Education, science and mental difference in South Africa

Azeem Badroodien
Centre for International Teacher Education (CITE), Cape Peninsula University of Technology

Abstract
This article historicises and problematises policy developments that dealt with difference between learners and across different layers of the learner population in South Africa from the 1920s. In so doing it shows how notions of ‘difference’, ‘sub-normality’, ‘feeble-mindedness’, ‘mental defect’ and ‘behaviour deviates’ became part of the education policy lexicon and highlights the implications for current policy thinking. The article provides a historical context for the current predominant view that it is necessary and appropriate in the public education system to separate learners with learning difficulties from other learners, as well as the normative view that the difficulties such learners experience are ‘naturally’ linked to their own deficiencies and are not the result (or burden) of the public schooling system. The main assertion in the contribution is that developments from the 1920s provided the policy infrastructure for key principles of classification and differentiation of children in South Africa to become firmly embedded within policy thinking, and to remain into the present. It did so by providing the emerging modern South African state with a ‘scientific’ mechanism to distinguish the ‘normal’ from the ‘abnormal’ and the ‘normal’ from the ‘difficult’ child within different communities and spaces. As such, race-making in South Africa and notions of inferiority and maladjustment did not take its main form as much within apartheid policy as within the scientific knowledge and language of the experts attached to different kinds of social institutions.

Keywords: history of mental handicap, special needs education, race, science, eugenics

Introduction
In the current educational environment policy-makers, principals and educators often refer to ‘difficult’ learners, how to address their particular needs and how to better
include’ them in the schooling system according to a social model of differentiation. They invariably do this in ways that assume that the term ‘difficult learner’ and understandings of ‘difference’ have objective and definitive meanings in the present.

The purpose of this article is to problematise the term ‘difficult learner’, to demonstrate that it has a much longer and more complex narrative and history in South Africa, and to show how it is tied to established notions of ‘difference’, ‘subnormality’, ‘feeble-mindedness’, ‘mental defect’ and ‘behaviour deviates’ that have been part of the state education system for almost a century.

It is asserted that the residue of many of these categories and forms of thinking about difference and difficult learners remains palpable within current thinking and education reform. At the most basic level this includes the contemporary position that it is necessary and appropriate in the public education system to separate learners with learning difficulties from other learners, as well as the normative view that the difficulties such learners experience are ‘naturally’ linked to their own deficiencies and are not the result (or burden), for example, of the public schooling system.

Importantly, the term ‘difficult learner’ can be traced back to a period from the 1920s when formal schooling in South Africa was reorganised to accommodate difference between learners and across different layers of the learner population. This reorganisation was heavily swayed at that time by an international language of eugenics and its starting philosophy, Social Darwinism – a broad philosophy or ideology that was used in the early 20th century to describe social evolution in terms of the ‘laws of natural selection’ and that stressed the importance of biological inheritance.

Eugenicists such as Francis Galton (cited in Gilham 2001) theorised that the ‘improvement’ of humanity could be attained by promoting reproduction between people with desired traits, and reducing reproduction between people with less-desired traits. As such, eugenics was a programmatic approach that developed practical strategies, based on explanations using genetics, to separate out, train and even sterilise ‘inferior’ learners.

In South Africa, the sway of eugenics did not, however, only contribute to formal understandings of ‘difference’ and ‘difficult’ learners within the schooling system. It also from the early 1920s helped refine earlier ideas about intellectual ability and learning difficulties and embedded them within institutional thinking.

Thus, the evolution of the term ‘difficult learner’ can also be traced to the inclusion of special education classes as a central reform within education provision from the 1920s. Special education was the view in the early 20th century that learners that had difficulty learning, who were disabled or who were just plain different should be educated separately. This standpoint was regarded at that time as an innovative reform worldwide that helped administrators and policy-makers to better differentiate learners by ability and grade – and thereby organise schools better and differ-
ently. A central claim for differentiation was that it would improve the lives of various categories of marginalised learners (like the disabled) by dealing with their needs differently.

For South Africa, as new and modern educational ideas about the schooling of the disabled and the ‘different’ were being spawned globally in the first half of the 20th century, educational transformation and reform incorporated a blend of bureaucratic and institutional reorganisation and a science of eugenics to construct particular categories of difference, deafness, disability and other forms of ‘deviation’ within the formal education system.

For this article, a crucial thread emerging from developments from the 1920s was that key principles of classification and differentiation of children became firmly embedded within policy thinking both in how mental hygiene was conceptualised and in how it was institutionally provided for. This helped shape the racial agenda of the National Party. That the mental testing movement gathered momentum at a time that coincided with urgent political debates on segregation, social indigency, the Great Depression of the late 1920s and the pressing question of the poor white1 was certainly no coincidence.

It is argued that the ways in which education provision and scientific knowledge (via the mental testing movement) came together to define difference from the late 1920s reinforced popular views on race in that period. But more alarmingly it served to confirm within education policy thinking from the 1940s (and since) the prevalent view that non-white learners were intellectually and biologically inferior and inherently ‘difficult’ – as opposed to white learners for whom more resources and greater social separation would supposedly resolve their educational challenges.

In the sections below, the article will show how connections were formalised between education, science, ‘difficult’ children and notions of difference from the 1920s with the introduction of formal psychological services, and how this was accentuated from the 1940s by the psychological testing movement that marked children in crucial ways according to their mental and social inadequacies. The article has two main narrative parts. The first focuses on the emergence of a language of difference and difficulty that became bound up within terms like mental deficiency and defect, as well as how policy-makers dealt with this from the 1920s. The second part explores special education provision from the 1940s and its influence on how education policy addressed difference and incorporated this institutionally. It also highlights how special education provision was racialised from the 1930s and the discourses that underpinned separate offerings.

