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The Origins of Camphill and the Legacy of the Asylum in Disability History

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SUMMARY: This essay analyzes the beginnings of the Camphill movement, an international network of intentional communities for children and adults with intellectual and developmental disabilities. At its founding in Scotland in 1939, Camphill was a community of refugees; both the staff and first disabled residents fled Nazi Austria and Germany. This circumstance precipitated an innovation: disabled and nondisabled people lived together in a family-style household. But the innovation was not so much in Camphill's structure: it was common for nineteenth and early twentieth-century asylums to resemble homes and to strive for a familial atmosphere. Furthermore, Camphill's focus on cures, vocational training, and productivity aligned with the prevailing mid-twentieth-century medical approach to disability. The innovation concerned content: Camphill did not invoke a sense of home; it was a home because its displaced founders needed it to be one. The essay concludes with a critical reflection on how the model Camphill created should be situated in disability history.

KEYWORDS: social model of disability, medical model of disability, curative education (Heilpädagogik), Karl König, colony asylum, village asylum, intellectual and developmental disabilities

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In July 1938, pediatrician Dr. Karl König pinned a farewell note to his patients on his office door and fled Nazi Vienna. He found his way to London and from there to northern Scotland. He was fortunate: of the estimated thirty-two hundred Jewish doctors trying to flee Austria, he was one of just fifty that the British Home Office admitted with special permission to requalify for practice in the United Kingdom.[1]

Nine months later, in April 1939, nine-year-old Peter Bergel left Amsterdam on a Kindertransport and from London made his way to a small village near Aberdeen, Scotland.[2] His family had fled to Amsterdam in 1937 and applied for visas to the United States.

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[1] Archive of the Society for the Protection of Science and Learning, Bodleian Libraries (Weston Library), Oxford (hereafter BWLO), MS SPSL 103/9, 473. On the persecution of Jewish medical professionals in Nazi Austria, see Ilse Reiter-Zatloukal and Barbara Sauer, "NS-Entrechtung österreichischer Ärzte und Ärztinnen," in *Österreichische Ärzte und Ärztinnen im Nationalisozialisus*, ed. Herwig Czech and Paul Weindling (Vienna: Dokumentationsarchiv des Österreichischen Widerstandes, 2017), 23–46. On Jewish refugees from the medical professions in the United Kingdom, see Paul Weindling, "Austrian Medical Refugees in Great Britain, 1938–1945" (forthcoming); and Paul Weindling, "Medical Refugees and the Modernisation of British Medicine, 1930–1960," *Soc. Hist. Med.* 22, no. 3 (2009): 489–511.

[2] Archive of the Central British Fund for German Jewry, World Jewish Relief, London (hereafter CBFGJ), Kindertransport Registration No. CH 1233.

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Although his parents were granted U.S. entry as German Jewish refugees, restrictions against "defectives" scuttled Peter's application.[3] He had contracted encephalitis at the age of three and was left with permanent brain damage. His Jewishness and his disability made him a double target in Nazi Germany. In 1933, eugenics legislation mandated forced sterilization of people with disabilities. Within six years, mass killing was sanctioned. That Peter found safe haven in the United Kingdom is remarkable because Kindertransport organizers screened children for health, fitness, and disability.[4] But because his parents had the resources to secure

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[3] On disability and U.S. immigration policy at the time, see Douglas Baynton, *Defectives in the Land: Disability and Immigration in the Age of Eugenics* (Chicago: University of Chicago Press, 2016).

[4] Negotiations between the NGOs that organized the Kindertransport and the Home Office hinged partly on the former's ability to offer assurances that the roughly ten thousand children admitted would not become burdens on the state. In addition to screening for disability, officials also selected children for their apparent potential to adjust to life in Britain, which disadvantaged the Orthodox and those who ostensibly looked "too Jewish." Louise London is interviewed about her ongoing research on this topic in Rosa Doherty, "Fit, Bright, Not Too Jewish—Kindertransport Policy for Which Children to Save from the Nazis Revealed," *Jewish Chronicle*, April 19, 2019, https://www.thejc.com/news/uk-news/fit-bright-not-too-jewish-uk-kindertransport-policy-revealed-1.483126. On health and fitness certification and the rejection of children with disabilities, see Paul Weindling, "Transplanting Vienna's Children, December 1938–August 1939: Differing Expectations Between the Place of Persecution and Reception" (Kindertransport 80 Years On: Critical

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his placement with a doctor, they were able to furnish the necessary guarantee that he would not need state support. In a small village outside Aberdeen, Karl König had just secured permission to open a residential school for children with disabilities. Peter was his first pupil.[5]

Approaches to Kindertransport Research and Historiography Symposium, Institute for Advanced Studies, University College London, January 24, 2019); Paul Weindling, "The Kindertransport from Vienna: The Children Who Came and Those Left Behind," *Jewish Hist. Stud.* 51, no. 1 (2020): 16–32. For a recent critical reevaluation of the Kindertransport, see Jennifer Craig-Norton, *The Kindertransport: Contesting Memory.* (Bloomington: Indiana University Press, 2019). And on British immigration restrictions based on disability, see Warren Rosenblum, "A Universal Madness: Disability and Immigration Policy in Modern History," in *Family, Separation and Migration: An Evolution-Involution of the Global Refugee Crisis*, ed. Oreste Foppiani and Oana A. Scarlatescu (Bern: Peter Lang, 2018), 183–96.

[5] On Peter Bergel's escape from Nazi Germany and his life in Camphill, see Trude Amann, "Peter," *Cresset* 15, no. 3 (1969): 8–10; and Alan Potter, "Intentional Community as a Continuing Response to the Holocaust—The Life of Peter Bergel and the Camphill Communities" (Camphill Research Network, Presentations and Discussion Papers, 2019), https://research.camphill.edu/wp-content/uploads/2019/12/Intentional-Community-as-a-Continuing-Response-to-the-Holocaust-A-Potter.pdf.

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Kindertransport records list König's school as an "institution," but it bore little resemblance to one.[6] Rather than a conventional boarding school with a teaching and medical staff, König set about creating a community of unpaid volunteers living alongside students and practicing holistic care that integrated education, health care, work on the land, and shared social, cultural, and spiritual life. The idea had germinated in Vienna in response to the crisis of Nazi annexation in March 1938 and found support among members of a youth group that König mentored.[7] Once in the United Kingdom, he negotiated visas for fifteen of these young doctors, medical students, and artists, and they helped him establish the school.[8]

Even after they arrived, the challenges were myriad. The British government interned all the men and some of the women as enemy aliens, thus reducing the staff to a small group who nevertheless continued to take in children with disabilities.[9] They also accepted several older, nondisabled children from Kindertransports as young helpers. These youngsters

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[6] Peter Bergel's Kindertransport records list his U.K. address as "Dr. Koenig's Institution for Child Psychology." CBFGJ, Kindertransport Registration No. CH 1233.

