Contesting certification: mental deficiency, families and the State in inter-war England

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Abstract

This article is an attempt to shed some further light on the people and the processes involved in the identification of mental deficiency in children and young people. In order to do this it turns away from the themes that have been most prominent in the historiography to date: elite and professional ideas, parliamentary and public debates and the formulation of policy. Instead the paper is concerned with a single instance of diagnosis of imbecility in an eleven year old schoolboy in a rural village in the English county of Hertfordshire. As far as is possible it reconstructs this diagnosis and charts and explains a remarkable and successful challenge to it in the High Court. In doing so it draws on a variety of documentary records – educational, legal and medical – as well as the testimony of some of the surviving members of the family concerned. In employing these sources particular attention is paid to the actions of the people involved in diagnosis, and it seeks to explain and understand those actions with explanatory tools taken from cultural history.

Keywords: childhood, psychology, special education needs

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Introduction

Recently a number of studies have been published which focus on the influence of psychological thought and practice around the world. In this work psychological thought is emerging as a much more diverse and protean field than was previously recognised; popular as well as professional, mystical as much as rational, often individualised and introspective, but also championed as a progressive human science with the potential to effect social transformation through educational schemes of self-improvement and elite programmes of social administration. This is an important historiographical advance. It alerts historians and educationalists to the existence of a rich psychological culture in which new – or at least significantly modified – ways of understanding human character or identity emerged. These diverse ideas were, of course, controversial and they were variously applied, frustrated and spurned in complex ways across different social, institutional and discursive sites.

In England one such site has been education. In an important challenge to much recent work that has emerged from a distinctively cultural history of education, Matthew Thomson points towards the limitations of studies inspired by Michel Foucault. Rejecting the predominant themes of control and regulation, Thomson explores a messy series of compromises between a psychology (or more properly, psychologies) struggling for survival amongst established patterns and idioms of British cultural life. Child guidance clinics, for example, were few in number and badly resourced because of the established dislike of taxation. Behaviourism had limited appeal because it sat uneasily with existing discourses of character and self-improvement. Similarly, mental testing was sporadic and inconsistent partly because the

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assumption that intelligence was fixed was unpopular with the self-improving ethos of the period, and partly because teachers were ill-informed and unenthusiastic about them.3

In many respects this picture of psychology mirrors recent developments in the study of psychiatry.4 Here, Thomson’s related and important work on psychiatry, eugenics and the mental deficiency similarly challenged a historiography permeated by notions of control and regimentation and emphasised that although an emerging psychiatric profession – and the voluntary agencies with which it worked – was influential in the development of institutional solutions, that influence was challenged and constrained by a variety of political, social and administrative factors. So whilst eugenic psychiatrists might have championed institutional solutions to the perceived problem of mental deficiency, these were constrained by strong humanitarian and libertarian strands in politics, by the commitment to notions of educability in the school system, by the social stigma attached to incarceration and by the mundane but very important complexities of administering and delivering policy on the ground.5 In short, Thomson has made important and groundbreaking contributions to the history of both psychological and psychiatric thought and practice in the England. Yet in two key areas, one empirical and one conceptual, there is room for further discussion and analysis.

Thomson’s Problem of Mental Deficiency remains the best available account of the complex and controversial processes involved in identifying the mentally and socially deficient in British history. However, and despite the case studies included at the end of the book, relatively little is known about either the people who were the target of these policies or those who enacted them. This is a significant absence. After all, a good deal of social and cultural
history remains committed to a project of historical recovery in the hope that it will foster positive individual and collective identities. This is one of the reasons why the inclusion in historical narratives of individuals and groups affected by the growing power of medical surveillance is so important. Yet there are empirical as well as ethical reasons for wanting to say more about those who were the target of the psychology, psychiatry and psychoanalysis. The interwar period is now portrayed by historians as an era in which an increasingly popular psychology of potential developed alongside the growing influence of an idealised and affectionate nuclear family. In such families fathers were, rhetorically and perhaps actually, increasingly home and child-centred with a recognised, if rather constrained role to play, in helping children realise that potential. In these circumstances psychiatric diagnosis and the punitive measures that could follow were potentially divisive and so, logically at least, extremely contentious. Yet, as Peter Bartlett has argued, ‘the nuts and bolts questions of how doctors and other social administrators determined whether an individual fell into the class of the feeble-minded (or mentally deficient)’ largely remain unanswered. Little is known about who practically identified mentally deficient people and there has been a paucity of work exploring how such decisions were communicated, administered and received.

This article is an attempt to shed some further light on the people and the processes involved in the identification of mental deficiency in children and young people. In order to do this it turns away from the themes that have been most prominent in the historiography to date: elite and professional ideas, parliamentary and public debates and the formulation of policy. Instead the paper is concerned with a single instance of diagnosis of imbecility in an eleven

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year old schoolboy in a rural village in the English county of Hertfordshire. As far as is possible it reconstructs this diagnosis and charts a remarkable and successful challenge to it in the High Court. In doing so it draws on a variety of documentary records – educational, legal and medical – as well as the testimony of some of the surviving members of the family concerned.

