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Dis/order and dis/ability

Benoît Majerus and Pieter Verstraete

On 13 January 1966, Maria V., an ex-patient at the Institute of Psychiatry in Brussels, wrote to her former psychiatrist asking him to provide her with medication to which she was entitled as long as she was in therapy with him:

> I am a sick person who has been cared for by you. I am still sick. I do not feel good. I have vivid dreams and I turn over 30 times every night … As long as I was taking my medicines, it was ok. Now I have run out of medication and I am sick … I am now going to see the doctor here, but the doctor no longer wants to prescribe me any medication, he wants you to write a letter stating that he is allowed to prescribe me this medication. Please help me, because I cannot continue to live without medicine.[1]

The letter comes from a patient file kept at this Brussels psychiatric institute. For a long time, histories of mental illness and histories of disability were mainly based on analyses of medical theories as described in scientific journals, textbooks, conference reports, etc., and were presented as progressive narratives. In the last thirty years, the emphasis has shifted from a predominantly medical perspective to one that also tries to include the voices of people with mental illnesses and disabled people themselves.[2] Bygone medical practices are no longer represented as unilateral activities where the initiative was taken only by the doctor, the nurse or another professional and where the targeted individuals passively underwent treatment, rehabilitation or special education. In adopting this new historical approach, historians turned towards neglected source material. As well as handbooks, academic journals, conference proceedings and laws, they drew on a variety of ego-documents and visual source material.

Personal letters and diaries are probably the best known of these sources, but historians also have made use of more tangible material such as works of art, demographic data like birth or death certificates and furniture or garments to underpin this historiographical reorientation.[3] All of these examples can easily be criticised for being too subjective, socially biased and intimately bound to particular contexts. That is of course true. But what is also true is that these sources have given rise to more nuanced and balanced views on what it was to be re-educated in the past, what it meant to be diagnosed as mentally ill and how people tried to align established medical knowledge with personal and/or collective convictions. In short, these new sources have helped to reveal the agency of the patients and individuals that were cared for and/or placed in special education initiatives.

Introducing readers of this book on Belgian medical history to the history of psychiatry and the history of disability simultaneously might seem to be an insurmountable task. Previously, even though several authors have tried to bring the two fields of study together,[4] they have largely remained separate with regard to the topics examined, the journals and conferences where research results are presented, as well as the methods used to explore the past. Indeed, while the history of disability mainly originated from the fruitful efforts of disability activism and critical academic theory in the 1960s and 1970s and has explicitly rejected a purely medical approach towards disability, the history of psychiatry seems to have followed a different historiographical pathway and is still largely situated within medical history.[5] To further problematise this combined discussion of the history of psychiatry and disability, one also can refer to the various conceptual and existential realities that lie behind the notions of illness/syndrome and disability: people diagnosed with mental illnesses or disabled people encounter different bureaucratic challenges, bodily realities and/or societal prejudices.

Despite these historiographical, epistemological, linguistic and existential differences, several reasons nevertheless seem to justify a combined discussion of the history of disability and the history of psychiatry. First, regardless of the manifold discussions about when and why the two categories became separated, there is a widespread and well-accepted narrative that in pre-modern times individuals with physical and mental disabilities were not distinguished from one another and were seen as forming part of the wider community of 'poor people'.[6] The histories of mental illness and disability, however, have more in common than their mere shared origins on the margins of society. Second, it can be observed that the historiographical traditions dealing with psychiatric illness and disability seem to have developed more or less in the same direction in the last twenty years. For just like the history of disability, the history of psychiatry has evolved from a merely encyclopaedic and Whiggish overview of important (and primarily male) doctors and medical inventions to a nuanced and critical approach that also reserves an important place for the voices of those with mental illnesses and takes into account broader social, political and cultural developments.[7]

In light of these general affinities between the historiography of psychiatric illness and disability, this chapter will examine the Belgian history of mental illness and disability by analysing the importance attributed to boundaries. Generally speaking, one can state that there first of all existed a phase that can be described as one in which boundaries are set up and human beings are increasingly classified, segregated from one another or gathered into subgroups. The second and third phases demonstrate an increasing unease with this tendency to demarcate and relegate. These phases are characterised by a desire first to cross and later even to blur the lines of the boundaries established in the first phase.

For a thorough understanding of what follows, three preliminary remarks should be made. First, it is remarkable that although the history of Belgian psychiatry can draw on a rather elaborate tradition, the history of disability in Belgium previously seems to have attracted much less attention from historians.[8] Second, concerning the terminology used, this chapter will speak in terms of disabled people and people with mental illnesses. At times, however, when historical terminology is used, certain terms will be placed in quotation marks. Third, and here the particular nature of the Belgian case immediately becomes clear, the history of disability and psychiatry cannot be written only by referring to doctors. Given the widespread presence of other groups of professionals such as religious orders, social workers, psychologists and pedagogues, a theoretical framework needs to be developed that overcomes the shortcomings associated with a too narrow interpretation of history in terms of medicalisation.

Establishing boundaries

Issues related to disability and mental illness began to be problematised in Belgium towards the end of the eighteenth century, just as in many other European countries. That is not to say that those who could not hear, see, walk or think in a rational way had not attracted particular attention before. Their differences already had been shaped to a certain extent by divergent religious and medical traditions.[9] Despite their particular status, however, the institutionalisation of these individuals remained rather limited. There were places where the poor and the sick were assembled, such as almshouses (*godshuysen* or *dullhuysen*).[10] However, the majority of disabled people and people with mental illnesses lived in the midst of the community in which they grew up. The tendency to segregate them from society and enclose them within the confined walls of an institution occurred to a large extent at the same time as Belgium's independence in 1830. The newly founded Belgian state was convinced that good governance required a detailed description of the population. The Belgian government therefore instigated several statistical enquiries shortly after its independence that led to a better overview of the prevalence of deafness, blindness and mental illness.

With regard to mental illness, in the 1840s the Belgian government asked three experts – Edouard Ducpétiaux, Joseph Guislain and Maurice Sauveur – to draw up a report on the 'mental institutions in the kingdom'. The report concluded that regulations needed to be introduced for the field, which led to the adoption of two laws, one in 1850 and one in 1873, creating a specific institution, the 'mental asylum', and specific professions, 'alienists' and psychiatric keepers. While the latter remained in virtual obscurity until the 1960s, when specific associations were set up, the role of the alienist soon gained professional recognition via two standard means: the establishment of a medical society in 1869,[11] the Belgian Phreniatric Society (Société phréniatrique belge, subsequently the Société de Médecine Mentale de Belgique), and the launch of two scientific journals, the *Bulletin de la Société de Médecine Mentale de Belgique* in 1872 and the *Journal de Neurologie et d'Hypnologie* in 1896 (see Chapter 5, p. 179). Nevertheless, this seemingly early specialisation should not disguise the fact that the field did not develop in a linear way. Psychiatry struggled for recognition in universities. It was some time before psychiatric education became standardised. Throughout the nineteenth century, courses were introduced in Belgian universities only to disappear a few years later. The Catholic University of Leuven was the only higher-education institution to provide a degree over time[12] – probably to some extent because of the important role of religious congregations in psychiatric care. Throughout the nineteenth century, psychiatrists also explored alternative approaches, which are often forgotten today but at the time were considered as viable options: hypnosis, 'pedotechnics', social defence and eugenics.

Just as with psychiatric disorders, statistical enquiries contributed to a heightened awareness of disability and to ever-more strident calls for institutionalisation and professionalisation. Again, it was Sauveur who was asked to map out the prevalence of blindness and deafness in the newly established country.[13] Although when the results were published, institutes for people with sensory disabilities already existed in Brussels and Ghent, the statistical overview led to the emergence of several others as well as the identification of new categories, like deaf-blindness. Indeed, Sauveur's report demonstrated that in Belgium, several deaf-blind individuals existed. In response to this finding, the founder of the Institute for the Deaf and Blind in Bruges, the Flemish priest Charles-Louis Carton, decided to take in the only deaf-blind person who was deemed to be receptive to education, Anna Timmerman.[14]

The use of statistical graphs, tables and figures to clearly illustrate the numbers of disabled people and people with mental illnesses transformed these issues into matters of public concern. What these numbers also catalysed was the idea that state intervention was necessary. But while statistical practices undoubtedly played an important role in the emergence of a more professionalised system for the care and instruction of disabled people and people with mental illness, other developments also need to be taken into account. These demonstrate that institutionalisation cannot solely be explained by referring to the activities of the medical profession. Several other groups of professionals, such as priests, statisticians and pedagogues, also recognised the value of an institutional approach.