[7] John Baum, "The Youth Group in Vienna," in *The Builders of Camphill: Lives and Destinies of the Founders*, ed. Friedwart Bock (Edinburgh: Floris Books, 2004), 23–28.

[8] Karl König, "The Candle on the Hill," *Cresset* 5, no. 4 (1961): 23.

[9] See Karl König, "W. F. Macmillan and the Beginnings of Camphill," *Cresset* 1, no. 1 (1953): 6; and John Baum, "It Was the Women Who Moved to Camphill," *Camphill Correspondence*, 2011, 4–5.

divided their time between spotty attendance at the local public school and work in the community, caring for disabled children only a few years their junior.[10]

The community soon began taking in disabled British children as well and almost immediately had difficulty meeting demand. The Macmillan family, who had a child with disabilities, helped them acquire a larger, better equipped house called Camphill Estate, and when the community began acquiring more properties, Camphill became the moniker of what was quickly becoming a movement. One might at first wonder at parents' eagerness to place their children in such an unorthodox setting, but the alternatives were institutionalization or home care with little or no support. Parents who could not manage full-time care at home, but did not want their children warehoused, faced a vacuum of options. Camphill filled that void. It also came with a certain cachet, as European doctors were highly sought after. Vienna had an international reputation for cutting-edge work in child psychiatry, and parents were aware of this reputation. As in so many cases where the state and medical establishment had failed children, parents became experts themselves. Among them, Camphill came to be known as the Eton of special education.[11]

In the 1940s, the original Camphill Estate grew into three separate communities in Scotland. From these, the movement spread in the 1950s to the rest of the United Kingdom, Ireland, and Central and Northern Europe. In the 1960s, 1970s, and early 1980s, hippies, activists, and conscientious objectors flocked to the villages and started new ones in the

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[10] Interview with a Kindertransport survivor, April 2019.

[11] Interview with an autism advocacy organizer and parent a former Camphill resident, April 2019.

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United States, Canada, South Africa, and Botswana. Thus Camphill grew from a little island of Central Europe in Scotland into a global movement promoting a holistic, eco-friendly lifestyle, communalism, and “lifesharing” with cognitively disabled people. Since the 1990s, it has expanded to include the U.S. West Coast and Hawaii, as well as India, Thailand, and countries from the former Soviet Union. Today, there are about 140 Camphill and Camphill-inspired communities around the world.

Camphill’s model of lifesharing with disabled people in intentional community is often lauded for anticipating mainstream challenges to the view of disability as biomedical defect, challenges that would come decades after the movement’s founding in 1939. In fact, Camphill has been very successful in crafting a narrative in which the disability rights priorities of emancipation and empowerment have been at its heart from its inception. The movement describes its “extended-family households” as incubators for a “mutually supportive environment” that cultivates “opportunities for each person to discover and develop their full potential” and “empower[s] people to grow, learn, and achieve together.”[12] As a result, Camphill has won the support of famous disability rights activists like Temple Grandin.[13]

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[12] Camphill Association of North America, “What Is Camphill?” (2022), https://www.camphill.org/about/.

[13] See Cision PRWeb, “NYC Benefit Invites ‘All Minds’ to Celebrate Inclusive Communities, Honor Work of Dr. Temple Grandin” (n.d.),

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The narrative of the movement as having anticipated the contemporary approach to disability as a social construct—the approach embraced by disability citizenship and justice advocates today—has made its way into what little English-language scholarly literature exists on the movement. For example, Kate Rossiter and Jen Rinaldi have described Camphill communities as "the organizational inverse of institutions."[14] They describe Karl König's mission as—from the outset—the cultivation of inclusive communities in which the contributions of each individual, disabled or not, was equally valued. They further maintain that today the communities practice (and, by implication, have always practiced) "*radical acceptance* of disability and, ultimately, human vulnerability and inter-dependence."[15] Religious studies scholar Dan McKanan also draws an analogy between the approach to disability in early Camphill and that of recent disability scholars and activists, but offers a more nuanced analysis that acknowledges the analogy's limits. His approach is simultaneously intellectually honest and sympathetic to Camphill: he acknowledges shortcomings, but he accepts the movement's basic claim that because its members were motivated by a social renewal impulse, their approach to disability—from very early in the movement's history—necessarily harmonized with and indeed anticipated more recent

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https://www.prweb.com/releases/nyc_benefit_invites_all_minds_to_celebrate_inclusive_communities_honor_work_of_dr_temple_grandin/prweb16230592.htm.

[14] Kate Rossiter and Jen Rinaldi, *Institutional Violence and Disability: Punishing Conditions* (Oxon: Routledge, 2019), 94.

[15] Ibid., 99.

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conceptions of disability that seek to overcome disablism by reforming society, rather than by changing disabled people.[16]

I aim to further complicate such accounts and the analytic framework on which they rely. I hold that Camphill's model of lifesharing was indeed innovative, but perhaps not in the ways or for the reasons one might expect. Camphill's familial accommodation in village settings was not new, which I show by contextualizing it in the history of the Scottish and German asylum. But although Camphill may have been similar in form, it was different, even innovative, in content. By this I mean that its communities not only *resembled* familial

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[16] Dan McKanan, *Camphill and the Future: Spirituality and Disability in an Evolving Communal Movement* (Oakland: University of California Press, 2020), 14, 176, 188–89. Dagmar Herzog also characterizes early Camphill as unusually progressive, but locates it in a different historical trajectory, that of movements that anticipated or were the roots of recent cultural approaches to disability that challenge and attempt to go beyond the rights-based activism behind the international legislative reforms of the past roughly fifty years. See Herzog, *Unlearning Eugenics: Sexuality, Reproduction, and Disability in Post-Nazi Europe* (Madison: University of Wisconsin Press, 2018), 87–89. Herzog's source is Zoë Brennan-Krohn, who suggests that Camphill made the shift to the social model in the 1970s, when medical treatment for intellectually disabled people had improved to the point that Camphill no longer needed to focus on health care. This suggests an understanding of the medical and social models as that is less relevant to the discussion I aim to join here. See Brennan-Krohn, "In the Nearness of Our Striving: Camphill Communities Re-imagining Disability and Society" (B.A. thesis, Brown University, 2009)

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homes—as did their mainstream precedents—they *were* homes. I argue that this crucial difference was the by-product of its founders' experience of displacement as refugees. Because the Nazis had seized their homes, torn apart their families, and murdered many of their loved ones, lifesharing was not just an atmosphere they attempted to cultivate as a method of patient treatment. Rather, it was their attempt to rebuild home and family for themselves as much as for their students. Against this background, I reflect on how the model they created should be situated in disability history.