In employing these sources particular attention is paid to the actions of the people involved in diagnosis, and it seeks to explain and understand those actions with explanatory tools taken from cultural history. The turn to cultural history can be partly explained by the switch from the micro to the macro: it helps explain the significance of what otherwise might be considered parochial or antiquarian. However, the turn to cultural history has hardly been without controversy. This much is clear from reviews of Mathew Thomson’s work where his choice of explanatory framework and his interrogation of new sources has been praised by historians and often interpreted as constituting a rejection of ‘disciplinary history’. Such comments are revealing of a continuing preference for empirical facts over theory in historical study, especially in the England. More importantly for the purposes of this article, the rejection of ‘disciplinary history’ is suggestive of the rather reductive view of power than can be traced in a number of the empirical studies of both psychology and psychiatry.

Adrian Wooldridge’s history of educational psychology, for example, is largely biographical and comes close to hagiography when writing about the pioneers of the discipline and their legacies. Any interest in the structural factors that might have underpinned the emergence of educational psychology, such as relationships of class, gender and race; disability; a newly
interventionist state; a slow shift to democracy; a populist demand for welfare capitalism, are dismissed as ‘polemical’ or ‘neo-Marxist’ and there is a flat refusal of the idea that knowledge has social origins. The result is a liberal history of progress in which a new science slowly disperses ignorance and superstition and shines new light on children and their learning.\textsuperscript{10} Or, to take a more nuanced example, Thomson argues that demands for welfare support and institutions of care for the feebleminded are evidence of the fact that new legislation and institutions for the mentally defective cannot ‘exclusively be attributed to the imposition of a more prescriptive view of normality’.\textsuperscript{11} Family demands for welfare support and care are interpreted as evidence of the fact that psychological thought was not imposed from above in a straightforwardly repressive and constraining manner. This has long been recognised. Yet it does not necessarily follow that the demand for services and their take up illuminates the limits of state power. Instead, it is important to retain a view of power as productive and to remember that projects of governance may generate subjectivities, or forms of self dependent on other social actors and other knowledge.\textsuperscript{12} In this view, demands for legislation and institutions may not be simple expressions of freedom but a sign of the success of the moral regulation projects that sought to create the ideal citizens for a market economy. This, of course, is a matter for debate. The simple point here is that both the rise of psychology and the exercise of highly constrained choice are best understood against a proper explanation and analysis of relevant social structures. Perhaps the point being laboured here – the need to steer a course between excessively empirical studies, where structure is a suspicious idea, and a strong constructionism in which meaningful action disappears, is best illustrated in the course of the article.\textsuperscript{13} This consists of three parts.
The first part of the article relates a brief history of the Keasley family and the examination of their son, Stanley, in 1937. In doing so it presents a conventional historical narrative that seeks to historicise the actors and the processes involved in Stanley’s diagnosis. In other words, it situates this particular story within wider and well known social forces; the development of a regulatory state, the political concern with families and their children, the empowering of professionals to enact this concern, and the relationships of class that permeated that professional discourse. Much of this narrative is reconstructed using conventional historical sources – local health and education records, political debates and so on – but it also draws on an oral history interview conducted with some surviving family members. This interview was recorded with two sisters of now deceased Stanley and, as with disability history more generally, it plays an important evidential role in what follows. The interview not only helped to augment the documents in the archive, it also allowed a silenced family narrative to emerge that helps us to understand the processes at work and their significance. Ethically it is important to recognise that this is, therefore, in one sense a shared narrative. An important element of what follows emerges from that interview and subsequent correspondence with the author that clarified issues and discussed an earlier draft of this article.

The second section of the article focuses on families and subjectivities to narrate the reaction of Stanley’s family to his diagnosis and seeks to account for their remarkable legal challenge. In doing so the article moves towards more cultural territory; it considers changing forms of subjectivity for parents or, more specifically, fathers in the inter-war period. It tentatively
suggests that fatherhood, and the changing forms of emotional and affective life apparent in that role, may be important in explaining processes of classification and reactions to them. A third and final section offers some observations on the wider significance of this story.

A family under examination

Stanley Keasley was born into the small village of Harpenden in Hertfordshire on May 3 1927. His father, Russell, was born in 1894 (and died in 1971) and brought up in the East End of London. He served in the 1914-1918 war where he sustained a bullet wound. Stanley’s mother was born in 1897 in the rather different environment of rural Bendish (near Hitchin) where she worked, like so many other women in the region, as a basket weaver. These environments, so different from each other geographically and culturally, were bridged by a Sunday bicycle ride that started a romance that ended in marriage in 1920. Three sons were born to the couple over the next seven years: in 1921, 1924 and Stanley in 1927. The young family settled in Harpenden sometime around Stanley’s birth and local trade directories suggest his family moved three times in the next ten years, a journey that took the Keasley family from a rented terraced house to purchasing a bungalow with a smallholding attached to it with the help of a loan from the Co-Operative Society. For most of this period Stanley’s father worked in printing as a machine setter for the Amalgamated Press. He worked on the night shift and made the thirty mile journey to London by bus or train in the early evening and returned home early next morning. At other
times, and for reasons that are not entirely clear, he took breaks from printing and took work that were closer to home; a period as a milkman is one clear memory of his daughters. What may be significant about this pattern of employment is that this was a father who was, to a considerable degree, present in the house and in the daily routines of family life.

