

that GID as a diagnostic category turns otherwise normal gender variance into a disease that must be treated and stigmatizes transgender people as disordered people who need to be cured. They point out that those who fail to conform often experience social ostracism and VIOLENCE and, in the case of GID, diagnosis and treatment meant to correct “disordered” gendered behavior and appearance. What is characterized as a process of cure and treatment is, they argue, a process of NORMALIZATION. As these theorists maintain, there is nothing “wrong” with transgender people. Instead, society’s norm of binary gender (man/woman, masculine/feminine, boy/girl) needs to be changed to reflect that people come in more than two genders.

Another site where the normalizing force of gender norms is called into question is intersex. The Intersex Society of North America (ISNA) argues that nonmedically necessary surgery should be performed only if an intersex adult, who is able to consent, requests it. Similarly, normalizing surgeries have been directed at disabled people. Like ISNA, disability studies scholars direct their critiques at the harmful consequences of norms of bodily appearance and function and medical efforts to normalize disabled bodies. Many disabled people describe experiences of having to be examined by numerous doctors, undergoing numerous surgeries, and being forced to wear prostheses, all in an effort to “normalize” or “correct” their bodies.

Just as the MEDICAL MODEL OF DISABILITY conceptualizes disability as a problem with the body that needs to be corrected through medical intervention, the medical model of gender conceptualizes a person’s failure to conform to societal norms of sex and gender as a problem that needs to be corrected through medical intervention in the form of psychotherapy or sex-reassignment surgery (SRS). Following the medical model, any gendered identification, appearance, or behavior at odds with a person’s assigned biological sex is considered a sign of an abnormality in need of a cure.

Disability studies argues for a social model rather than a medical model of disability. According to the social model, disability is not a problem inherent in bodies; it is an effect of society’s failure to accommodate bodily variety. Disability studies is an interdisciplinary field of scholarship that emerged as a result of the DISABILITY RIGHTS MOVEMENT beginning in the 1960s and has led to a reinterpretation of disability. In addition the 1960s and 1970s witnessed the burgeoning of social justice movements such as the second wave of U.S. feminism, civil rights, the anti-war movement, the gay liberation movement, the black power movement, and the American Indian movement. Scholars in disability studies have integrated insights from these movements in their analysis of disability. For disability studies scholars, disability, like race and gender, is a product of the social, cultural, and built environment, not a biological fact about the body. Some

scholars in this field observe that the STIGMA attached to disability reflects the extent to which those bodies marked as disabled meet dominant expectations of how bodies should appear and function. Similarly, gender-variant bodies are bodies that do not fit into the dominant gender ideology that structures expectations and the built environment (the idea that there should be bathrooms clearly marked “men’s” and “women’s” as if bodies come in only two genders founded on two natural, distinct sexes). The social model of disability (see SOCIAL CONSTRUCTION OF DISABILITY) advanced by disability studies contends that the problem is the norms of embodiment and the built environment, not disabled or gender-variant people themselves.

See also CURES; FEMINIST DISABILITY STUDIES; INTERSEX/INTERSEXUALITY; QUEER DISABILITY STUDIES.

Kim Hall

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#### genetics

The science of genetics focuses on understanding the roles genes and DNA play in human variation and heredity. Over the past few decades, molecular biologists—scientists who specialize in genetic research—have pioneered new procedures and products out of the promise of better living through genetics. In the United States, genetic testing, prenatal screening, cell-line research, and drug and hormone therapies have been marketed and institutionalized as state-of-the-art technologies offering patients and consumers powerful “choices” to intervene in their biological destinies.

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As currently practiced, genetics thus reflects the long history of disability in the United States, in which disability is considered an undesirable genetic abnormality best dealt with by elimination.

Some scientists, ethicists, and disability rights supporters have expressed concerns about this growing enthusiasm around genetic approaches to individual and public health issues. Promises of DISEASE prediction, treatment, and cure or eradication of hereditary IMPAIRMENTS tend to be based on reductive reasoning that falsely equates human biology with genetics. Genetic epidemiologist Abby Lippman coined the term “geneticization” in the early 1990s to refer to this increasingly popular process of reducing differences between individuals simply to their DNA codes. While a substantial number of diseases, impairments, and differences classified as medical or biological “disorders” originate from a combination of environmental, social, physiological, economic and behavioral factors, the predominant focus today is on genetic influences. Scientists and the media reinforce this reductive thinking that falsely equates human biology with genetics.

