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Looking Back

Ancient Greece Through the 19th Century

As early as ancient civilizations (Chahira, 2006), there is documentation of a range of responses to “the atypical human” from fascination to revulsion (Barrett, n.d.; Longmore & Umansky, 2001a). Examining images and text historically is always an interpretative practice; thus, we urge the reader to consider that our interpretations are made on the interpretations of others. However, the benefit of looking at history without assuming its truth value gives us a two-way, opaque, but important window on how civilizations responded to embodied difference and how our own interpretation of that response foregrounds the values and prejudices that undergird our 21st-century stance (Cohen & Weiss, 2003; Rose, 2003). In this chapter, we visit diverse notions of and approaches to atypical bodies through chronological and varied geographic contexts up through the end of the 19th century as the basis for understanding the evolution and roots of current definitions of and responses to disability. An investigation of historical text directly or indirectly focusing on disability reveals the following commonalities:

1. What is atypical differs according to context.
2. In each era there have been several potential, assumed, and accepted explanations for a single atypical human characteristic.

3. These explanations form the basis for legitimate categorization and subsequent response to category members.
4. The responses proffered provide an analytic window on the beliefs, values, politics, economics, intellectual trends, and level of technological development of the times, as well as a reflective platform on how current definitions of disability influence how we interpret history (Rose, 2003).

A Lexical Lens and Disability

Historical scholars such as Olyan (2008), Chahira (2006), and Rose (2003) have analyzed text, image, and artifact as the basis for cobbling together historical events and their meanings. Given the evidentiary primacy and availability of text (Clapton & Fitzgerald, 1997), we therefore enter our history through a linguistic portal as this symbolic element of social and cultural groups is critical and often the central data source through which to interpret contextually embedded values and meaning (Baudrillard, 1995; Belsey, 2002).

Looking through a lexical lens, the term *disability* has only recently become a signifier for the grand category of atypical bodies. Early Islamic literature does not contain a single term for embodied conditions, but rather tethers what would be considered today as disabled to illness of the body and heart (Rispler-Chiam, 2007). In the Western world, disability's predecessor, *handicap*, was alleged to have emerged from the cap-in-hand proclamation, in which Henry VII in 1504 CE, recognizing the plight of injured soldiers, formally allowed these worthy citizens to beg in the streets as a means to their own subsistence. More broadly, the recognized use of the term handicap is an equalizing scoring system in which less competent or accomplished persons are artificially advantaged to increase the likelihood of their success when positioned against a superior opponent. In the early part of the 20th century, the term handicap was apprehended by medicine and ascribed to individuals with bodily differences that ostensibly placed them at a disadvantage. Ultimately the word *handicap* in this sense came to mean a specific embodied condition such as a physical or mental handicap. Given the current pejorative notion of bodily inferiority, it is no surprise that a euphemistic term to replace *handicap* was sought to describe bodies that did not conform to the "typical." It is curious that the term *disability* was selected as a respectful replacement for handicap, given that the prefix *dis* emerged from DIS, the name given by ancient civilizations to the ruler of Hades, or the underworld. DIS was portrayed as punishing mortals by extracting their health, well-being, and capacity to function in their environments.

Unfortunately, that we must approach history with current language creates conceptual confusion, and thus we ask you to bear with us and consider

Rose's (2003) dilemma. As she indicated, the nascence of medicine, the historical absence of diagnostic categories, and the critical differences in how economic, cultural, political, religious, social, military, and technological elements of environments were configured and played out over history, which renders the lexical term but not the phenomenon of disability, irrelevant to times before the 20th century. But how does one communicate to a contemporary audience for the purposes of historical analysis without naming the entity under scrutiny with familiar contemporary parlance? Naming disability as the object and subject of study presupposes that it existed and was recognized, albeit differently. We have attempted to partially resolve the quagmire by using the terms typical and atypical to denote a full range of frequency of behavior and appearance, from most to least respectively. As we discuss in detail in other chapters, we have selected this terminology rather than normal/abnormal or able-bodied/disabled to circumvent the value judgments that are embedded in them and to reflect the absence of both of these binaries in historical data (Rose, 2003). With that clarification, let us now gaze back to antiquity.