Stanley started attending the local elementary school in September 1932 and appears to have been in regular and unremarkable attendance until 1937. His sisters remember his scholarly progress as ‘slow’ and as confirming the family knowledge that Stanley found formal academic learning difficult. Additional lessons provided by family friends to help progress his reading and writing yielded no marked improvement, and his speech was remembered as difficult to understand. An operation to remove Stanley’s adenoids around 1934 or 1935 brought no marked changes. He transferred to the senior department of his elementary school in September 1935. Yet despite evident difficulties with academic progress, Stanley’s sisters do not remember any complaints about his behaviour at school, or any difficulties in his relationships with pupils or teachers. There is no extant documentary evidence that testifies to such problems. Outside school hours Stanley was often with his father, spending long hours tending to the pigs and chickens kept on the family smallholding. In fact, the motivation for moving to this property may have been the desire of Stanley’s parents to do what they thought was best for him. Although it had smaller living accommodation the land that accompanied it allowed Stanley to practise work about which he was both enthusiastic and competent.
Even though there is an obvious danger of inventing an idealised and idyllic picture of childhood, it does seem as though Stanley, sometimes working late into the night at a hobby he was enthused by, often with his father, protected by a loving family and well known in the local community, was a happy and loving child.

Stanley underwent a medical examination in 1937, two years after his transfer to the senior department of his local elementary school. That examination was conducted by Dr Arthur Norman Boycott who had graduated Doctor of Medicine from the University of London in 1893. The date may be considered significant both because it saw the foundation of the Darwinian inspired Child Study Movement in the UK, and because it was the year in which psychiatry instruction, but not examination, became a compulsory part of undergraduate medical examination. Boycott’s formal education in his future specialism was therefore likely to be framed in a rather general biological and heredity framework but limited insofar as specialist study was concerned; it perhaps amounted to no more than an independent engagement with the growing number of psychiatry textbooks designed for students. Yet these textbooks, and individuals like Boycott who might have read them, were certainly decisive in what Nikolas Rose has called the construction of modern selves. Briefly, between 1870 and 1925 the rise of the psy disciplines, ‘their languages, types of explanation and judgement, their techniques and their expertise’, began to influence the ways in which people thought about and imagined their own subjectivity. Thomson has similarly argued that although there were limitations to the application of these ideas, the outstanding development of the era was the ‘regulation of the psychological subject from above’. Ordinary people

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‘inhabited a world in which their consciousness was beginning to be measured, classified and managed with direct consequences for their life opportunities whether they knew about it or not’.21 Boycott was amongst the first generation of those proliferating experts whose activities were central to the expansion of the state. They were crucial in the identification of ‘problem’ groups and behaviours, and the strategies they helped to devise in order to cure or contain them slowly became more invasive.

Strategies for the cure and containment of problem groups and behaviours obviously required experts who, in turn, benefited from the increasing availability of professional opportunities. Yet, quite how these opportunities were experienced in practice remains under researched. Published research on the school medical service in Britain has tended to concentrate on macro questions of finance, policy and administration.22 And even where medical officers do appear in historical narratives there is tendency to read off their identities and attitudes from the monographs, annual reports and submissions to official investigations produced by elite actors. By way of contrast, Louise Westwood’s recent study provides interesting evidence of how women were not just victims of psychiatry, but also beneficiaries of the roles that it opened up, even if these often remained outside of the institutional mainstream.23 However, the general paucity of biographical and prosopographical studies of these new experts (particularly in the field of education) means that it is difficult to assess the typicality of Norman Boycott’s career. His first professional appointment, testimony to the great confinement of the late 19th century, was almost certainly at the Surrey County Asylum, Cane Hill, near Coulsdon. He was appointed Superintendent at the Hertfordshire County Asylum
(or Hill End) in 1898, arriving in December, some four months before its official opening and whilst construction was still ongoing. Initially designed to accommodate some eight hundred patients, Hill End was designed by the influential and prolific G.T. Hine who carved out a successful career as a specialist in the field of asylum buildings. Engaged on an initial salary of five hundred pound per annum, Boycott’s duties were many and varied in this early period. He engaged all the people employed at the asylum, invited tenders for the supply of shrubs, made recommendations for salary increases, submitted lists of required appliances for the farm and dairy and furnished his own cottage on asylum grounds with institutional funds.