The Medical Context

Any analysis of Camphill's model of care for people with disabilities must begin with an overview of Karl König's notion of disability and approach to curative education in their historical context. An integrative approach to special education in German-speaking Europe, curative education dated to the mid-nineteenth century.[17] It was practiced at the University of Vienna Children's Hospital, which established a Curative Education Department under pediatrician Dr. Erwin Lazar (1877–1932) in 1911. An ambitious field, it sought to offer a

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[17] The term *Heilpädagogik* (curative education) was introduced in the early 1860s. See Jan Georgens and Heinrich Deinhardt, *Die Heilpädagogik: mit Berücksichtigung der Idiotie under der idiotenanstalten* (Leipzig: Fleischer, 1863). For a recent critical analysis of its origins, see Vera Moser, "Gründungsmythen der Heilpädagogik," *Zeitschrift für Heilpädagogik* 58, no. 2 (2012): 262–74.

unifying, scientific basis for all aspects of child development and welfare, which extended to what some, including König, described as “care for souls.”[18]

König argued that curative education needed its own diagnostic method. The status quo was for practitioners to rely on diagnoses rendered by one or more of the specialists who treated various of their patients’ medical and psychological conditions. This was problematic, he argued, because it meant children became identified by a list of deficits and behaviors related to the “auxiliary diagnoses” made by pediatricians, psychologists, sociologists, and educators.[19] These diagnoses then took on unjustified predictive power over a child’s potential in life. König argued that intelligence, in particular, was too often taken as a measure of an individual’s potential for self-actualization, fulfillment, and success. Instead, he argued for an approach that melded psychiatry, pediatrics, psychology, and sociology in a

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[18] Edith Sheffer, *Asperger's Children: The Origins of Autism in Nazi Vienna* (New York: Norton, 2018), 33. For Lazar’s definition of the field, see Erwin Lazar, *Medizinische Grundlagen der Heilpädagogik für Erzieher, Lehrer, Richter under Fürsorgerinnen* (Vienna: Julius Springer, 1925). For König’s characterization of care for souls, see Karl König, *Das Seelenpflege-bedürftige Kind*, ed. Peter Selg (Stuttgart: Verlag Freies Geistesleben, 2008). Viktor Frankl also conceived of logotherapy in these terms. See Frankl, *The Doctor and the Soul: An Introduction to Logotherapy* (New York: Knopf, 1955).

[19] Karl König, “Some Fundamental Aspects of Diagnosis and Therapy in Curative Education,” *Cresset* 1, no. 2 (1954): 8.

holistic approach to pedagogy. Only the resulting holistic perspective could generate more accurate diagnoses based on "true knowledge" of the whole child.[20]

As this approach required intervention in all aspects of a child's life, it could not be practiced in an outpatient setting. In König's view, it required a residential facility equipped to fulfill all of the child's needs in an environment protected from the hostility of mainstream society.[21] The particular shape of home and community life that developed around these aspirations took a couple of decades to solidify. At first, Camphill accepted children with a wide variety of diagnoses including visual, hearing, physical, intellectual, and developmental disabilities, emotional and behavioral problems, as well as an ill-defined inability to fit in.[22]

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[20] Ibid., 7. König did not introduce this holistic perspective to the United Kingdom. British reformers who followed developments in German psychiatry had criticized approaches that analyzed patients as "bits and pieces" at the turn of the twentieth century. See Louise Westwood, "Explorations of Scottish, German, and American Psychiatry: The Work of Helen Boyle and Isabel Hutton in the Treatment of Noncertifiable Mental Disorders in England, 1899–1939," in *International Relations in Psychiatry: Britain, Germany, and the United States to World War II,* ed. Volker Roelcke, Paul Weindling, and Louise Westwood (Rochester, N.Y.: University of Rochester Press, 2010), 181.

[21] Karl König, *The Camphill Movement* (Danby: Camphill Press, 1981), 10.

[22] I use the umbrella category of "intellectual and developmental disabilities" in the American sense of the term to mean diagnoses including Down syndrome, autism, and what at the time was called mental retardation. This is distinguished from the American term "learning

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There were divisions for blind and deaf children as well as for children with Down syndrome, autism (variously diagnosed as post-encephalitic or psychotic), cerebral palsy, epilepsy, neurotic conditions, and "retardation," as well as a home and agricultural training program for delinquent boys.[23] In principle, curative education was applicable across this wide spectrum. Its clinical application was community life itself. Each household was structured as a family, with a "house father," a "house mother," their children, one or two short-term volunteers called "co-workers," and five or six disabled children or, in the communities founded to care for children who aged out, disabled adults, who were referred to as "villagers." Like so many terms used in Camphill, "house father" is a direct translation from the German, *Hausvater*, which means head of household. It also carries particular historical connotations of power and leadership beyond the domestic home that are significant because Camphill households were more than nuclear-family domestic dwellings—they blended public and private, work and the domestic, and their heads of household were at once parents, caretakers, social workers, and work masters.[24] The term "villager" is similarly loaded with romanticized premodern meanings.

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disabilities" and the British term "learning difficulties," which refer to weakness in particular academic skills in the absence of sensory or intellectual impairments.

[23] See "The Superintendent's Report for 1947," Karl König Archives, Aberdeen (hereafter KKA), no record number available. This is the first year for which such a report is available.

[24] On the historical uses and significance of the term *Hausvater*, see Otto Brunner, "Das Ganze Haus' und die alteuropäische 'Ökonomik,'" in *Neue Wege der Verfassungs-und Sozialgeschichte*, 2nd ed. (Göttingen: Vandenhoeck & Ruprecht, 1968), 103–27.

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Camphill's familial atmosphere and rural idyll could appear visionary. In a 1949 article in the British journal *Picture Post*, Scottish journalist Fyfe Robertson described how the community made him question two prevailing notions about children with disabilities: first, that they felt less deeply and thus needed only impersonal care and, second, that they were uneducable and incurable. Camphill convinced him that, in fact, disabled children's feelings were deeper than those of their nondisabled peers and that they could "flower wonderfully" if they were given the affection they needed along with "good, naturally grown, balanced food; intelligent medical care; [and] a serene and regular life." His article, titled "A School where Love Is the Cure," paired intimate photographs of children and their caregivers in the home, at the clinic, and working the land, with descriptions of how they blossomed.[25] But though Robertson was impressed with all aspects of Camphill, he did not suggest that every aspect was novel. He focused on two distinct dimensions—the emotional and the structural—and described the first as singular, the second as exemplary. He was right: Camphill's structure—familial accommodations in a congregate setting within bucolic, rural surroundings—was not entirely new. Thus even though he noted König's insistence that Camphill was not an institution, it still seemed natural to him to describe the school's residences as "cottages," the term used for patient housing in mainstream Scottish institutions (but not in Camphill).[26] As Robertson recognized, König's vision for the form of his special school does not look particularly novel when compared to a previous generation of asylums,

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[25] Fyfe Robertson, "A School Where Love Is the Cure," *Picture Post*, 1949, 28–31.

[26] Ibid., "institution," 31; "cottages," 28.

namely the rural colony or village asylums of nineteenth- and early twentieth-century Central Europe and Scotland.