Early Civilizations

Ancient Greece has caught the intellectual attention of disability history scholars for several reasons. First, there is a fertile body of recorded text and imagery that portrays what we refer to today as impaired bodies. Second, the thinking of Greek philosophers is considered timeless as ancient thinkers have advanced ideas that remain relevant and potent in the 21st century (Thiher, 2002). Third, Ancient Greece provides a complex historical tapestry from which threads of current attitudes and practices toward human difference continue to be respun into new cloths. Fourth, the Greeks were technologically and intellectually sophisticated and thus have great relevance to contemporary times.

A prevalent belief expressed in disability studies literature about the Ancient Greeks was their antipathy toward those with bodies that were at the extreme ends of the atypical range. Responses were ostensibly the expulsion of these bodies from Greek communities, resulting in death (Braddock & Parish, 2001). However, Rose (2003) cautions us to eschew such simplistic and monistic analyses of disability history in Ancient Greece given the complicating factors of geographic expansiveness and naturally circumscribed cultural diversity. So when we speak of Ancient Greece we are referring to the *Greeces* that encompass the multiple elements of Greek culture.

It is curious that the present use of the prefix DIS is consistent with the recorded devaluation of atypical bodies in Ancient Greece reflected in classic myths such as the *Iliad and the Odyssey* (Rose, 2003). Similar in role and

function to our art and media today, these and other myths reciprocally depict and enshrine value (Harrison, 2006). From analysis of these texts and other symbols, it appears that those who were mildly atypical experienced a range of support and inclusion in community life from none to full but that in many areas, extreme deviations from the typical were considered inhuman (Braddock & Parish, 2001; Martin & Volkmar, 2007; Rose, 2003), particularly in newborns. As we noted above, there is significant disagreement among scholars regarding the interpretation of legitimate responses to atypical bodies in Ancient Greek civilizations. Rose asserts the inaccuracy of the prevailing view of Greeks as murderers of deformed neonates who were allegedly labeled as monstrosities and expelled from communities to die. She does not deny this practice but claims its limited occurrence across the Greeces. Rather, analysis of myth and symbol reveal the historical common denominator of multiple explanations and responses to atypical bodies and minds on the basis of why the atypical had occurred, its frequency, and whether it could be cured (Rose, 2003; Thiher, 2002). For example, baldness, a typical referent that was conceptually located adjacent to weakness, incompleteness, and other conditions that were explained as imperfections, was tolerated but not valued (Rose, 2003). Supporting Rose's assertion about the pluralistic responses to atypical bodies, Hephaestus, the god of fire, was portrayed as mobility-impaired but with extraordinary power that immortalized him in Greek mythology as magical (Yong, 2007).

Curiously, inferior intelligence was ascribed to the descriptive condition of the inability to hear (DePoy & Gilson, 2004; Rose, 2003). Note the similarities of our contemporary "diagnostic" practice of labeling those whose performance is inadequate on IQ tests as cognitively impaired. Similar to the Greeks, intelligence is used as a grand abstract term that is inferred as a set of capacities and skills and then tautologically reified through observation of those definitional elements. A primary difference between the Greeks and contemporary Western cultures in assessing intelligence lies in the asserted indicators of the construct. As we examine throughout chronological time, because explanation is an inference, multiple inferences such as one's level of intelligence, goodness, or moral judgment have been inductively theorized, ascribed to human behaviors and indicators, and then counted to ensconce these theories as truth (Baxter, 2007).

While the explanation for human variation in activity in ancient civilizations did not meet the criteria for viable science according to contemporary positivist models, Aristotle's early scientific studies and systematic description of the observable world provided a means to identify what was "natural," through what we would consider empirical or logical methods. At the same time, Hippocrates development of medicine and the application of empirical knowledge to treating illness placed rational thought somewhat in

opposition to previous mystical explanations of atypical activity. The permeable boundaries between philosophy, literature, and science created a fertile ground for defining, observing, and metaphorically depicting the natural as its opposite, alterity (Thiher, 2002).