1 The article utilises statutory terms used under apartheid such as coloured, white, Indian, African and native, and also descriptors such as European, non-European, non-white and black, to refer to, delineate or identify the different role-players in South Africa within historical context.
With regard to both parts, it is argued that the main contribution of psychological testing was that it provided the emerging modern South African state (something that has continued into the present) with a ‘scientific’ mechanism to distinguish the ‘normal’ from the ‘abnormal’ and the ‘normal’ from the ‘difficult’ child within different communities and spaces, and in so doing to address a variety of pressing societal and political challenges. These challenges criss-crossed the realms of education, social welfare, health and correctional services. How difference was understood from the 1930s also penetrated how poverty, criminality and social dysfunction were conceptualised and addressed within formal scientific discourses and policy frameworks.

**The science of ‘dangerous minds’**

In engaging with issues of difference amongst learners it is important to locate such a discussion against the background of social science research on children, research that over the centuries invariably focused on and highlighted ‘their potential for change’. Within this discussion it is notable that the main focus within social science research before the late 19th century was on the bodies of children and how they were physically socialised and ordered to play particular roles in society.

Then, as research sought to better track their development, the focus on the bodies of children (as captured in the work of Charles Dickens) shifted to a focus on the ‘minds’ of children. The rationale for the shift was the belief that human traits were innate and that the role of science was to uncover which traits were innate, which were learnt and how these influenced their actions (Lea & Foster 1990).

This was followed in the early part of the 20th century by attempts to also understand the emotions of the child and how these shaped the way they learnt. In this regard, intelligence quotients (IQ) testing were seen as an important mechanism to capture the relationship between the emotions and mental capacities of children. A further focus from the 1920s worldwide was the emphasis on the adjustment and integration of children within communities and how ‘social communities’ were constructed around ‘social problems’. It was argued that the needs and problems of various communities could be addressed and regulated by better understanding and ‘managing’ the minds and emotions of children.

It is against this backdrop that the scientific emergence of mental testing and difference in South Africa should be understood. It is argued that the need to find out how the ‘body’ and ‘mind’ of children connected with their social and material environments found expression in focused attention on the psychology of children and how to guide them in that period, as well as the introduction of medical facilities like child guidance clinics and various other kinds of social institutions for children (Badroodien 2001; Hay 1991: 45).

Psychology provided the science that supported a number of important claims by the ‘childcare’ movement at the time, namely that children needed to be helped to better
adjust’ to their environment (especially with regard to their emotional development). The emergence of the science ‘of the mind’ brought into focus an abiding concern amongst the medical and pedagogical professions, as well as amongst social workers, educationalists, penal reformers, policy-makers and parents with the potential dangers (of and for) children in a rapidly urbanising and modernising society. This opened the way for different kinds of professionals to be involved in debates about children and their roles (as well as their potential to disturb social relations) in society. Notably, these developments were regarded as ‘progressive’ humanitarian impulses that for the first time treated the ‘child as a child’ and were better trying to ‘understand its condition’ (Foster 1990: 38).

In that regard, the focus on science from the 1920s was a period in the history of South Africa that gave children (and notions of childhood) a greater sense of depth than at any other time, as well as trying to address their needs in humane and sustained ways. The excavation of the body-mind unity within social, medical and psychiatric research, along with foci on the environmental and familial influences on the actions of children, not only provided detailed insights into individuals and groups in that period, but led to the emergence of a variety of practitioners and programmes (such as doctors, dentists, nutritionists, medical inspectors, school feeding schemes) that sought to deal directly with the challenges confronting children (Foster 1990: 38).

This focus on the science of the ‘minds of children’ in South Africa was, however, heavily overlain by a variety of political, social and economic challenges and concerns, in a period that Dubow (1995: 146) describes as dominated by an over-prevalence of ‘social pathology’ and a specific focus on ‘race deterioration within the broader body politic’.

**Mental handicap and eugenics in South Africa**

For South Africa the manifestation of the above developments is best viewed within ‘mental handicap’ policies that emerged from the 1910s. Mental handicap in that period was understood globally as ‘a concept of medical and social origin that applied to people deemed to deviate mentally from the norm’ (Lea & Foster 1990: 291), which culminated in their needing to be treated differently. From a eugenicist perspective, the view was that those who suffered from mental defects were a menace to society, potentially causing social problems such as pauperism, prostitution and unemployment, and were easily convinced to partake in illicit activities (MacMurchy as cited in Dodd, 2001: 127).

With the above in mind, the Mental Disorders Act of 1916 legally separated those regarded as ‘mentally defective’ into three groups, namely idiots, imbeciles and the feeble-minded. These were individuals whose intelligence quotients (IQs) were all below 75 (Union of South Africa 1916).

The first two groups were deemed to be a serious menace to society, and could nor-
mally be institutionalised in hospitals for the insane, asylums and almshouses. How-
never, it was felt that it was the third group – the feeble-minded – that needed ordinary
state intervention and that the Mental Disorders Act of 1916 should pay particular
attention to. That was because the feeble-minded were generally found to be –
a parasitic, predatory class that was not capable of self-support or managing their own
affairs. They caused unutterable sorrow at home and were a menace and a danger to the
community (Anastasi 1982: 5-6).

The feeble-minded were deemed to be those whose –
presence and conduct subjected their families to humiliation; an intolerable burden to
the teacher and to the schools; and recruited the ranks of criminals, prostitutes,
vagrants, almsmakers and the insane (Huey 1912, as cited in Lea & Foster 1990: 5)

As such, it was noted that –
[i]f defectives were not treated in terms of the 1916 Act and remained in a bad
environment they would become … more degraded and more useless and swell the ranks
of criminal, poor white, inebriate and prostitute classes, thus leading to enormous
unnecessary expenditure not only by the State, on prisons, mental hospitals, charities
but also by the church, public and private charitable organisations (Union of South
Africa 1921: 2).