Driven by God, money and the lure of work

As in other European countries, the emergence of institutes for deaf and blind people can be seen as part of a broader transformation of how religion and economics were interconnected throughout the Middle Ages. For a very long time indeed, it was common in Western societies to see blind individuals, for example, asking for alms. In return for the money given, the beggars would pray for the soul of the generous benefactor. Although this traditional exchange of money for religious well-being began to be questioned by people like Juan Luis Vives as early as the sixteenth century, it only became more seriously problematised towards the end of the eighteenth century.[15] As a consequence of this general transformation, many of the first handbooks on deaf and blind education reserved an important place for the issue of begging and directed educational efforts towards a vocational outcome (to replace the occupation of begging) for poor disabled people, or a pleasant pastime for disabled people who were wealthy.[16] In line with this European trend, the emergence of educational institutes for deaf and blind people in Belgium also demonstrates this problematisation of existing begging practices. In 1785 in Liège, for instance, Constantin de Hoensbroeck issued a call for essays that focused on the following topic: 'On the means of caring for blind people of both sexes and occupying them with light work of which they are capable, either by grouping them in a public establishment or by providing them with occupations and care at home that will keep them from begging.'[17]

Religion also played an important role in the emergence of a widespread network of care and educational institutions for disabled people and people with mental illnesses. In Belgium, the majority of institutes founded in the nineteenth century were the result of the initiative taken by religious actors/congregations from the early days onwards (see Chapter 2, p. 68). This can partly be explained by the liberal nature of the Belgian government, which consequently decided to intervene as little as possible in the field of charity and social care. This certainly applies to institutionalised care for disabled people. Towards the end of the nineteenth century, the large majority of existing institutes for deaf and blind people were founded and led by members of religious orders.[18]

The same religious predominance can be observed for the care of the mentally ill. The 1850 Mental Treatment Act placed the treatment of psychiatric patients in the hands of private entrepreneurs, and this did not change with the 1873 law. Alongside private secular institutions, religious congregations soon stepped up to the task. Following the periods of French and Dutch rule in Belgium (1794–1814 and 1815–30, respectively) under which the Catholic Church suffered considerably, it subsequently began to recover, especially via the creation of several religious congregations[19] that were involved in teaching and healthcare, particularly psychiatry. These congregations soon came to dominate the field. The first report by the Standing Committee of Psychiatric Asylums (Commission permanente d'inspection des établissements d'aliénés) emphasised that just 27 per cent of establishments housing psychiatric patients had lay keepers; the vast majority of subordinate staff were exclusively or primarily provided by religious congregations. Moreover, twenty-five years later, in 1876, religious staff took care of 74 per cent of psychiatric patients. This high proportion also reflects the fact that even establishments administered by municipal hospice boards (*commissions d'hospices*) or laypeople assigned most supervisory tasks and treatment to congregations.[20] There are several reasons for this. First, it represented a continuation of past practices that were only briefly interrupted by the French Revolution: the involvement of religious communities in treating the poor and sick was typical of the future Belgian territories in the eighteenth century.[21] The other reasons can be divided into ideological and financial dimensions: both the Catholics and the liberals, the two dominant political parties at the time, wanted to restrict the role of the state in the charity sector (albeit for different reasons), and the daily costs of asylums run by religious congregations were much lower than those of institutions run by lay staff. Before the First World War, in Geel, a chief nurse was paid around 1,450 francs, a Mother Superior 600, a nurse around 1,000 and a nun 400.[22]

The politics of ignorance

Although the economic and religious reasons underpinning the emergence of institutionalised care for people with psychiatric illnesses and disabilities are already well known, recent authors have also pointed towards the influence of broader political developments. 'Political' here refers to the different and changing ways of wielding power over others. Towards the end of the eighteenth century, partly as a result of the process of secularisation, it was thought that good governance was dependent on detailed knowledge about the lives and the behaviours of a nation's citizens. Several factors complicated this approach, such as solitude. The value of solitude, for example in religious practices, was increasingly called into question. Solitary people were 'problematic'. One category of people identified with solitude was profoundly deaf people, as it was hard to understand what they were talking about when they communicated using sign language.[23] Several of the early articles on the need to educate profoundly deaf people and blind people alluded to this solitary state. In an anonymous contribution to the *Encyclopaedia Britannica* of 1778, which later was identified as being written by Thomas Blacklock, the political relevance of blind people was referred to in terms of their numbers: blind people were not to be neglected, as they constituted a relatively large proportion of the population. More important, however, according to the author, was the unfortunate nature and the limited capacity to live an active life of blind people who had not received any kind of education or instruction.

This reference to the unfortunate character of non-educated profoundly deaf people and blind people arose time and again throughout the nineteenth century. In Belgium, there is also abundant source material to be found that underlines the importance of the 'unfortunate' trope for the newly established legitimacy of special education. One revealing example is the autobiographical letters that were sent by several pupils at the Institute for the Deaf and the Blind in Bruges to their director Charles-Louis Carton when they graduated. In all of these ego-documents – which were probably commissioned by those in charge of the institute themselves – reference was made to how the pupils thought about the world and about others before having benefited from the positive influence of the education provided at the institute. Louise Ryspeert, for instance, a profoundly deaf girl born in 1844, wrote the following about how she thought about death before entering the institute:

> Mr. Carton, my thoughts about death may perhaps make you laugh. The coffins gave me a sense of horror; I felt sorry for the dead: 'No, I never want to die,' I thought. 'The dead may not come to life anymore,' they might be stifled in their coffin or remain dead in the

> absence of food and drink … I thought that one died when one got a thick neck; I was careful not to eat too much, and all morning I touched my neck to feel whether it was not yet too thick.[24]

By referring to how she thought about the world before entering the institute, Louise underlined the importance of education in ridding her of her irrational and 'uncivilised' thoughts. Although it is not known whether the director made use of these letters, for example in fundraising campaigns, the practice itself demonstrates one of the many ways in which the expertise of particular professionals – in this case, members of religious orders – was promoted and intimately linked to the idea of the institute.

Following a different pathway, one can argue that treatment for people with mental disabilities, at least internationally, arose from the same preoccupation with people's inner thoughts. In France, indeed, the first institutionalised approaches towards children with mental disabilities were the result of the application of phrenological thinking and craniometry practices. Following a long and heated discussion about whether 'idiocy' should be considered as a form of mental illness, the famous psychiatrist Esquirol decided that this was not the case, firmly stating that: 'Idiocy is not a disease, it is a state in which the intellectual faculties have never manifested themselves or have not been able to develop themselves.'[25] Esquirol's definition largely contributed to the established distinction between mental illness and mental disability or intellectual/learning disability. The former refers to a situation where the person is said to require psychiatric treatment. The latter refers to children/adults who need special or inclusive educational programmes.

Despite this early nineteenth-century differentiation between mental illness and disability, the first separate educational initiatives for 'feeble-minded' children only emerged in the 1830s and 1840s, stimulated by the work of Edouard Séguin and French phrenologists such as Belhomme, Voisin and Delasiauve.[26] In Belgium, it was not until 1852–53 that a separate section for mentally disabled children was set up in the psychiatric institute of the Brothers of Charity in Ghent. In the wake of the new legal framework introduced in 1850 that laid down the obligation to provide education to those who could benefit from it, the institute decided to set up *Kinderkoer*, where those who were thought to be receptive to the beneficial influence of education would be educated.[27] In reality, however, children with severe mental disabilities could still frequently be encountered within the confines of a psychiatric institution until well into the twentieth century.

'Pillarisation' and the advent of compulsory education

While the aforementioned religious, economic and political factors clearly played a role in the history of disability and the history of mental illness in Belgium, the discussions about compulsory education in the nineteenth century only seem to have affected the history of disability, even if the discussion on moral treatment can also be viewed in this context. In Belgium, however, the debate remained primarily an intellectual one; it had no real influence on the daily practices of alienists and nurses and the experiences of psychiatric patients.

The rise of special education towards the end of the nineteenth century cannot be understood without including the discussions surrounding the introduction of compulsory education. While in other European countries such as France, the introduction of special classes and schools for so-called feeble-minded children (*enfants retardés*) almost immediately followed the introduction of compulsory education, this was not the case in Belgium. Indeed, the Belgian law that made education for children compulsory was introduced relatively late, in May 1914, whereas the first classes/schools for 'feeble-minded' children had already been founded in Brussels and Antwerp towards the end of the nineteenth century.[28] Therefore, the idea that the introduction of compulsory education forced a large number of children who could not attain required educational standards to attend schools cannot be applied to the Belgian context.

