The Praxis of Disability and Schools in Ohio from 1925-1939

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This paper provides a summary of the analysis of school enumeration returns in Ohio from 1925 through 1939, prior to state-wide school consolidation, in 26 counties. Data suggests that a wide range of students with disabilities were accommodated and included in the public-school system. The paper discusses legislation, medical, and clinical definitions of disability for this time period. Results may have had implications on school consolidation in Ohio.

Introduction

"Mary Ervin is slow and a very peculiar disposition….Greg Ohl is afflicted with a goiter and is very slow" (Woodward, 1923, para. 1).

The language of disability categories is something of a moving target. Where terms like *crippled*, *slow*, of *peculiar disposition* were once valid categorical qualifiers, today we have moved away from terms like these to people-first language, with an origin point in the Denver Principles Statement from the Advisory Committee of People with AIDS (Ariss & Dowsett, 1997). The American Psychological Association (2010) supports the use of people-first language followed by the descriptive phrase. An example would be "students with learning disabilities" or "a child with autism." Language, and more importantly labels, has consistently been used to categorize children to both better suit their needs in school districts and counties, including in the state of Ohio. Historically, in some cases this categorization has taken the form of inclusion and, in others, segregation.

For instance, from an inclusionary perspective, Comings (1922) observed that a new initiative planned "to normalize these cripples, at least in a measure; but the great motive is to make them happy and comfortable, to eliminate a physical burden, to add to the joy of living" (p. 658). "Normalize" in Comings' notion was the attempt to make normal, and include those clinically labeled abnormal, in the industrial world, so they would therefore not be reliant on charity.

Inclusive education has, as a basic premise, the idea of education for all. Underlying presumptions at the heart of this paradigm are that of equal opportunity, the acceptance of diversity, and heterogeneity. Inclusive education reflects the opportunity that a significant part of the population that participates in school, those with differences in ability, are not shunned from the opportunities that education affords (Batalla, 2009). The opposite of inclusion is segregation. Ferri and Connor (2005) have defined this as the practice of legally dividing students in schools or classes according to difference. This difference in the United States has manifested in separation based on gender, race, religion, and ability.

The decision process of whether any given child with exceptionalities would be placed in an inclusive or segregated setting was highly couched in the clinical and medical basis of thought in the 1920s and 1930s in Ohio. The other factors contributing to placement was the distribution of special services and transportation. This research provides a summary of the analysis of school enumeration returns in 26 counties in Ohio from 1925 through 1939, prior to state-wide school consolidation, paying particular attention to disability categories being used at that time. This research aims to answer the following questions: (a) what are the categories of disability identification in Ohio from 1925 to 1939, (b) did the identification of students in these categories change or remain stable over time, and (c) did these factors lead to a change of policies and services within the state of Ohio?

Review of the Literature

The Establishment of Special Education Services in Ohio

In the first decade of the twentieth century services began being offered to people with disabilities within the community. Some of these services eventually were assimilated into the public school system and specialized institutions. The Ohio Department of Education (1985) noted that in 1904, at the Cincinnati Public Library, a class for individuals who were blind was started by Georgia and Florence Trader, sisters who had founded the Cincinnati Library Society for the Blind in 1901. Robert Irwin of the Cleveland Public Schools pressed for "extending public school classes to blind children" (p. 9) and in 1909 a class for children who were blind was established, along with a class for partially sighted pupils that was opened in 1913. In 1913 and 1914 the Boards of Education in Cleveland, Cincinnati, and Dayton (Schmidt to F. W. Miller, February 12, 1914) requested permission from the State Commissioner of Common Schools, as per sections 7755 to 7761 of the General Code of Ohio:

> To establish and maintain within its limits one (1) day school at an average attendance of not less than three pupils for the instruction of deaf persons, residents of this state, over the age of three; one (1) day school for the instruction of blind persons, residents of this state, over the age of four. (Grantman to F. W. Miller, September 27, 1913)

The Board of Education in Cleveland further requested permission to establish a school for the crippled, as per "the Doster Law" (Nyre to F. W. Miller, August 18, 1913). The board noted that the request was made based on school attendance figures from the previous year (1912), and indicated the need to provide instruction to "not less than 90 crippled persons, residents of this state, on the age of five . . . [adding] the enumeration of 1913 however, shows considerable increase in the number of these unfortunate people" (Nyre to F. W. Miller, August 18, 1913). The Doster Law ensured that classes for the deaf, blind, and those classified as crippled were provided and supported by state funding (McDonald, 1915). Specialized teacher training was also supported by this legislation (Ohio Department of Education, 1985). In terms of the education of the deaf, the Doster Law:

> Made provisions for deaf children to be taught the manual method of instruction 'in a separate school' when, after the nine-months trial period, the oral method was not

> successful. This law also made the children with defective hearing eligible for special education provisions. (Ohio Department of Education, 1985, p. 7)

The Doster Law also impacted the instruction of the blind by "establishing public school programs for blind children over the age of 4 and set $200 per child as the maximum amount reimbursement to school districts for those programs" (Ohio Department of Education, 1985, p. 10). For the students in the crippled category of disability the Doster Law provided programs for pupils and specified that for students "over the age of 5, set aside up to $150 per child per year as the amount reimbursable to school districts for such programs" (Ohio Department of Education, 1985, p. 12). House Bill 716 modified the Doster Law in 1920 "by adding a provision requiring the state superintendent of public instruction to prescribe standard requirements for schools conducting classes for the deaf" (Ohio Department of Education, 1985, p. 7). The Doster Law ensured that funding was provided to school districts to support the education of individuals with disabilities and House Bill 716 targeted the standardization of the educational program outcomes for the deaf.