It was for this reason that the reports of the Commissioner of Mental Hygiene between
1916 and 1932 annually highlighted the dangers posed by those with different and
milder learning disabilities and the need to understand their connection to social
problems like delinquency, prostitution, indigency, alcoholism, youth unemployment,
reformatories and the juvenile courts. The main theme of these reports was that
‘defectives’ constituted a sizeable proportion of the cases that were linked to ‘social
disorder’ and that there was an urgent need to test, recognise, register and remove
those children who suffered from mental and learning disabilities.

Crucially, given the socio-economic conditions that prevailed in the 1910s, the
majority of those deemed to be ‘feeble-minded’ belonged to what was referred to at that
time as ‘the poor white challenge’ and was tied to the tenuous social position of the
white working class in urban centres (Chisholm 1989). As such, the elimination of the

<table>
<thead>
<tr>
<th>Category</th>
<th>IQ range</th>
<th>Description</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiots</td>
<td>Below 25</td>
<td>Poor motor skills, extremely limited communication and little response to stimulus – severe learning disability</td>
<td>Requires care throughout life and unlikely to be educable in the formal sense</td>
</tr>
<tr>
<td>Imbeciles</td>
<td>25–45</td>
<td>Unable to progress past a mental age of about 6 – moderate learning disability</td>
<td>Can be taught basic life skills and simple tasks with supervision</td>
</tr>
<tr>
<td>Feeble-minded</td>
<td>50–75</td>
<td>Adequate learning skills to complete menial tasks and to communicate – mild learning disability</td>
<td>Requires mild support, but educable</td>
</tr>
</tbody>
</table>
feeble-minded was seen as fundamental to the future of the ‘white race’ in South Africa (Dubow 1995: 147).

As the Mental Disorder Act of 1916 observed, ‘white inferiority was mainly one of irresponsibility and unreliability and the special education system which we recommend is designed to correct this. The problem in the economic sphere in South Africa is merely a portion of the larger problem of the conflict between a civilised and an uncivilised race. A contributory cause of poor whiteism is the inability of this class of European to maintain a civilised standard of living in the face of competition with non-Europeans in semi-skilled and unskilled occupations’ (cited in Union of South Africa 1930: 6).

Owing to the ‘peculiar racial and economic facts connected with the education and training of subnormal children in South Africa’ (Union of South Africa 1930: 4) in that period, the Van Schalkwyk Commission Report contended in 1930 that it was not as concerned with mental defect as it affected non-Europeans:

Mental defect amongst non-Europeans, particularly Natives, does not present the serious problem that it does amongst Europeans on account of the far less complex state of the non-European society and the relatively simple demands made upon non-Europeans in social adjustment (Union of South Africa 1930: 20).

It further noted that:

On a closer study of the problem it will be seen that the way in which mental defect affects Europeans is somewhat different from its effects in the case of non-Europeans. The criterion for mental defect is an innate deficiency of mental powers that manifests itself in a lack of social adaptiveness to the outside competitive world. On the basis of this criterion it should be admitted that higher mental qualities are generally considered necessary for a European. He needs these qualities to fend for himself in South Africa far more than are required by a non-European, especially the Native, for whom the niche in the present economic system is easily found (Union of South Africa 1930: 20).

This meant that the emergence of the concept of mental handicap in South Africa was not only grounded in a theory of difference between ‘normality and abnormality’, but also grounded in a firm theory of ‘race’. As Lea & Foster (1990: 14) have noted:

Those who were regarded as mentally handicapped in South Africa received differential treatment on a number of bases, firstly, on the basis of their being ‘handicapped’, secondly, on the basis of the severity of the handicap, and thirdly, on the basis of their racial classification.

In the latter regard, the approach to mental handicap was most vividly captured in the Van Schalkwyk Report of 1930 in the following observation:

To suggest that the white subnormal could be inferior to the normal native would be absurd (Union of South Africa 1930: 6).

This meant that the conceptualisation of mental handicap in South Africa was developed in ways that not only sought to separate out the ‘normal’ from the ‘abnormal’, but also to calibrate this so that some of those that were regarded as ‘abnormal’ should in status, based on eugenics and racial hierarchy, remain above some of those that were ‘normal’.
In that respect, mental handicap was not a medical condition that existed independently of the social and political realms of society. Rather, it was closely associated with the political, scientific and professional agendas of the emerging modern state at that time, with the large-scale ‘regulation’ and ‘upliftment’ of the feeble-minded, for example, deemed necessary for its continued development.

Mental hygiene thus mainly focused on resolving the needs of the white subnormal child from the 1920s. As white subnormality was regarded as a consequence of ‘poor whiteism’, policy attention focused exclusively on the ‘upliftment’ of ‘poor whites’ through addressing their social conditions.

The Commissioner of Mental Hygiene, DT Dunston, noted in 1929:

Now, the (white) South-African-born rightly regards himself as separated from the coloured and natives by an unbridgeable gulf created in the history of our country and our people. When we therefore find some of our poor mixing intimately with these inferior ethnic types, we may justifiably conclude that by doing so they sacrifice the heritage of race, through a certain community of interests with them. It will thus be seen that Mental Hygiene concerns itself with much more than mere intelligence and mental deviation; it deals with economic inadequacy, social mindedness and adaptation to approved standards of living (Union of South Africa 1929: 28-29).

Institutional provisioning for mental disability

As the ‘feeble-minded’ were deemed socially to be a very dangerous group of people (given that they did not supposedly have much personal control, could be easily influenced and could be used as a tool by anybody), they were regarded as constituting a particular insidious threat to the health and welfare of modern South African society (Union of South Africa 1921: 5; Dubow 1995: 148).