The HUMAN GENOME PROJECT, which completed mapping the genome sequence in 2003, demonstrates this reductionism on a much larger scale. Since the beginning of the project, the human genome has been touted as the genetic “book of life” that would ultimately reveal the complex secrets of the species. However, the mapping of a “prototypical” genetic text constructs a simplistic and arguably fictional opposition between NORMAL and abnormal genomes—and positions disability as a mistake that must be corrected through genetic research. Despite claims of scientific objectivity, the projects of genetics and genomics are not neutral, nor should the complex processes of mapping be considered merely descriptive or factual. Inevitably, genetics plays a powerful role in defining what it means to be human and, as such, participates in the long historical process of NORMALIZATION.

Disability rights supporters, in particular, have voiced strong concerns about the eugenic impulses in modern genetic research and technologies. Historically, genetics and EUGENICS emerged at the turn of the 20th century, during a period of increasing scientific interest in understanding biological variation and heredity. Eugenicists wanted to use new breakthroughs in SCIENCE for human betterment, which they defined as decreasing the reproduction of genetically “inferior” or “unfit” groups while increasing that of the “better” classes. Classifications of “fit” and “unfit” fell along racial, economic, and behavioral lines, and depended on diagnosing individuals, families, and whole groups as biologically unsound. Traits as diverse as alcoholism, POVERTY, disease, disability, promiscuity, and criminality were seen as evidence of hereditary “FEEBLEMINDEDNESS”—a broad term for those marked to be “weeded out” of the human FAMILY. While the

most dramatic atrocities of eugenics were carried out in the extermination practices in Nazi Germany in the 1930s and 1940s, the United States, the United Kingdom, and other countries were actively engaged in INSTITUTIONALIZATION, eugenic sterilization, immigration controls, and marriage restrictions in the early 1900s that were rationalized by stigmatizing assumptions about disability.

While modern genetics disavows any connection to the determinism of eugenics, emerging genetic technologies can be used to perpetuate assumptions that disability is undesirable. Prenatal screening provides a compelling case in point. In the United States, predictive reproductive technologies have become almost standard procedure among the well insured and anyone engaged in fertility treatment. Pregnant women are encouraged to undergo prenatal testing for multiple conditions such as DOWN SYNDROME, cystic fibrosis, other bodily “anomalies,” identifiable diseases, and disabilities. This process of identification, however, often presumes that women will select to abort such fetuses. Anomalies are not presented as natural human variations, but as aberrations that will result in suffering for the future child and CAREGIVING burdens for the parents and family. As many feminist disability theorists have pointed out, alternative narratives of disability experience are rarely provided to expectant mothers, and as long as the medical establishment characterizes disability as undesirable, abortion of impaired fetuses will be seen as the only responsible choice. By evoking the promise of greater reproductive freedom, the language of choice and selection can obscure biased assumptions and coercive practices at the heart of new reproductive technologies. Selective abortion could be considered to fall within the historical context of eugenic sterilization, where women diagnosed as “feeble-minded” were surgically sterilized against their wills. In contemporary situations, expectant mothers and their partners are encouraged to be active participants in the process, but the goals of eradicating disability are still foundational to the establishing of such testing as standard practice.

One of the great unknowns in genetic research is the role of variation and mutation in human evolution. There is widespread agreement that variation is an inherent part of the human genome, so our cultural marking of specific “disorders” for removal may play a much larger and deleterious role in human adaptation. More than a refined map of genetic markers, disability studies scholars and activists assert, Americans need a strong critical engagement with genetics and genomics to challenge the assumptions behind research agendas, and offer alternative narratives with which to interpret our genetic “book of life.” Likewise, ongoing historical study of genetics offers new ways to interpret the meaning and lived experience of disability in the United States.

See also AMNIOCENTESIS; FEMINIST DISABILITY STUDIES; IDENTITY; IMMIGRATION POLICY; INVOLUNTARY STERILIZATION; MEDICAL MODEL OF DISABILITY; RACE; REPRODUCTIVE RIGHTS; STIGMA.