A significant amount of legislation in Ohio in 1904 aimed at standardizing processes in order to unify the education system in public schools. One statute required all boards of education "to prescribe a graded course of study for all schools under their control in the branches named in sec.4007-I of the Revised Statutes of Ohio (eight common branches including civics and hygiene)" (Major, 1905, p. 228). According to the prescribed standards for classes for crippled children, as amended in 1925 and cited in Hadley (1927), the 7761 section of the General Code of Ohio dictated that standards be set for the instruction of students in the categories of deaf, blind, and crippled in a day-school setting. These schools would be eligible for state funded reimbursement, per pupil, as long as they followed the same standards as other schools in areas such as "methods of instruction and supervision, the qualifications of teachers and the conditions and terms under which they are employed, the special equipment and agencies for instruction provided, and the conditions of rooms and buildings in which they are held" (p. 125). Further, sections 7755 and 7761 of the General Code required that the director of education appoint a qualified person to inspect and report on the conditions of the classes and instruction provided to pupils (Hadley, 1927). Section 7755 was amended by Johnson-Ott and Williams and bills passed in 1925 which stated "The director of education may grant permission to any local board of education to establish and maintain a class or classes for instruction of deaf or blind persons over the age of three, or of crippled persons over the age of five" (p. 128). Section 7760 of the Ohio General Code defined the eligibility of pupils as:

> Any person of sound mind who, by reason of * * * [*sic*] being so crippled as to be physically unable to properly care for himself without assistance, cannot properly be educated in the public schools as other children, shall be considered * * * [*sic*] crippled within the meaning of Sections 7755 and 7757 of the General Code * * * [*sic*]. (Hadley, 1927, p. 125)

According to the Ohio Department of Education (1985), the 1925 amendment "mandated that school districts comply with state standards or lose their state subsidy" (p. 19).

The establishment of education legislation in the early twentieth century in Ohio can be characterized as a process of establishing common practices and regulation of those practices. It was also characterized as a time of opportunity for individuals with disabilities to have access to special services couched in the premise that through enumerating and categorizing students by class of disability they may be drawn together and centralized to receive services. As such, those who were labeled as crippled, blind, deaf, or partially deaf, under legislation, were to be given special services under the direction of teachers with specialized training. Further, there was oversight of this process by a director of education in order to provide quality assurance for the programs being offered. Finally, funding was allotted for programs which provided these services, and as a result, the impending doom of losing state subsidies hovered over districts that failed to comply.

Early School Enumeration Efforts

Gesell (1921) discussed the categories of disabilities and services provided to children with exceptionalities in schools and special classes. Further, he noted the importance of school enumeration and regulation of school registers, in order to identify and serve pupils in rural and village communities. The state of Ohio used the system of enumeration since 1908 to identify students with disabilities:

> Enumerators of school youth are required to report the number of Imbeciles or feeble-minded youth between the ages of six and twenty-one years. A like report is required of all children physically disabled, blind, deaf, or mute children between six and twenty-one, noting the sex of all such children. (Snyder, 1908, p. 285)

A large scale enumeration occurred in 1913, when Ohio Governor James M. Cox called for a complete survey of schools to be made in order to assess, as he suspected, how poorly small district schools were meeting the needs of modern industrial and social life in Ohio (Riegel, 1920). From Riegel's perspective this survey was meant to assess the current state of affairs in Ohio schools and to "pave the way for speedier centralization and consolidation of one-room district schools" (p. 34). In essence, the premise was to take account of the training level of teachers, the curriculum delivered to students, the salary earned by teachers in these districts, and the state of buildings and other facilities. In this sense, this enumeration provided a compelling, if not skewed, perspective, in moving toward the consolidation of schools. The survey asked the right questions to get the answers Governor Cox and State Commissioner of Education, Vernon W. Riegel, wanted to make educational stakeholders in the state of Ohio aware of, and the following year, the Rural School Code was put into effect. The Code "provided for county superintendents and supervisors over smaller districts within the county; required academic and professional training for all new teachers henceforth, and gave communities wider powers to centralize and consolidate schools" (Riegel, 1920, p. 35). In this manner, communities could actively decide on consolidation, and given the way that country schools were being portrayed as being staffed by unqualified teachers, with inferior qualifications and unmaintained antiquated facilities, it was not very difficult for the state to make a compelling case for consolidation of resources (DeYoung & Howley, 2009).

School Consolidation and Services for Students with Disabilities

The consolidation of smaller schools into larger schools was something of a movement of the time, although contested by some contemporary educational research. For instance, in providing examples of performance of children in urban versus rural schools, Wallin (1914) found that "among 8,942 graded pupils [in urban schools] in Bureau County, Illinois, 57.5 per cent were behind the normal, while only 8 per cent were ahead, and among 2,090 rural pupils, 53.5 per cent were retarded, and only 12 per cent ahead" (p. 105). Contrasting this with identification rates of retarded versus accelerated students in the city of Chicago in the same time period, Walling (1914) observed that "in three Chicago schools the per cent retarded was 68.1, the per cent accelerated 8.1" (p. 105). This denotes less of an incidence of students behind the level of normal study (at grade level achievement) and a higher incidence of gifted students attending rural schools, when using the Binet-Simon Intelligence Test. In any case, educational policymakers and administrators in the early part of the twentieth century came to believe in the rhetoric that the larger centralized consolidated school could serve more students at the same grade or developmental level and thus be more cost efficient. The Cuyahoga County, Ohio Superintendent A.G. Yawberg (1918) noted the progress being made with the consolidation and centralization of schools, reporting that 45 schools had been "abandoned" between 1915-17, and promising that the remaining 51 schools would be replaced "by modern, efficient new buildings within four years" (p. 39).

It was claimed that the consolidation of schools improved the education provided to students as well as the quality of the building. According to Yawberg (1918), this new system provided a "better grading and classification of the pupils" (p. 40). The identification of students with disabilities led to specialized services being made available to them. In 1926, Wallin (1927) surveyed superintendents of schools in 145 Ohio cities with a population of more than 2,500 students in special classes. Results indicated that special classes contained students mentally deficient (the current classification of intellectual disabilities) as well as backward children (a spectrum which encompassed learning disabilities as well as emotional disturbances, by current context) in the same room instead of keeping them separate. Some districts offered ungraded classes for these children. Ungraded classes in this time period were characterized as classes for "giving individual attention merely to pupils retarded in various subjects" (Wallin, 1914, p. 384) with the intent to "restore its pupils as soon as possible to ordinary school conditions" (Groszmann, 1910, p. 163). Wallin (1927) called for "proper examination, differentiation, and classification of the mentally handicapped children" (p. 247), noting:

> Satisfactory differentiation cannot be made merely upon the basis of standardized tests. Psychological and educational diagnosis require a synoptic study of a child's entire physical and mental make-up and an investigation of his genetic background. It is doubtful that a city or county of less than a hundred thousand population has sufficient money at its disposal to establish a mental clinic worthy of the name. (p. 248)

Wallin (1919) had argued earlier that "the only reason for differentiating children at all in their school work is to make it possible to better adapt the instruction to meet individual needs" (p. 227).