Thus, in his deliberations with the Union Government, modernising psychologist DT Dunston argued that a narrow conception of mental hygiene as well as a concentration only on immediate relief measures would only result in ‘the lowering of the mental and social standards of the white nation as a whole, with increasing poverty and degeneration’ (Union of South Africa 1929: iii). He urged that mental hygiene be treated as a form of ‘preventative medicine’ and that it deal with all forms of ‘social inadequacy’, including conditions like delinquency, prostitution, alcoholism and dependency. This, he asserted, ‘would do as much for the betterment of the race as gardening, forestry and animal breeding can do in their respective fields’ (Union of South Africa 1929: iii).

Mainly, Dunston claimed that the mental health and abilities of the ‘feeble-minded’ could be best developed via forms of instruction and formal education. This called for much greater coordination within the state system in terms of differentiating learners and dealing with their respective needs.

This process had been started in the 1910s when the Mental Disorders Act of 1916 distributed ‘mentally defective’ learners to a variety of different authorities. For example, the needs of vulnerable children as defined in the Children’s Protection Act
of 1913 were overseen by the Union Education Department, while the needs of those in reformatories were administered by the Department of Prisons, and the needs of learners in secondary and primary education were dealt with by the four Provincial Education Departments at that time (Union of South Africa 1945: 6).

However, the challenge for union government authorities at the time was that they did not have a clear idea of which learners should be sent where. As such, in a meeting between the Union Government and Provincial Administrators in Bloemfontein in September 1918, it was agreed that all school learners needed to be tested urgently and those that needed assistance selected for special education. It was also agreed that those children who could not be slotted into the designated programmes of the education, prison or provincial departments would be transferred to the control of the Commissioner of Hygiene (Department of Interior) and placed in designated institutions for the ‘mentally defective’.

This agreement was subsequently amended in 1923 when it was agreed that the Union Education Department should oversee the needs of all ‘mentally defective’ children (with financial support coming from the provinces) and the Department of the Interior be freed up to focus on preventative work in mental hygiene.

This was a seminal moment in how mental handicap was approached in South Africa at that time, since it allowed for a closer connection to be made between the ‘minds of children’ (education) and their social and institutional realities (social welfare). With the establishment of psychological services for schools, child guidance clinics, juvenile affairs boards and juvenile courts, as well as other child welfare and similar societies whose work brought learners into contact with the problems of mental hygiene, valuable services were thereafter rendered to schools by the Commissioner of Hygiene. For the first time this clarified and highlighted some key challenges of ‘mental’ and ‘behavioural’ disabilities in school-going children in South Africa. Services that were rendered included the clinical treatment and examination of pupils, as well as intelligence surveys (IQ tests).

This development then informed the passing of the Vocational Education and Special Schools Act, No. 29 of 1928, which identified different types of institutions that could be provided for those learners ‘incapable’ of benefiting from education and training at ordinary schools. It also informed the further reclassification of different groups of mentally handicapped children into ‘supernormal’, ‘normal’, ‘backward’ and ‘very backward’, ‘feeble-minded’, ‘imbeciles’ and ‘idiots’.

The ‘feeble-minded’ group was broken down into three further subdivisions, namely (a) those presumed to be feeble-minded, (b) those who had been diagnosed as such, and (c) those who were certifiable. In line with this, the Union Education Department became responsible for those diagnosed as feeble-minded, the provinces for the supernormal, normal, backward and those presumed to be feeble-minded, and the Department of Interior for the certifiable (Union of South Africa 1945: 9).
This reorientation was done to ensure that provincial departments at the local level could assist in ‘detecting defects of behaviour at its most incipient stage of schooling’. As such, it was recommended that the system of school medical inspection services be extended and improved to increase opportunities to address the needs of mentally handicapped pupils (Union of South Africa 1945: 10). It was hoped that once learners were identified according to the above classifications special education classes and interventions would be provided. In this respect, the Van Schalkwyk Committee identified at least 30 144 white subnormal children in 1928 who needed assistance or intervention.

Still, by 1935 greater levels of special education provisioning had not yet materialised. The Secretary of Education reported in that year that there were only 1 672 places in educational facilities of the provinces and only about 400 places in Union Education Department schools. This was because it was considered impracticable, undesirable and expensive at the time to remove different types of handicapped children from ordinary schools and move them to suitable educational facilities for ‘mentally handicapped’ children.

Administrative changes and more funding after 1937 partly resolved this problem. However, many felt that more legislation and policies were needed that went beyond dealing only with mental handicap and included more far-reaching issues affecting the white population, namely white youth employment and white youth displacement from rural areas. It was felt that the language of prevention and cure needed to be given more support and consideration, and to be extended into all other aspects of the lives of ‘this lower social and economic strata of civilised society’ if they were expected ‘to withstand the penetration of the best elements of the uncivilised race’ (Union of South Africa 1930: 192). This was a significant shift away from earlier notions that all mentally handicapped people were potentially malicious, evil, and criminal, and was best illustrated by a shift in terminology from ‘feeble-mindedness’ to ‘subnormal’ in that period.

**Race and the ‘body politic’ of mental handicap**

In 1945, the Inter-Departmental Committee on Deviate Children reported that while much progress had taken place in the field of mental handicap to de-stigmatise white ‘deviants’, much more support was needed for white learners:

(a) It was required that educational facilities be extended to those groups of handicapped children for whom then-existing provision was inadequate, especially those children not resident in the large cities.

(b) Organised measures to discover children in need of special education were required.

(c) Medical and related services needed to be extensively used in dealing, in a preventative way, with the problem of physical and mental handicap.

(d) More stringent measures needed to be adopted to ensure that handicapped children were placed in suitable employment after leaving school. (Union of South Africa 1945: 14)
At that point, however, informed by the rapid urbanisation and industrialisation of the 1940s and the social challenges allied to the Second World War, Union government officials felt that state policy needed to incorporate the whole population when identifying those who demonstrated mental deficiencies.