When atypical activity was explained in immoral terms, the community, not surprisingly, was not amenable to providing support. However, when atypical performance resulted from war injury—where the explanation was known and considered to be heroic—some cities maintained a pension fund to be made available. (To what extent funds were disbursed to women is not known; however, women were not allowed citizenship status and likely were not eligible for funds.) Thus, as far back as ancient civilizations, variations of the human condition were identified in contrast to what was typical, and some explanations for extreme variation were met with legitimate acceptance and supportive responses while others were not tolerated (DePoy & Gilson, 2004).

Table 2.1 identifies the values and contextual factors of the ancient Greeces that were important in shaping views of what was typical and atypical—how those activities, appearances, and experiences were explained and what values legitimated who was considered human, subhuman, and/or superhuman.

Table 2.1 Contextual Factors in Ancient Greeces

Context	Contextual Factors
Dominant social values	Emphasis on beauty, perfection of form, loyalty to the state, hard work for the benefit of Greece
Geographic/natural	Southern Europe isolated from surrounding area by mountains; maritime travel still primitive
Economic	Agricultural sufficiency supported city dwellers; trade routes established across the Mediterranean
Political	Greek world organized into city-states; highly effective fighting techniques established them as leaders in war; earliest democracies provided one vote/one man for all citizens of the state (male landowners); social organization promoted through rhetorical public debate
Religious	Polytheism; knowledge of the gods transmitted through story; divination
Intellectual	Organization of knowledge by Aristotle; development and standardization of education; medical studies by Hippocrates; spiritual and supernatural hegemony

Spotlighting different histories, we turn our attention to literature from early Jewish, Christian, and Muslim civilizations. With the exception of some human differences such as short stature (Chahira, 2006), atypicality was not a popular or seminal topic of discussion in existing texts and documents. However, text from the Hebrew Bible, early Christian and Muslim documents, and images of the times are rife with symbolic referents to diverse atypical human conditions, appearances, and behaviors. Analysis of these precious snippets reveals four major themes relevant to atypical bodies (Clapton & Fitzgerald, 1997; Olyan, 2008; Yong, 2007):

1. There is no grand category of disability discussed in the Bible or other theological documents examined.
2. Categories of specific “defects” are aligned with devaluated, stigmatized, and excluded status.
3. The Hebrew Bible is replete with binaries such as ugly/beautiful and lame/not lame, and the devalued category of the binary is most frequently linked to terms depicting descriptors that might be included in contemporary disability definitions (e.g., ugliness linked to lameness).
4. While specific disease and defect are treated somewhat differently, most are residents of the “undesirable neighborhood.” Some imprisoned there more than others.
5. Responses to people with embodied differences are diverse.

From textual analysis, it appeared as if Islam was more extreme in its marginalization of “defects” than the Hebrews, but both shared a metaphoric and textual disdain for atypical bodies and behaviors. According to Rispler-Chiam (2007), Islam viewed specific embodied conditions as “illness of the heart” (p. 9) yet the writings about atypical conditions, illness, and incapacity are complex and contradictory. The extent to which “illness” is caused by Allah is uncertain, given the internal inconsistency of the text. However, the term *unbelievers* emerges in many of the writings related to illness, providing the opportunity for cure if the afflicted become legitimate believers (Rispler-Chiam, 2007).

In the early Jewish theological texts, those who were “blemished” were prohibited from joining the Jewish priesthood because of spiritual beliefs that only priestly perfection should link God and the earth (Abrams, 1998). However, congregation members did not carry those same expectations for earthly matters; thus, those with atypical appearance were permitted to be full participants in spiritual activity. Even with the permission to worship, those who were atypical in Jewish communities were in large part viewed as punished by God. The explanation for atypical appearance and activity was therefore spiritual

and moral reprehensibility. As we will see in the next chapter, the beliefs and attitudes of these so-called primitive early civilizations continue to inhere in current thought and praxis. Curiously, in Egypt, representation of individuals with short stature suggested that this group was well integrated into Egyptian society providing that functional deficits were not present (Chahira, 2006).

The references to disability in early Japan differ according to religion. Shinto texts suggest that a disabled offspring was caused by impurity of the parents (Nakamura, 2006). The metaphoric story of the Leech child is curious in that the disabled infant is excluded but returns as a deity, revealing the complexity of embodied difference (Nakamura, 2006).