Nevertheless, one should not forget the typically Belgian context of 'pillarisation', which also had a huge impact on the educational landscape. Towards the end of the nineteenth century, the various ideological struggles around schools and schooling – for instance the First School War in 1878 – led to a situation where the majority of children were already going to school. Teachers were therefore confronted with children who had learning difficulties well before the introduction of compulsory education.

While the introduction of compulsory education did not have a huge impact on the care of people with mental illness, it should nevertheless be noted that many proponents of special education for 'feeble-minded' children had a medical background. Doctors such as Auguste Ley and Ovide Decroly played a huge role in the emergence of special schools in Brussels and Antwerp, respectively, around 1900.[29] What is important to note, however, is that these educational activities started to form a kind of institutionalised subfield within the setting of psychiatric care structures.

Taken together, the aforementioned economic, religious, political and educational factors gave rise to a professionalised network of care and educational initiatives. One of the main outcomes of these initiatives was that an ever-increasing number of disabled people and people with mental illnesses became differentiated and institutionalised. Shortly after the turn of the twentieth century, Belgium had six institutes for 'the blind', ten institutes for 'the deaf and dumb', one institute for physically disabled people and several special education classes for 'feeble-minded' children. In 1912, figures from the Standing Committee for the Inspection of Institutions of Alienated Persons referred to 54 psychiatric institutions with approximately 16,000 patients.[30]

The advent and promotion of an institutional approach towards disabled people and people with mental illnesses in Western Europe almost immediately led to counter-initiatives and criticism. Sometimes these initiatives arose within the institute; sometimes they were taken by individuals who did not have specific connections to a particular institution. A good case in point is the nineteenth-century German *Verallgemeinerungsbewegung* (generalisation) movement.[31] Proponents of this movement emphasised the fact that an institutional approach would never lead to a situation where all disabled children were educated in special schools or institutes. Instead, they argued for the integration of disabled children in regular schools as well as an overhaul of teacher training institutes. Although it is unclear to what extent the *Verallgemeinerungsbewegung* led to heated discussions and specific initiatives in Belgium, it is clear that several counter-initiatives paralleled the aforementioned institutional approach.

In what follows, two specific examples of these counter-initiatives will be introduced. The first refers to a long-standing tradition of family care for people with psychiatric disorders. The other looks at the emergence of rehabilitation in the context of the First World War. Both examples demonstrate that the development of an institutional approach did not lead to a situation in which the institute was completely cut off from the rest of the world or where there was no room for more societal care practices. On the contrary, it seems that, at least in the Belgian context, the walls of the institute have always been porous, and the institutional approach has needed to be justified time and again against alternative notions of care, education and treatment.

A disruptive care practice: the Geel colony

When the asylum system faced the first wave of criticism in Europe in the second half of the nineteenth century, many referred to the family colony of Geel as an alternative, a place where the 'insane' lived 'as a family and in freedom', to quote the subheading of a French book published in 1867. And a hundred years later, when a second wave of criticism hit psychiatry in the Western world, Geel was again hailed as a solution: it is not surprising that an American research project, the Geel Family Care Research Project, was launched at a time when anti-psychiatry was seriously undermining psychiatric legitimacy: 'As always, the regime at Geel is alluring, holding out the hope that its ancient practices can still serve as a model for an alternative system of psychiatric care in the community.'[32]

Twice in a century, Geel was held up in international networks on public and mental health (see Chapter 4) as an alternative for dealing with madness, which was traditionally structured through a medical approach, psychiatry and a specific space, the asylum (Figure 8.1). The legend of St Dymphna in the Late Middle Ages inspired the creation of a pilgrimage site in Geel, a village near Antwerp, for those seeking treatment for psychiatric disorders. From the thirteenth century onwards, the families in this village began taking patients into their homes, via a system coordinated by the canons at the Church of St Dymphna. When the Belgian government began introducing regulations for institutions to treat the mentally ill in the 1840s, questions were raised about what would happen to Geel.

Figure 8.1 Geel – Drève de l'Infirmierie. Postcard.

Unlike other countries such as France, where similar setups did not survive the establishment of the nation state – which brought with it a system of biopolitics that conferred the task of managing psychiatric patients on medical specialists – the Belgian government decided to acknowledge the existence of this system for treating the mentally ill by creating a 'state-run colony for the family-based treatment of mental problems' in 1850.[33] Although this involved a degree of 'medicalisation' – the decision to assign patients to households was now in the hands of a doctor – it was a long way from the general tendency to intern patients in asylums that characterised most of the systems introduced in the latter part of the nineteenth century.

However – and this is a point that is often raised – Geel did not welcome all psychiatric patients. 'Raging madmen or madwomen' and 'senile' patients were not accepted. The town of Geel was divided into sectors, each administered by a doctor. Regulation was introduced to clarify the rights and duties of host families, who could be stripped of their permission to take in patients if they failed to comply. Finally, a patient record was created for each person treated in Geel. So although the mid nineteenth century represented a break with previous centuries, with the state partly taking back control via doctors and the considerable sway they held over patients and especially their families, the situation in Geel remained unusual in that the patients living there enjoyed relative freedom.

While patient numbers varied considerably over the nineteenth and twentieth centuries – from 850 in the early 1860s to more than 3,000 by the beginning of the Second World War – they remained high, despite a significant fall after the Second World War, with 1,700 patients in the late 1960s. In this rural town, patients represented up to a quarter of the population: their presence was seen as a normal part of everyday life. Accounts of people walking in town and engaging in conversation with passers-by, not aware that they were talking to patients, can be found in most reports about Geel, both in the Belgian and European mainstream press and in debates on the treatment of psychiatric patients. Anthropological work in the 1970s showed a more ambiguous picture. Lodgers were accepted in the public sphere, as the following notes from an anthropologist's notebook describing a march by a brass band show: 'A middle-aged resident, rather small in stature, accompanies the brass band to the side of the road: he waves his arm to the rhythm of the music … This patient wears a smart suit, very neat. His tie is rather improvised and he wears shabby, inelegant shoes on his feet. He thus accompanies the brass band, approximately at the same level as the drum major, on the side of the road, but slightly in front of the road.'[34] His presence was tolerated for the whole march. But at the same time, lodgers were segregated in cafes, where they were not integrated into 'normal' social circles and were not members of local associations, despite no explicit rules banning them from membership.

Geel became the focus of attention during the contentious discussions about psychiatry in the late nineteenth century, which looked at issues such as the role of psychiatry and 'no restraint' and notions of 'recovery' and 'chronicity'. It was described by some as a place 'that could help asylums get rid of incurable patients who were taking up room and preventing them from carrying out their real mission as hospitals dispensing treatment'.[35] But Geel's management did not agree with this vision, which reduced it to a centre for the chronically ill, and used statistics to argue that recovery figures were just as good as in other asylums in Belgium, if not better.

For Geel's opponents, the relative lack of doctors, more liberal regulation and less direct supervision all ran counter to the paradigm on which psychiatry had developed and gained professional recognition: the asylum as a place that protects psychiatric patients from the abuse they suffer in their local communities. The many visitors to Geel even pointed to a 'lack of science',[36] an assertion Geel's supporters countered by emphasising that the isolated conditions within closed asylum structures were medically counterproductive for psychiatric patients.

