**The Eugenics Movement in Connecticut, Maine, New Hampshire and Vermont**

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**Introduction**

“When you get out, it’ll be in a pine box” (Wyman, personal communication, 1999 in Murphy 2011:140). Staff at Pineland, Maine’s school for the feebleminded, told this to teenage resident Charlie Wyman when he was returned to the school after running away. Charlie lived at the school for 11 years in the 1930s after the state took him from parents who could no longer afford to keep him. Although he was classified as a “moron” by the school, he referred to himself and many in the school like him as poor orphans. He recounted to reporters that he was beaten regularly and forced to work while there. He attempted to run away twice and was returned by people eager for the twenty-five dollar reward; his third attempt was successful (Murphy 2011:139-140). Thousands classified as “morons” in New England during the Eugenic Movement faced a lifetime of segregation and abuse in institutions. But for roughly 1,800 people in Connecticut, Maine, New Hampshire and Vermont this and other supposedly medical diagnoses resulted in sterilization (Kaelber 2011).

The Eugenics Movement in the United States, while often overlooked, represents an important time our history; a time when fledgling science, social thought and political action converged to segregate and abuse the most vulnerable among us (DuBois 2010; Gallagher 1999; Largent 2008; Murphy 2011; Paul 1965). These laws and practices touched almost every corner of the country and New England was no exception (DuBois 2010; Gallagher 1999; Murphy 2011; Paul 1965). While unified by history and culture, the New England states have also differed in terms of population, economy, religion, etc. (University of Virginia Library 2007). The effect of the Eugenics Movement is representative of the similarities and differences that define this region of the U.S. This paper looks at the eugenics movement in Connecticut, Maine, New Hampshire and Vermont by examining the sterilization laws that governed these states; the height of operation and the groups that suffered most under them; as well as the institutions that were responsible for implementation. In addition, it takes a brief look at institutional closings, the transition to community care, and the state of community care.

**THE LAWS[[1]](#footnote-1)**

Connecticut

Connecticut was the first state in New England to enact a sterilization law; it was also the most ambiguous and loosely defined in the nation (Paul 1965:294, 296). The process outlined in the law consisted of a 3-person board: the superintendent of the institution, a doctor and the surgeon appointed by the superintendent who made the decision.

Such board shall examine the physical and mental condition of such persons and

their record and family history, so far as the same can be ascertained, and if, in the

judgment of a majority of said board, procreation by any such person would produce

children with an inherited tendency to crime, insanity, feeble-mindedness, idiocy,

or imbecility, and there is no probability that the condition of any such person so

examined will improve to such an extent as to render procreation by any such

person advisable, or if the physical or mental condition of any such person will be

substantially improved thereby, then said board shall appoint one of its members to

perform the operation of vasectomy or oöphorectomy, as the case may be, upon

such person (Loughlin 1922:20).

This excerpt constitutes the majority of the brief 1909 law. It was explicitly for eugenic use although it covered sterilization for therapeutic purposes. The eugenic intent of the law is clear but while language is similar to Vermont’s law, its application was decidedly more medical, as will be discussed later. It applied only to inmates of both state hospitals, Middleton and Norwich, and was amended in 1919 to include the State Training School at Mansfield in 1919 (Laughlin 1922:20). The law did not stipulate consent but wasn’t compulsory; it did not include any means of appeal or any other safeguards for use, but there is evidence that institutions adhered to a policy of gaining consent from patients or guardians, for a time (Paul 1965:296). It wasn’t until 1965 that a bill was passed that provided safeguards and by that time use was coming to an end (Paul 1965:297). All in all Connecticut performed sterilizations for over 50 years and operated on 557 individuals (Kaelber 2011).