Buddhists looked to bad Karma from previous lives as the causal element of atypical conditions. Yet the centrality of compassion in Buddhism rendered obligatory responses of care. Confucianism situates responsibility for embodied difference within a royal hierarchy, with the emperor at the accountability helm. Those who were least able to work were most devalued.

Middle Ages

There is limited knowledge of disability in the Middle Ages, with the majority of the literature focusing on Western civilizations. This part of our historical journey, while taking some short voyages beyond Europe, is therefore lexically and analytically situated mainly in Judeo-Christian civilizations and interpretations. According to Metzler (2006), who concentrated her inquiry on Europe, the negative stigma currently held about the Middle Ages as intellectually vacant both limited scholarly investigation of disability in this era and further glazed the analysis with pejorative and inaccurate assertions of disability being exclusively linked to sin and punishment. Evidence from accounts of miracle healings, theological literature, the scant medical writings of the era, and images in art indeed reveal that the typical Western European tapestry against which the atypical emerged was frayed and threadbare, characterized by pervasive poverty and deprivation (Farmer, 2002; Metzler, 2006). Although there were variations circumscribed by diverse geographies, cultures, and beliefs (Green, 2006), human conditions such as blindness, deafness, and lameness associated with impoverished living conditions were woven into daily life and image (DePoy & Gilson, 2004; DePoy & MacDuffie, 2004; Green, 2006). As discussed above, terms such as disability, impairment, and illness were not part of the lexicon of the Middle Ages. Rather, Latin words such as *imbecillis*, *deformans*, and *defectus* were used to describe embodied phenomena (Metzler, 2006; Yong, 2007). Curiously, because of their association with extreme poverty, these conditions and others such as blindness or lameness were typical and thus were not central to aberrant identities (Green, 2006). As

we noted, there is significant disagreement on the extent to which supernatural and divine explanations were ascribed to impairments. Different from Braddock and Parish (2001) and Winzer (1993), Metzler suggested that as the Middle Ages unfolded, the emergence of medicalization, albeit unlike contemporary medical thinking and practice, started to unseat sin and divinity as the major legitimate explanations for and responses to disabling conditions. The importance of the church in the Middle Ages cannot be diminished however. Embodied difference in appearance, behavior, and experience spanned the theological explanatory range from monster to miracle, and according to Yong (2007) was interpreted as a concrete sign of God's creativity.

Among historical accounts of disability in Islamic nations, Rispler-Chiam (2007) notes that there is disagreement among scholars regarding the degree of tolerance toward individuals with atypical appearance and behavior in the Middle Ages. Because of the variety of explanations for the occurrences of extreme difference in activity, appearance, and experience (from sin to supernatural and natural causes), treatment and community responses were diverse across the globe (Green, 2006).

Of particular note was the growth of institutional and charity approaches to individuals who were atypical, particularly for those who were not embedded within strong kinship systems of their own (Farmer, 2002; Green, 2006). The seeds of faith-based hospitals were sewn in the Middle Ages, as it was not unusual to find members of the clergy in the Christian religions, Islamic societies (Barrett, n.d.), and Buddhist Monks in the Far East (Nakamura, 2006) providing medical treatment to those who were considered ill. The role of faith in healing also has its roots in the Middle Ages. People who could not see or think as most others did, among other human differences, were often the objects of faith healing, a practice that provided concrete evidence of God's love, presence, and power (Finucane, 1995).

Charity in the form of service and almsgiving exonerated the giver in the eyes of God, once again providing a purposive explanation for the extremes of human difference. Through the work of St. Francis of Assisi, the suffering of the poor and sick (particularly individuals with leprosy) gave a moral role to the recipients of care as well as those providing care. Faith-based care for those who approximated the low end of worth was born and now serves as the archetype of contemporary secular charities and institutions (DePoy & Gilson, 2004).

Consistent with Metzler's (2006) claims about the unrecognized richness of the Middle Ages, Braddock and Parish (2001) refer to evidence of some town support for people with atypical thinking and other forms of activity. However, because of the extreme poverty of the population at large, they note that many families would not have been able to provide long-term support, and so it was not unusual to find atypical individuals ultimately turning to begging for survival. This phenomenon is reflected in the literature

and artwork of the times, in which beggars are often depicted as individuals who are blind and lame (DePoy & Gilson, 2005/2006; Farmer, 2002).