Although other countries introduced similar systems – Veldwijk (1886) in the Netherlands, Dun-sur-Auron (1892) in France and Uchtspringe (1894) in Germany – Belgium was unique in the Western world for the sheer number of psychiatric patients treated via this system. No other country had such a high proportion of psychiatric patients living with families: in 1900 in Belgium, nearly 3,000 patients were hosted by families (mostly in Geel) out of a total of 16,300 psychiatric patients interned.[37]

While Geel was held up as a model for theoretical discussions among alienists, the system also had a considerable economic impact in several areas, from the local to the transnational level. For the families hosting patients, it often brought considerable economic benefits. In a region of Belgium with little industrial activity, accepting patients, most of whom could be given farming work to do, provided host families with regular additional income because of the allowances they were paid. But in times of high inflation – especially during the two world wars – it was no longer economically advantageous to take in patients, and the institution had difficulties finding host families. Similarly, if the required medical checks became too restrictive, families sometimes opted out. The interest from local communities was often matched by a desire from Belgian town and city councils to reduce costs: they had to pay a significant proportion of the expenses required for psychiatric patients and could make savings by placing them in Geel rather than in asylums. This economic model was even appealing to neighbouring countries: in 1938, of the 3,000 'boarders' in Geel, 754 came from the Netherlands.[38]

When the asylum model came under increasing scrutiny in the 1960s, Geel (and to a lesser extent Lierneux[39]) was the focus of much attention. At a time when Geel itself was experiencing difficulties – with the industrialisation of agriculture and the need for fewer labourers, the number of willing host families began to dwindle – for many it was seen as an exemplary model for community-based psychiatry that should be developed. L'Equipe, the first sector-based mental health service in Belgium, set up in 1963, can clearly be seen as a continuation of Geel – and not just because its first director, Jean Vermeylen, was born in Geel and his psychiatrist father worked there.[40]

In/out: the challenge of re-education and reintegration

A second example of the porous nature of boundaries can be found at the beginning of the twentieth century. At the outbreak of the First World War, Belgium had a well-established network of care and educational institutes for disabled people, but the state largely remained in the background.[41] This hands-off approach drastically changed through the war years, 1914–18, in response to the impact of the new industrialised warfare. With the sheer scale of the conflict and the introduction of new military weapons such as toxic gases, machine guns and tanks, the First World War destroyed the minds and lives of millions of men and women.[42] Belgian military forces were affected too, and as early as 1915 the Ministry of War decided to open a professional rehabilitation institute for those soldiers who had one or more amputated limbs, had lost their sight or had other bodily problems.[43]

Although at this time only disabled soldiers were said to fall under the responsibility of the state, this radical shift in the government's attitude towards disabled people would have a lasting effect on the overall relationship between the state and disabled people. Alongside religious congregations and other private initiatives, the state increasingly became an important player in the development of overall care and educational system for disabled people. The First World War also had an impact on the vocabulary used to speak about disabled people. The pension system, for instance, set up by the state to financially remunerate the sacrifice made by disabled soldiers, undoubtedly contributed to the spread of thinking in terms of percentages when dealing with disabled individuals. But although shell-shocked soldiers were considered as 'invalid' soldiers

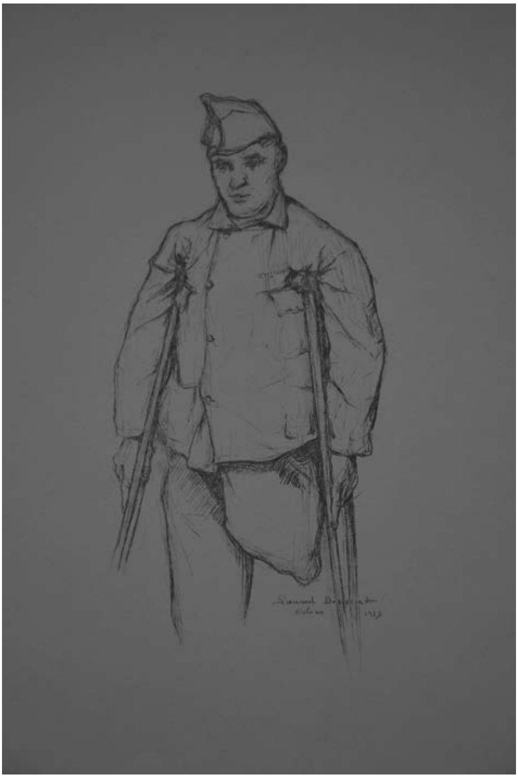

Figure 8.2 'Invalide' – drawing by Samuel De Vriendt, dated 1923, Woluwé.

at that time, the Great War had a much less significant impact on post-war Belgian psychiatric developments (Figure 8.2).[44]

As well as reconfiguring the position of the state towards disabled people, the Great War also had an impact on existing care practices in another area, in that it emphasised the importance of work. Preparing pupils for a life of work in the community had already been on the agenda of educational institutes for some time. The Great War, however, clearly highlighted the importance of work as part of care and educational practices. The main aim of the war-related rehabilitation discourse was to restore invalid soldiers to full fitness in economic terms, to restore their bodily powers and desire to work. On top of that, the fact that these individuals were adult men also opened up a relatively new field, that of adult special education. Again, this was not completely new, since during the nineteenth century several initiatives had also been launched to expand care and education to those pupils who graduated from institutes for 'the blind' and 'the deaf and dumb'.[45] But these initiatives mostly occurred within the confines of the institutes. What becomes clear when we look at what happened in the context of care for blind people is that in the immediate aftermath of the war, four organisations were set up and were almost entirely dedicated to caring for adult blind individuals.[46]

Given the impact of the rehabilitation discourse on the nature of and approach to care practices, it can be seen as the culmination of an idea that had been fermenting for some time within the confines of educational and psychiatric institutes, namely that the scope of the institute needed to be expanded, both geographically and existentially. Another example taken from the history of disability can further illustrate this point: the major debate between oralism and manualism in issues related to deaf education. Just like in other Western European countries, Belgium was confronted with increasing criticism for the use of sign language in educational institutes.[47] Influenced by eugenicist thinking, sign language had been associated with 'animal' and immoral behaviour. It was also claimed that teaching deaf people to communicate using sign language would ultimately harm them, since once they left the institution they would not be able to communicate with speaking people in society. Reflecting these and other arguments, it was decided at an 1880 conference of directors of Western institutes for deaf people that from that moment onwards sign language would be prohibited in deaf institutes.

Recent historical research has demonstrated that the move from manualism to oralism should not be interpreted as a radical shift but as a gradual process. This was also the case for Belgian institutes that provided schooling for deaf pupils, such as at the Ghent Institute for the Deaf-Mute. In an unpublished document, Sister Ghislena Spillemaekers described the separation between pupils who were still allowed to use sign language and those who were not:

> Given the fact that one already needed to tackle a shortage of available rooms [before the introduction of the oral method], achieving the separation depended on considerable cooperation and foresight,

> vigilance, surveillance and extra sacrifice from the staff … As the number of speaking pupils rose, they were given more premises, but the glass doors along which they could have come into contact with the elderly [those who still were allowed to sign] were always carefully covered with curtains.[48]

The gradual move from manualism to oralism represents a broader evolution in which people increasingly started to question the role and the actual functioning of psychiatric and disability institutes. More and more attention was directed to the conditions of those living outside the institute. What people learned in institutes and how they were cared for of course remained important, but these aspects were increasingly accompanied by questions as to how life in the institute would eventually lead to a more or less successful life in society itself. The central place attributed to work in these discourses, however, sometimes stands in stark contrast with the lived realities of the disabled people themselves. One example is what happened with the Belgian war-blinded, who, just like other physically disabled soldiers, were retrained for a new trade or profession.[49]

Among the eighty-eight officially recognised Belgian blinded soldiers, some were able to fulfil the high expectations to be found within the discourse of rehabilitation, but some who were not. Isidore van Vlasselaer, for instance, was described in a personal file that can be found at the Royal Archives in Brussels as a courageous man of good moral character.[50] According to the author of the report, he seemed perfectly happy at home and occupied himself with his son's studies. He would have been happy to go to Brussels to be retrained at the Royal Institute for the Belgian War-Blinded were it not for the fact that he would have to leave his wife and son behind. The report stated that if circumstances allowed, Van Vlasselaere would voluntarily come to Brussels.[51] The life of the blinded soldier Julien Dhont, however, was very different as it was described as extremely painful, both morally and physically: 'He enjoys all his intelligence, he hears everything but no longer knows how to communicate by any means with the outside world: he cannot express a desire or make known his physical needs either orally or in writing.'[52] As well as demonstrating the existential challenges raised by the institutional approach, these two references to the personal lives of two Belgian war-blinded soldiers also make another point clear, namely the fact that education and educational qualities were increasingly affected by decision-making processes that gave rise to official and powerful statements about individuals' futures. Based on this kind of expertise, several groups of professionals would very soon start to compete with one another to safeguard or expand their sphere of activity.