New Hampshire

New Hampshire was next in New England; when it passed its first law in 1917, it was voluntary but not widely used. A revision to it was passed in 1929, after the decision in the U.S. Supreme Court case Buck v. Bell (Landman 1932:80; Paul 1965:415,). This law was compulsory, covering all inmates in state and county institutions (Brown 1930:26). In his interpretation, Landman, author of *Human Sterilization: A history of the sexual sterilization movemen*t, describes the law: “it provides that in the interest of the state economy, eugenics and personal therapeutics, the superintendent of any state institution may recommend to be salpingectimized or vasectimized any inmate suffering from a hereditary form of a mental disorder” (1932:80). The decision-making process was clearly in the hands of superintendents and based on eugenic considerations. Research shows the law was used eugenically and although consent was not required under the law, institutions had to give the patient notice, hold a hearing and allow for an appeal to the state supreme court (Paul 1965:415). New Hampshire’s law was the most extensively used law in New England, allowing for the sterilization of 679 individuals in a roughly 40-year span (Kaelber 2011). This number puts it well over its northern New England counterparts and over Connecticut, whose law was in effect a decade longer (Kaelber 2011).

Maine

Maine was the third New England state to pass a sterilization law, in 1925, again not widely used before Buck v. Bell (Murphy 2011:109; Paul 1965:369). Under the law the Maine School for the Feebleminded, later known as Pineland, held the most power and was the center of the operation (Murphy 2011:110; Paul 1965:366). When state institutions recommended sterilization for patients, two of the three state superintendents had to sign off on it. Maine’s law also had an explicit extramural component. Any doctor in the state could recommend the procedure for an un-institutionalized individual, which would be reviewed by a panel of three doctors who would determine questions of consent. Although the decisions were filed at Pineland, no state institution was involved in the extramural operation (Paul 1965:366). The law was considered voluntary; it was based upon requests from the patient or the responsible party, but that process was lax and could easily have been manipulated (Murphy 2011:107). The law did provide for an appeal process although it was explicitly for eugenic use (Landman 1931:90; Paul 1965:366). In 1929 an amendment was made which, according to Landman, “alters those who may authorize the sterilizing when a patient is incompetent to do so” (1932:90), raising questions, unaddressed by Paul[[2]](#footnote-2), as to how voluntary the law was. It is possible that this amendment gave more power to the institution over those dependent on the state without making the law compulsory. Maine’s law was active for 40 years, resulting in over 300 known sterilizations; only a little over half of those took place at Pineland which means that the extramural component was used (Kaelber 2011; Paul 1965:367).

Vermont

Vermont was the last state in New England to pass a sterilization law. In 1912 the state house passed a law, which was compulsory, covered public and private institutions and prisons and included a three-strike measure for multiple criminal offenders, but the governor vetoed the law (Greenberg 1999; Laughlin 1922). The 1931 law passed and covered both state institutions and extramural operations. The extramural operation of the law appears to have been the primary focus, as opposed to the secondary. The majority of the law is solely about the procedures and legalities of the extramural operation (Gallagher 1999:185). Although extramural is not mentioned explicitly, it applies to any “person resident of the state” (Gallagher 1999:185), and ends: “The physician and surgeon, after performing such operation, shall endorse on each of the duplicate certificates, when and where he performed such operation, keep one of said certificates, and mail the other, postage prepaid, addressed to the commissioner of public welfare, at Montpelier, Vermont, to be kept in his office” (Gallagher 1999:185). These excerpts make clear that it applied to un-institutionalized residents of the state.

In his analysis Paul asserts that both the institutional and extramural procedures operated on a voluntary basis. The procedure was requested or recommended, then a panel of one doctor and two surgeons would decide on the eugenic/therapeutic justification and whether the person fully understood, and could submit voluntarily. The extra-mural section stresses the need for consent: “such persons voluntarily submits to such operation” (Gallagher 1999:185). But section 3 “Inmates of State Institutions” does not address consent at all when outlining the legal procedure: “If such person is being supported by the state in any institution in the state the commissioner of public welfare is authorized to contract with two competent physicians and surgeons, not in the employment of the state, to examine such idiots, imbeciles, feeble‐minded or insane persons as he has reason to believe should be sterilized” (Gallagher 1999:185). Consent is never mentioned once. This is salient when coupled with the apparent lack of an appeal process. In Landman’s interpretation he uses “legal representation” (1932:93) when referring to gaining consent for an operation from an incompetent patient, illuminating how the state could have skirted issues of consent. While institutions required a panel to confirm the recommendation, superintendents held the most power when recommending the procedure for patients (Greenberg 1999). No sterilization records have been released by the state as such, it impossible to tell how it was used, institutional involvement and the effect the extramural component (Greenberg 1999). Still, Vermont had the shortest sterilization period and the lowest numbers in the region (Kaelber 2011).