Not all differences were tolerated even if they were attributed to or associated with poverty. In areas where the population believed in demonic explanations for aberrant bodies, those who behaved in ways that were described as “mad” were feared and persecuted as witches. Increasing social disorder in part was attributed to such individuals, and their murders therefore served as a rallying point for the masses (Stiker, 2000).

Table 2.2 summarizes the seminal contextual factors that shaped explanations of and responses to atypical bodies during the Middle Ages in Western Europe.

Table 2.2 Contextual Factors in the Middle Ages

Context	Contextual Factors
Dominant social values	Catholicism, charity, homogeneity
Geographic/natural	Bubonic Plague killed nearly half the population in Europe in the mid-1300s CE
Economic	The population initially engaged primarily in rural farming through feudalistic arrangement; labor shortages pressured wages upward; monetary system developed; urban centers developed; technological advances improved agricultural production; medicalization emerged
Political	Manorial lords held power over serfs through landownership in exchange for military service; Catholic Church sponsored the Crusades; professional guilds controlled membership and production standards as towns developed
Religious	Primacy of Catholicism throughout England and the rest of Europe initially, challenged by Luther and Calvin in the 1500s CE; waning power of the Catholic Church, especially in England, resulted in the Reformation, a time of persecution for Protestants and other heretics
Intellectual	Intellectual advances were primarily in the area of religion, as reconciliation was attempted between the existence of hardship, mishap, and monstrosity on the one hand and belief in an all-knowing, loving God on the other

The Enlightenment

Moving forward in chronology, as the complexity and differences around the globe became known to civilizations, history outgrew its boundaries as a single narrative of one's own people. However, similar to our discussion of the Middle Ages, the majority of analyses of disability during this era occur through a Western European lens.

In Western Europe and traveling across the Atlantic Ocean to the fledgling United States, an amalgam of both enlightenment and religious thinking prevailed. As the belief in the supernatural was slowly being dethroned by science at the end of the Middle Ages, views of difference were being drastically altered. Advances in scientific knowledge about the anatomy and physiology of the human body contributed to a growing sense that illness and differences in human activity could be explained by observations in the physical world (Stiker, 2000). These views are reflected in the literature and art of the Renaissance period (McClellan & Dorn, 2006; Thiher, 2002). For example, Francis Bacon was particularly important in advancing the systematic study of these observable phenomena (Michalko, 2002; Weller & Wolff, 2005). In 1605 CE, Bacon published *The Advancement of Learning, Divine and Human*, in which he refuted the notion of moral punishment as the cause for behavior that was considered "mad." Humanism in art, emphasizing actual knowledge of underlying physical form, also emerged at this time, depicting detailed and accurate representations of the human body (Nauert, 2006).

Central to shaping notions of the desirable human form were Leonardo da Vinci's creations. Despite Herculean male proportions, da Vinci's Vitruvian Man became the gold standard on which architecture hung and still hangs its form and function hats (DePoy & Gilson, 2007; Margolin, 2002). Moreover, the separation of mind and body with the mind characterized as logical and triumphant over and controlling of the flesh (Michalko, 2002) located disability within the weakened body, opening it up for scrutiny and cure. The power of this perspective slowly became globalized in non-Westernized, nondeveloped countries during Renaissance colonialism (Livingston, 2005). Yet, as noted by Livingston (2006), the divergent perspectives on the nature of humans between Western and non-Westernized cultures were in conflict limiting the application of rationale individualism that formed the basis for embodied notions of disability to understanding disability in African civilizations.

In the West, moral explanations of difference in human activity, appearance, and experience did not disappear as philosophers, clergy, playwrights, artists, and others continued to illustrate the metaphoric use of atypical bodies and minds to communicate diverse meanings (Mitchell & Snyder, 2000;

Thiher, 2002). Thiher points to the centrality of Shakespeare and Cervantes in shaping contextual notions of madness that still prevail today.