Boycott moved into the superintendent’s cottage December 1900 and from there presided over the expansion of the asylum and its facilities, and all its activities, for the next twenty-five years. There were physical changes to the building: a dark room was added in 1901 and a bigger photographic room followed in 1905; two new admission blocks, one for men and one for women, were approved in 1914. There also occasional innovations in daily routines: Boycott introduced an annual ball for staff and purchased pianos for use in wards. Most of all, however, Boycott spent some twenty seven years performing the established rituals of asylum practice: he admitted patients, examined expanding registers, walked the corridors and toured the wards of this vast building. He submitted monthly and annual reports to the management committee and, after the twenty seven years were up, Dr Boycott retired in October 1925 on a pension of £1015, 14 shillings and 1d.

Thousands of patients passed through Hill End Asylum during Boycott’s long years as superintendent. Every diagnosis he made and medical decision he took were, in one sense, an
exercise of power. Anderson, the author of an unpublished history of the Hill End Hospital offers a picture of the young Boycott as an idealistic humanitarian. Not unlike Thomas Midwinter, a fictional contemporary of Boycott’s in Sebastian Faulk’s novel Human Traces, Boycott wants to cure his patients, or at least make them sufficiently well to allow discharge.26 Yet early in his career he is already complaining that he is receiving the wrong category of patient: most were judged by him to be chronically ill and to have little chance of recovery. In his report for the year ending 31 March 1901, Boycott estimated that of the 333 patients then at Hill End only four could be considered as having a chance of recovery. This, he complained, was a misuse of resources with damaging effects to the asylum community:

It is good for morale of both staff and patients when new cases come in and get well.
At present we have a new asylum, with modern appliances being used simply as a storehouse for chronic and irrecoverable patients.27

Whether Boycott’s own morale, and his optimistic view of at least some forms of mental illness, survived the many years of growing patient numbers who were rarely cured must be open to doubt. Anderson certainly suggests that Boycott quickly became a frustrated and disillusioned medic. Working in a field lacking in status and esteem, in charge of a storehouse for chronic patients with little hope of recovery, Boycott’s time would most likely have been spent with the administrative procedures that were such a characteristic part of psychiatric medicine.28

Boycott’s retirement did not, however, mean the end of his career. In an example of the ways in which psychiatrists and psychiatric perspectives could be influential beyond the confines

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of institutional spaces and disciplinary specialism, Boycott soon took on a peripatetic post with the school medical service examining, visiting and reporting on cases under the 1913 Mental Deficiency Act and the 1914 Elementary Education (Defective and Epileptic Children) Act. Under the former legislation, the local state had a duty ascertain, certify and make provision for mental defectives in their areas and such provision was envisaged as encompassing institutional care, a system of guardianship or statutory and voluntary supervision in the community. Under the latter legislation a separate system of education and care was established for all children under the age of seventeen. In Boycott’s place of peripatetic employment the duty of care had been met by the opening of a new residential special school, Kingsmead, for 150 ‘educable and improvable mentally defective children’ in 1919.29

David Parker attributes the opening of this special school, and the administration of the system for mental defectives, to the influence of the school medical officer between 1919 and 1940, Dr. Henry Hyslop Thomson.30 Thomson had significant influence in local government. He championed welfare reforms during and after the First World War and, argues Parker, ‘aspects of special education became Thomson’s jealously guarded personal preserve’.31 Thomson’s missionary zeal was required early in the life of Kingsmead when the parents of 37 of the first 50 children recommended for transfer refused their children’s admission. This level of opposition was probably not a surprise. The debates over the 1914 Education Act in both Houses of Parliament had continually returned to the principles and the practices of identifying mentally deficient children and sending them away from families for residential
care. Despite lengthy debate, and a particular libertarian concern about the growing intrusion of the state into family life that can also been seen elsewhere in continental Europe and North America, it was both the intention and the effect of the legislation that this decision be transferred to representatives of the State. For if in theory the state upheld the privacy of the family by making transfer to special schooling conditional on the written consent of the parents, it qualified this consent by stating that it could not be ‘unreasonably withheld’. Ultimately, and in practice, judgements about sound reasoning were in the hands of medical and other lay professionals.

In parliamentary debates the President of the Board of Education, Joseph Pease, defended the expertise of medical practitioners employed by the Board of Education and was at pains to defend the jurisdiction of the doctor over the identification of the mentally deficient child: ‘though I agree that those who have had teaching experience of these children ought to be consulted, after all the evidence has been secured, I think the final decision must be with a medical man’. That decision was formalised in the requirement that two medical signatures were required to confirm a child’s mental deficiency and, despite arguments for a diagnostic role for a teacher, their relegation to an advisory capacity. Medicine, in the shape of School Medical Officers and their staff, were given the authority to judge the present state and future potential of the child. In doing so the state and the law sought from medicine expertise as to the psychology of the child: it was, publicly at least, a definitive science charged with establishing the medical facts of particular cases.
Despite the anticipated and actual opposition to the transfer of children to special schools, Thomson persisted in Hertfordshire. His tendency, notes Parker, was to equate ‘parental intransigence with ingratitude’ and he was more than prepared to resort to legal compulsion the moment persuasion had failed’. This was a determination born partly from the long-established ambivalence that physicians displayed in their attitudes to the parents of children they assessed, but strengthened by the growing conviction in the interwar period that parental ignorance and neglect were the root causes of mental deficiency. Residential schooling was the source of hope because it could offer intensive training removed from the baleful effects of parents and Thompson continued to push for early diagnosis and transfer, despite the evident controversies that it caused. In 1925, for example, he persuaded the education committee to purchase an intelligence test to encourage the identification of children who would benefit from special schooling. Parker argues that he was one of those medical progressives driven by the idea that accurate diagnosis would facilitate specific systems of education that would ultimately bring improved learning. Responsible for the assessment and classification of children, the role of the school medical officer, and the kinds of ideas and frameworks that they drew on and applied were quite clearly crucial.