Psychiatric care in mid-nineteenth-century Germany consisted of a network of rural asylums presided over by physician directors who lived on site in the role of patriarch. Patients were housed according to diagnosis, with their proximity to the director indicating their relative status: the most educated lived closest to him, followed but the calm and, on the periphery, "agitated persons and the raving mad," on whom restraints were commonly used.[27] Patients did occupational therapy in the form of work in the crafts and on the land. The asylums were situated in rural areas in accord with the "natural philosophical bias in favor of the rural idyll," away from the ostensibly pathological influences of city life.[28] The criterion for committal was incurability; rural asylums were to provide indefinite custodial care for those who would live out their lives at the institution. This removal to a closed, congregate setting was "considered fair and humane because they were integrated into a family setting where patients and staff lived together and shared the same communal facilities of the asylum; the patients' isolation was viewed as a remedy."[29]

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[27] Heinz-Peter Schmiedebach, "Inspecting Great Britain: German Psychiatrists' Views of British Asylums in the Second Half of the Nineteenth Century," in Roelcke, Weindling, and Westwood, *International Relations in Psychiatry* (n. 18), 12–29, quotation on 16.

[28] Ibid., 15.

[29] Ibid., 15.

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The second half of the nineteenth century saw major psychiatric reform. In the 1860s, German alienists (the contemporary term for doctors who treated mental illness) toured asylums in the United Kingdom and introduced a swath of conceptual and structural reforms in German psychiatry.[30] These included changes both to the criteria for commitment and to the asylum system. Specifically, reformers replaced curability with duration as the criterion for asylum commitment, and they advocated for nonrestraint, which had become the standard in Britain by the mid-nineteenth century. Instead of committing "incurable" cases for indefinite custodial care, they would provide medical care based on whether a patient's symptoms were acute or chronic, and they would adapt care for the chronic to an "emancipatory logic" that promised better therapeutic effectiveness and aimed to make the mentally ill economically productive.[31] Acute patients (and well-off, chronic patients who could pay to avoid the stigma of commitment to an asylum) would be seen in new urban mental hospitals that also served as teaching facilities. Chronic patients would be sent to "colony asylums." Rural, agricultural institutions set in large, attractive grounds, colony asylums offered more freedom of movement than their predecessors and included recreational facilities and chapels, trappings of village life meant both to make patients' long-term commitment more palatable and to cultivate their initiative to work. The director would

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[30] For an overview, see Cornelia Brink, *Grenzen der Anstalt: Psychiatrie und Gesellschaft in Deutschland, 1860–1980* (Göttingen: Wallstein Verlag, 2010).

[31] Eric J. Engstrom, *Clinical Psychiatry in Imperial Germany: A History of Psychiatric Practice* (Ithaca, N.Y.: Cornell University Press, 2003).

still live on site, but in private quarters away from the patients, nearby the research facilities and mortuary.[32] Another new arrangement was family care. Inspired by the Scottish practice of "boarding-out," families in areas nearby colony asylums would receive payment to take in nonviolent, quiet patients (usually women) under doctor supervision and include them in all aspects of the household's daily life. The Scottish boarding-out system had evolved largely as a stopgap because asylum construction could not keep pace with patient committal, but it was and sometimes still is viewed as a progressive reform measure.[33]

About two decades later, in the 1880s and 1890s, these reforms had resulted in an extensive system of mental hospitals in Central European cities and a network of agriculturally productive colony asylums that, in turn, became the basis for a new wave of reform in the United Kingdom. While the colony asylum model did not take hold in England,

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[32] Schmiedebach, "Inspecting Great Britain" (n. 25).

[33] It was even referred to at the time as the Gheel of the north, in reference to the Belgian town's centuries-old tradition of households taking in people with mental illness as guests or boarders. The comparison is imperfect. See Gillian Allmond, "Liberty and the Individual: The Colony Asylum in Scotland and England," *Hist. Psychiatry* 28, no. 1 (2017): 30. See also Harriet Sturdy and William Parry-Jones, "Boarding Out Insane Patients," in *Outside the Walls of the Asylum: The History of Care in the Community, 1750–2000*, ed. Peter Bartlett and David Wright (London: Athlone Press, 1999).

in Scotland it became the model for a "village asylum" system that dominated psychiatric care until the advent of deinstitutionalization in the 1960s.[34]

Scottish village asylums cultivated a deliberate homelike atmosphere. Patient housing was segregated from medical facilities in purpose-built or acquired villas that resembled middle-class homes on extensive grounds in rural areas on the outskirts of cities. The houses, or cottages, as they were often called, were intentionally situated seemingly at random rather than in a recognizably planned formation, and each structure was designed in a different style, to create the illusion of a village that had grown up organically. Patients were allowed to move around the grounds freely, under staff observation. The construction and operations costs were greater than those of the pavilion-style institutions preferred in England, so some 25 percent of patients slated for village asylums had to be accommodated though the boarding-out system. Gillian Allmond argues that Scottish psychiatrists and state authorities were willing to bear these higher costs because the village asylum modeled the Scottish Calvinist ethic of improvement.[35] The greater autonomy that patients enjoyed was supposed

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[34] For a discussion of such institutions for people with intellectual disabilities and mental illness in the context of a general history of disability in nineteenth-century Scotland, see Iain Hutchison, *A History of Disability in Nineteenth-Century Scotland* (Lewiston, N.Y.: Edwin Mellen Press, 2007).

[35] Allmond, "Liberty and the Individual" (n. 31). In Germany, such institutions had emerged as an extension of the "colonization" of the poor, an older tradition that was also "part of an

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to inspire them to cultivate their individuality, or personal initiative. In other words, the reformers behind Scottish village asylums held that in a wholesome, homelike atmosphere in nature, patients would be moved toward self-improvement. And through work on the land, they might not only improve personally but also make the asylums self-sufficient or even part of the market economy.[36]

By 1900, all new asylums in Scotland were built on the village model and institutions for children with intellectual and developmental disabilities were tailored essentially as feeder schools for the village asylum system. In Germany and the United States (the colony system had also taken off in the latter), this pedagogical trend was known as medico-pedagogy or physiological education. Special schools and colonies run on this model provided "training" in order to prepare disabled children to become productive members of long-term residential institutions. Drawing on principles from Edouard Séguin in the United States and Friedrich Froebel in Germany, this form of education entailed a blend of "hand work"—manual work in the crafts and on the land—and "head work," in core academic subjects. The idea was that children with cognitive disabilities learned best by doing and that it was thus important first and foremost to educate their senses and muscular systems.[37]

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improvement ethic, which sought to render productive a sector of the population seen as both morally lacking and socially threatening." Ibid., 31.

[36] Schmiedebach, "Inspecting Great Britain" (n. 25).