Blurring boundaries

Ever since an institutionalised network of care and education structures for disabled people and people with mental illnesses emerged in the early 1800s, the envisioned boundaries have continuously been subject to criticism. Although these critical voices and activities led to a substantial number of initiatives that ultimately established bridges between society and the institutional archipelago, until the 1960s the care, education and treatment of disabled people and people with psychiatric disorders remained dominated by an institutional approach. Just like in other countries, the legitimacy of the institution was increasingly questioned, leading not only to a crossing of institutional boundaries but also to a blurring of the borders that separated the institution from society. While, to a certain extent, scholars have already begun to examine these processes on an international level and for other countries, there is little to no information available about Belgium. It nevertheless seems a promising and necessary field of study given the trend towards inclusion that started in the late 1970s and early 1980s, as well as the sometimes ahistorical interpretations of this movement. The second half of the twentieth century is often presented as a monolithic period in which people with psychiatric illnesses and disabilities were finally taken out of institutes. While to a certain extent this holds in Belgium for disabled people, the hypothesis runs into difficulties when applied to care infrastructures for people with mental illnesses. Special educational initiatives have indeed been increasingly criticised, and eventually this movement led to the introduction of the M-Decree in the Flemish-speaking part of Belgium in 2015. This decree stipulates that children with special educational needs should in principle be educated in mainstream schools and not relegated to a system of special schools. Although the story of the introduction of this inclusive approach towards the education of disabled people remains to be written, it seems to be very much in line with other innovative care practices that have been introduced for disabled people. One of these is the introduction of the personal assistance budget (see Chapter 6, p. 232), which will be described in what follows.

While the introduction of the M-Decree in 2015 and the development of the personal assistance budget did indeed seem to confirm the trend towards more inclusive approaches to care and special education, they do not tell the full story. There is of course much more to say about the second half of the twentieth century. Not only did particular segregational approaches continue to exist, but it is also important to point out that some inclusive practices, as well as some of our historical interpretations of these inclusive practices, seem to misguide us. A good case in point here is the deinstitutionalisation movement. Just like in other countries, Belgium too was affected by ideas inspired by the international anti-psychiatry movement. However, when one takes a closer look at how the precise numbers of beds that were available in psychiatric institutions between 1960 and 2000 developed, it seems logical to conclude that these ideas led to the increased inclusion of people with psychiatric illnesses. Taken together, the numerical approach to psychiatric inclusion in Belgium and the stories behind the introduction of the personal assistance budget seem to necessitate more complex frameworks if we are to understand the particularities of the history of special care and education initiatives in the second half of the twentieth century.

Deinstitutionalisation … and its limits

Just like in other Western countries, the role of institutions – whether schools, barracks or hospitals – was strongly contested from the 1960s onwards in Belgium. The iatrogenic nature of asylums and institutes for disabled people was particularly emphasised. Several organisations were particularly vocal in their criticism, the most well known being the Groupe d'Études pour une Réforme de la Médecine (GERM), a think tank for medical reform, and Groupe information asiles (GIA), an information group on asylums.

Strongly inspired by a similar group set up by Michel Foucault and others in 1972 in France, GIA was composed of doctors, nurses, psychologists, social workers and asylum patients. Psychiatrists had lost their monopoly: not only did other professionals contest their knowledge, but also patients whose accounts had long been considered as proof of their condition were now taken seriously. It was the first time that former psychiatric patients (*ex-psychiatrisés*, as they called themselves) had become publicly involved in this field. They were able to contribute their unique experience and expertise, which was particularly valued in this movement. The former psychiatric patients in GIA were members of the Mouvement de libération des marginaux mentaux (Movement for the liberation of marginalised psychiatric patients).

Nevertheless, the idea of deinstitutionalisation remained problematic. The number of beds in psychiatric institutions decreased very slowly from 27,303 in 1958 to 25,536 in 1973 and 23,220 in 1982. The high level of institutionalisation made Belgium an exception inside Europe.[53] Belgium was also witnessing significant growth in other institutions that housed patients previously interned in psychiatric asylums – ‘oligophrenic patients’ (now referred to as mentally disabled people) and elderly people. There was a significant increase in medical-educational establishments for mentally disabled patients from the 1960s onwards. Between 1972 and 1979, they doubled in number and their capacity rose from 18,000 to 25,000 patients.[54] While this led to the removal of disabled patients from psychiatric asylums, where they had represented a significant proportion of the population,[55] the patients were transferred to other institutions (Figure 8.3).

The same was true for elderly people. The general inspector for asylums in the Ministry of Public Health, Edmond Bruyninckx, estimated in 1957 that a third of interned patients were aged over seventy.[56] In this area too, the 1970s saw an increase in capacity but also a change in the nature of the care offered. First, there was an increase in new institutions for elderly people – in the early 1970s, the Belgian government planned not only for the addition of 4,500 beds for elderly people over a seven-year period,[57] but also for the creation of new institutions for geriatric psychiatry. Second, rest homes, which had a capacity of almost 60,000 beds in 1970, were gradually turned into nursing homes so that they could house a more fragile elderly population.


© Archives RTBF-Sonuma, Faits Divers : Le psychiatre, son asile et son fou, Jean-Jacques Péché, 1971

Figure 8.3 Excerpt from the 1971 television programme 'Faits divers' about the Lovenjoel Psychiatric Hospital.

Rather than deinstitutionalisation, a more appropriate term would be 'transinstitutionalisation', even if other less institutionalised structures were also beginning to emerge. In Belgium, the latter were essentially organised within the CSM network (Centres de santé mentale or mental health centres). In addition to these centres, other more radical alternatives to institutional psychiatry were starting to be developed. While this was not exclusive to Brussels,[58] the Belgian capital did see a large number of initiatives of this nature. This can probably be explained by the absence of a strong Catholic influence – which had a particularly restrictive effect in Flanders – and the wave of protest led by the Université libre de Bruxelles.

These CSMs demonstrate how the idea of deinstitutionalisation can be seen as part of the broader sweep of the history of psychiatry in the twentieth century. They developed from the Ligue nationale belge d'hygiène mentale (National Belgian League for Mental Hygiene), which was set up in 1923. Inspired by a movement launched by a former psychiatric patient, Clifford Beers, in the United States in 1908, the league promoted treatment outside the confines of institutions and encouraged the notion of 'mental health'. The League was involved in several prevention campaigns (tackling drug addiction, diagnosing 'abnormal' children, etc.) and opened dispensaries – there were eleven in Belgium as of 1933. After the war, from 1953 onwards, the Belgian government began funding these dispensaries, and in 1975, a new legislative framework gave greater clarity to their role and incorporated them into a broader public health policy similar to the sectorisation policy pursued in France.

In 1972, 32 CSMs for adults were affiliated to the league, offering treatment for more than 8,000 adults in Belgium. Compared with the 25,000 patients in psychiatric establishments, this figure was certainly not negligible. Over the following decade, the number of centres quadrupled – by the late 1970s, Belgium had 135 CSMs – but there was a distinct regional imbalance. While the situation in Brussels reflected the standards laid down in the royal decree adopted in 1975, with one centre for 50,000 inhabitants, Flanders lagged behind – of the 113 centres planned, there were only 59.[59]

The League stipulated four categories of services that CSMs should provide: 'medical services', 'psychological services', 'social services' and 'psychotherapy and rehabilitation'.[60] We will look in more detail at how they worked in practice by examining two of the Brussels-based institutions, those in Anderlecht and Saint-Gilles. These two centres emphasise the heterogeneous nature of CSMs. The Anderlecht-based L'Equipe, set up very early on in 1961, became a key centre in terms of the diversity of services it provided (aftercare, day care, occupational rehabilitation, occupational therapy, etc.), and also its role as a flagship institution. It served as a benchmark in the 1970s and 1980s for advocates of the CSM system. It produced a considerable volume of highly visible scientific research, which helped legitimise this social approach to psychiatry. The centre in Saint-Gilles was set up fourteen years later and was essentially just a consultation centre.

But the two institutions did have some points in common. They were both based in urban areas, unlike most psychiatric establishments, which tended to be situated in the countryside or on the outskirts of towns. This urban setting also facilitated close cooperation with other players. In its first annual report, the Saint-Gilles CSM provided a list of the bodies it worked with, which included the social workers in the Commission d'Assistance

Publique (CAP, or Public Welfare Committee), the town's police department and social services, the Little Sisters of the Assumption, the Jewish social services, the parish assistance and support group, polyclinics in the town and the Association of Belgian and Immigrant Women.[61]

The rise of neo-liberal care practices

Another way to illustrate the tendency not just to cross borders but also to blur them is to take a closer look at the introduction of the personal assistance budget in the Flemish region of Belgium. The personal assistance budget revolutionises the traditional care structure by directly giving a certain amount of money to disabled people that they can use to pay for the help they need. Since the money can be used to pay for care in an institution, this new approach cannot be put on a par with deinstitutionalisation. However, what is undoubtedly involved in the introduction of this new scheme is a reversal of the traditional relationship between expert and patient. The personal assistance budget is based on the idea that there is no better expert than the disabled person. He or she knows best what is best for him or her.