This differentiation and instructional adaptation paradigm was somewhat at odds with the framework promoted a year later by Riegel (1920), the State Commissioner of Education, who characterized the amelioration of services as the result of "standard methods of presentation. . . . a uniform course of study . . . [and] county uniformity of textbooks" (p. 35) along with a myriad of other standardized, uniform modes of operation, curriculum, and methods of instruction. Uniformity is not the current method we employ in meeting individual student needs, so there may have been a mismatch between the intent of the school system's improvement measures (in standardizing) and the end product for individual students with disabilities (in being treated uniformly) in consolidated schools.

This brief history of intervention services in Ohio does portray a compelling story of good intent in providing better services leading to the education of children with disabilities, as well as the darker aspects of "following the money" toward the savings of consolidated schools.

Methodology

Archived school census records were accessed at the Ohio Historical Society (specifically, The State Archives, item number 1575, Enumeration Returns from 1923-1949). The data set was incomplete for the years 1923 to 1924, and consolidation of one-room schools in Ashland County was completed by 1939; therefore, the focus of this research was 1925-1939[1]. It was the researchers' original intent to focus solely on Ashland County, but the preliminary analysis of the data proved to be compelling and the researchers expanded the data set to 26 (out of 88) counties in Ohio (alphabetically encompassing Adams County to Fulton County) in order to place Ashland County within the larger context of what was happening in the rest of the state at the time.

The researchers believe that the sample size is adequate for the purpose of this study, since it included counties of various sizes and populations, in rural and urban settings, across the state, and it allows for an in-depth discussion of the demographics of disability identification over a period of 14 years (Patton, 2002). The researchers took a picture of each enumeration return for each of the 26 counties for the years 1925-1939. Using a spreadsheet, a dataset was created containing the number of students in each distinct disability category, along with the total number of boys and girls by age level. The 1930 to 1939 enumeration records indicated the disability categories along with the total number of boys and girls by age level, and also the type of instruction students with disabilities received. This information was transcribed into the dataset as well.

Findings

Findings are displayed thematically by disability category and by modality of instructional services offered. Data displayed represent the number of students in school at the time of the enumeration and their corresponding disability category. As a caveat, students could have been counted multiple times if they qualified for multiple categories of disability[2].

[1] The data for 1936 was missing from the data set so this data was unable to be included.

The enumeration returns provided clear instructions on how to fill out the form; specifically that the total number of students aged 1-21 enumerated for each disability category should add up to the total number of students accounted for in the listings of instructional services provided at Home, School, and None. Despite this, there was still a discrepancy between the number of youth enumerated in each disability category and the total number accounted for in the modalities of instruction. For example, for Fayette County, four students were identified as crippled, one as partially Deaf, two with speech defects, and seven feeble minded. In the place of instruction one was educated at home, one in the regular school and ten with no instruction. As such, we deduce that some students must have had multiple disabilities.

Numbers of Students with Disabilities

Feeble minded. An increase over time in frequency in the category of "feeble minded" students was observed. In 1925, in the 26 counties accounted for, 709 students were enumerated in this category; whereas by 1939, 1,329 students were enumerated in this category. This is down from a high of 1,853 in 1934.

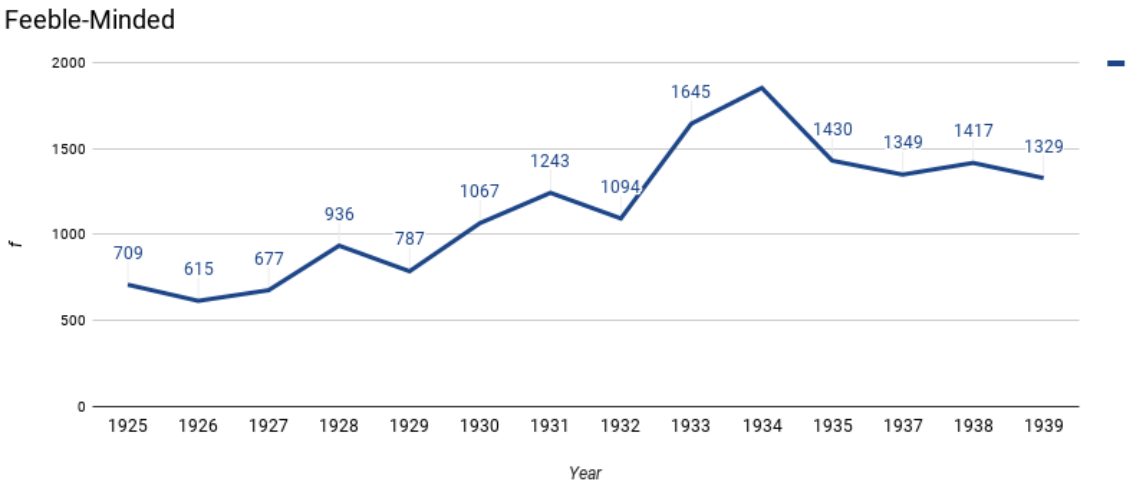

Figure 1: Feeble Minded Students

Crippled. In the category of "crippled" students, an increase in frequency was observed, peaking at 3,205 identified students in this category in 1927, then returning to a baseline level of 1,817 in 1928. This number of students oscillated slightly over time, but remained fairly stable, increasing to 1,986 students in this category by 1939.