Explanations for the distinction between atypical birth-based and acquired human characteristics were developed during this time (Stiker, 2000) and served as platforms for value distinctions as well. For example, some birth-based failures in activities necessary for typical growth were explained as “monstrosities,” while differences in what individuals did that resulted from observable explanations such as injury were regarded as natural (Stiker, 2000). Distinctions were drawn between activity, appearance, and experience that were consistent with what today would be referred to as mental illness and mental retardation (McClellan & Dorn, 2006; Thiher, 2002; Yong, 2007).

As in early civilizations, the legitimate response to people who behaved in atypical ways was in large part influenced by how these behaviors were explained and how the explanations were valued. Moving forward in the Enlightenment era, however, brought increasingly complex explanations for all human activity, appearance, and experience, including the atypical. Particularly of note in Westernized developed countries, as religious hegemonic explanations gave way to philosophical and systematic intellectual rationales (McClellan & Dorn, 2006), the interplay of economics and social factors in influencing analysis of all human experience emerged and influenced explanations of the atypical as well.

For example, the population of the poor often contained a disproportionate number of individuals who exhibited atypical activity and appearance. As evidenced by the English Poor Laws, social explanations for these differences were met with resources, while explanation seated in individual blame was not (Scanlon, 2008). Even with the assertion of objectivity (Durant, 1991), the social bias toward self-discipline was therefore apparent in legitimate responses early in the history of Western civilization as well as in some, but not all, non-Western regions (Nakamura, 2006; Olyan, 2008). As example, in civilizations such as Botswana, a highly social context, individualism did not fit conceptually with indigenous beliefs and practices, and thus a colonized view of disability as restricted to individual body was not useful to advance analysis of atypical explanation and response in these environments (Livingston, 2006).

With economics now embedded within the European explanatory canon, the differential role of individual wealth in response to the atypical could be interrogated and postulated. Not unlike current times, those with resources were not necessarily governed by the legitimacy criteria that shaped the response to poor individuals. Treatments for the atypical with medical explanations did exist and were available to those who could pay (Metzler, 2006). Although it is likely that economic status had always played a role in judgment and response, prior to the Enlightenment the primacy of religion in shaping values and legitimate responses obfuscated or overshadowed other influences.

In the Enlightenment, the recession of religion as explanatory for natural phenomena, the emergence of epistemologies which created a foundation for the social science of economics, and the emphasis on systematic production made it possible to identify the role of economic status in creating different legitimacy criteria for the poor and the rich (Kaul, 2008).

Based in large part on Cartesian and positivist thinking, institutions for those who behaved in ways that were observed and classified as mad developed and flourished during the 17th century. These served to remove irrational thinkers from public view rather than as a means to change behavior (Thiher, 2002). This era also saw the proliferation of poorhouses, punitive institutional settings for the poverty-stricken, many of whom could not work due to embodied conditions (Wagner, 2005). Although some whose most basic needs could not be met outside of institutional settings sought solace and home in these edifices (Weller & Wolff, 2005), institutions primarily were characterized by harsh conditions (DePoy & Gilson, 2004), clearly indicating the devaluation of institutional residents.

In colonial America, explanations for frailty that were based in illness and aging were valued as worthy of care. Thus, in small communities with no other resources, the care of frail elders was provided by families, women in particular (Green, 2006). The ethnic, cultural, and religious homogeneity of early colonial America fostered acceptance of poor, ill, and elderly members who were not seen as blameworthy (Axinn & Stern, 2000). Further, atypical activity, appearance, and experience that were explained by poverty were not always distinguished from those explained by illness, and so informal arrangements for the care of the poor were not necessarily different from those provided to individuals whose atypical characteristics were explained by illness (see Table 2.3). This phenomenon is not surprising, given the infancy of medical thinking about human activity.