[37] Mark Jackson, "Permeating National Boundaries: European and American Influences on the Emergence of 'Medico-Pedagogy' in Late Victorian and Edwardian Britain," in Roelcke,

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By 1939, when König arrived in Scotland, this Progressive Era reform agenda still furnished the paradigm for special schools and village asylums, but in practice they were functioning as updated versions of the custodial institutions they had replaced.[38] This, too, was part of a transnational trend. Inspired partly by German reformers who fought to give mentally ill and disabled people *more* access to research-based medical treatment (as opposed to custodial care), progressives on both sides of the Atlantic had pushed for deregulation that would empower doctors to craft individualized treatments.[39] But according to David Rothman's classic analysis, convenience trumped conscience; medical administrators used deregulation to reduce rather than to individualize care.[40] Thus in Scotland by the 1940s,

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Weindling, and Westwood, *International Relations in Psychiatry* (n. 18), 30–47. For more on the German context, see Sieglind Ellger-Ruettgardt, *Geschichte der Sonderpädagogik: Eine Einführung* (Stuttgart: UTB, 2019). And for a discussion of Heilpädagogik (curative education) within this broader context, see Gottfried Biewer, *Grundlagen der Heilpädagogik und Inklusiven Pädagogik* (Bad Heilbrunn: Verlag Julius Klinkhardt, 2017) and Moser, "Gründungsmythen der Heilpädagogik" (n. 15), 265.

[38] Mark Gallagher, "From Asylum to Action in Scotland: The Emergence of the Scottish Union of Mental Patients, 1971–2," *Hist. Psychiatry* 28, no. 1 (2017): 101–14.

[39] On the German anti-psychiatry movement, see Schmiedebach, "Inspecting Great Britain" (n. 25).

[40] David J. Rothman, *Conscience and Convenience: The Asylum and Its Alternatives in Progressive America* (New Brunswick, N.J.: Aldine Transaction, 2012). In addition to

village asylums were well on their way to exhibiting the abysmal conditions in place in the 1960s when the long process of deinstitutionalization was initiated. They had the same chronic problems of overcrowding, understaffing, neglect, and abuse as their English and American counterparts.[41]

If Camphill imagined itself as a critique of such institutions, the critique did not extend to questioning the value of congregate settings per se. In other words, Camphill's founders did not anticipate the critique of institutions as inherently dehumanizing. In fact, the movement exhibited elements reminiscent of both the nineteenth- and twentieth-century asylum forms discussed above. For example, Camphill's approach clearly aligned with medico-pedagogy. Children learned traditional subjects at the community school alongside a variety of "hand work" skills, such as candle making, woodwork, weaving, and doll making. They practiced a form of movement therapy called curative eurythmy, in which the body "speaks" through poses that correspond to letters of the alphabet. They also worked alongside staff members in their households, in the community garden and farm, and in the bakery.[42]

Rothman, for more on individualized diagnosis and personally tailored treatment as well as the concern about "maladjustment" that was an important context therefor, see Hans Pols, "'Beyond the Clinical Frontiers': The American Mental Hygiene Movement, 1910–1945," in Roelcke, Weindling, and Westwood, *International Relations in Psychiatry* (n. 18), 111–33.

[41] Gallagher, "From Asylum to Action in Scotland" (n. 36).

[42] Robertson, "A School Where Love Is the Cure" (n. 23).

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As with their late nineteenth-century predecessors, the schools aimed to train disabled children to become productive members of long-term residential villages or colonies. Indeed, it is probably no accident that when Camphill began establishing communities for adults in the mid-1950s, they called them "villages." These villages placed great emphasis on cultivating individuality, and, just as in the German and Scottish traditions of personal improvement that so influenced the village asylum system, this had strong moral overtones and was measured in terms of personal initiative and productivity. Indeed, König's goal for Camphill's first "village settlement" for adults was that it be a productive, "self-supporting" ecosystem.[43]

But there are also ways in which Camphill looked like older, mid-nineteenth-century, rural asylums, "institutions of discipline and care, expressions of both bourgeois moralism and solicitude."[44] And König's role could be aptly described as "pinnacle of the institution, head of the household," like the model alienist asylum director envisioned by the architect of Central Europe's mid-nineteenth-century asylum system, Dr. Heinrich Laehr (1820–1905).[45]

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[43] Karl König, "Seven Years of Botton Village," *Cresset* 8, no. 4 (1962): 4–8. For more Camphill's first villages for adults as "working communities," including Department of Labour oversight of the working conditions and hours, see Donald Perkins, "The Newton Dee Village Community," *Cresset* 11, no. 3–4 (1965): 239–41.

[44] Engstrom, *Clinical Psychiatry in Imperial Germany* (n. 29), 1.

[45] Heinrich Laehr, *Fortschritt?—Rückschritt!*, vol. 1 (Berlin: Oehmigke, 1868), 26, as quoted in Engstrom, *Clinical Psychiatry in Imperial Germany* (n. 29), 1.

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Indeed, Camphill's rhetoric of equality among all community members notwithstanding, early Camphill volunteers recall being afraid of him—his exacting standards had to be met and his authority was absolute.[46] But that authority not only concerned enforcement of standards, it also related to the emotional dimension of the director's paternal role. Heinz-Peter Schmiedebach describes how, in the 1840s, German doctors held that "in no country other than Germany were asylum members, both inmates and staff, united in a great family whose centre was the physician. The doctor created the atmosphere and made the asylum into a place of care and cure."[47] In a similar vein, early volunteers remember the tone of calm, even "reverence" that König created, down to the detail of how he walked—slowly and deliberately, with a certain gravitas that commanded quiet attention.[48]

But how do we contextualize and understand Camphill's rather anachronistic approach? König seems to have been using old forms, and he appears to have been animated by the optimism of progressive reform at a time when his contemporaries had abandoned progressive idealism. Accounts from the period sound like something out of a fairy tale, as if on entering Camphill, one accessed a long-lost time before modernization and industrialization had ruined rootedness and community, before expediency and efficiency had replaced intimacy and compassion. To understand where this romantic, nineteenth-century culture and aesthetic came from, one has to turn briefly from Camphill's medical context to its cultural one.

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[46] Interview with a retired Camphiller, July 2019.

[47] Schmiedebach, "Inspecting Great Britain" (n. 25), 18.

[48] Interview with an early Camphiller, May 2018.

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The Cultural Context

From the beginning, Camphill's purpose was not only to provide care but to create a sense of confessional community. König was as a follower of Rudolf Steiner, the Austrian occult philosopher and founder of anthroposophy, a Christian spiritual movement that is part of the tradition of Western Esotericism. As Corinna Treitel explains, anthroposophists, like members of other esoteric movements in early twentieth-century Germany, imagined themselves as offering solutions to modernity's worst side effects. Though their movements were products of modernity, they often reached far back into the past for models of a more salubrious future.[49] König envisioned a community that harked back to an idealized version of medieval agricultural life. To realize this vision, he would need a group of fellow anthroposophists ready to embrace deep religiosity, close-knit kinship within traditional households, homogeneous and ritualized social and cultural life, farming, gardening, and craftwork using traditional methods. They would also need to reject modern technology and popular culture.[50]

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[49] Corinna Treitel, *A Science for the Soul: Occultism and the Genesis of the German Modern* (Baltimore: Johns Hopkins University Press, 2004). See also Anne Harrington, *Reenchanted Science: Holism in German Culture from Wilhelm II to Hitler* (Princeton, N.J.: Princeton University Press, 1996).