Mark Jackson is one of a number of authors who have argued that the medical section at the Board of Education, and school medical officers more generally, did not share the eugenic or hereditarian views that prevailed in other departments of government or wider civil society. Far from insisting on a biological explanation for mental deficiency, these officials worked to promote the notion of educability and attempted to delay classification so that every child had
a good chance of displaying their capacity for learning (however this was defined).38 A similarly positive view of other professionals employed in the education system is apparent in other work. Mathew Thomson, for example, argues that teachers showed little support for abstract mental testing but were enthusiastic about a child-centred psychology that could promote new and meaningful forms of learning.39 Similarly, Sutherland argues that where testing was adopted, it was characterised by a complex view of intelligence and a sophisticated attempt to balance some of the weaknesses of the tests.40 These arguments, and the implicit professionalization narratives in which knowledge and empathy incrementally develop, are best treated with caution. Arguably the definitive statement of interwar school medical practice, James Kerr’s weighty Fundamentals of School Health, finished a long chapter on ‘subnormal intelligence’ that reviewed evidence from North America and continental Europe by reminding his readers of their public duty as scientific professionals:

Allowing for wastage from migration and death, two-thirds of the mental defectives should have constant custodial treatment from school days on, not merely as a matter of State economy, but so that by direction and regulation of their activities they may make the fullest and happiest use of their lives, the common aim of all. As concerns the community they are nothing but a burden which is constantly increasing, so that now it has become a public duty to prevent these people coming into existence, so far as that is possible. This is a purely scientific question, and will only benefit coming generations, but it is a duty with which no idle speculative sentiments or vain
religious scruples should be permitted to interfere and for their own happiness, as well as the benefit of others, they should be sterilized.\textsuperscript{41}

Judging by this advice, it might be supposed that many policymakers, doctors and teachers still supported the idea that the classification of children on the basis of different and relatively fixed levels of mental capacity was both possible and desirable. In this respect the rather ambivalent attitude of educationalists to psychological testing can be misleading. Whilst teachers cautioned against the exclusive use of tests for classification, and argued that their experience was a necessary part of knowing the child, they did not fundamentally depart from the view that tests measured something real and significant.\textsuperscript{42}

Perhaps what psychiatrists like Boycott and school medical officers like Thomson brought to any diagnostic encounter was not radically different to assumptions elsewhere in popular culture. What may have been important was the air of scientific legitimacy they lent to these discussions, an expertise that made possible particular kinds of legislation. The punitive segregation policies of the 1920s and the 1930s, for example, required a clear delineation of the distinction between the normal and the defective child, between the educable and the ineducable.\textsuperscript{43} It is at least likely that Boycott’s medical training and his asylum career meant that he assumed that such a distinction existed, was identifiable and warranted separate systems of care and education for young people. After all, these were the assumptions built into mental deficiency legislation and the growth and development of special schooling from the early twentieth century. Such assumptions were contested, of course, not least by Binet and Simon, French pioneers of intelligence testing who were outspoken in their criticisms of

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the vague and relativistic medical terminology that was capable of wide variations in interpretation. Other examples of such criticism are not difficult to find.

Despite this imprecision, there was a general allegiance to the idea that mental defect was innate and its aetiology inherited. Perhaps this explains why doctors, who were encouraged to use some version of the intelligence tests that were becoming widely available, often did not do so. Instead, there remained a significant commitment to what were considered the visual signs of deficiency.

All this helps to explain how in 1937, almost forty-five years after his graduation and over ten years after his retirement, Norman Boycott came to examine Stanley. No medical records have been located that document that examination and exactly what took place is likely to remain obscure. Yet it has been possible to suggest what Boycott was supposed to be looking for and to explore the influence of the wider medical and social context on his practice. Engaged to inspect the health of schoolchildren and working with a medicalised notion of deficiency that preached the danger of such children in the community, Boycott was asked by a local head teacher to inspect Stanley. This request must itself be understood in the context of a zealous school medical officer who had pushed a reluctant education committee to provide expensive residential provision for mentally deficient children. It is perhaps not surprising that Stanley was diagnosed as mentally deficient and recommended for transfer to special school.
Challenging the state

If the recognition of parental rights under the terms of the 1914 Education Act were somewhat ambiguous, it did provide the potential to challenge the growing influence of the state in the private sphere of the family. That potential was, of course, constrained by class and gender. Challenging the law, and the medical expertise on which it depended, required specific knowledge, attitudes and dispositions and it was extraordinarily expensive.