Many were by then comfortable that ‘the ‘different’ problems of the ‘races’ could be medically ‘treated’, and that different kinds of training and learning geared towards their re-adjustment into society could be provided. This was largely informed by the view that ‘the behaviour of the behaviourally handicapped was a reflection of his inward mental organisation, which was essentially governed by hereditary and environmental factors’ (Union of South Africa 1930: 179).

This approach to racial difference within the mental hygiene movement was particularly evident in the establishment of the Inter-Departmental Committee Report on Deviate Children in two parts. The first part focused strictly on the needs of the white population, while the second part – published in 1950 – focused on the needs of ‘non-European’ children.

On the one hand, the idea of two reports was partly driven by the belief that non-white learners were biologically inferior and therefore did not merit the same kind of scientific attention. Head of Psychology at the National Bureau of Educational and Social Research, Dr ML Fick, had claimed in 1939 that he could conclusively show that ‘all objective estimates, whether based on achievement or intelligence tests, indicated a marked inferiority of the African mind by comparison with white learners’ and that ‘this inferiority, occurring in certain tests in which learning or environmental conditions are equalised for the native and European groups, does not appear to be of a temporary nature’ (Fick 1939: 56; Dubow 1995: 217). Similarly, the Chief Inspector of Native Education, Werner Eiselen, claimed in the 1940s that ‘the ‘native’ was not educable in precisely the same way as the European, and thus education policies had to be remoulded accordingly’ (Fick 1939: 56).

On the other hand, it was firmly based on the view that while non-white defect could be attributed mainly to biology and its contribution to their own social degradation, white deficiency could be traced mainly to environmental factors tied to mixing with the non-white population in adverse social conditions. The former required strict segregation, confinement and ‘medical cure’, while the latter needed social separation and educational intervention. Dubow (1995) notes:

> Whereas poor scores registered by ‘blacks’ tended to be interpreted in terms of immutable biological heredity, lack of achievement on the part of impoverished ‘whites’ was most often attributed to environmental – and hence remediable –factors.

As such, one of the first things that the Report on Deviate Children set about doing in 1945 was to re-interpret and extend its terms of reference to include identifying what sort of treatment should be pursued for each group.

According to the Committee’s interpretation of its terms of reference, the emphasis in its
investigations should fall primarily on the measures which are regarded as necessary to secure for handicapped children more effective vocational training and to facilitate their absorption and adjustment in the labour market. Since this applies to children who are suffering from physical and mental, including behavioural handicaps, it is indicated that the investigation should also cover the field of medical and mental treatment (Union of South Africa 1945: 2).

Subsequently, the *treatment of difference* was pursued in very dissimilar institutional ways for each population group. For the white learner population the focus was firmly on treatment and prevention, particularly with regard to those whose behaviour was deemed to be deviate.

A child who cannot properly adjust himself in society creates problems for himself and for those with whom he comes into contact (Union of South Africa 1945: 157).

**Behaviour deviates**

At that time the needs of white behaviourally deviate (or subnormal) learners were addressed on the one hand by the Union Education Department, via institutions attached to the Children’s Act, and on the other hand within schools governed by the provinces.

In the first instance, the statutory provisioning of children deemed to be troublesome or uncontrollable, or criminal, and dealt with in terms of the Children’s Act was assigned to the Union Education Department, which was meant to oversee their re-education. A behaviourally deviate child was regarded as one that:

The 1945 report noted that learners committed to Children’s Act institutions ‘included those whose misbehaviour had not brought them into conflict with the law, but which created serious behaviour problems for themselves, their parents, their teachers and the community’ (Union of South Africa 1945: 158). As such, it was recommended that institutions rely even more on ‘scientific expertise’ in addressing the needs of white subnormal learners.

i) Whatever the cause of the behavioural aberration, the person as well as his behaviour and all incidental circumstances must be carefully analysed and studied before any conclusions are drawn and decisions made regarding the treatment to be prescribed for a particular deviation ...
ii) Preventive measures applied with the best of intentions will not succeed unless they are based on a thorough and extensive knowledge of the psychology of the personality and its adjustment ...

iii) To meet with success the treatment will have to be carried out scientifically by specially trained officials who will study each case separately in order that the most suitable treatment may be prescribed. These specialists, who will indicate what the general policy is, must be assisted by persons with a sound knowledge of the psychology of the deviate child, particularly as regards his adjustment in daily life, because the behavioural aberrations may be a result of physical or mental handicap. (Union of South Africa 1945: 158)

In the second instance, the 1945 report noted that prevention of subnormality among white learners could only be properly addressed if it was entrusted to local provincial education authorities. The report observed that legislation focused far too sharply on the end product, instead of giving provincial authorities the power to intervene and ‘take suitable and timely preventative measures while the behaviour was still in its initial stages’ (Union of South Africa 1945: 163). With white learners the focus was thus on laying the foundation so that they were not committed to Children’s Act institutions or did not deviate behaviourally.

The Inter-Departmental Committee of 1945 noted:

The great majority of persons affected by the Children’s Act are children attending provincial schools. More thorough preventative work (by ordinary schools) will address those behavioural aberrants who evade the demands of their environment by withdrawal or escape from reality and by regression, introversion and fantasy. Such cases do not experience to the full their impulses and desires, but attempt to realise them by less than satisfying means such as constant daydreaming and so forth. (Union of South Africa 1945: 164)

As such, it recommended that:

The matter be approached more deliberately from the preventative point of view, by moving the focal point in the consideration of this problem from the central government to the authority entrusted with the instruction of these children during those years when the unfavourable behaviour symptoms manifest themselves for the first time. If this is carried out, the number of children sent to reformatories, industrial schools and other institutions in terms of the provisions of the Children’s Act will in future decrease considerably. (Union of South Africa 1945: 164)