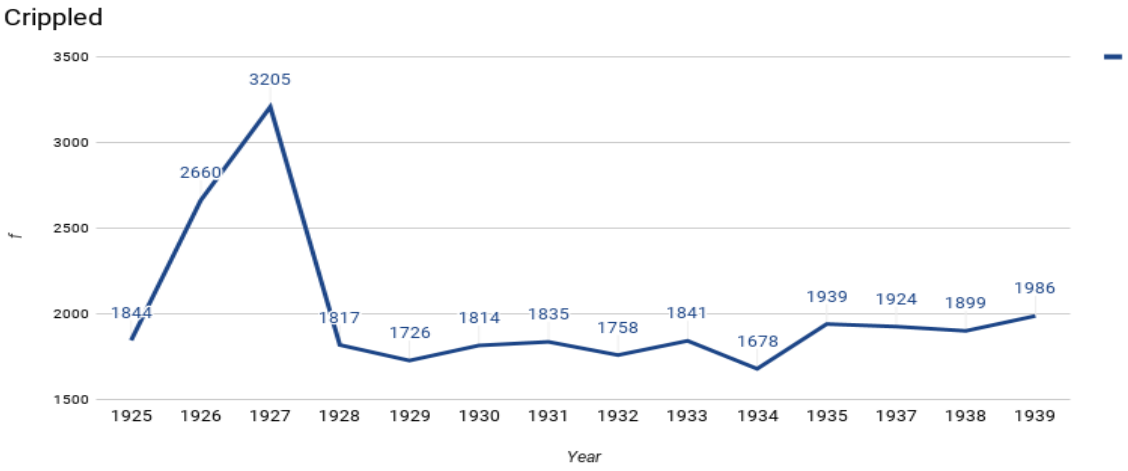

Figure 2: Crippled Students

Deaf/Partially deaf. In the categories of Deaf and Partially Deaf, the enumeration in each category seemed to oscillate in function of each other. That is, in any particular year, when one category (Deaf) increased or decreased, the other category (Partially Deaf) showed the reverse trend. This effect was not only consistent over individual years (e.g., 1927, 1931), but also over spans of multiple years (e.g., 1925-1926, 1935-1937).

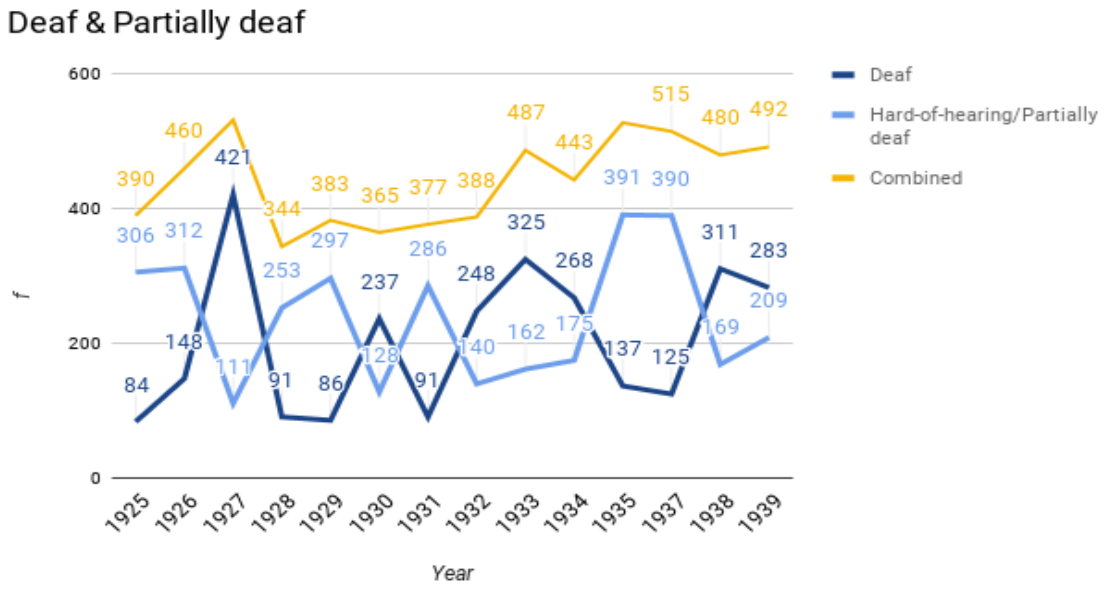

Figure 3: Deaf and Partially Deaf Students

Totally/Partially blind. The enumeration for the category of Totally Blind seems to have spiked in 1927, with 581 students in this category, in 1934 (436 students), and in 1939 (318 students). Beyond these years, there seemed to have been a slight increase of identification of students in this category over time; where in 1925 only 26 students appeared in this category, in 1938 there were 52 students enumerated as being Totally Blind. In the Partially Blind category there were

also two distinctive peaks in 1926 with 669 students in this category from the 26 counties and in 1937 with 679 students enumerated.

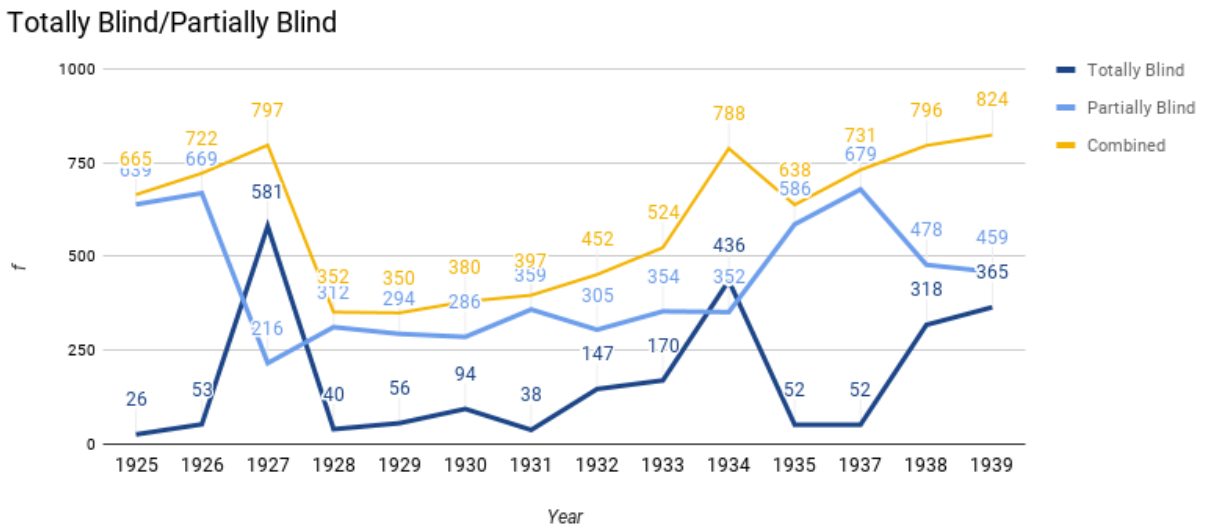

Figure 4: Totally Blind and Partially Blind Students

Speech defects. The category of speech defects began with a high plateau of enumerated students in this category for the period of 1925-1927 (1,813, 1,838, and 1,867 respectively for those years), followed by a steep decline between 1928 and 1929, dropping from 1,547 students in this category to a mere 310. Following this there appeared to be a slight increase over the decade from 1929-1939, ending in 1939 with 541 students in this category.