**STERILIZATION PATTERNS IN CONNECTICUT, MAINE, NEW HAMPSHIRE AND VERMONT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | % women | % mentally ill | % “mentally deficient” (  intellectually disabled) | % mentally deficient/  intellectually disabled women | total | # per 100,000 during peak period | Length of time |
| National | 61% | 44% | 52% | 66% | Est 60,000-70,000 |  | 1907-1980s  est 76yrs |
| Connecticut | **92%** | **74%** | 26% | **86%** | 557 | 3 | 1909-1963  **54 yrs** |
| Maine | 83% | 7% | 72% | 83% | 326 | 2 | 1925-1963  38 yrs |
| New Hampshire | 78% | 37% | 56% | 67% | **679** | **8** | 1917-1959  42 yrs |
| Vermont | 67% | 6% | **83%** | 65% | 253 | 6 | 1931-1957  26 yrs |

The Peak Years

Maine, New Hampshire and Vermont all saw a significant rise in sterilization rates in the 1930s, while Connecticut hit its peak earlier in the late 1920s (Kaelber 2011; Paul 1965,). Connecticut’s law was passed in 1909 but by 1921 they had only sterilized 27 people; in the next ten years that number jumped to 173 (Paul 1965:294). The early peak seen in Connecticut corresponds with early implementation of the law, but it may also be a product of Connecticut’s medical approach, and its large institutionalized population, by 1929 Connecticut had opened a third state hospital bringing the number of beds up to roughly 6,000 (Creighton 1939:1-2)

Maine and New Hampshire both had legislation in place before Buck v. Bell but did not start sterilizing in earnest until after it passed (Paul 1965: 369, 418). The Supreme Court decision was important but there were other factors at work too. By the time the laws came into use northern New England institutions were already facing overcrowding and institutions and superintendents had the most power under these laws (DuBois 2010; Murphy 2011). Sterilization rates corresponded heavily to the ideological beliefs of the superintendents; pro-eugenic superintendents meant high numbers of sterilizations, although there were exceptions (DuBois 2010; Murphy 2011:109-110; Paul 1965). The 1930s was a period of strong eugenic belief, and all of New England saw pro segregation and sterilization superintendents (DuBois 2010; Gallagher 1999; Murphy 2011). Institutional information shows that this was particularly true of Pineland in Maine and Laconia State School in New Hampshire, whose sterilization number correspond directly their to pro-eugenic superintendents (DuBois 2010; Murphy 2011: 109-110).

Another reason for peak rates in the 1930s was the economic depression. Every institution in New England was overcrowded, understaffed and without sufficient resources almost from the day the opened until the day they closed (Creighton 1939; DuBois 2010; Murphy 2011). But the depression and the following war years were particularly hard because more people turned to institutions when they could no longer care for their sick and elderly (DuBois 2010; Murphy 2011:119, 130). The increased strain prompted many institutions to sterilize and release patients to make way for the incoming population (DuBois 2010). This practice explains some of the disparity between New Hampshire’s numbers and Maine’s. In Maine, Pineland stayed fiscally viable by keeping able-bodied patients in the school and using them as free labor to maintain the physical plant and help the limited staff to care for the disabled (Murphy 2011:88, 118). As opposed to Laconia, in New Hampshire institutions relied on releasing patients in order to keep the population at a manageable level. This method resulted in a higher release rate during the difficult depression years (DuBios 2010). In his documentary on Laconia State School, Gordon DuBois, former Laconia Sate School worker, stresses the difficult economic situation in the 1930s, which could further explain New Hampshire’s high sterilization rate (2010).