By highlighting the need to devolve authority for the treatment of the white subnormal child down to provincial authorities, the 1945 report envisaged preventative programmes that included the following:

(a) Nursery schools as an integral part of the education system
(b) Visiting teachers as part of the teaching establishment of the province
(c) Clinics for mental hygiene as part of the therapeutic services of the educational system: ‘Itinerant psychologists may in co-operation with a medical inspector of schools or a local doctor provide clinical guidance and treatment in areas with no access to mental hygiene clinics; Universities and university colleges in co-operation with the education departments could also render useful clinical services’
(d) Special schools (Union of South Africa 1945: 165)
The suggested institutional offerings were meant to achieve two things, namely (1) to locate the behaviourally deviant white child back within the community and to provide a variety of rigorous interventions to help ‘reorientate’ them with their families, and (2) to develop a different set of special schools that could differentially address the different categories of handicap needs amongst white learners. In the latter regard, the subsequent Special Schools Act, No. 9 of 1948, defined the ‘mentally handicapped child’ as the child:

who, in the opinion of a head of department, is capable of deriving appreciable benefit from a suitable course of instruction, but deviates to such an extent from the majority of children in body, mind and behaviour that he (1) cannot derive sufficient benefit from the instruction normally received in the ordinary course of education, or (2) requires special education in order to facilitate his adaptation to the community, or (3) should not attend an ordinary class in an ordinary school because such attendance may be harmful to himself or to the other pupils in the class. (Union of South Africa 1948: 50)

Special education, the disabled child and the family after 1945

The shift in focus from the earlier period where mental defect was addressed mainly through institutional intervention and psychological testing to one where resolving the needs of ‘disabled’ children was tied to the community and the family had, however, enormous implications for the provision of state intervention after 1945. At the time, the experiences of the Second World War had largely dramatised for many social reformers the ‘dangers’ of not addressing the existence and needs of slum children, with their frail ‘diseased-racked’ bodies and ‘emotionally-disturbed’ minds, as well as the needs and influence of their families (Marks & Andersson 1992: 156).

As such, a new world order that assumed the virtues and inevitability of a particular kind of modern society both locally and internationally, and where a different relationship between the state and the needs of different kinds of families was being developed, merged with older ‘scientific discourses’ of mental hygiene. This meant that for South Africa the focus on the family was conceptualised in relation to the variety of social, political and economic considerations previously linked to issues of race, institutional provision and professional knowledge.

The family was conceptualised with regard to four key areas that saw to the care and re-education of struggling learners. Firstly, after 1945 the Union Government sought to address the challenges confronting many families (tied to their mental and medical health) by providing a variety of maintenance grants, child grants, foster care and adoption services. It was hoped that these would serve as ‘healthy alternatives’ for children who were exposed to adverse situations within their families. Secondly, by 1945 the history and experience of providing public childcare had revealed a need for more personalised care of individual children within families, as well as a greater focus on their ‘healthy’ emotional development. It was asserted that if parents could be
taught to show greater affection to their children this would lead to families being more stable. Thirdly, interest in the psychological condition of children reinforced the idea of a properly functioning family in that period, and the need for family members to help learners engage productively with their everyday lives. In this regard, child guidance clinics were regarded as very important support structures to help guide families. And lastly, during the Second World War the concept of the ‘problem family’ emerged to describe those that did not maintain adequate standards in their lives, and whose parents failed to help them. It was claimed that parents could be helped towards ‘responsible’ and ‘mature’ behaviour via better social services, financial aid and welfare grants.

Until 1945, all of the above services were provided only for white learners. However, with the rapid increase in urban (especially non-white) populations in the 1940s, the Union Government came under enormous pressure to extend some of these services to the rest of the population, where children from a new ‘breed’ of ‘problem families’ could receive long-term preventative aid. At the time, the previous eugenicist notion that non-white children were inherently defective led to their families being regarded as spaces of ‘fear’, ‘chaos’ and complete disorder. As such, the scientific engagement with the psyche and emotional wellbeing of families invariably highlighted their impact on the social order of the city and country, and how society needed to be protected from them. The key difference from the previous era, when maladjustment among the poor white population was blamed mainly on their social environments, was that the relationship between poverty/deprivation and depravation for non-white learners after 1945 was closely linked to their race and social class position. This was greatly helped by the fact that understandings of ‘problem families’ and their associated neuroses, as well as ‘problem children’ and why it was necessary to separate them from their social environments, had for the first time in South African history developed a much more ‘informed’ perspective for politicians, social theorists and social workers when they thought about how to differentiate learners and their varying needs (Moross 1949: 1).

Marks & Andersson (1992) observe that the novelty of knowing a lot more about learners, their communities and their needs was that medical practitioners could be part of bigger teams that were trained to observe, in the homes of the people, both the environmental and the social factors that were working for or against health. In so doing, their records became available for all other scientific partners to consult when dealing with individuals from these kinds of homes, which assisted research that sought to understand the social causes of disease and malfunction (as cited in Marks & Andersson 1992: 156).

**Special education and anxieties of social disorder**

By 1950 there were only 21 state and state-aided institutions that addressed and provided for the ‘social and mental needs’ of non-European (or coloured and African)
learners in relation to their health (Union of South Africa 1950). This small number of institutions for ‘deaf, blind, cripple and behaviour deviates’ in the 1950s remained the only institutions available until the late 1960s.

Thereafter, there was a flurry of legislation for the provision of special education for non-European children again only in the 1960s, mainly because of the establishment of separate departments for Coloured Affairs, Indian Affairs and Native Affairs.

Part of the challenge for practitioners in the mental hygiene sector at the time was that until then mental health policies and discussions had focused mainly on the ‘mild retardation’ and ‘subnormality’ of the white population. As the position of the ‘poor white’ population had largely been transformed by the 1950s, there was far less urgency to deal with mental health issues than there had been in the 1930s (Marks & Andersson 1992). Also, as the ‘mental health problems’ of the ‘non-white’ population at that time were associated mainly with ‘social disorder anxieties’ tied to the rapidly modernising society, policy remained unclear and confused about how the needs of the non-white population would be addressed.