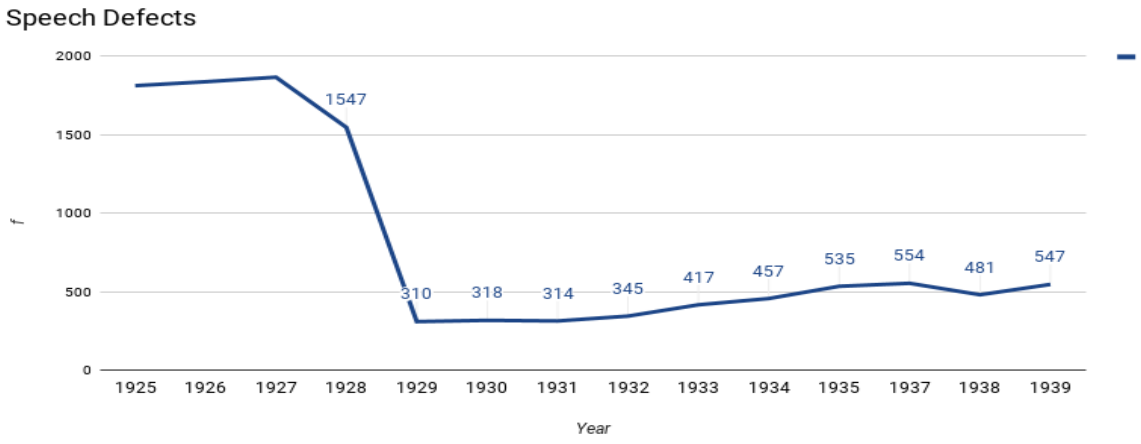

Figure 5: Students with Speech Defects

Types of Instructional Services

From 1930 to 1939 the Ohio school enumerations included a description of the types of instructional services offered to students identified in the disability categories. Three categories of enumeration were reported: (a) instruction occurring at home with a special teacher, (b)

instruction in public schools, and (c) no instruction. The most prevalent mode of receiving instruction from 1930-1939 in the 26 counties was through the public schools, followed by no instruction, and finally by home instruction with a special teacher. It should be observed that Columbiana County and Allen County did not report data in these three categories in 1937, resulting in a dip in enumeration in that year. Otherwise an increase was observed over time on the enumeration of students in all categories.

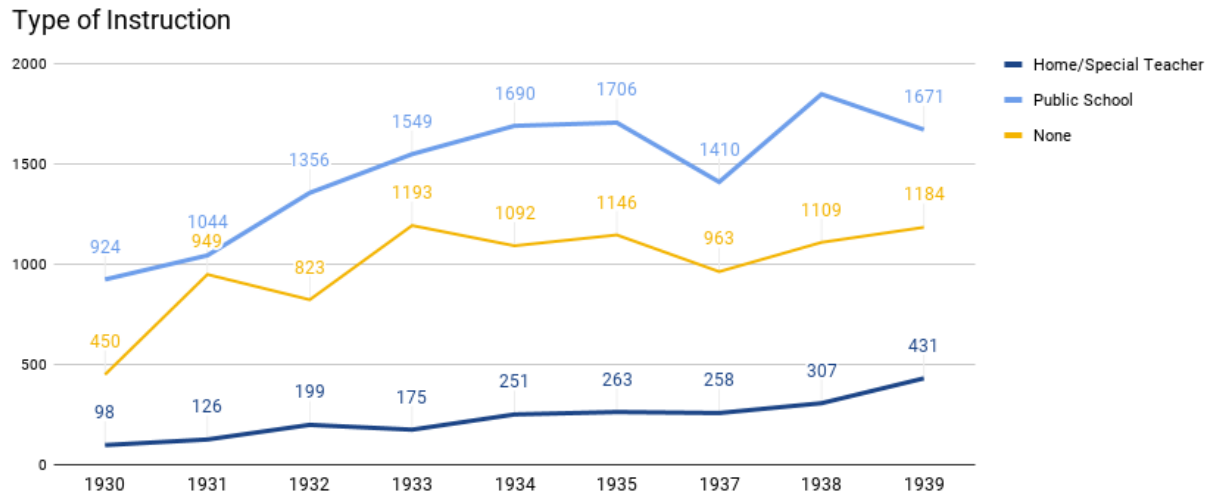

Figure 6: Type of and Frequency of use of Instructional Services

An analysis of the overall population of students enumerated in the 26 counties between 1930 and 1939 shows a population increase between 1930 and 1932. Numbers began to drop each of the following years. It is possible that students with disabilities, once enumerated, remained in the system over time, receiving instruction either in the school or from a special teacher in the home (or no instruction at all). In addition, an increase of the overall disability identification was a trend from 1930 to 1939. It does not appear that these increases are a function of the total school population increasing or decreasing over time, as disability identification increases even when the total enumerated school population decreases between 1933-1939.

Table 1
Disability Identification against Total Population Enumerated

	Students Enumerated by Year								
	1930	**1931**	**1932**	**1933**	**1934**	**1935**	**1937**	**1938**	**1939**
Feeble Minded	1067	1243	1094	1645	1853	1430	1349	1417	1329
Crippled	1814	1835	1758	1841	1678	1939	1924	1899	1986
Deaf and Partially Deaf Combined	365	377	388	487	443	528	515	480	492
Blind and Partially Blind Combined	380	397	452	524	788	638	731	796	824
Speech Defects	318	314	345	417	457	535	554	481	547
Total Identified with Disabilities	3944	4166	4037	4914	5219	5070	5073	5073	5178
Total School Population Enumerated	570045	586576	596503	595060	586548	576877	561689	548312	543157
Percentage Identified with Disabilities	**0.69188**	**0.71022**	**0.67678**	**0.82580**	**0.88978**	**0.87887**	**0.90317**	**0.92520**	**0.95332**

Discussion

In the early part of the twentieth century medical practitioners became increasingly preoccupied with epidemiology, the study of the distribution and determinants of health-related states and events in specified populations in the United Kingdom and the Americas (Centers for Disease Control and Preventions, 2016). One such doctor was James Kerr Love, a well-known Scottish otologist. Virdi-Dhesi (2016) recounts how "Love conducted several statistical studies of the ears of deaf schoolchildren, discovering that the majority of them were not completely deaf, but had some level of 'residual' hearing" (para. 3). Love further proposed that by using "proper medical treatment, the hearing could be intensified enough to warrant a 'cure.' For other cases, children could be taught to make use of that residual hearing through invasive training using acoustic aids and other kinds of hearing technologies" (para. 3). This perspective reflects the belief that every child is educable given a proper environment and adaptations.