Gender

Gender was a prevalent factor in sterilization patterns across the country and New England. In all four states, women were the vast majority of victims. Females as the “root” of degeneracy can be traced back to the early case studies, which identified women as the carriers of bad germplasm (Rafter 1992:21; Wray 2006:76). While feebleminded did not apply strictly to women, the historical association was ingrained by the time the majority of the laws passed and its inclusion may have helped to perpetuate women as the focus. Women were easily targeted and persecuted for several reasons. The most obvious is that they had children, who were the physical manifestation of degenerate behavior and were responsible for limiting women’s means and mobility (Rafter 1992:25). While men often fled from unwanted children women had no such escape, and children were a way into families (Gallagher 1999:53-64). In Vermont the Children’s Aid Society was a major part of the eugenics campaign and they helped to make children a focal point of the eugenics movement. The Society would identify miscreant children and then target their parents as unfit. Records from both private and public agencies were compiled on families and because men had the freedom to leave, mothers were disproportionately targeted (Gallagher 1999:75-77). Vermont also focused on young girls who were seen as the breeders of future feebleminded generations and a particular problem (Gallagher 1999: 61). While there is a smaller body of work on the eugenic campaigns in the other northern New England states, Pineland’s most eugenic superintendent, Steven Vosbergh was quoted saying: “It is a sad fact that the tendency of feebleminded females is to lead dissolute lives…A feebleminded girl has not sense enough to protect herself…What Maine needs is accommodation for 1200 of such feebleminded women in a central institution” (Murphy 2011:104). From this it is clear that Maine’s eugenic proponents saw women as the root of the problem.

Traditional female roles were changing at that time; middle class female professionals were emerging in fields like sociology and social work that brought them into direct contact with “degenerate” female populations. Early eugenicists like Charles Davenport, biologist and leader in the Eugenics Movement, identified women as better suited to studying families and individuals for degeneracy (Wray 2006:75). The Eugenic Records Office at Cold Spring Harbor, the center for eugenic and hereditary research, was training these young women to find problems. They were sent to confirm and perpetuate the eugenicist’s belief, not to look earnestly at the problems of individuals and society they encountered (Gallagher 1999:66,75; Wray 2006:75). In these roles middle class women strove to define themselves against the subjects they came upon. They had money, power, independence and virtue, whereas poor women had no education, no options and no power (Rafter 1992:25-26).

Unlike Maine, New Hampshire and Vermont, Connecticut was more urban, took a medical approach and passed a sterilization law almost a decade before the others. The majority of sterilizations in Connecticut were performed on women and the mentally ill. These numbers suggest that women were not being diagnosed with feeblemindedness on the level of the northern state but instead with more “medical” afflictions like hysteria, depression or anxiety. This would also be consistent with early notions of “hysteria” and the early passage of the law (Wikipedia 2012a). But the numbers also show that of those deemed mentally deficient, 86% were women, which demonstrates that, perhaps later, Connecticut clearly associated women with mental deficiency.

**“Mentally Deficient” vs. Mentally Ill**

There is a pronounced difference between the percent mentally ill and percent mentally deficient sterilized in Connecticut and northern New England. The majority of Connecticut’s victims were labeled as mentally ill whereas in Maine, New Hampshire and Vermont the majority were labeled as mentally deficient (Kaelber 2011). The tangible differences of urban vs. rural, coupled with sheer size of the population as well as statewide approaches to the institutionalized population, allow for an explanation for this disparity.

While an urban vs. a rural population may seem trivial, for eugenicists early casework focused on rural populations. The Jukes to the Tribe of Ishmael posited that feeblemindedness was a rural affliction; rural populations were isolated, uneducated, inbred etc (Wray 2006:76). In Vermont, the involvement of the Country Life Movement is indicative of that rural focus and led to explicit attempts to segregate and disenfranchise that population (McReynolds 1997:322-323). In Vermont and Maine rural populations were targeted in an effort to retake areas for tourism (the mountains in Vermont and the coast in Maine). In both states rural populations were, in some cases, rounded up on the grounds of being feebleminded and institutionalized (Gallagher 1999:49-50, Murphy 2011:75). Connecticut, by comparison had a more urban population, roughly 31% according to the 1930 census as opposed to close to 50% in northern New England (University of Virginia Library 2007). At the turn of the century in Connecticut mental illness was considered an urban problem; schizophrenia, anxiety and depression all appeared more in urban populations (Burr 1903).

