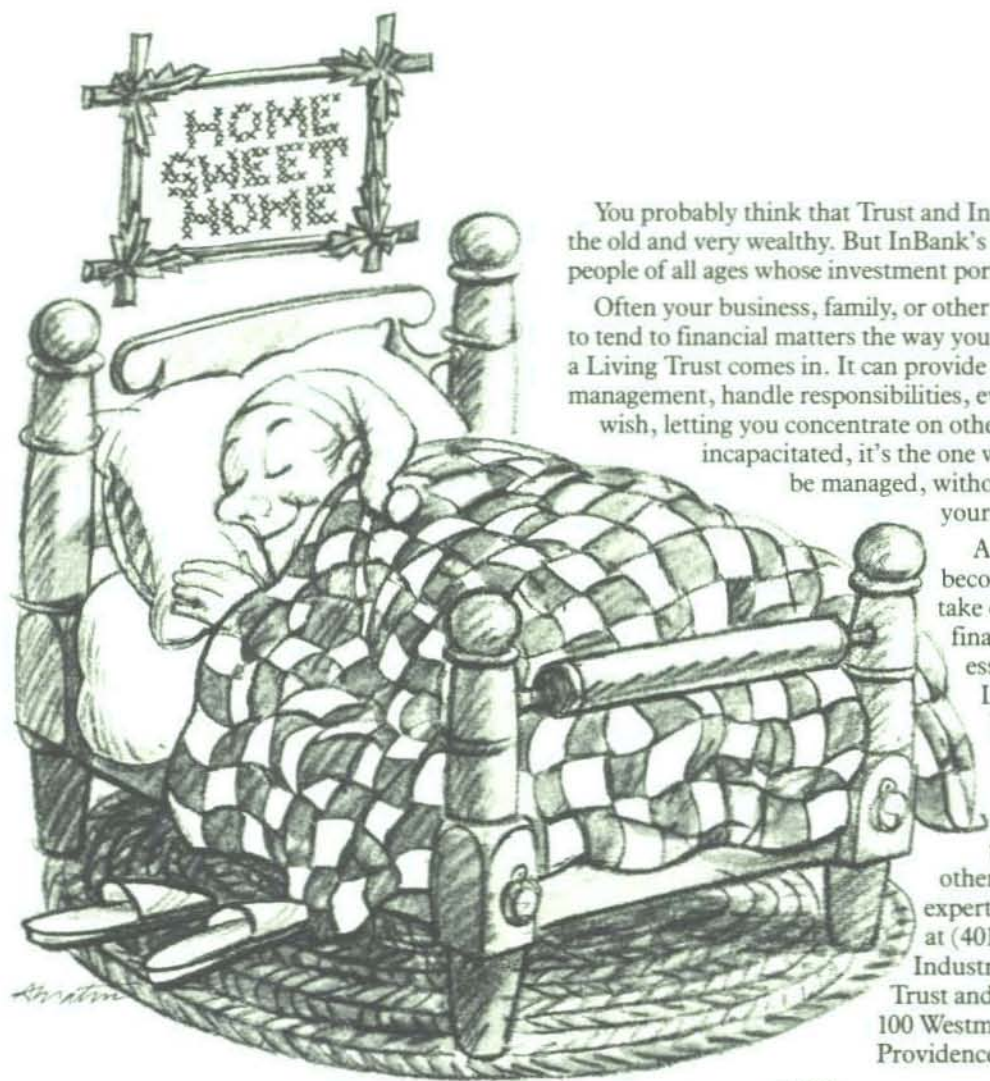
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