[50] This raises complex questions given that one strain of eugenicist rhetoric about people with disabilities in the early to mid-twentieth century stigmatized reliance on technology. Nazi eugenicist propaganda, for example, labeled people with physical and sensory disabilities

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König found such a cohort among anthroposophists who, like himself, were converts from Judaism. König self-identified as a Christian, as did the fifteen young people who followed him to Aberdeen.[51] They had been part of a youth group of about thirty to forty young anthroposophists who had been holding regular meetings and attending König's lectures in Vienna. All but two of them had Jewish heritage. This was no accident. In fact, König was in Vienna only because he had had to give up his medical practice in Germany—after the Nazis came to power, he was stripped of his medical license. He was also expelled from the Anthroposophical Society, which was itself (as anthroposophists are quick to remind us) banned in 1935.[52] Though he could practice in Vienna until 1938, the climate of anti-

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who used assistive technologies as unnatural "machine people." Harrington, *Reenchanted Science* (n. 47), 185ff.

[51] Sources differ on when König converted and to which Christian denomination (before finding anthroposophy). Divergent accounts appear in Peter Selg, "A Biographical Sketch," in *Karl König: My Task: Autobiography and Biographies*, ed. Peter Selg (Edinburgh: Floris Books, 2008), 58, and Bertha König, "Meine Kindheits- und Lebenserinnerungen" (1966), KKA, no record number available, 35–36. According to Viennese archival records, König officially withdrew from the Jewish Community in 1929 (when he was twenty-seven). See Archives of the Jewish Community of Vienna, Withdrawal Records, 1915–1945, No. 88614.

[52] For a full account of König's life and the various rifts within anthroposophy, see Selg, *Karl König: My Task* (n. 49) and Hans Müller-Wiedemann, *Karl König: A Central-European*

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Semitism (including among non-Jewish anthroposophists) was such that the youth group was almost certainly the only available anthroposophical audience for König. Likewise, he was the only anthroposophical leader to whom they had access.[53]

Circumstances, then, forced them together. But those circumstances also forced them to innovate. There was an existing network of anthroposophical boarding schools for children with disabilities in Germany—one had been founded by König's non-Jewish wife—and the Vienna youth group's vision for a special school would naturally have been an extension of this network. But in the United Kingdom, they had to reimagine their school with what they had: one house that had to serve as an educational center and as living quarters for students, teachers, and medical professionals. Most importantly, this one structure needed to become home for a group of displaced people of all ages and abilities whose lives had been torn apart. The youth group members had reassembled in Scotland only after months of uncertainty as each fled Austria separately, using whatever connections they could muster. The one member

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Biography of the Twentieth Century, trans. Simon Blaxland-de Lange (Whitby: Camphill Books, 1996).

[53] On anti-Semitism among anthroposophists, see Peter Staudenmaier, *Between Occultism and Nazism: Anthroposophy and the Politics of Race in the Fascist Era* (Leiden: Brill, 2014), and Hans Büchenbacher, *Erinnerungen 1933–1949*, ed. Ansgar Martins (Frankfurt: Info 3 Verlag, 2014). Both concern Germany, but the climate would have been similar in Austria. Reflections by König's followers also support this conclusion. See Baum, "Youth Group in Vienna" (n. 7), 25.

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who decided to remain in France was deported to Auschwitz; all of those who made it to Scotland lost family members in the Holocaust.[54] The home they made in Aberdeen was thus utopian because it had to be—its founders had to reimagine home collectively because they had lost their families. So had some of the first children Camphill welcomed. They could not be sent home on holidays in order to maintain a separation between family and professional space—they had arrived alone on Kindertransports. Furthermore, the constraints of the space—the building that needed to house everyone and everything—forced the founders to experience their school in intimate terms. Indeed, young staff members often shared rooms with the students because there was no space for private accommodation.[55] In this way, Camphill became as a space of mutually transformative relationships between nondisabled and disabled people.[56]

As one of Camphill's early volunteers described it,

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[54] For an overview, see Bock, *Builders of Camphill* (n. 7). In her memoir, König's mother mentions being one of eight children, some of whom were able to flee Austria. See König, "Meine Kindheits- und Lebenserinnerungen" (n. 49), 6, 8, 29, 45. König's father had three sisters, all of whom were killed in the Holocaust: Josephine Charmatz, 11203589, 5051005, 4958062, ITS Digital Archive, accessed at the U.S. Holocaust Memorial Museum on June 13, 2017 (hereafter ITS); Sali Karolanyi, 11202759, ITS; Lea Wohlmuth, 1.2.1.1, 11202618, ITS.

[55] Interview with a Camphill coworker who joined the movement in the 1950s and remembers sharing a room with Peter Bergel, May 2018.

[56] Karl König, "Meditations on the Camphill Movement," *Cresset* 6, no. 2 (1959): 16.

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> Necessity played a big part, needs of the underprivileged, the retarded, and needs of the refugee, the homeless, came together. Camphill's beginning in the 1940s in the north of Scotland in a tiny house was the fold in which a community-building impulse could grow, which carries new ethics of recognition and understanding, the real meeting from soul to soul, ego to ego.[57]

König suggested that the community should aim "not to try to create a Middle European island in this place," but "try . . . to act for the good of this land, this country."[58] But no speedy acculturation process followed. Community life continued in German, which made the incorporation of local Scottish people nearly impossible.[59] And König, who had been so fortunate to receive a visa that allowed him to requalify for practice in Britain, never finished his studies at St. Andrews.[60] As a result, Camphill remained cut off from its neighbors. One of

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[57] Janet McGavin, untitled contribution in *Memories of the Beginning: Camphill in America, 1961–1986*, ed. Mary Elmquist (Unpublished, 1986), 13.

[58] Baum, "Youth Group in Vienna" (n. 7), 33.

[59] A diary kept by an early Camphill coworker indicates that lectures were still held in German in 1951. See Nina Oyens's Diary, Tuesday, May 29, 1951, KKA, no record number available.