The Victorian Era

Proceeding into the Victorian era, values of continental Europe, England, the newly colonized America, and less developed countries began to take divergent courses, as did conceptualization and legitimate judgment and response to the atypical. According to Holmes (2004), the works of Victorian authors such as Dickens illuminate the atypical in Western Europe as melodrama, a cultural stage so to speak in which the atypical is showcased as anomaly, failure, or unfortunate freak. From her analyses, Holmes further induces a forward thinking definition of disability as those conditions for which European cultures were not prepared. It is curious to note the appearance of this perspective in Victorian literature given the asserted ownership and dating of

Table 2.3 Contextual Factors in the Enlightenment Era

Context	Contextual Factors
Dominant social values	Poor distinguished as <i>worthy</i> or <i>unworthy</i> ; in America, small communities that were ethnically, culturally, and religiously homogeneous cared for their own poor
Geographic/natural	Expansion of Western civilization to the <i>New World</i>
Economic	Beginning of industrialization: mass production and cost minimization; science of economics began; businesses of printing and journalism develop; banks established; profit motive developed
Political	Money is equated with power; English Poor Law of 1601 legislated financial relief in the community, especially for workhouses
Religious	America: homogeneous Puritanism
Intellectual	Rationalism; Bacon publishes <i>The Advancement of Learning, Divine and Human</i> in 1605 and refutes sin as the cause of madness; systematic thought extended to economics and society; literacy level increases

the “social model” as emerging in the United Kingdom in the 1970s. Further supporting Holmes’s definition is the growth of the Victorian asylum (Wright, 2001; Yong, 2007), which continued the Medieval creation of segregated, incarcerating environments for “imbeciles” and “lunatics.” Such institutions removed atypicals from public spaces as well as unburdened the women who had been responsible for providing care. Collecting atypical individuals under a single roof so to speak facilitated the medicalization of these two groups, as they became an easily accessed object for scientific scrutiny (Yong, 2007).

In the United States, of particular consequence to legitimate definitions of and responses to difference is the growth of the American economy rooted in large part in the uninvited procurement of land on which American Indians lived and on the importation of slave and immigrant labor from other countries (Axinn & Stern, 2000; Holstein & Cole, 1996). The existing system of poor relief in colonial America that was based in communal values and shared beliefs was ultimately challenged by the influx of people from diverse geographic regions of the world and by indigenous people (Wagner, 2005). The juxtaposition of indigenous and immigrant people peppered with economic prosperity and increasing economic concern created a complex

backdrop for understanding responses to atypical bodies. The rationale for inclusion and in-home responses to the atypical that were apparent in early colonial America were breaking down and quickly became unseated by contemporary “medical” explanations (Axinn & Stern, 2000), feathering the nest for medical and ultimately broader professional colonization and ownership of the “atypical body and mind” (DePoy & MacDuffie, 2004; Mink, Solinger, & Piven, 2003; Teghtsoonian, Moss, & Teghtsoonian, 2008).

Despite the appearance of medicine, morality and social circumstance were still dominant explanations for unusual behavior, experience, and appearance in the United States. Moreover, with the vast resources available to *everyman* in the New World, tolerance (and thus acceptance of poverty as a legitimate explanation for the atypical) and charitable responses quickly degenerated. Poverty was assumed to be a self-imposed condition resulting from intrinsic laziness in an environment that was rich and in which economic productivity was becoming a paramount value (Axinn & Stern, 2000; Wagner, 2005).

In response to the increasing social costs and disapproval of poverty, the towns and cities began to build poorhouses for the poor of all ages, the sick, and those behaving in a manner consistent with what today would be categorized as intellectually impaired, mentally ill, or socially deviant (Wagner, 2005; Yong, 2007). These categories of people held dependence and lack of productivity in common. Circumstances within the poorhouse were particularly and intentionally harsh to encourage families to support their members at all costs rather than abandon them to the care, and thus the expense, of the local government. The elderly were increasingly represented among the population in poorhouses as attitudes toward the unproductive frailty of old age grew increasingly unfavorable and illegitimate for sound community response (Wagner, 2005). Those who aged well were considered morally “worthy,” and those who did not were “unworthy” of comfort and support.

As noted by Holstein and Cole (1996), the life of a 19th century immigrant was not often conducive to aging well, and thus emergent categories of legitimate worthiness were in large part a function of poverty of racial and ethnic groups. Recognizing this trend, disabled immigrants were often expelled from the United States at entry points such as Ellis Island (O’Brien, 2004). While poverty, illness, and morality had been the primary explanations until now, observable diversity categories, including race, ethnicity, and other intrinsic human differences, were all thrown into the “explanation stew” without the public recognition that poverty and economic circumstance of these groups were underlying factors in explaining the atypical.