Michelle Jarman  
Lennard J. Davis

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**G.I. Bill** See WORLD WAR II.

#### **Gifford, Peleg** (ca. 1777-1853) *merchant*

Peleg Gifford was born around 1777 in Providence, Rhode Island, the son of a prosperous white shoemaker and merchant, and died there on November 30, 1853, having long been "the terror of the town." A rising star in the new China trade, Gifford began in 1803 to experience intermittent bouts of MENTAL ILLNESS that would continue until his death 50 years later. How authorities dealt with this intelligent but often violent man illustrates the treatment of mentally ill people during the first half of the 19th century.

As a boy, Gifford lived in a large house on Providence's waterfront. His father died in 1795 and an older brother in 1796. Then in 1797 a yellow fever epidemic killed his mother and four siblings in a matter of months. Gifford settled his parents' estates, acted as guardian to his three surviving sisters, and in 1798 married Rebecca Cummings. Gifford traveled to East Asia several times as a supercargo or merchant's representative.

The first sign of mental disability came in Manila, Philippines, harbor in November 1802 when Gifford went on a drunken rampage and flogged the captain's coachman. Returning to Providence in August 1803, Gifford faced overwhelming debts and numerous lawsuits. He responded with drunken and violent behavior. The Providence Town Council decided that he was "insane and a dangerous Person to be at Liberty" and committed him to the workhouse. Losing both his house and his wife, Gifford received no medical treat-

ment. At that time Rhode Island had no institutions solely for the treatment or care of people with MENTAL ILLNESS. The workhouse was a damp, miserable place where the poor and disabled were warehoused. Gifford was periodically confined, often in a specially built cage, in the "Bridewell," a smaller adjacent building for violent or alcoholic people. He escaped as often as possible. For more than a decade the council would commit him for the protection of the community and then release him as soon as his symptoms abated. Occasionally he was well enough to work. In 1805, for example, he sailed to Africa as a passenger on a slave ship seeking his uncle, Pearce Coggeshall, who had encouraged him to come. Falling out with the captain, he was forced to buy and sell slaves to earn his passage back on a different ship. Gifford never again was able to support himself and, when not incarcerated, lived on allocations from the town of Providence. This man, who had been entrusted with a budget of \$20,000 to \$40,000 to stock a ship in Canton in 1803, spent much of 1809 in the Providence County Jail for failure to repay a \$100 loan.

In June 1814 Gifford deliberately burned down the First Congregational Church of Providence to which he and his family belonged. Depositions of people who saw him in the days around the fire reveal that he had long threatened to burn much of the city, especially the churches. "Damn the Meeting House," he is reported to have said, "they ought to be burnt."

After this act of arson, Gifford was incarcerated, without any formal legal or medical findings, in one institution after another. He spent the next 14 years at the workhouse. In 1828 he was the first person admitted to Dexter Asylum, a new institution for the poor and insane. Although the building and its farm setting were a significant improvement on the workhouse, Dexter still provided no treatment for people with mental illness. Shortly after his arrival Gifford was confined in a dungeon six feet below the ground and spent the next eight months there until his escape in May 1829. Recaptured, he remained at Dexter until December 1847, when he was transferred to Butler Hospital for the Insane, Rhode Island's first institution for people with mental illness, again on the day it opened. There Peleg Gifford came under the care of Dr. Isaac Ray, an early proponent of a new therapy for people with mental illnesses known as the "MORAL TREATMENT." Although his history at the institution is still confidential, it is likely that in his final years he was treated with a compassion absent from the previous half-century of his life.

When Gifford died in 1853, newspapers carried no obituaries. In a newspaper article about one of his escapes in the *American Mercury* on May 26, 1829, however, an anonymous writer had summed up his experiences and the attitude of his contemporaries:

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U.S. Commission on Civil Rights. 1989, September. *Medical Discrimination against Children with Disabilities*. Washington, DC: U.S. Government Printing Office.