Moreover, in patriarchal social systems the rights of the family were usually proscribed to men who had control over property, income and material resources and whose authority was sanctioned in law and in a range of social practices. Indeed, it may be that it is the constraints of these rights, and the fact that mothers dominated exchanges with welfare agencies, that explains the marginalisation of resistance and, more specifically, fathers as actors in the classification of children.47

The prospect of a legal challenge from the parents of Stanley Keasley must have seemed remote. Stanley’s father had regular employment as a printer but the family were not wealthy and had no significant disposable income. He had no direct experience of the law and he was not an autodidact able to draw on independent learning.48 It seems that any explanation of the legal challenge that followed Stanley’s diagnosis must consider not just the legally sanctioned public role of the father, but changing interwar models of masculinity, domesticity and the ways in which they were lived by individuals.49 In other words, whilst fathers may have been legally empowered to act in certain ways in the public sphere, their willingness and capacity to do so was conditioned not just be material factors but by changing discourses of
masculinities and their impact on emotional states and experiences. The latter have escaped sustained scholarly attention in Britain, not only because of the elusive character of feelings but also because there is an abiding tendency to see men as only public actors. However Michael Roper has recently suggested that familial relationships may have a foundational significance for explaining social action. Moreover, there is evidence to suggest that in working class families fathers were not the geographically and emotionally distant caricatures suggested by Victorian separate spheres models. Instead, and as Megan Doolittle has recently suggested, irregular work patterns and relative poverty encouraged interdependence and intimacy in working class families. But quite how this and the heightened inter-war discourse on the domestic male impacted on the emotion of fatherhood remains unexplored. Perhaps it was the depth of family relationships, and particularly the relationship between father and son, that help explain the extraordinary response to Stanley’s diagnosis.

Shortly after the initial diagnosis, Stanley’s father was interviewed by an unnamed official of either Hertfordshire County Council or Harpenden Urban District Council. At the meeting, his father his reported as saying the boy was not feeble minded and that this view was supported by both his own medical officer and a medical attendant at the Ear, Nose and Throat Hospital, London. Stanley’s sisters recall what may well have been this interview as a vigorous argument between their father and the School Board Man who had come to deliver the news that Stanley was an imbecile.

Stanley’s father wrote to the Local Education Sub-Committee in October 1937 to confirm his objections to the diagnosis. That letter is reported to have stated that both a General
Practitioner and the surgeon who had operated on Stanley judged him ‘not deficient in any way’, but that ‘the father would not incur the expense of forwarding a Doctors report’. At the request of the County Council, the Local Education Sub-Committee summoned Stanley’s parents to a meeting designed to persuade them to agree to Stanley’s transfer to a local special school. The minutes of the committee report that the ‘the father attended and stated he was not prepared to agree to the boy going [to the special school]. He also promised to forward certificates to this effect from a specialist and his local doctor’. By December no such certificates had been provided.

Stanley appears to have been examined once again by Dr Boycott in May 1938 who once again diagnosed him as feeble minded. That second examination prompted the threat of legal proceedings to compel attendance at special school ‘in the interests of the child’. Yet alongside this threat, however, the education authorities continued to try and persuade. To this end the County Council recommended that ‘a lady member of the sub-committee should first see the parents again...with a view to persuading them, in the interests of the child, to attend [special school]. In July two women members of the Local Education Sub-Committee

...reported the interview [they] had with the parents from which it appeared the father was still unwilling to allow the boy to attend [special school] and has also made certain complaints as to the treatment of the boy by the Head Teacher. The Committee, after hearing the Head Teacher, decided that the statements of his father were without foundation.
Now faced with what had become a stand-off, the County Council anticipated legal action and warned the women members of the local committee that they may be required in Court to give evidence in the proposed prosecution of the father. It is suggestive of the continued gendering of public action that the father is repeatedly identified as the public head of the household, that he is liable to prosecution and that both women members of the local education committee objected to giving evidence in Court.

In a third and final examination of 5 October 1938 Dr Boycott examined Stanley again. He reported that ‘no improvement since he was examined last May and should now be classed as an imbecile. He is not educable at a special school: but should benefit at an occupational centre’. As the Certifying Medical Officer, Dr Boycott signed a certificate of imbecility within the meaning of the 1913 Mental Deficiency Act and this was countersigned by Dr Hyslop Thomson as the School Medical Officer. The County Council are recorded as making arrangements for Stanley’s removal from school to the local mental hospital. That removal never occurred. The next reference to Stanley in the education records of the local committee shows that the certificate of deficiency had been quashed and that arrangements were being made for Stanley’s return to school.