Of particular historical importance to understanding contemporary disability theory and practice responses were the abstract creations of Quetelet (1969) who invented the mathematical constructs of the normal or bell-shaped curve and measures of central tendency. These two ideas form the foundation

of contemporary empirical knowledge and fabricated the dissection of humanity into the two categories of “normal” and “abnormal” (DePoy & Gilson, 2007). Applying the bell-shaped curve to human variation, Quetelet (1969) extrapolated the concept of “the normal man,” who was considered to be both physically and morally normal. Synthesizing probability theory with the “normal man” construct, normal was not only interpreted as the most frequently occurring phenomenon but also morphed in translation to what “should be.” Observation therefore turned to prescription, and anyone with observed phenomena on the tail ends of the curve was categorized as “abnormal.” Fields of study and professions (with medicine in the lead) which espoused and reified these positivist approaches to inquiry as truth (such as normal and abnormal psychology, medicine, special education, social work, and so forth) all distinguished between normal and abnormal and claimed the “abnormal” as their epistemic and ontological property as well as their axiological obligation (DePoy & Gilson, 2004, 2007).

What sense do we make of all this in Western cultures? Consider the hallmark of the industrial era: mass production. Mechanization and production standards were based on statistical projections of what an average worker should “normally” accomplish within a given set of parameters, at minimum. Efficiency experts, such as Fredrick Taylor (Kanigel, 1999), aimed to study and increase the rate of normal production as a basis for economic growth.

As industrialization advanced and associated economic productivity with legitimate goodness, links between standardized expectations, moral judgment, unemployment, and disproportionate poverty among people with activity, appearance, and/or experiential differences further located legitimacy of explanations in terms of productivity. The attribution of “not” normal activity, appearance, and experience to assumed productivity limitation was and remains an important determination of current disability legitimacy.

Legitimate support responses to abnormal individuals, as expected, followed value judgments about who was worthy and who was not. Poverty in and of itself was no longer considered a legitimate explanation for atypical activity or need for supports or services, and thus the poor were not treated well (Axinn & Stern, 2000; Stone, 1986; Wagner, 2005; Yong, 2007). Those who could not compete were unable to find jobs to generate income and thus fell into the ranks of the morally reprehensible to be met with the legitimate response of incarceration in poorhouses. What made people legitimately “good” was the capacity to earn (Longmore & Umansky, 2001b; Scotch & Schriener, 1997). As presented in Table 2.4, complexity of contextual factors increased during the Victorian era, setting the stage for the dominance of economic resources in shaping notions of typicality, explanations for atypicality, the criteria for legitimately acceptable explanations, and legitimate rationale for community response.

Table 2.4 Contextual Factors in the Victorian Era

Context	Contextual Factors
Dominant social values	Increasing diversity in ethnicity, values, and customs across the population; productivity; profit
Geographic/natural	Immigration from diverse parts of the world
Economic	Industrialization; economic expansion across the country using slave labor; global markets available even for produce after the development of steamships and refrigeration
Political	Democracy with two-party system (Republicans and Democrats)
Religious	Mainly Christian, but diverse across slave and Asian populations
Intellectual	Quetelet (invention of statistics and the concept of normative thinking); Locke (ideas are not innate); Hume (knowledge depends on a series of perceptions); behaviors are based in “habits” of thinking; utilitarianism (virtue is the greatest good for the greatest number of people)

It is curious to note that the term *disability* in the early 20th century did not include medical diagnostic conditions, as revealed in the 1906 edition of the *Standard Dictionary of the English Language* (2010) that proffered:

Lack of ability of some sort

Impotence

The state of being disabled

A crippled condition

Lack of competent means

Inability (the disabilities of poverty)

Legal incapacity or the inability to act (the disability of lunatics and infants)

Note that these definitions are both expansive and progressive in that they do not delimit disability to specific diagnostic explanatory conditions or exclusively embodied phenomena but rather approach disability from a broad descriptive stance not entwined with explanation.