Connecticut is also an exception due to the size of the population; 1930s census data shows Connecticut’s population was twice the size of Maine, which had the largest population of the three northern states (University of Virginia Library 2007). Given their relatively large population, Connecticut’s response to the “problem” was different; New Hampshire and Maine built training schools, Connecticut built state hospitals (Creighton1939; DuBois 2010; Murphy 2011: 50). Connecticut’s hospitals grew far beyond the numbers seen in Pineland or Laconia, but they did not sterilize as many patients as New Hampshire (Kaelber 2011). Connecticut diagnosed more mentally ill patients and so possibly retained more legitimately ill patients and released fewer who could support themselves outside of the hospital. Given the number of people institutionalized in Connecticut versus any of the northern states it is evident that they were sterilizing at a much lower rate compared to the size of the institutionalized population. This again could be due to the ambiguity of the law, or it could be indicative of a much larger population that was mentally ill.

**INSTITUTIONS**

Norwich State Hospital, Connecticut

The first institutions opened in Connecticut were state hospitals. By 1930 there were three with a combined capacity of 6,000, making all three significantly larger than any institution in northern New England. The State hospital in Middleton opened in 1866, Norwich State Hospital was opened in 1904 and Fairfield Hospital was opened in 1929 (Creighton 1939:1-2). Throughout their history these hospitals suffered from severe overcrowding. It was especially acute during the depression when both families and institutions were feeling strained economically. In the late 1930s Norwich was 18% over capacity (Creighton 1939:17). By 1939 Norwich was not accepted by the American Medical Association and it did not meet the minimum requirements from the American Psychiatric Association (Creighton 1939:9). Due in large part to lack of quality the hospital was under staffed and unable to attract well-trained and committed personnel, doctors or nurses (Creighton 1939:9).

A board of directors officially ran Norwich but the majority of the power lay with the superintendent (Creighton 1939:7). As was seen in northern institutions it is likely the superintendent wielded the most authority over sterilizations (Paul 1965:295). Paul can only attribute specific numbers to Southbury Training School, leaving the vast majority of procedures unattributed to specific institutions, but there was no extramural operation in Connecticut, so the hospitals had to have participated (Paul 1965:303). A report conducted by the state in 1939 does not mention sterilization, which begs the questions of whether Norwich was not utilizing the law at all at that time or if state officials were simply not writing about it (Creighton 1939).

As discussed above, Connecticut’s approach was decidedly more medical than the northern states, but that approach was based upon the fact that they were dealing with a much different population, not only larger but more urban. The majority of Norwich patients suffered from “mild psychoses”; they treated people with schizophrenia and had a large ward dedicated solely to patients with tuberculosis (Creighton 1939: 26). These were considered hospitals for medical treatment and patients there were considered mentally ill (Burr 1903, Creighton 1939; Paul 1965: 295). Norwich’s peak population was over 3,000 in 1955 (Wikipedia 2012b).

Pineland, Maine

Pineland opened in 1908 as the Maine School for the Feebleminded (Murphy 2011:48; Kimball[[3]](#footnote-3)). It was the first school of its kind in Maine, although two hospitals for the insane, a reform school and a school for the deaf were in operation. The founders saw Pineland as an alternative, a place specifically for the feebleminded where they could be cared for and receive schooling and training (Murphy 2011:50-51). Like elsewhere in New England, the school quickly filled up, faced economic pressure and from the beginning its purpose was distorted. Older residents were admitted; children were kept after 21; and there was statewide pressure for the school to admit more women (Murphy 2011 68-71).

Maine’s sterilization law was targeted at the feebleminded population. The Country Life Movement aided Vermont’s Eugenics Survey but a strong KKK presence helped propel Maine’s legislation into law (Gallagher 1999:48, Murphy 2011:108). Despite Catholic opposition, the Law was passed in 1925 and Pineland became the focus of its implementation (Murphy 2011:110). All known institutional sterilization in Maine happened at Pineland from 1925 through the 1960s (Kaelber 2011; Murphy 2011:110; Paul 1965:369). Accounts of Pineland agree that the superintendents were the most powerful forces within the institution and sterilization numbers reflected their beliefs (Murphy 2011: 109, 113). Stephen Vosburgh, a physician and Pineland’s third superintendent was a strong advocate on behalf of the sterilization law and utilized it, carrying out the majority of Pineland’s known 189 operations, and overseeing the peak years in Maine (Murphy 2011:113). His successor, Nesib Kupelian, a physician at Pineland for 12 years, carried out 72 sterilizations during his tenure from 1938-1953 and was the “last avowed eugenicist” (Murphy 2011:126). Peter Bowman, a German psychiatrist and progressive figure at the school, followed him and advocated for patient release and community options while overseeing the last spike in sterilizations, 18 people in 1955 (Murphy 2011:145-146, Paul 1965:369).