The introduction of the personal assistance budget in Belgium can only be understood when seen in the context of what happened in the United States during the 1970s, when Edward Roberts, who was paralysed after contracting polio when he was fourteen years old, started his studies at the University of California, Berkeley.[62] Roberts experienced a huge number of practical issues as he used an iron lung. This huge machine that took over his respiratory functions made it impossible for him to rent a regular student room on campus. The solution that was sought for Roberts, being lodged in the campus hospital, eventually led to the foundation of the Center for Independent Living, an organisation that continued to call for a reorganisation of existing care structures for disabled people in the light of values such as autonomy, emancipation and participation.

It was Roberts's Center for Independent Living and its corresponding ideas that eventually, after passing through Sweden, affected the Flemish care landscape in the 1980s. Midway through the decade, two disabled Flemish people, Jan-Jan Sabbe and Luc Demarez, asked to meet with the Swedish professor Sven-Olof Brattgard to talk about the concept of *Fokuswonen*. Unfortunately, Brattgart could not meet them as he was sick, so Sabbe and Demarez needed to reorganise their study trip. In the end, they met Adolf Ratzka, who had taken up Roberts's ideas and introduced them to Sweden. Inspired by this meeting, in 1987 the two decided to organise a day to explore the issue of housing for disabled people. Ratzka was invited but cancelled at the last minute because of illness. His lecture, however, which was entitled 'Opstand van de verzorgden', was read aloud and not ignored, with a summary being published in a leading Belgian journal. One of the issues that caught the attention of the journalist was the idea of personal assistants: 'These are not nurses, educators, helpers or people who think they know better than the disabled person what is good for them and how everything has to be done. No, assistants are employees who carry out tasks according to the wishes of the disabled employer.'[63]

The first experiments with the personal assistance budget that were conducted in the early 1990s should not, of course, be interpreted in the sense that disabled people had previously never occupied the position of employer. Instead, what the introduction of the independent living idea brought about was an official recognition of the informal status of employer. The first steps towards the official introduction of the personal assistance budget were taken in 1992 when a steering group, Cliëntgebonden budget, was founded. However, it was not until 1995 that Minister Wivina Demeester started a one-year experiment to give twenty disabled people an individual budget each that they could use to pay for the care they needed.

The government's reluctance was not well received by several groups of disabled people. Through lawsuits and public demonstrations, they fought for their right to make autonomous decisions about what kind of care they needed and how this care should best be organised.[64] One example is the lawsuit filed by Jan-Jan Sabbe in 1989 against the Public Centre for Social Welfare (OCMW), which did not want to cover the additional living costs caused by his disability. Another example is the protests by the public action group Genoeg gerold! on 18 November 1994. That day, Minister Wivina Demeester gave a lecture at an academic gathering that focused on ‘integration by means of technical aids’. Given the problems with reimbursement of such measures – as a result of the system organised by Demeester’s ministry – several groups of disabled people found it highly ironic that she had come to speak at this event, and they therefore disrupted her presentation.

The outcome of these and many other events was that disabled people – at least in theory – stopped being seen as dependent, passive and ‘pathological’ individuals. Instead, the voices they raised, the actions they organised and the allies they mobilised time and again emphasised the fact that they were people like anybody else. While their pleas were heeded on several sides, it is also important to note that their voices were coupled with a new neo-liberal conception of care.

Conclusion

The Belgian history of disability and mental illness can be written as a complex and often contradictory narrative of boundaries. Just like in many other Western countries, approaches to physical disability and mental illness – the lived realities connected to the terms, as well as the terms themselves – are the outcome of several eighteenth-century processes that led to the problematisation of particular lifestyles. Not being able to see, hear, walk or think in a ‘logical’ way was increasingly seen as a problem that should be taken care of in a professional context where appropriate care, education and instruction could be given. The boundaries that were established in order to gather and contain the people concerned were manifold and clearly present: one can think of the tangible brick walls that enclose an institute, the straitjackets used in psychiatric asylums and the material obstacles encountered by disabled people who wanted to participate in society. However, this list should also include non-tangible boundaries such as widespread attitudes of pity and the dominant views on how we ‘should’ communicate with one another. All of these boundaries are real and have shaped the lives of disabled people and those with psychiatric disorders as well as those who can be identified as professionals.

And these boundaries have never been radically removed. People have always looked out for cracks in the walls, for openings that would enable them to transgress the boundaries or explore more societal care practices. In contrast to what is often implicitly accepted, these crossings of boundaries have always paralleled the very establishment of the boundaries themselves. What the Belgian case study described here also makes clear is that although these boundaries were transgressed from the moment they were established, their legitimacy has been increasingly challenged from the 1960s onwards. While many other scholars have already described this in some detail, what our Belgian case study makes clear is that the outcome of these processes can and should be analysed critically. A common understanding of deinstitutionalisation, for example, cannot be found by exploring the history of mental illness in Belgium. When one considers the neo-liberal empowerment of disabled people that was and is implied in the introduction of the personal assistance budget, several critical questions can immediately be raised.

While the very presence of boundaries, the reality of their transgression and the counterproductive consequences of the critical movements that originated in the 1960s are of course not unique to the Belgian context, there are nevertheless various aspects that do make the Belgian case study unique. First and foremost, unlike other European countries deaf and blind people were almost always taken care of in the same institutions. Second, religious communities played a huge role in Belgium, and state involvement came at a relatively late stage compared to other Western countries. Third, the history of special education cannot solely be understood by means of the existing historical frameworks, which mainly focus on the introduction of compulsory education in order to explain the emergence of special schools.

Notes

1 ‘Ik ben een zieke die bij u verzorgt is geweest. Ik ben nog steeds ziek. Ik voel mij niet goed. Ik droom ‘s nachts. Draai mij wel 30 keer rond in een nacht … Nu zoolang ik mijn medicamenten innam ging het nog. Maar nu heb ik geen medicamenten meer en nu be ik ziek hoor … Ik ga nu hier naar de dokter maar de dokter wil mij geen medicamenten meer voorschrijiven, hij verlangt een brief van u waarin staat dat hij

mij die medicamenten mar voorschrijiven. a.u.b. Wilt u mij helpen, want zonder medicamenten kan ik hensch niet verder'. Archives du CPAS, Institut de Psychiatrie, Ancienne Série, no. 13500. The name of the patient has been anonymised.

2 A. Bacopoulos-Viau and A. Fauvel, 'The patient's turn: Roy Porter and psychiatry's tales, thirty years on', *Medical History*, 60:1 (2016), 1–18.

3 B. Majerus, 'Material objects in twentieth century history of psychiatry', *BMGN: Low Countries Historical Review*, 132:1 (2017), 149–69. See also S. De Veirman, 'Deaf and disabled? (Un)employment of deaf people in Belgium: a comparison of eighteenth-century and nineteenth-century cohorts', *Disability and Society*, 30:3 (2015), 460–74.

4 See, for instance, L. Bradley, 'A mad fight: psychiatry and disability activism', in *The Disability Studies Reader*, ed. L. J. Davis (New York: Routledge, 2013), 115–31; B. Linker, 'On the borderland of medical and disability history: a survey of the fields', *Bulletin of the History of Medicine*, 87:4 (2013), 499–535; and S. Gilman, 'Madness', in *Keywords for Disability Studies*, ed. R. Adams, B. Reiss and D. Serlin (New York: New York University Press, 2015), 114–19.

5 For a good introduction to (the history of) disability history, see, for instance, C. J. Kudlick, 'Disability history: why we need another "other"', *American Historical Review*, 108:3 (2003), 763–93. For the history of psychiatry, see G. Eghigian (ed.), *The Routledge History of Madness and Mental Health* (London: Taylor & Francis, 2017).

6 The best-known example of this approach probably is Michel Foucault's *Le grand renfermement*, which is situated in the second half of the seventeenth century. Although heavily criticised, the gist of Foucault's argument has been taken up by other scholars like Henri-Jacques Stiker, who in his book *A History of Disability* discusses at length the historical category of 'the poor'. M. Foucault, *Histoire de la folie à l'âge classique* (Paris: Plon & Stiker, 1961); H.-J. Stiker, *A History of Disability* (Ann Arbor: University of Michigan Press, 1997)

7 See, for instance, the introductory chapter to P. K. Longmore and L. Umansky (eds), *The New Disability History: American Perspectives* (New York: New York University Press, 2000).