By 1914 Wallin (1914) wrote that "the question as to the need of the inspection of school children for the detection of contagious and communicable diseases. . . may be said to be closed" and further, that "the schools, unless properly medically supervised, may, and frequently do, become virulent foci for the dissemination of fatal community diseases" (p. 1). Wallin (1914) also noted the other function of school medical inspection as being the screening and identification of "defective vision, defective hearing, defective nasal breathing, adenoids, hypertrophied tonsils, cardiac diseases, defective teeth and palate, malnutrition, orthopedic defects, tubercular lymph nodes, lateral curvature of the spine, stoop shoulders, nervous exhaustion and pulmonary disease" (p.1). His concern about the health and welfare of children followed the logic that "the school administrator and teacher must be vitally interested in any conditions which may cause irregular attendance or impair the pedagogical efficiency of the learner" (Wallin, 1914, p. 6).

Wallin (1927) later suggested that psychological and educational evaluations of children with disabilities must be provided by a clinical psychologist who specialized in differential education and who had the medical knowledge to interpret and apply medical findings. This put further emphasis on his long standing belief that non-psychologists should not be allowed to use psychometric tests to diagnose individuals, since they did not have the academic background to interpret those tests properly (Wallin, 1914). This would place diagnostic testing in the hands of those with legitimate training, who would use educational rigor in their work, unlike those practicing pseudoscience and quackery.

What are the Categories of Disability Identification in Ohio from 1925 to 1939?

It was found that through the school enumeration system, students with disabilities were identified as "feeble minded," "crippled," "deaf or partially deaf," and "speech defective." Two additional categories, not discussed in this paper, were "epileptic" and "other," which included heart defects, nervous conditions, and tuberculosis. The researchers chose not to pursue an analysis of these additional categories, due to the following factors: (a) the epilepsy category was incongruent with the research question related to the impact of policies and services for students with disabilities within the state, since there was no response within the legislation that addressed incidence rate and identification and (b) the "other" category ranged in identification from zero students to 23 over the 14 years of analysis.

Feeble minded. The diagnostic criteria for being diagnosed as feeble minded were somewhat evasive. To flesh out the diagnostic criteria as related to potential services, Wallin (1919) observed that: "the most striking pedagogical disabilities are in spelling, reading and numbers. Children with such defects often vary from normal to above normal intelligence to borderline or high grade feeble-mindedness" (p. 229). Wallin (1914) noted that feeble-minded children were commonly identified using the 1908 Binet Intelligence Testing scale, which worked on a range from Feeble-Minded to Retarded to Normal to Accelerated. Wallin's (1914) clinical practices and research resulted in sub-categories based on his more holistic treatment approach, but still grounded in psychometrics: Idiots (most severe), Imbeciles, Morons, and Doubtful (least severe). The Idiot to Doubtful classifications counted as a continuum of the Feeble-Minded category, followed by Border Cases (bordering feeble-mindedness), Backward, Retarded, Normal, and Supernormal (gifted).

According to the National Committee (1919) feeble-minded individuals remained as children in their mental abilities. They explained that, "Idiots, are absolutely helpless. Mentally they are infants. Others, known as imbeciles, have a mental capacity corresponding to that of a child of from three to seven years" (p. 121). Individuals identified as idiots and imbeciles were considered teachable to the point that they could care for themselves, avoid danger, and complete simple tasks. The National Committee (1919) further explained, "morons, have the mental capacity of children eight to twelve years of age. Many of them can be taught to do complex manual labor, under direction, so long as it involves no planning, reasoning and independent judgment" (p. 121). It was observed that individuals classified as feeble-minded could not live independently, or they would "drift into immorality and crime. Many of them are the objects of charity. Their immoral tendencies and lack of self-control make the birth rate among them unusually high. Their defect is transmissible from parent to child" (p. 121). Gesell (1921) further

explained that feeble-mindedness was not curable and that "public school training, supplemented by a system of community after-care, will reduce. . . . institutional commitment, and . . . . the classic consequences of feeble-mindedness: vagrancy, prostitution, dependency, crime—and more feeble-mindedness" (p. 79).

Crippled. Ohio was "the birthplace of the International Society for Crippled Children" (Hadley, 1927, p. 9). An early school for crippled children in Cleveland, OH received state funding starting in 1913. A school in Dayton, OH, also received state aid in 1917 and the school in Cincinnati began receiving state aid in 1920 (Hadley, 1927). Hadley (1927) reported that in the school year of 1926-1927 a total of 901 children who were considered crippled were educated in 56 day school classes. A total of 250 children received an education in hospitals or convalescent homes. A total of 112 children, in 40 counties, received home instruction from "duly accredited teachers" (p. 11).

In order to be admitted into special classes, the students would have to qualify under Section 7760 of the Ohio General Code which stated "Any person of sound mind, who by reason * * * [*sic*] of being so crippled as to be physically unable to properly be educated in public schools as other children" (as cited in Hadley, 1927, p. 17). Mental ability was determined by a "mental test" (such as the Binet Scale) approved by the state department of education. The physical disability category included children who used crutches, braces, casts, those with serious bone diseases, paralysis, amputations, and cardiac conditions (Hadley, 1927).

Deaf and partially deaf. It appears that the origin of the epidemiology of the deafness in the early part of the twentieth century has much to do with co-existing diseases affecting the ear. In accounting for the communicable diseases affecting hearing, Love (1913) observed in 1909 that the following common childhood diseases/conditions had these corresponding effects on hearing: Scarlet fever and measles resulted in semi-deafness with poor speech, meningitis resulted in total deafness with loss of speech or with preservation of speech, obstruction in the nose and nasopharynx resulted in hardness of hearing without loss of speech, and constitutional syphilis resulted in slight deafness or total absence of hearing.

Blind and partially blind. Similar to the category of Deaf and Partially Deaf, childhood diseases were sometimes culpable in terms of their effects on eyesight. In 1920, causes of blindness were reported for the population of United States as tabulated by the U.S. Census Bureau. In Ohio alone, 11% (263) of the total population of 2,291 individuals who went blind that year had their blindness attributed to common childhood communicable diseases or conditions such as measles, scarlet fever, or influenza.

Speech defects. Wallin (1919) noted that to be able to provide a differential diagnosis, prognosis, and treatment, it was very important to identify speech deficits to distinguish these conditions from the assumption of the child being mentally defective. Flack (1921) defined speech defects as "degrees of deficiencies and defects of speech (either organic or functional) among the children of the ungraded classes" (p. 89).