What made Pineland different from other institutions is the extent it utilized resident labor. Every superintendent relied upon the able-bodied population of Pineland to remain operational (Murphy 2011:117-119); especially during the depression and WWII when other institutions were discharging at high numbers, Pineland worked hard to keep people inside (Murphy 2011:130-131). Even Bowman, the reformer, was loath to let the free labor go (Murphy 2011:146, 152). One cause of this pervasive problem was that over time Pineland became home to more serious medical patients (Murphy 2011:145). Pineland needed resident labor, to care for these patients, to keep the school operating and to make maintain the appearance of a training school (Murphy 2011:117, 152, 172). But what started out as a school for rehabilitation ended up as a dumping ground for the mentally ill (Murphy 2011:165). Pineland didn’t have the resources or the staff to deal with this population and the conditions inside deteriorated steadily over the years. Religious groups and journalists periodically exposed conditions, but it wasn’t until the 1990s that Pineland closed under the pressure of public opinion and fiscal realities (Murphy 2011:136, 158, 174). Pineland’s peak population was almost 1,500, half of Norwich’s but also in 1955 (Murphy 2011:157).

Laconia State School, New Hampshire

New Hampshire, like Maine and Vermont built state institutions at the turn of the century when the poor house/farm model fell apart. It had a state hospital in Concord but Laconia State School became the center for the eugenics movement and sterilizations in the state. (DuBois 2010, Kaelber 2011). Laconia opened in 1903 as a school for the feebleminded to children no older than 21, but by 1905 the mandate changed; children were kept past 21, particularly women, and older people were admitted. Laconia soon faced the overcrowding seen elsewhere in New England. There was strong public belief in New Hampshire that the feebleminded needed to be isolated, kept away from society for their own protection and the protection of society. The depression and WWII were incredibly hard in New Hampshire. As more families were unable to care for their disabled, Laconia became the publicly accepted place to put them, under a growing perception that the institution had resources unavailable to the public (DuBois 2010).

In reality, the institution was over crowded, understaffed and home to rampant abuse by staff and residents (DuBios 2010). As discussed above, New Hampshire’s first sterilization law required consent from the patient or guardian but in 1929 the law became compulsory. The superintendent had a considerable amount of power under the law. The school’s 2nd superintendent, Benjamin Baker, was a strong advocate for sterilization and utilized it during his 35-year tenure at Laconia. By 1947, 264 sterilizations had been performed there; by 1958 that number would rise to 400, meaning sterilizations continued even under later “progressive” superintendents like teacher Richard Hungerford, Laconia’s first non-medical professional superintendent (DuBois 2010).

New Hampshire remains somewhat of an anomaly in northern New England, sterilizing over 600 people compared to Maine’s roughly 300 and Vermont’s roughly 200 (Kaelber 2011). Pineland and Laconia were very similar; Laconia largest population was 1,100 and Pineland’s was slightly more at 1,445, but Laconia sterilized over 200 more people (DuBois 2010; Kaelber 2011; Murphy 2011:157). The eugenic environment in Maine and New Hampshire was similar, both sterilization laws passed easily, but the laws were different, New Hampshire’s was compulsory and Maine’s was not. This coupled with the fact that Pineland had more superintendents during peak years, who brought differing degrees of dedication to sterilization and their heavy reliance on resident labor as well as Maine’s extramural application explains some of why the gap was so big between similar states and institutions (DuBois 2010; Murphy 2011; Paul 1965). Laconia’s peak population was a little over 1,000, meaning it was significantly smaller than Norwich and smaller than Pineland but its peak was in 1955, indicating a significant trend in the social environment throughout New England to support such large numbers at these institutions (DuBois 2010).