The 1945 report had noted that the most pressing issue related to the mental hygiene of the non-European population was the lack of reliable data about the number of ‘deviates’ for whom provision needed to be made. This was the first priority of the committee when they met to write the second volume of the Report on Deviate Children in 1950. In that regard, debates focused mainly on how they would collect reliable data, with two issues being identified:

(a) Two of the three non-European groups, the Indians and the Natives, have each its own social system and attitudes towards life which is different to that of the third group, Coloureds, which belonged to western civilisation'

(b) In the absence of compulsory education for Non-Europeans, it is going to be difficult to assess the nature of their special needs' (Union of South Africa 1950: 142-143)

As such, the committee did not foresee the establishment of a comprehensive programme of special education for the non-European population. It did, however, recognise that certain kinds of special education needs had to be prioritised, namely:

1) Deviates totally incapable of fending for themselves (cripples, the deaf, the blind, epileptics)

2) Deviates that were considered a danger to society through their misbehaviour (Union of South Africa 1950: 143)

Special education, mental testing and institutional care

Yet even in providing some of these special education facilities quite different approaches were taken. On the one hand, for example in the case of ‘native’ children, facilities were provided for children who ‘suffered on account of blindness, deafness or epilepsy or any other physical defect’, and then only those children with easily detectable or obvious defects, as the state was not willing to have to spend monies testing vision and hearing in ‘native’ children (Union of South Africa 1950: 2).
Furthermore, there was no attempt to provide for ‘native’ children who were diagnosed with ‘mild mental handicap’\(^2\) based on three views:

1. For African children ‘behavioural’ disorder was associated mainly with being a ‘danger to society through bad behaviour’ and prisons were the main way of dealing with this condition amongst the African population (see Paton 1986).
2. African learners were located mostly in non-urban locations and thus they did not pose an immediate challenge to social disorder anxieties.
3. African learners were deemed ‘uneducable’, ‘untrainable’ and therefore, in terms of mental hygiene, ‘incurable’. (Union of South Africa 1950: 2)

This was influenced by research in the 1950s by medical practitioners such as JC Carothers (The African Mind in Health and Disease) who argued that his approach, ethnopsychiatry, helped explain ‘African backwardness’ and that it clearly showed links between criminality and ‘African culture’ and ‘African personality’ (McCulloch 1995: 44-45). In that period, it was common for the languages of psychology and psychiatry to describe illness associated with mental health in terms of racial and cultural difference, where it was asserted that the ‘African’ was simply ‘not equipped to cope with civilisation’ (Vaughan 1991: 107). It was only in the late 1970s that any special needs facilities were made available for African learners.

Moreover, in terms of how to collect data about the mental health needs of the African or native population, the Committee approached the Department of Native Affairs to get headmen, ministers and native teachers in African villages to oversee the collection of data. The committee first piloted this in the Transkei before doing the survey in the rest of the country. Notably, it was presumed that the African participants would not provide reliable data, and as such they were expected to identify potential deviate children and then take them to the nearest town, where magistrates would complete the survey documents and collect the data (Union of South Africa 1950: 1-2; 142).

On the other hand, coloured children were regarded as part of ‘Western civilisation’ and because they were mostly urban dwellers, it was numerically possible to subject them to surveys. Also, because of the social disorder anxieties associated with the coloured population in urban settings, it was felt that a fuller spectrum of scientific and medical expertise needed to be utilised to better understand the needs and challenges of the coloured ‘mental deviate’, especially the subnormal coloured children struggling with mild learning disabilities.

Whereas surveys of white learners were previously undertaken by teachers in ‘white’ schools, based on their preoccupation with capturing any signs of difference amongst white learners at an early stage, for surveys of coloured learners it was decided to make sole use of the medical staff of the different provincial education departments.

\(^2\) It is notable that the Bantu Special Education Act no 24 of 1964 expressly excluded mention of any ‘mental’ or ‘behavioural’ deviation
key challenge at the time was that the standardised tests used for white learners were, it was argued, not applicable for coloured learners and that different testing instruments were needed for non-white subnormality (Union of South Africa 1950: 142). In the end though, the focus was less on getting reliable data that would lead to the introduction of preventative programmes for coloured learners and more on thorough investigation, identification, intervention and surveillance.

In engaging with the needs of the coloured mental deviate, however, the focus on reclaiming the child and keeping the family together was firmly tied to notions of ‘criminological’ and ‘moral’ defect, namely ‘that “coloureds” constituted a naturally thieving community’ within urban spaces (Chisholm 1989: 167-168). The systematic survey of their mental difficulties thus mainly observed ‘pathologies’ among them through the prism of hereditarian theories of crime (Dubow 1995: 156; Union of South Africa 1947: 8). In fact, the committee was so concerned about their contribution to social disorder that it recommended that even stronger measures and efforts be taken to fully assess the extent of maladjustment amongst coloured children.

This approach to their needs was supported by the findings of the Commission of Enquiry into the Cape Coloured Population in the Union (the Wilcocks Report of 1937) (Union of South Africa 1938), which recorded the incidence of social disorder and deviance amongst coloured children to be the highest in the world. The Report on Deviate Children noted that it therefore followed ‘that the extent of behavioural deviation amongst the coloured population would also be very high’ (Union of South Africa 1945: 151).³

Contrary to how the needs of white learners were addressed, where it was felt that learner behaviour could be remedied within the family and the community, for coloured learners the focus was on taking them from their social environments and subjecting them to rigorous re-training via institutional care (Badroodien 2001).