During the early part of the twentieth century, speech defectives were seen as a highly treatable subgroup within the categories of school aged children with disabilities. Wallin (1919) observed,

"While some speech defects do not respond at all to treatment, or at least very little, many can be almost or entirely cured" (p. 229). He strongly believed that public schools were responsible for treatment, arguing "No other agency will or can supply this treatment to our large number of speech defectives" (p. 229). Gesell (1921) observed that while "stuttering is a disease . . . it is definitely curable and responds to corrective training" (p.78) and further that as far back as 1909 some states had been remediating speech deficits by allowing students to attend "portions of a day and term to a speech improvement class and permitting them to remain in their regular room the rest of the time" (p. 79).

Did the Identification of Students in These Categories Change or Remain Stable Over Time?

In response to the research question *Did the identification of students in these categories change or remain stable over time*? it was found that disability identification trends fluctuated according to the identification of students based on diagnostic measures, medical advances, shifting definitions of disabilities over time, and epidemiology.

Feeble minded. As to the steady increase represented in this data set there could be several contributing factors. This increase is most likely an increase in identification over time rather than an increase in the actual numbers of students "becoming" or being born with feeble mindedness over the years. One issue revolves around over-identification because of psychometrics being solely utilized without using other means of clinical observation. Wallin (1914) observed that "The Binet rating gives 10 per cent more feeble-minded and from 15 to 20 per cent less backward cases" (p 148). He further implored, "I am entirely clear on the proposition that the Binet rating in the hands of mere Binet testers will give entirely too many feeble-minded cases" (p. 148). The problem rested in the fact that different clinicians and non-clinicians were using the Binet test and applying it in different ways and in conjunction with other assessment methods making feeble mindedness a shifting diagnosis (Mort, 1932).

Another problem was the common practice of the wait to fail model in which "if we consider the pupils who were retarded three years (or two years if under nine years of age) as feeble-minded, the discrepancy would be perceptibly increased" (Wallin, 1914, p. 148). That would mean there would be a yearly increase not only because of students being classified into the feeble minded category, but also because of new students from a less severe disability category transitioning to the feeble minded category.

Crippled. School enumeration data noted a spike in accounting for children in the Crippled category in the years of 1926-1927. This logically parallels the enrollment trends of children being matriculated in the newly created state-funded programs specific to this target population in 1926 and 1927, which were meant to meet the same academic standards as the regular or typical classroom in the same school district. By 1926, Ohio claimed that more than half of its counties had special classes connected to the public school system and because of legal provisions any community with eight or more children diagnosed as crippled, who by state standards would benefit, could establish a special class (Hadley, 1927).

Teacher preparation to support these programs was lacking at the time. Hadley (1927) found that Ohio teacher training programs did not offer specialized coursework for those interested in working with students qualified as crippled. Teachers did need to have three years of teaching experience in regular grades in order to teach special classes. Hadley (1927) believed that "Experience in a rural school is valuable, as the teacher has learned to keep several groups busy while one group is reciting" (p. 21). This experience was seen as beneficial, since teachers in special classes were expected to differentiate instruction for those students who needed more assistance than others.

Deaf and partially deaf. Two possible reasons explaining the oscillation of children identified in the categories of Deaf or Partially Deaf would be the progression of certain diseases moving them from the category of Partially Deaf to Deaf and the other being the core belief that oralism was a cure for deafness. According to Edson (1920):

> The value of right training for deaf children can be seen clearly by a visit to a school or institution for such children. Through lip reading these children become very expert in carrying on ordinary conversation with people whom they meet. Congenital deafness is a more difficult proposition than deafness caused by disease or accident owing to the impossibility of securing the natural resonance of the voice. Much is made of rhythmic work in all vocal training. (p. 123).

Blind and partially blind. The oscillation of the data presented in this study regarding blindness could be a result of the transition from the category of Partially Blind to Blind. The constant pattern of progression of the categories can be due to stability of the loss of vision and the accommodations in place to educate pupils in the classroom and or special schools. A decline in the reported category of Blind could also signify students leaving the Public School System for a specialized institution.

Speech defects. The decline of identification in the category of Speech Defects, as presented in the data, can be the result of a general progression toward more specialized training of professionals and the early identification and delivery of services to students who required speech therapy. For instance, Edson (1920) noted in the New York City Response that "each [speech] teacher visits the schools assigned to her, trains the pupils having speech defects either singly or in small groups, visits classes to observe the results of her efforts and instructs the grade teachers how to follow up the work" (p. 123). This intervention model demonstrated a collaborative approach between a specialist, such as a speech therapist, consulting with the classroom teacher to provide strategies for training the student out of the speech deficit.

A severe drop in the category of students identified as Speech Defective occurred between 1927 and 1929. This may have been due to effective treatment planning in schools and districts, focused on the remediation of speech deficits, as identification plateaued and remained at a much lower rate after those years.

Did Category and Incidence Rate Lead to a Change of Policies and Services Within the State of Ohio?

As noted previously, the identification of students with disabilities increased in all categories from 1930-1939 in Ohio (see Table 1). With this increase in identification rate of disabilities, the next question is how these students were being served in terms of instruction, or rather, to reiterate this study's third research question of whether category and incident rate led to policy and service changes. To answer this question we must look at what service modalities were offered in Ohio in this time period. This study identified three categories of instructional type for students with disabilities between 1930 and 1939 as determined by the state of Ohio: at home with a special teacher, at the public school, and no instruction. The overwhelming majority of students, across all years, were educated within the public school system, which denotes inclusion of students with disabilities in the regular education classroom, special classes, or special schools as early as 1930, affording most students with a "chance to get an education" (State of Ohio Department of Education, 1985).

Perhaps a more concerning figure is that in any given year between 1930 to 1939 there was a range of approximately 450 to 1,100 students statewide who did not receive educational services at all. Students who were being educated at home under the direction of specialized teachers rose from 98 in 1930 to 431 in 1939. Home delivery programs would have been the least cost-effective options for schools given the one-to-one ratio of student to teacher and the lack of centralized resources, resulting in this option being the least utilized. In 1939, the services provided by public schools began to decline, while the number of students receiving no education or home education rose. This data shows that in 1938, students with disabilities receiving instruction in public schools were enumerated at 1,848. This decreased to 1,671 students in 1939. It may be the case that students with disabilities started to become disenfranchised from public school education.