8 For a recent overview of the history of psychiatry, see the special issue of the *Journal of Belgium History*, 4 (2017). No comprehensive academic overview of the history of disability in Belgium has been published yet. The interested reader can find bits and pieces that zoom in on particular fragments, such as a history of deaf people, an introduction to the rehabilitation of physically mutilated First World War soldiers, the impact of the Great War on the emancipation of blind people in Belgium in the interwar period and an analysis of the visual representation of

'mentally retarded' patients at the Guislain institute. See L. Raemdonck and I. Scheiris, *Ongehoord Verleden. Dove frontvorming in België aan het begin van de 20ste eeuw* (Ghent: Fevlado-Diversus, 2007); C. van Everbroeck and P. Verstraete, *Verminkte stilte: De Belgische invalide soldaten van de Groote Oorlog* (Namur: Presses universitaires de Namur, 2014); P. Verstraete, 'Remastering independence: the re-education of Belgian blinded soldiers of the Great War, 1914–1940', *Educacio i Historia*, 19:31 (in press); and P. Devlieger, I. Grosvenor, F. Simon, G. van Hove and B. Vanobbergen, 'Visualising disability in the past', *Paedagogica Historica*, 44:6 (2008), 747–60. The different levels of attention from historians can also be appreciated by taking a closer look at how heritage is dealt with. In the case of mental illness, Belgium has a well-known cultural institution that focuses on the history of psychiatry from an artistic point of view (Museum Dr Guislain). Although there are also several museums dedicated, for instance, to the history of blind or deaf people in Belgium, these are much less well known by the general public.

9 For an overview of medical literature concerning profoundly deaf people and blind people, see, for instance, C. Guyot and R. T. Guyot, *Liste littéraire philocophe ou catalogue d'étude de ce qui a été publié jusqu'à nos jours sur les sourds-muets; sur l'oreille, l'ouïe, la voix, le langage, la mimique, les aveugles etc. etc.* (Amsterdam: N. V. Boekhandel & Antiquariaat B. M. Israël, [1842] 1967).

10 In Bruges, for example, a home for fourteen blind individuals is thought to have been founded in 1304 by Count de Béthune. In memory of this event the city of Bruges organises a *Blindekensprocessie* every year. There is little to no information to be found with regard to the blind inhabitants of that charitable institution, however. Anon., *Oorsprong & vermaerdheyd der Kappelle van O.L.V. van het blinde lieden Gasthuys, gezeyd Blindekens, binnen Brugge, Ter oorzaek van den vij-honderd-jarigen jubilé, den 15 augustus 1815* (Bruges: Weduwe De Moor en Zoon, 1815).

11 This was the second association of specialists to be created in Belgium. See K. Velle, *De nieuwe biechtvaders: de sociale geschiedenis van de arts in België* (Leuven: Kritak, 1991), 112.

12 B. Majerus, 'Een fragmentarische geschiedenis van de Belgische psychiatrie (19de – 20ste eeuw)', *Geschiedenis der geneeskunde*, 14:2 (2010), 92.

13 D. Sauveur, *Note sur la statistique des sourds-muets de la Belgique* (Brussels: n.pub., 1835). One of the publications where the impact of Sauveur's statistical overview on the emergence of education for disabled people can be seen is the journal that was published in 1837

and 1838 by Charles-Louis Carton, the founder of the Institute for the Blind and Deaf in Bruges: *Le sourd-muet et l'aveugle*.

14 P. Verstraete and Y. Söderfeldt, 'Deaf-blindness and the institutionalization of special education in 19th century Europe', in *Disability History Handbook*, ed. M. Rembis, K. Nielsen and C. Kudlick (Oxford: Oxford University Press, 2015), 265–80.

15 For a good discussion of government action towards the poor, see G. Procacci, *Gouverner la misère. La question sociale en France 1789–1848* (Paris: Seuil, 1993). Applied to the history of disability, see P. Verstraete, 'The politics of activity: emergence and development of educational programs for people with disabilities between 1750 and 1860', *History of Education Review*, 38:1 (2009), 78–90.

16 See one of the first essays on the education of blind people that was published by Valentin Haüy in 1784: *Essay sur l'éducation des aveugles*. In the opening chapter of the essay Haüy clearly states that the main goal of the educational institute was: 'Pmo. Pour occuper agréablement ceux d'entr'eux qui vivent dans un état aisés Sdo. Pour arracher à la mendicité ceux qui ne sont point avantagés des faveurs de la Fortune, en leur donnant des moyens de subsistance; & rendre enfin à la société leurs bras ainsi que ceux de leurs conducteurs' (7–8) ('First of all, to pleasantly occupy those of them who live in a well-to-do state. Second, to snatch from begging those who do not benefit from the favours of fortune, by giving them means of subsistence; and finally give back to society their arms and those of their conductors.')

17 'Sur les moyens d'entretenir les aveugles des deux sexes et de les occuper utilement par un travail léger et dont ils soient capables, soit en les rassemblant dans un établissement public, soit en leur procurant chez eux des occupations et des secours qui les mettent à l'abri de la mendicité'. G. Claes, *Blindenonderwijs en blindenzorg in België (1835–1880)* (Leuven: Niet gepubliceerde licentiaatsverhandeling, Faculteit Letteren en Wijsbegeerte, KU Leuven, 1972), 16.

18 It should be noted that the Belgian practice of housing deaf and blind people together in a single institution is rather atypical when compared to other European countries.

19 Between 1800 and 1892, eleven male and seventy-one female congregations were created in Belgium. See C. Dhaene and L. Dhaene, *Sint-Jozef Kortenberg. Van 'Maison de Santé' tot Universitair Centrum. 145 jaar zorg voor geesteszieken, 1850–1995* (Kortenberg: Universitair centrum Sint-Jozef, 1995), 26.

20 *Onzième rapport sur la situation des asiles d'aliénés du Royaume (1874–1876)* (Brussels: Fr. Gobbaerts, 1878), 8.

21 W. van Waesberghe, 'Het Belgische Krankzinnigenbeleid in de XIXde eeuw', *Annales de la Société Belge d'Histoire des Hôpitaux et de la Santé publique*, 22 (1984), 80–1.

22 'Asiles – colonies d'aliénés de Gheel. Personnel. Fixation du taux des traitements, ainsi que du taux moyen des émoluments tenant lieu de supplément de traitement (15 mai 1912)', in *Recueil des circulaires, instructions et autres actes émanés du ministère de la justice ou relatifs à ce département* (Brussels: n.pub., 1912), 194–7.

23 For this line of thought, see P. Verstraete, 'Savage solitude: the problematisation of disability at the turn of the eighteenth century', *Paedagogica Historica*, 45:3 (2009), 269–89; and Y. Söderfeldt and P. Verstraete. 'From comparison to indices: a disabling perspective on the history of happiness', *Health, Culture and Society*, 5:1 (2013), 249.

24 Letter from Louise Ryspeert to Charles-Louis Carton, Bruges, 19 April 1862 (Charles-Louis Carton Archives, Bruges), n.p.

25 Esquirol (1818) in Bourneville, *Recueil de mémoires, notes et observations sur l'idiotie* (Paris: Imprimerie topographiques des enfants, 1891), 152.

26 P. Verstraete, 'The taming of disability: phrenology and bio-power on the road to the destruction of otherness in France (1800–60)', *History of Education*, 34:2 (2005), 119–34.

27 M. van Walleghem, *Ontwikkeling van de basisfuncties bij jonge mentaal gehandicapte kinderen* (n.pub., 1973); and V. Massin and B. Majerus, 'Des psychiatres et des enfants: Une histoire belge autour du congrès de 1937', *Revue d'histoire de l'enfance 'irrégulière'. Le Temps de l'histoire*, 18 (2016), 149–66.

28 For more detailed information about the introduction of compulsory education in Belgium, see M. De Vroede, 'De weg naar de algemene leerplicht in België'. *BMGN*, 75 (1970), 141–66.

29 See, for instance, A. van Gorp, *Tussen mythe en wetenschap: Ovide Decroly (1871–1932)* (Leuven: Acco, 2005).

30 *Quatorzième rapport sur la situation des asiles d'aliénés du Royaume (1892–1911)* (Brussels: J. Goemaere, 1913), 64–5.

31 A. Leonhardt (ed.), *Hörgeschädigte Schüler in der allgemeinen Schule: Theorie und Praxis der Integration* (Stuttgart: W. Kohlhammer Verlag, 2009).

32 W. Parry-Jones, 'The model of the Geel lunatic colony and its influence on the nineteenth century asylum system in Great Britain', in *Madhouses, Mad-Doctors, and Madmen: The Social History of Insanity in the Victorian Era*, ed. A. Scull (Philadelphia: University of Pennsylvania Press, 1981), 201–17, at 213.