The High Court hearing took place on 25 and 26 April 1939. The intervening period must have been extremely difficult for Stanley’s family, and especially his father who was concerned for the future of his son, subjected to repeated attempts to persuade and cajole acceptance of the diagnosis and unsure about the outcome of the legal challenge he had mounted. In any case Stanley’s sisters remember their father departing for London when the

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case was to be heard, dressed smartly and disappearing for almost a week whilst the fate of their brother was discussed and decided. 60

In explaining their decision to quash the certificate of deficiency, both Judges Humphreys and Singleton referred to how the 1913 Mental Deficiency Act section 31 provided that where there was doubt as to the educability of any child, the matter would be referred to the Board of Education. 61 Given that there clearly was some doubt based on what appeared to be diametrically opposed medical opinions both judges expressed surprise and concern that the Board of Education had not been consulted at any time. In fact, it emerged in Court that Stanley’s father had expressly made this request but it was ignored. 62

The legal ruling was careful to avoid taking a view on the different medical opinions that were expressed. Instead the ruling concerned the production of the certificate. It became clear during questioning that only one of the two medical signatures on the certificate, that of the certifying officer, had actually examined the child. Judge Humphreys called it ‘an illustration of an internal administrative system. In plain English, the name of Dr Hyslop Thomson appears on that certificate as certifying this child to be an imbecile when ex concessis he had never even seen the lad’. Judge Singleton – a man of ‘stout Lancastrian common sense’ according to one biographer – continued:

It is admitted that this court has power with regard to that certificate, and, there being that power, I think that we should be failing in our duty if we failed to quash that certificate, which, going forth to any one or, to any body of persons, would lead him or them to think that the boy had been examined by two doctors, both of whom certified he was an imbecile.
No such state of things existed. I hope that never again will it be found that a doctor has put his hands to a certificate of that kind without realising what it means, and how it may be interpreted by others.63

Yet this powerful rebuke heralded no significant changes in policy or practice. Instead, the Board of Education took the opportunity to remind some Local Education Authorities that there was nothing in the recommended arrangements to ‘countenance the signing of the Certificate by a second practitioner who has not examined the child’.64 However, at the same time as rejecting the suggestion that practices of notification exceeded their legal powers, correspondence in the Board of Education files at the National Archives reveals continued uncertainty into wartime at the legality of both diagnostic and regulatory practices.65 Despite public insistence that there was no need to change policy and practice, and almost twenty-five years after a senior Board of Education official had confidently predicted narrowing down problematic diagnosis, progress was proving elusive.66

Mental deficiency, psychologies and childhood

The representation of feebleminded children as a danger to the community, their identification by medical and educational professionals and their removal to specialist institutions are themes now fairly well established in the historiography of western European and North American education. However, our knowledge of these processes remains at a fairly generalised level. Specific accounts of how these processes worked out in practice at
the local level remain scarce. This attempt to recount and explain the experience of one child deemed mentally deficient in Britain in the 1930s lend themselves to some wider reflections on mental deficiency, psychologies, administration and childhood.

The construction of mental deficiency has to be understood against a wider history of state formation. In Koven and Michel’s terms a relatively weak central state like Britain continued to rely on local government and private welfare organisations to develop and deliver social policy. This helps to explain both the level of diversity one sees in British welfare provision and the continued importance of volunteer social administrators and professional experts in its application. So whilst Hertfordshire clearly represents a district in which policies of institutionalisation and segregation were favoured, there are other places where community care was much more important. However, the relative absence of both detailed local studies and comparative national work means that diversity of provision and practice has not been fully explored nor adequately explained. The political and cultural investment in the project of social science that was routine for major industrializing centres in Europe and North America present some explanatory possibilities, but pursuing these will require comparative work and greater attention to the ways in which different spaces interpreted and developed specific ideas and practices.

People were central to the process of transferring, adapting and applying ideas to social policy. It follows that both individual and collective biographies have the potential to complicate generalised pictures of the twin processes of educationalisation and medicalisation that were undoubtedly significant in this period. Even a brief reconstruction

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of Norman Boycott’s career, for example, casts some doubt on the idea that physicians working in the educational sphere were somehow more optimistic and more humanistic than medics employed in other areas. Indeed, Boycott’s peripatetic employment as a school medical officer suggests that the institutional boundaries between medicine and education, and between psychiatry and psychology, were porous. But because so little is known about the careers of those first generation school medical officers, many of them women, there is no way of estimating how widespread this kind of movement was, nor evaluating how the education and professional experiences of these doctors impacted on the practice of identifying mentally deficient children.

If the historical identities of doctors warrant further examination, so too do those women who were often volunteers, who played a key role in the administration of educational services. These women undertook casework with children and their families, they gathered information and they collated it in the form of reports that were often used in the process of certification and in the provision of community care.70 In other words, women who walked towns and cities gathering information and helped to name, or make up, people.71 Tracing their generational histories, especially for the period beyond the nineteenth century, is crucial because they were co-authors of those artefacts, or social technologies that became so important in the provision of education and for the identities of children and their parents.