In 1930, 548 students with disabilities were instructed at home with a special teacher or received no educational services, whereas 924 students with disabilities were attending public schools for services; by 1939 there were 1,671 in public school services and 1,615 students in either home instruction or being provided no instructional services at all. This would mean a ratio of 1:1.686 of students with disabilities at home (with or without educational services) versus being served in public schools in 1930 compared to a 1:1.035 ratio in 1939. According to the Ohio Department of Education (1985), the state of Ohio was concerned with the number of students with disabilities not officially served by public schools in the 1930s. As a result, "in 1939 the legislature responded to this issue by creating a supervisor position in the Ohio Department of Education" (p. 33). This individual was responsible for developing and coordinating an instructional program to educate students with disabilities not previously served under the public system, and "By 1944, approximately two-thirds of deaf, blind, crippled, and partially sighted children in Ohio were being served, but not more than one-third of hard-of-hearing children were in organized programs" (Ohio Department of Education, 1985, p. 34). These figures denoted a positive move toward the re-enfranchisement of students in several of the previously enumerated disability categories. Only in 1975 with federal legislation (the Education for All Handicapped Children Act; Public Law 94-142) were all students with disabilities granted the right to a free and public education, once again returning schools in Ohio to an inclusionary model.

It is clear that the state of Ohio collected data in terms of disability classification in order to determine the appropriate education settings and services for students with disabilities. The State

of Ohio Department of Education Enumeration Returns (1925-1939) provide clear evidence that students with disabilities were included in all forms of education, from rural one-room country schools, to larger city schools, to private institutions. What remains nebulous are the daily practices of inclusion being practiced in each classroom, in each school, and in each district to provide a place for education for students with disabilities in this period. This could be a potential focus for future research, but only through an exhaustive search of district *Teacher's Reports to Successor*[3] to identify classroom strategies could this could be accomplished.

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[3] Teacher's Reports to Successor are best described as qualitative and quantitative grade books with annotations for each student, passed on from one teacher to another each succeeding year.

References

American Psychological Association (2010). *Publication manual of the American Psychological Association*. Washington, D.C.: American Psychological Association.

Ariss, R. M., & Dowsett, G. W. (1997). *Against death: The practice of living with AIDS.* Amsterdam: Gordon and Breach Publishers.

Batalla, D. V. (2009). Política nacional de educação especial na perspectiva da educação inclusive brasileira [National politics of special education in the perspective of inclusive Brazilian education]. *Fundamentos en Humanidades, 10,* 77–89.

Centers for Disease Control and Prevention. (2016). Teacher road map: What is epidemiology? Retrieved May 1, 2018 from https://www.cdc.gov/careerpaths/k12teacherroadmap/epidemiology.html

Cummings, W. R. (1922). Crippled children and their benefactors. *The Journal of Education, 96*(24), 658-660.

DeYoung, A. J., & Howley, C. B. (2009). The political economy of rural school consolidation. *Peabody Journal of Education, 67*(4), 63-89.

Edson, A. W. (1920). The education of mentally and physically handicapped children. *Ungraded, (5),* 121-125.

Ferri, B. A., & Conner, D. J. (1993). Tools of exclusion: Race, disability, and (re)segregated education. *Teachers College Record, 107*(3), 453-474.

Flack, H. (1921). Methods: Articulate speech. *Ungraded, 6*(4), 89-90.

Gesell, A. (1921). Public school provision for exceptional children. *The Annals of the American Academy of Political and Social Science, 98,* 73-81.

Groszmann, M. P. E., (1910). What consideration should be given to subnormal pupils? Journal of Proceedings and Addresses of Forty-Eighth Annual Meeting of the National Education Association of the United States, 160-166.

Grantman, W., (1913, September 27). Correspondence, Cincinnati, Ohio. State Archives Series 1575. Enumeration Returns, 1923-1949.

Hadley, H. C. (1927). *Education of crippled children in Ohio*. Columbus: The F. J. Heer Printing Co.

Love, J. K. (1906). *Diseases if the ear*. New York: William Wood & Company.

Love, J. K. (1913). *The causes and prevention of Deafness*. Kennington: Wayre & Son, Ltd.

Major, D. R. (1905). School legislation in Ohio. *The School Review, 13*(3), 221-231.

McDonald, R. A. F. (1915). *Adjustment of school organization to various population groups*. New York City: Teachers College, Columbia University.

Mort, P. R., & Gates, A. I. (1932). *The acceptable uses of achievement tests: A manual for test users.* New York: Teachers College, Columbia University.

Nation Committee (1919). The feeble-minded. *Ungraded, 4*(5) 121-122.

Nyre, S., (1913, August 18). Correspondence, Cleveland, Ohio. State Archives Series 1575. Enumeration Returns, 1923-1949.

Ohio Department of Education. (1985). History of special education in Ohio: 1803-1985. Worthington, Ohio: State Department of Education.

Riegel, V. M. (1920). Rural school progress in Ohio. *The Journal of Education, 92*(2), 34-35.

Schmidt, C, J., (1914, February 12). Correspondence, Dayton, Ohio. State Archives Series 1575. Enumeration Returns, 1923-1949.

Snyder, J. H. (1908). Legislation affecting the schools of the state, enacted in 1908. *Ohio Educational Monthly, 57*, 285-287.

U.S. Bureau of the Census. (1920). *The blind in the United States*. Washington, DC: U.S. Department of Commerce.

Virdi-Dhesi, J. (2016, June 29). Re: Deafness as a public health issue in the 1920s & 1930s (Part 1of 2). Retrieved from https://nyamcenterforhistory.org/2016/06/29/deafness-as-a-public-health-issue-in-the-1920s-1930s-part-1-of-2/

Wallin, J. E. W. (1914). *The mental health of the school child: The psycho-educational clinic in relation to child welfare.* New Haven: Yale University Press.

Wallin, J. E. W. (1919). Meeting the needs of the mentally handicapped child in school. *Journal of Education, 90*(9), 227-230.

Wallin, J. E. W. (1927). Special classes for handicapped children. *Educational Research Bulletin, 6*(12), 247-251.

Woodward, E. (1923). *Teacher's report to successor.* Archives of the Ashland County Historical Society for the Anderson School, Ashland, OH.

Yawberg, A. G. (1918). Consolidation. *The Journal of Education, 87*, 39-41.