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FindLaw, [www.findlaw.com](http://www.findlaw.com)

National Counsel on Disability, <http://www.ncd.gov>

## ☐ **FEEBLEMINDEDNESS**

By the early 1900s, *feeble-minded* was widely used by eugenic social reformers and mental health professionals in England and the United States as an umbrella term referring to all degrees and types of “congenital defect.” Upon its inception, this term attempted to replace earlier, more offensive categories such as moral and intellectual idiocy, but by uniting discrete social, medical, behavioral, and economic stigma under one name, the category provided dangerous interpretive flexibility. By 1915, the American Association for the Study of the Feeble-Minded defined the category broadly to include any person deemed “incapable of performing his duties as a member of society in the position of life to which he is born.” Similarly, in England, the Royal Commission on the Care and Control of the Feeble-minded defined a feeble-minded person as incapable of competing on equal terms or of managing his or her affairs with “ordinary prudence.”

Such wide-ranging classifications allowed eugenicists to conflate myriad social problems such as poverty, growing immigrant and nonwhite populations, unemployment, and criminality with purported medical and scientific diagnoses of cognitive impairment. In effect, influential eugenicists reductively explained complex cultural issues as part of a crisis brought on by a menacing and ever-expanding army of “subnormal” classes. As examples, Walter Fernald applied feeble-mindedness to groups as diverse as the blind or cognitively impaired to those with poor social

conduct. Harry Laughlin, an active proponent of sterilization and eradication policies, built on Henry Goddard's model to define “social inadequates” as those who failed chronically in maintaining themselves as “useful” citizens. Laughlin's inadequate classification brought together the criminal, poor, vagrant, physically and cognitively impaired, chronically ill, and visually and hearing impaired with the leprous, tuberculous, syphilitic, orphaned, and alcoholic. In this way, the process of diagnosing feeble-mindedness became a simple project of locating disability, disease, moral impropriety, or economic dependency, and using these traits as evidence of mental deviance.

In an effort to further refine taxonomies of feeble-mindedness, eugenicists designated specific subcategories such as the *idiot*, *imbecile*, and *moron* to reflect the range from lower to higher grades of mental defect. The introduction, maturation, and proliferation of mental testing during this period allowed eugenicists to attach particular mental ages to these categories. By 1920, these designations were solidified: Idiocy indicated a mental age up to two years; imbecility from three to seven years; and the moron category referred to those graded from 7 to 12 years. Goddard invented the term *moron* to designate those individuals most difficult to identify as mentally deficient because of their seeming normalcy. Many eugenicists considered such “borderline” individuals the greatest threat to social progress and reform.

The process of naming, labeling, and classifying individuals is inevitably a process of differentiation, and in the case of identifying feeble-mindedness, it also provided eugenicists with a troubling rationale for treating people with coercion, disrespect, and profound inhumanity. Using ungrounded hereditarian arguments and misplaced medical diagnostics, anyone designated within these categories of subnormality became particularly vulnerable to state-sanctioned segregation, institutional confinement, and enforced sterilization. Once someone was *diagnosed* as feeble-minded, this person was rhetorically constructed as a social menace or economic burden and represented by eugenicists as part of an urgent problem in need of eradication.

—Michelle Jarman

principle of universal rights based on citizenship entitlements and through denying that either “women” or “disabled people” constitute a unitary or stable subject on which to base political actions. Despite this, postmodern feminism has developed as an influential strand within feminism, criticizing both the “grand narrative” of feminism and the extreme relativism of postmodernism. Ironically, perhaps, the emphasis that postmodern feminism places on the deconstruction of accepted categories (such as disabled), multiple identities, and the politics of difference may provide fertile ground for a more insightful—though local, contested, and provisional—understanding of disability issues than that provided by previous strands of feminist thinking.

—Mary Boulton

See also Gender; Gender, International; Reproductive Rights.

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## ▣ FERAL CHILDREN

Before the seventeenth century, outside of myth and legend, only scattered and fragmented stories of feral or wild children appear in European history. Suddenly, during the 1600s, several accounts emerge; there are descriptions of a wolf boy in Germany and children abducted by bears in Poland; and, in 1644, the first story appears in English of John of Liège, a boy lost by his parents in the woods who took on animal-like behaviors to survive on his own for years. Early descriptions of such children detailed their non-human qualities: running on all fours, foraging and hunting for food, exceptional hearing, and absence of language. As several such children were rescued from

the wild and brought back into human society, their continued animalistic behavior coupled with a seeming inability to master language fascinated philosophers, who began to wonder if such children actually belonged to a different species than the human family.