33 In 1884, the Belgian government created a second family settlement, this time in French-speaking Belgium, in Lierneux. However, this colony never reached the same size and fame as Geel: *Lierneux 1884–1984: psychiatrie d'hier et d'aujourd'hui* (Herstal: Impr. de la Province de Liège, 1985).

34 'Un pensionnaire d'âge moyen, plutôt petit de taille, accompagne la fanfare au bord de la chaussée: il agite le bras au rythme de la musique … Ce patient porte un costume de bonne coupe, très soigné. Sa cravate est plutôt improvisée et il porte aux pieds des chaussures grossières, peu élégantes. Il accompagne ainsi la fanfare, à peu près à hauteur du tambour-major, sur le côté de la chaussée, mais légèrement devant la chaussée'. E. Roosens, *Des Fous Dans La Ville? Gheel (Belgique) et Sa Thérapie Séculaire*, Perspectives Critiques (Paris: PUF, 1979), 73–4.

35 E. Régis, *Précis de Psychiatrie* (Paris: Gaston Doin, 1907), 34.

36 *Sixième rapport de la Commission permanente d'inspection des établissements d'aliénés: 1859* (Imprimerie de M. Hayez, 1861), 123.

37 W. van Waesberghe, 'Het Belgische Krankzinnigenbeleid in de XIXde eeuw', *Annales de la Société Belge d'Histoire des Hôpitaux et de la Santé publique*, 22 (1984), 84.

38 J. Rathé, G. Goris and G. Vandercruys, *De Duitsers kwamen niet: de lotgevallen van de Joodse patiënten in de Geelse kolonie (1940–1945)* (Geel: MGraphics, 2011), 21.

39 *Lierneux 1884–1984*.

40 J. Vermeylen, 'Né à Geel', in *Histoire et institution, les 20 et 21 octobre 1995. Rencontres préparatoires au congrès organisé à Bordeaux par l'Union Internationale d'Aide à la Santé Mentale en juin 1996* (Brussels: L'Equipe, 1995), 5.

41 One of the contexts where the government already displayed a degree of awareness concerning disability issues was the army. It was known that many men had become (partially) blind after contracting a disease in the army. Another example is of course the debates that were held with regard to work injuries. See J. Vandendriessche, 'Ophthalmia crossing borders: Belgian army doctors between the military and civilian society, 1830–1860', *BTNG: Journal of Belgian History*, 46:2 (2016), 10–33; and J. Deferme, J., 'De schuld van het toeval: de Belgische wet op de arbeidsongevallen (1903) als een breekpunt in het parlementaire sociale denken', *Tijdschrift voor sociale geschiedenis*, 27:1 (2001), 57–76.

42 For some introductory works on the connection between the First World War and disability, see J. Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London: Reaktion Books, 1996); D. Cohen, *The War Come Home: Disabled Veterans in*

Britain and Germany, 1914–1939 (Berkeley: University of California Press, 2001); and D. A. Gerber (ed.), *Disabled Veterans in History* (Ann Arbor: University of Michigan Press, 2000).

43 P. Verstraete and C. van Everbroeck, *Verminkte stilte: de Belgische invalide soldaten van de Groote Oorlog* (Namur: Presses Universitaires de Namur, 2015).

44 Ruben Debusschere, 'De militaire psychiatrie in België voor de Eerste Wereldoorlog: verkenning van een discipline in wording' (master's diss., KU Leuven, 2013).

45 Moreover, in the nineteenth century various initiatives were also taken that were directed solely towards disabled adults. A good example of this is Pasteur's rehabilitation initiative for mutilated miners, introduced around 1900 in the region of Charleroi. See P. Pasteur and L. Caty, *L'assistance aux estropiés par la création d'écoles d'apprentissage et d'ateliers. Rapport à la députation permanente du conseil provincial* (Frameries: Impr. Provinciale Dufrane-Friart, 1907).

46 Licht en liefde, Brailleliga, Algemeen Vlaams Blindenverbond and Oeuvre National des Aveugles.

47 D. Baynton, D., *Forbidden Signs: American Culture and the Fight against Sign Language* (Chicago: University of Chicago Press, 1996).

48 'Daar men om deze scheiding te verwezenlijken maar over de te voren reeds onontbeerlijke lokalen kon beschikken, werd daartoe van het toenmalig personeel veel overleg en vooruitzicht, groote wilskracht, waakzaamheid, toezicht en verdubbelde opoffering vereischt … Naarmate de klappers in getal toenamen, kregen zij meer lokalen tot hunne beschikking, maar de glazen deuren langs dewelke zij met de ouderen zouden hebben kunnen in aanraking komen waren altijd zorgvuldig met gordijntjes behangen.' Unpublished document, Archives of the Sisters of Love, Ghent.

49 The blinded soldiers were initially cared for in the French Institute for the Blind in Amiens. Given the negative impact of this situation on their morale, they were soon transferred to the Port-Villez rehabilitation institute. In 1919 a special Royal Institute was founded for them in Boitsfort; it remained open until the last blinded soldier was rehabilitated (1921).

50 Personal file of Isidore van Vlasselaere/Archives of the Royal Palace/ Archives of Queen Elizabeth no AE 806/ Brussels.

51 Ibid.

52 Confidential file on Julien Dhont/Queen Elizabeth Archives no. AE 806/Archives Queen Elizabeth/Royal Archives/Brussels.

53 Helena Medeiros, David Mcdaid, Martin Knapp, MHEEN Group and Judit Simon, 'Shifting care from hospital to the community in

Europe: economic challenges and opportunities', *MHEEN II Policy Briefing*, 4 (2008), 10.

54 *Annuaire statistique de la Santé Publique* (Brussels: Ministère de la santé publique et de la famille, 1979), 240.

55 In Beau-Vallon, an asylum for approximately six hundred patients, the category 'oliogophrenia, idiocy, imbecility, mental retardation' accounted for 36 per cent of patients between 1961 and 1970. L. Lacroix and A. Roekens, 'Des patientes, des vies', in *Des murs et des femmes. Cent ans de psychiatrie et d'espoir au Beau-Vallon*, ed. A. Roekens (Namur, Presses Universitaires de Namur, 2014), 74.

56 E. Bruyninckx, 'Considérations sur le problème des vieillards atteints de troubles mentaux', *Acta Neurologica et Psychiatrica Belgica*, 7 (1957), 537–50.

57 'Troisième âge', *Bulletin d'information pratique pour la santé mentale*, 9 (January 1971), 14.

58 In Leuven, Passage 144, a non-medicalised institution, inspired by Ronald Laing and the International Philadelphia Association, is supported by criminology professor Steven de Batselier. When the academic authorities of the Katholieke Universiteit Leuven threatened to dismiss Batselier, several student demonstrations were held to support him. AMSAB-ISG, APL-B, box 141, affaire Steven De Batselier, De Batselier S. and M. Lietaert Peerbolte, Passage 144: terug naar de baarmoeder (Antwerp, Soethoudt, 1979). In Antwerp, a group of psychiatrists, lawyers, caregivers and former patients gathered together to publish the magazine *Spuit*, which was in print from 1975 to 1980. Interview conducted on 15 February 2016 with Sam Landuyt.

59 J. Orenbruch, C. Bastyns , I. W. Domb and M. Toledo, *La nouvelle politique psychiatrique belge*, vol. 1 (Brussels, 1979), 350.

60 *La folie parmi nous – Pour une politique de la santé mentale*, coll. 'La revue nouvelle', 10 (1973), 334.

61 AMSAB-ISG, APL-B, box 140, rapport d'activités du Centre de Santé Mentale Sectorisé de Saint-Gilles (1975), 7.

62 For an introduction to the history of polio, see W. Gareth, *Paralyzed with Fear: The Story of Polio* (Basingstoke: Palgrave Macmillan, 2013).

63 Artikel uit De Standaard (1988), cited in A. Looten, *Een geschiedenis van het persoonlijk assistentiebudget in Vlaanderen, 1987–2001* (Leuven: Niet-gepubliceerde Masterproef, Faculteit Psychologie en Pedagogische Wetenschappen, KU Leuven, 2001), 25.

64 For some stories about the disability protests, see S. Barnartt and R. Scotch, *Disability Protests: Contentious Politics, 1970–1999* (Washington, DC: Gallaudet University Press, 2001); J. Shapiro, *No Pity: People with Disabilities Forging a New Civil Rights Movement*

(New York: Three Rivers Press & Fleischer, 1994); and D. Zames and F. Zames, *The Disability Rights Movement: From Charity to Confrontation* (Philadelphia: Temple University Press, 2001).

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