[60] The British Central Office for Refugees' Medical Department and the SPSL kept track of the fifty Austrian doctors permitted to requalify in the United Kingdom. König does not appear on their lists of those sitting for exams, in postqualification employment, etc. See BWLO SPSL 103/9. The Karl König Archive staff confirmed that he did not finish his requalification. On German and Austrian Jewish refugee medical professionals in Britain, see

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the nondisabled Austrian Jewish children who arrived through the Kindertransport recalled hearing rumors at school suggesting that Camphill gatherings were covert Nazi rallies.[61] The misunderstanding reveals local prejudice, but it also reflects Camphill's isolation from the surrounding community. Camphill's founders had made up a Jewish subculture within German anthroposophy, a network of anthroposophists that was relatively closed off from mainstream anthroposophy not by choice but because of exclusion.[62] In Scotland, they

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Weindling, "Medical Refugees" (n. 1); Weindling, "Austrian Medical Refugees" (n. 1); Karola Decker, "Divisions and Diversity: The Complexities of Medical Refuge in Britain, 1933–1948," *Bull. Hist. Med.* 77, no. 4 (2003): 850–73. A mythology has developed in the Camphill movement surrounding how Karl König got on the list of fifty Austrian doctors to begin with. König claimed it was a mystery. There is speculation that the chairman of the British Anthroposophical Society was behind it, as he apparently knew the British home secretary. See Nick Thomas, "Preface," in Bock, *Builders of Camphill* (n. 7). According to König's mother, he applied. König, "Meine Kindheits- und Lebenserinnerungen" (n. 49), 41.

[61] Interview with a Kindertransport survivor, April 2019.

[62] On the idea of the German Jewish subculture, see David Sorkin, *The Transformation of German Jewry, 1780–1840* (New York: Oxford University Press, 1990). Sorkin describes Jewish activity on a society-wide scale that is essentially the same as that of the majority culture in content; exclusion forces Jews to mirror rather than join the majority, making them, ironically, visible as Jews. Within German-speaking anthroposophy, König's group fits a similar pattern, with one important exception. Sorkin's Jewish subculture does not exhibit

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conceived of themselves as a German diaspora community. König's parents, who managed to flee Vienna and lived in the Camphill Estate's gate house, were the only link to Jewish Aberdeen.[63]

The share of people with Jewish heritage in Camphill soon dwindled. Nazi Germany's defeat in 1945 ended the community's isolation from non-Jewish anthroposophy in Central Europe. By the late 1940s, a cohort of twenty-five young non-Jewish Germans had arrived in Scotland and a three-year training course, the "Camphill Seminar in Curative Education,"

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negative feelings about Jewish culture. This is not the case for König, as I discuss below. Yet one would lose sight of Camphill's parallel relationship to "mainstream" German anthroposophy if one dismissed subculture as an analytical framework in favor of the other relevant option—radical assimilation—which focuses more on identifying the reasons for apostasy than on the subsequent lived experience of those who converted or ceased to practice Judaism. On radical assimilation, see Todd Endelman, *Leaving the Jewish Fold: Conversion and Radical Assimilation in Modern Jewish History* (Princeton, N.J.: Princeton University Press, 2015).

[63] Even they had contact mostly with other Jewish refugees. König, "Meine Kindheits- und Lebenserinnerungen" (n. 49), 55. They did not become anthroposophists. Indeed, at a certain point, Karl König forbade his mother from attending Camphill seminar meetings because she too often interjected, "but Karli, this is nonsense!" Interview with a former Camphiller, March 2018; interview with a retired Camphiller, July 2018. For more on her dim view of spiritual "seekers," see König, "Meine Kindheits- und Lebenserinnerungen" (n. 49), 31.

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was initiated to integrate them.[64] Many more young Germans followed, supplying the workforce for Camphill's expansion across the United Kingdom and beyond. Thus, although the communities increasingly consisted of a patchwork of nationalities, Central Europe remained Camphill's diasporic homeland.

Jews are a small minority today. Yet the Jewish refugee origin story is still invoked as an illustration of the movement's mission. König himself had crafted that story:

> We dimly felt that which, later on, became clear recognition; that the handicapped children, at the time, were in a position similar to ours. They were refugees from a society which did not want to accept them as part of their community. We were political, these children social refugees . . . they provided us with the conviction that we fulfilled a necessary task and were not superfluous and useless members of this country.[65]

This linked experience of persecution became a leitmotif of the movement, and it remains inspirational today. It has also made its way into the academic literature, where one can find Camphill described as "an anti-fascist alternative to concentration camps."[66] Yet accounts that

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[64] Erika Nauk, *We Came . . . : Biographic Sketches of the Twenty-Five Participants of the First Camphill Seminar in Curative Education, 1949–1951* (Aberdeen: self-published, 2009).

[65] König, "Meditations on the Camphill Movement" (n. 54), 12.

[66] Zoë Brennan-Krohn, "In the Nearness of Our Striving" (n. 16), 21. Like the view that Camphill's anthroposophical social renewal impulse necessarily aligns with the disability rights movement's demands for social reform, this view reinforces a narrative that originates in the Camphill movement. See Müller-Wiedemann, *Karl König* (n. 50), 177. The interpretation (citing Brennan-Krohn) also appears in Robin Jackson, "The Austrian

recycle the Jewish refugee origin story do not include the refugees' complicated relationship with their German homeland. König and his young followers thought of Central Europe as a spiritual impulse that they had rescued when they fled into exile.[67] In the process, they perpetuated the racist and anti-Semitic threads in Rudolf Steiner's thinking. König even carried over Steiner's anti-Semitism in his own interpretation of the Holocaust, which used the Wandering Jew myth, the materialist caricature, and the hyperintellectual stereotype to make a supersessionist argument that modern Jewish politics and culture were evidence of "Judaism knowingly preparing itself for annihilation."[68]

Though König identified as a Christian, his life and work cannot be understood outside the context of Jewish history. And this German-Jewish context—its complexity included—is relevant here because it helps explain the unique home life cultivated in Camphill houses. Households were not simply engineered to support children with disabilities; they re-created a very specific sense of home for German-speaking anthroposophists who found themselves in exile because of their Jewish heritage.

Provenance of the Worldwide Camphill Movement," *J. Austrian Stud.* 46, no. 4 (2013): 38–39.

[67] Interview with a retired Camphiller, June 2018.

[68] Karl König, *The Destinies of Sigmund Freud and Josef Breuer*, trans. Peter Engel (Stuttgart: Verlag Freies Geistesleben, 1962), 21. For the full argument, see Karl König, *The Destiny and the History of the Jewish People: Three Lectures Given in the Camphill Hall* (Aberdeen: Camphill Village Trust, 1966).

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Clinic or Community?

Camphill's first two decades saw much experimentation and negotiation as community members sought to solidify their holistic approach that fused homemaking and care provision. The method they developed early on for determining each disabled child's care regimen is an illustrative starting point. The children's needs were discussed on a rotating basis in weekly gatherings called "college meetings" led by a doctor. One staff member presented a child's case history, and each community member who lived with or taught the child presented a report. The goal was not only an overview of the child's "habits, achievements, faults, and failures" but a "complete picture of his individuality [because] to recognize the child's individual nature at once means to realize the necessary curative and educational treatment."[69] Under the physician's guidance, the child's "many symptoms, signs and features are collected until . . . the image of the child arises." The results did not take the form of a treatment plan; the effects were understood to be more intangible and, paradoxically, more immediate: "We have sometimes experienced that already on the next morning the child was fundamentally changed in his being and behavior. He subconsciously experienced the great effort which was made to understand his special situation and responded quickly."[70] These meetings illustrate Camphill's eclectic influences well. The esoteric is evident in the claim to unmediated, intuitive effects, but the progressive reform agenda discussed above is also evident in the emphasis on personalized care for each

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[69] König, *Camphill Movement* (n. 19), 32.