Brandon Training School, Vermont

Brandon training School opened as the Vermont School for the Feebleminded in 1915. Authorized as a training school for feebleminded children, Brandon was built on the grounds that it would primarily house degenerate women (Greenberg 1999). Compared to Pineland and Laconia, there is little information about the operation of the school or the sterilizations that occurred there. There were other institutions in the state for the feebleminded and an asylum, but Brandon was intimately connected to the eugenics movement through its first superintendent Truman Allen, who was a public and outspoken advocate for segregation and sterilization, (Gallagher 1999:74, Greenberg 1999). He was also helped found the Colony for Feebleminded Women in Rutland (Gallagher 1999:74). Given the power superintendents were given under the law, Truman and his pro-eugenic successor Thorne held considerable power and likely implemented their beliefs and the law at Brandon (Gallagher 1999:174).

There are no numbers for any institution in Vermont so it is impossible to compare Brandon to Pineland and Laconia on the basis of numbers. But this much is clear: more than the other two institutions, Brandon was focused on women. That Vermont sterilized the lowest percentage of women in New England could be a result of other institutions and the extramural component of Vermont’s law. Brandon was not as large as the other institutions, never topping 1,000 (Vermont 1993:3). Sterilizations may also have been kept low in Vermont due to the amount of time the law was operational and the public environment regarding sterilization. Although the law passed in Vermont, it was not under the same fervor that it did in Maine and New Hampshire (DuBois 2010; Gallagher 1999; Murphy 2011).

**INSTITUTIONAL CLOSINGS AND COMMUNITY CARE**

Laconia Leads the Nation

Laconia was the first institution of its kind in the country to close its doors in 1991, a huge step considering it likely sterilized more people than any other institution in New England (Kaelber 2011; Paul 1965). The trajectory of its closure was representative of changing attitudes towards people with disabilities and an effort to approach these issues from a non-eugenic standpoint (DuBois 2010). It began with growing parent involvement, and public awareness of the conditions in the school. Laconia gradually became home to more severely ill patients; inadequate facilities and staff resulted in terrible living conditions, and a medical approach that relied primarily on restraint (DuBois 2010). Toward the end of its life Laconia did make strides in education and therapy but by that point the state was on the path to closure (DuBois 2010). Although there were strong advocates for closure in the school and the state, Laconia was in uncharted territory. One of the most contentious issues during closing was how former residents would assimilate to community life and how communities would assimilate to them. Closing advocates fought to set up comprehensive community care, but also to change decades of ingrained social beliefs (DuBois 2010).

This struggle was duplicated throughout the country but in New England, it was Pineland who followed Laconia’s path most closely. Pineland and Laconia were established and run in similar ways, differing only in sterilization practices, as discussed above. Likewise, their closings were similar. Pineland’s population changed dramatically over the course of its existence; what started as a place of rehabilitation for the feebleminded became a place to put Maine’s mentally ill (Murphy 2011:165). It was parental involvement and changing administrative approaches that started Pineland on the path to change (Murphy 2011: 144, 152,). But even as it was reforming, poor conditions and abuse prompted the state to close the school (Murphy 2011: 160-164, 169, 239). Like Laconia, parents and family of people at Pineland were hesitant about the change to community care, believing that while it wasn’t perfect, Pineland was a safe place, and society at large was not (Murphy 2011:229).

Vermont’s Transition

Vermont’s Brandon Training School closed its doors in 1993 after a 15-year transition to community care (Vermont 1993). The process started in 1978 after the passage of the Judicial Review Law, which confirmed that community care was the best option for residents of Brandon (Vermont 1993:3). This realization brought into focus the lack of established community care available and put into motion a reworking of Vermont’s community care system. The process included moving money from institutional use to community use, including utilizing the Medicaid Home and Community Based Waiver Program, but also involved an intense placement process of former residents in community living arrangements (Vermont 1993). While Brandon staff was involved in this process it was community providers who ultimately made decisions about where people ended up (Vermont 1993:12). Since the majority of Brandon residents were originally from the surrounding area that is where most of the placements were made (Vermont 1993:9). Some residents went to small group homes, some were housed with former Brandon staff and some went to families who could provide care along with a typical family setting (Vermont 1993:13-14). While the process was intense, it yielded results, no re-institutionalizations, no psychiatric treatment, few medical treatments or incidences of abuse (Vermont 1993:8).