This focus on dealing with their needs through institutional care was based mainly on:

1. The absence of an effective system of education for ‘non-European’ learners
2. The lack of general compulsory school attendance for non-white learners
3. The inadequacy of reliable medical and clinical services
4. The absence of well-trained staff to assist such learners
5. The lack of reasonably adequate school accommodation for children already at school
6. The ineffectiveness of a system of leisure-time activities under the control of ‘non-European’ aides
7. The lack of goodwill to improve the socio-economic conditions of ‘non-European’ populations, especially in urban settings (Union of South Africa 1945: 6)

³ For Indian learners with mental health deficits, it was always felt that their numbers were so small that they could be accommodated at facilities providing for coloured learners. Little attention was ever paid to surveying the needs of Indian learners
A further challenge for special education provision for coloured learners was that policy-makers were worried that:

(a) The high costs of special education would come at the cost of the education of the ‘normal’ coloured child

(b) The state already did not possess the means or the staff to meet the full needs of ‘normal’ children, let alone those with special needs, and thus it was preferable to consider the needs of the large numbers of ‘non-European’ children not at school (Union of South Africa 1950: 144)

As such, the only institutions that meaningfully dealt with the behavioural needs of the coloured learner from the 1950s were those that were erected under the Children’s Act of 1937, namely industrial schools and reformatories. While these were followed in the 1960s by the introduction of child guidance programmes at some schools, and also the establishment of child guidance clinics, as a way of more systematically identifying the maladjusted behavioural deviate (Hay 1991; Union of South Africa 1955: 7), these latter facilities at no point made any real inroads into helping coloured learners struggling with disabilities.

Moreover, in trying to resolve the limited provision of special education facilities for coloured learners in the 1950s, the state became more predisposed to ensuring that learners from different racial groups were accommodated separately than to providing differentiated care (Union of South Africa 1950: 149).

**Behaviour deviates and institutional care**

The history of mental health and handicap in South Africa provides a useful case study of the medicalisation of a social problem, where aspects of human life were treated as medical problems and diagnosed and studied over time. In the process, health professionals and others with scientific knowledge came to define prevailing concepts of health and illness in manners that shaped the ways ordinary learners came to experience life. Over less than a century, mental defect and behaviour deviance were transformed from a social challenge into a medical problem, and labelled as an ‘illness’ that required ‘isolation’, ‘regulation’ and ‘modification’.

Given the view that mental ‘defects’ were ‘invariably dangerous’ and ‘evil’, it was initially through the legal system, through the children’s and juvenile courts, that the needs of these learners were addressed (Badroodien 2001; Chisholm 1989). Thereafter, through the thinking and mechanisms attached to these courts, and through a racialisation of social interventions, a variety of practices that had hitherto been separate came together. Dubow (1995: 14) describes this period as a ‘great age of buoyant positivism’ and ‘a period in which the perfectibility of mankind was seen as coterminus with the advance of science and reason’; where positivist science as an autonomous force and dispassionate virtue would provide ‘objectively valid solutions to social and political problems’.

Subsequent developments in psychology and the preponderance of IQ testing from the
1930s then served to ‘legitimise’ the extension (and the intervention) of the judicial principle into the social life of children and their families. And from the 1940s, the psychological approach served to highlight the different ways in which poverty, defect and delinquency were linked, and led to a greater focus on the family and community when dealing with the needs of the mentally maladjusted.

Crucially, however, the mental handicap movement in South Africa evolved in ways that not only separated out the ‘normal’ from the ‘abnormal’ and ‘needy’, but also developed an explanation of difference that allowed white subnormal children to, in terms of social status, remain above non-white normal children.

This dualism can be traced back to the ideas of criminologist WA Willemse from Pretoria University in the 1930s, who developed criminological typologies that calibrated ‘bio-physiological types’ (such as the ‘feeble-minded’) and forms of criminal deviancy in ways that could measure the social health of the country. It was this hereditarian theory of crime and deviance, using environmental explanations, that created a convenient intellectual dualism, whereby poor white learners could be portrayed as the victims of an unjust social and political system, while the social circumstances of ‘non-European’ learners could be shown to reinforce their inherent cultural and biological inferiority (Dubow 1995: 160).

**Conclusion**

Arguably, in the current period the institutional framing and conceptualisation of difference as outlined in the sections above continue to shape how ‘difficult’ and ‘needy’ learners are perceived. It is a definition of difference that has collapsed notions of neglect, morality, poverty and deviance all into one term, ‘difficult’, without acknowledging how these different notions came over time to frame how the special education needs of white, coloured and African learners were addressed.

It has been argued in this article that developments in science (psychology) not only served to identify those who threatened social order, but also developed principles of classification and differentiation that both impacted on the subsequent racial agenda of the Nationalist Party after 1948 and remained bound up within the discourses, vocabularies and thinking of state institutions into the present. Through the scientific languages of psychologists, educators, social workers and even criminologists, understandings of difficult and intellectually-challenged learners continue to include variations of the ways in which the ‘native mind’, the ‘feeble-minded’ and the ‘criminally-tainted and insane’ were previously understood (Dubow 1995: 245). It is notable that race-making in South Africa and notions of inferiority and maladjustment did not take their main form as much within apartheid policy as within the scientific knowledge and language of the experts attached to different kinds of social institutions.
References

Notes on the author
Azeem Badroodien is an associate professor and deputy director at the Centre for International Teacher Education (CITE), hosted at the Cape Peninsula University of Technology. He is a sociologist and historian of education and has taught previously at the University of the Western Cape, Nottingham University in the UK and the University of Hong Kong, and within the Education Policy Studies Department at Stellenbosch University. He also previously spent five years as a chief research specialist at the HSRC, working on the intersection of education and work. Azeem has conducted extensive research within the domain of youth at risk and the historical provision of education and training in state institutions designated for them.

Address for correspondence
badroodiena@cput.ac.za