Another observation concerns the significance and use of these artefacts and social technologies. On the whole the explanatory potential of administrative, educational and medical sources has been hampered by a combination of archival and theoretical

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conservatism amongst historians; this helps account for the dominance of institutional histories in this area. However, the graphs, charts and record cards co-authored by teachers, doctors, and volunteer case workers act as a ‘mediator between categories of social actors’, they take on some of the properties of historical actors, making problems visible, circulating them for inscription and action.72 The certificate issued by the medical authorities in this case can be constructively considered in just this fashion: it identified Stanley as a particular type, a child visualised on the page and whose ability to practice normality was severely curtailed. Dr. Hyslop Thomson did not need to see Stanley in order to know him. It is tempting to interpret this extraordinary state of affairs biographically; a result of Thomson’s particular brand of missionary zeal. Yet an understanding of historical context, a reading of this practice against the growing power of the science of childhood, is far more persuasive and offers evidence of a damaging scientism sweeping Europe and North America in the 1920s and 1930s.

In the midst of this scientism resistance remained possible and is demonstrable. This usually came in fugitive form; moving house, for example, to escape the jurisdiction of a particular local authority. However, the Keasley case was unusually public. The decision to threaten and then enact legal protection against the local authority was both extraordinarily brave and, as far as this author is aware, unprecedented in this field in the England. It is also significant that the certificate of mental deficiency issued to Stanley was quashed on what amounts to a technicality. The High Court judges explicitly avoided any comment on Stanley’s condition; they saw this as the expertise of the medical profession and were no doubt cognisant of the

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fact that, under the terms of the 1914 Elementary Education (defective and epileptic children) Act, there was no legal machinery to review or appeal the original diagnosis. As a result, it is hard not to find in this case confirmation of the growth of medicine in the field of education. Where a zealous local authority was determined to implement seemingly progressive welfare measures, was willing to ignore the protests of family and eschew the advice of the Board of Education, there were was little that could be done to legitimately prevent the institutionalisation of a family member. Were it not for the legal challenge, Stanley would have completed his schooling at a residential special school. Instead, his formal schooling remained incomplete but he remained at home, living in the community and eventually went onto long employment with the local authority.

In recent years psychology’s influence over education policy, parenting and childhood has taken a distinctively positive form. Instead of identifying difference, positive psychology studies normality, seeking to understand the components of a meaningful and happy life. In classroom applications, positive psychology seeks to develop those skills and attributes that will foster emotional well-being through the life course. This certainly seems like a more progressive and optimistic form of psychological regulation than was apparent in the inter-war period. But perhaps Stanley Keasley’s story serves as a reminder that faith in science, and scientific method, has frequently outstripped convincing demonstrations of either its accuracy or validity. In this case at least, familial affection, and time and patience, seems to have been a more reliable and benign guide to educational potential.  

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Notes


3 Thomson, Psychological Subjects, chapter 4.


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This section draws on the author’s interview with Marie Clarke and Peggy Gagesley, Harpenden 25 January 2008. Transcript and correspondence in author’s possession.

Kelly’s Trade Directory of St. Alban’s, Harpenden and Hatfield 1938-39.


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24 That a specialism in asylum building was possible – Hine called it ‘almost a distinct profession in itself’ – owed much to the nineteenth century conviction that architecture could contribute to the relief of madness. Hill End was a two storey symmetrical building on a rural site near St. Alban’s. It was so located in order to offer patients the fresh air and invigorating views necessary for recovery. See Jeremy Taylor, Hospital and Asylum Architecture in England 1840-1914 (London: Mansell, 1991): 150-154. Hine designed four major asylums with over two thousand patients each for the London County Council (Claybury, Bexley, Horton and Long Grove).

25 Herfordshire Record Office (HRO), Herfordshire County Lunatic Asylum, Abstracts of Minutes, 27 February 1900 – 25 March 1903.


28 Anderson, Hill End Hospital: 170-171. On the status of psychiatry see Thomson, Mental Deficiency: 120-121.


31 Parker, “‘A convenient dispensary’ “: 77.


33 1914 Elementary education (defective and epileptic children) Act, s.2.


35 House of Commons Debates, 5 May 1914 vol 62 cc166-227.

36 Parker, “‘A convenient dispensary’ “: 77.


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HRO, HEd 5/13/3 Local Education Sub-Committee minutes 19 October 1937.

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National Archives, Education (ED), 50/268. ‘Mentally Defective Children 1939–43’; Board of Education to Herts and Kent Local Education Authorities, 17 May 1939.

NA, ED, 50/268 ‘Mentally Defective Children 1939–43’.

NA, ED 50/112. Minute by G.E. to Sir George Newman (Chief Medical Officer) 16 September 1920.

Seth Koven and Sonya Michel (eds), Mothers of a New World: Maternalist politics and the origins of welfare states (London: Routledge, 1993).

For this argument – and the relative strength of philosophy and history in Europe as compared with the United States – see, for example, Dorothy Ross, “Changing Contours of the Social Science Disciplines” in Theodore M. Porter and Dorothy Ross (eds) The Cambridge History of Science Volume 7: The Modern Social Sciences (Cambridge: Cambridge University Press, 2003).


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Andre Turmel, A Historical Sociology of Childhood: Development Thinking, Categorization and Graphic Visualization (Cambridge: Cambridge University Press, 2008), 120.