This question was taken up with great seriousness in the eighteenth and nineteenth centuries as science attempted to name, classify, and understand the intricacies of the natural world and human development. The most widely known feral child of the early eighteenth century was a boy found in Hanover in 1724. Peter the Wild Boy—as the famous Dr. Arbuthnot named him—became a fascination of the English royalty, living for the next few years both with King George I and the Prince of Wales. Like earlier children found in the wilderness, however, Peter’s unbreakable silence and unique ability to survive much as an animal would compelled scientists to address this animal-human divide. Within a decade of Peter’s discovery, Carl Linnæus, the hugely influential natural historian, actually included feral man, *homo ferens*, as one of six distinct human species. Notably, *ferens* is the only classification listing individuals—rather than whole races—as examples.

In the 1792 translation of Linnæus’s *Natural Systems* into English, however, a note was added that such children were probably “idiots” who had been abandoned or had strayed from their families. It was this conflation of feral nature and disability that was taken up by Jean Marc Gaspard Itard in his project of civilizing one of the most famous cases in Europe, Victor of Aveyron, a wild boy caught in 1800 in the forests near Lacaune. Philippe Pinel, the foremost physician in France, dismissed Victor as an “idiot,” but to Itard, the boy was a living artifact—an atavistic body on which to test Rousseau’s notions of original perfection against a belief in language as the only means through which human identity could be forged. After several years of training, however, Victor was still unable to use language, a failure that further solidified an understanding of feral children as mentally “infantile” and “inferior.”

In many ways, the systematic education, training, and confinement of cognitively disabled people in the nineteenth and early twentieth centuries drew on the legacy of “civilizing” projects taken up by teachers of

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## ▣ KALLIKAK, DEBORAH (1889–1978)

*American subject of eugenics research*

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In his widely read eugenic study of 1912, *The Kallikak Family*, Henry H. Goddard introduced Deborah Kallikak as a quintessential example of “defective” heredity. At the age of eight, Deborah entered the Vineland (New Jersey) Training School after troublesome behavior marked her as potentially “feeble-minded.” As Goddard and his field-workers gathered information on her familial background to assess the possibility of “hereditary taint,” she became scientifically valuable for her relationship to a large and extended family “notorious for the number of defectives and delinquents it had produced” (Goddard 1912:16). Goddard invented the surname Kallikak from the Greek words for beauty (*kallos*) and bad (*kakos*) to indicate that the distant progenitor had produced both a *good* line and a *bad* line of descendants. In effect, Goddard’s study scientifically designated Deborah, her living relatives, and her ancestors on the “bad” line as human *evidence* of the hereditary nature of feeble-mindedness.

At the time of Goddard’s writing, Deborah was 22 years old, but Binet tests charted her mental age at 9. Her accomplishments, however, make this diagnosis troubling. Deborah loved music, writing stories, gardening, and caring for children, but her inability to understand numbers and money, lack of abstract thought, and stubbornness convinced Goddard she was feeble-minded. The most biased aspect of his diagnosis was the presumption she would lead a “vicious, immoral, and criminal” life outside an institution (Goddard 1912:12). Goddard used Deborah to exemplify the

dangerous “borderline” types he designated as “morons,” highly functioning but “defective” individuals who, if not properly identified and confined, threatened society with the inevitable result of producing more of their kind. Deborah died in 1978; she lived 81 of her 89 years in an institution.

—Michelle Jarman

*See also* Developmental Disabilities; Eugenics; Henry Herbert Goddard; Mental Retardation, History of.

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## ▣ KANNER, LEO (1894–1981)

*Austrian-American psychiatrist*

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Leo Kanner was one of the most influential American clinical psychiatrists of the twentieth century. He has been referred to as the “father of child psychiatry” in the United States, and his textbook *Child Psychiatry*, first published in 1935, remained a standard reference work for 50 years. Kanner is perhaps best known for his description of “early infantile autism” in 1943 as a distinct clinical syndrome. Based on his observation of 39 children with similar behavior, Kanner described a common profile whereby the children did not relate “in the ordinary way” to people or situations. Instead,