Community Care in Connecticut

Connecticut, like the rest of New England, transitioned to a primarily community care model, and while community living was preferred to institutionalization, it was not without problems. As of 2000, patients in Connecticut, as a whole, preferred community living because of the freedom, choice and privacy they had, although many lived with poverty and isolation (Dailey, Chinman and Davidson 2000:364). In addition, there were dangerous stereotypes of the mentally ill that clouded serious issues (Daily et al 2000:376). The most pressing issues facing Connecticut’s mentally ill population was the duel diagnosis of substance abuse and mental illness, victimization and isolation. While the mentally ill community is no more violent than the general population, persons suffering with substance abuse were at a much greater risk of being violent and becoming homeless (Dailey et al. 2000:376). In addition, while public perception of violence was high, it was still the mentally ill population who were victimized at higher rates than the general population (Dailey et al 2000:377). Isolation was also a major problem and a contributing factor in substance abuse and victimization (Dailey et al 2000:378). Isolation, whether caused by medication issues or poor community support, was dangerous for anyone living in the community support network (Dailey et al 2000: 378). This brief look at community care from 2000 suggests that Connecticut was dealing with a bigger, more urban problem than Vermont. While community care was the preferred option, the scope of Connecticut’s operation could have been a problem, causing care to be focused more on medical treatment as opposed to community development.

CONLCUSION

This paper examined the sterilizations and institutionalizations that were the result of the eugenics movement in Connecticut, Maine, New Hampshire and Vermont. Analysis began with a look at the laws of each state, which demonstrated the impact they had on when and where sterilizations occurred, who was in charge and how they were conducted. For example, in New Hampshire the law became compulsory in 1929, which resulted in peak years in the 1930s. It covered all state institutions and was explicitly for eugenic purposes, which resulted in the sterilization of primarily female feebleminded patients at Laconia State School for the Feebleminded (Loughlin 1922:20; Paul 1965:296-297). The paper also addressed the patterns across states, which demonstrated that all three northern states experienced their peak in 1930s, and sterilized mostly mentally deficient patients, whereas Connecticut experienced its peak slightly earlier and sterilized mostly mentally ill patients (Kaelber 2011). These differences were the result of different laws and different populations. But all of New England sterilized women at much higher rates, which was a result of the eugenics movement as a whole as well as individual state campaigns (Gallagher 1999; Kaelber 2011; Murphy 2011). The paper then turned to the institutions themselves, again finding differences between northern New England where schools and reformatories were built and Connecticut where hospitals were built, but finding that all were home to rampant abuse, neglect and overcrowding (Creighton 1939; DuBois 2010; Murphy 2011). The paper also briefly addressed the institutional closings, and transitions to community care, again finding a similar trajectory in northern New England and different problems in Connecticut, most likely the result of their vastly different populations and needs.

While there has been an increase on information about the Eugenic Movement in New England in recent years, there is very little compared to the scope of the operation. Both the movement itself and the institutions are lacking in publicly available information. In all northern states an attempt has been made to address some aspects of eugenics but Connecticut has virtually none. While there is some good information on Vermont the lack of precise sterilization numbers and institutional records makes it difficult to piece together the full story. The gaps in information highlight the reality that eugenics in New England has been virtually forgotten. Even the buildings have been forgotten, either converted into something new or standing vacant; in both cases an effort has been made by these states to wipe their history away. But echoes of eugenics remain in our society. Institutions still exist, along with abuse and there are still murmurs of returning to institution-based care (Murphy 2011: 252). In addition our society is facing a whole new set of eugenic ideals, with amniocentesis, genetic testing and the Right to Die movement, all of which have become controversial because of the implication that they will be used to avoid or destroy a disabled life (Bane, Brown and Carter 2003; Behuniak 2011; Switzer 2003). This controversy will only be heightened as technology advances and public opinion changes. It is now necessary to look back at what our past has been in order to make good decisions for our future.

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1. Both Connecticut and Vermont laws were found in their entirety, but neither Maine nor New Hampshire’s could be found thus, so the author relied on several sources for a complete interpretation. [↑](#footnote-ref-1)
2. Julius Paul, a political science professor at ??? who focused on public law and medical ethics and author of *Three Generations of Imbeciles are Enough: State Eugenic Sterilization in America, Thought and Practice* [↑](#footnote-ref-2)
3. Richard Kimball’s book was published by the Libra Foundation who had just bought the Pineland property; the book is a cursory look at Pineland’s past with little mentioned about sterilization of the reality of life there. [↑](#footnote-ref-3)