[70] Ibid., 33.

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individual. Moreover, the prominence of the doctor calls to mind the traditional role of the asylum superintendent.

But the role of the doctor also extended beyond that of the superintendent. König's ambitions were greater—in addition to a village he also envisioned a cutting-edge psychiatric hospital and nursing program. Admissions and dismissal data from the mid-1940s used the umbrella category of "pupils and patients" and the superintendent's reports included a section on medical research and clinical work.[71] König saw patients at an office on Harley Street in London and at Camphill, where he also had plans to build a hospital.[72] Camphill also seems to have had fruitful relationships with the medical establishment: König served as a consultant to researchers at Maudsley Hospital, and the community hosted medical conferences that brought together superintendents from mainstream institutions and Camphill volunteers.[73] Camphill's early reporting on admissions and dismissals also used medical

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[71] See "The Superintendent's Report for 1947" and that for 1949–52, KKA, no record numbers available.

[72] In the interim, a sick bay was created in one of the wings of Camphill Estate and a medical lab was set up in nearby Murtle Estate. "The Superintendent's Report for 1947," KKA, no record number available.

[73] König admitted children referred by Maudsley researchers and reported on their progress in Camphill. The details, unfortunately, remain inaccessible as the Maudsley Hospital Autism and Child Psychosis Archive was recently transferred from its clinical home to the Kings College Archives and is not yet open to researchers. For a very brief discussion of König's

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connection to Maudsley, see Bonnie Evans, *The Metamorphisms of Autism: A History of Child Development in Britain* (Manchester: Manchester University Press, 2017), 122, 165–66. That Maudsley researchers were interested in working with Camphill is less surprising than it might seem. Maudsley was deeply influenced by German psychiatry from its founding in 1908, an influence that was only reinforced by the influx of refugee physicians from Nazi Central Europe. According to Rhodri Hayward, a particularly British style of psychiatry emerged in the interwar period from this blending of medical cultures. Seeking to distance themselves from Nazi eugenicist psychiatry, British specialists avoided theoretical dogmatism or nosological certainty and practiced "therapeutic recklessness," or a willingness to work with a wide variety of experimental approaches. See Rhodri Hayward, "Germany and the Making of 'English' Psychiatry: The Maudsley Hospital, 1908–1939," in Roelcke, Weindling, and Westwood, *International Relations in Psychiatry* (n. 18), 67–90. Sir Michael Rutter (1933–2021)—the eminent British psychiatrist and long-standing consultant at Maudsley—remembers the collaboration with König in the 1950s and 1960s as fitting this trend. In response to my surprise that Camphill and Maudsley had found common ground, he wrote, "What you describe as the fraught relationship between the Camphill movement and the mainstream practitioners, so far as I am aware this was only applicable to the philosophy behind Camphill schools and not at all in relation to the manifest support and help that they provided to individuals." Sir Michael Rutter, message to the author, March 27, 2019.

categories. In the 1940s, the superintendent's reports list many dismissed children as having been "cured."[74] In 1947, 43 percent of the children discharged were described as "practically cured" and able to enroll in "normal school" or take up employment.[75] But by the mid-1950s, the language for this outcome had changed to "greatly improved and adjusted" and the percentage had dropped to 30. And by the early 1960s, the language had shifted again, this time to "succeeded," and the rate had dropped to 20 percent. At this point, Camphill reported

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[74] It is not specified what conditions were being "cured." Interestingly, the idea of curing disability has since become so foreign to Camphill that early Camphillers are shocked to hear of these reports. One community member suggested that this was probably a translation error. I suspect this is not the case because the reports were edited by the community's one founding member who was a native English speaker (born in Australia). Interview with a retired Camphiller, July 2019.

[75] As context for this claim, the 1949 *Picture Post* article mentioned above reported that 100 of Camphill's 180 students were nonverbal or had significant speech impairments. Robertson, "A School Where Love Is the Cure" (n. 23), 31. Curiously, the article also reported cures across a surprising range of diagnoses including epilepsy, paralysis, and deafness. Interestingly, autism (described as "the after-effects of inflammation of the brain") is mentioned as the condition that Camphill had the least success in curing. I have not found such outcomes listed in Camphill's reports, though presumably the article reflects claims made by community members.

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a trend toward admitting more "severely disturbed" children.[76] At least into the 1960s, the movement used the mainstream categorization of children with disabilities into those who were "educable" versus those who were not and were instead prescribed "training."[77] All children in Camphill learned craftwork, gardening, and farming; "trainable" children focused on these activities. As the numbers above suggest, by the mid-1950s, the movement had begun to specialize in training, and when, in 1955, the first community for adults was opened, it was organized around putting that training into practice in craft workshops, gardens, and farms.

Camphill's diminishing medical credentials must go some way to explaining this shift. Since König never finished his medical requalification at the University of St. Andrews, he did not have a U.K. license. The one young doctor among the founding group from Vienna who did requalify left the community to start his own school. Camphill was left with a first generation of staff many of whom had foreign medical degrees or advanced medical training, but no local credentials. The second generation had far less medical training. Among the group of twenty-five who joined the movement in the late 1940s, only two were British, neither of them had medical qualifications, and among the remaining twenty-three new arrivals from Germany, two had some form of nursing training but they never qualified in

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[76] See "The Superintendent's Report for 1947" and those for 1952–55, and 1961, KKA, no record numbers available.

[77] See Karl König, "Various Types of Handicapped Children and Their Training" (lecture, December 3, 1957), KKA, R07D1_0436.

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Britain.[78] Soon relationships with mainstream medical researchers and authorities began to decline and even sour. The 1958 Superintendent's Report noted a drop in subscriptions to Camphill's journal from public authorities. And by the early 1960s, the reports revealed a thoroughgoing shift. The medical section was gone, the Harley Street medical center was described as "the naughty child of the movement," and updates on each community indicated that children with different diagnoses were now living together instead of in dedicated units.[79]

Thus intentionally or not, Camphill was beginning to specialize and to create a social and built environment unappealing or inaccessible to the full diversity of children who had initially been admitted. Medical resources alone cannot explain this; Camphill's anthroposophical mission was also an important factor. The movement's anthroposophical emphasis on craftwork, horticulture, and farming without the use of modern machinery was ill suited to children with visual, auditory, and physical disabilities. So were the accommodations: most Camphill buildings were old estates often on unpaved roads and with minimal renovations and/or additions. Blind and deaf children also needed teachers and house parents with specialist training, which Camphill could not provide, given that almost all staff members were volunteers with no professional experience or credentials. Children with sensory, physical, and learning disabilities who did not have cognitive impairments were

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[78] Nauk, *We Came* (n. 62).

[79] A doctor who had been working with König and under whose British license König was continuing to practice had also been fired. "The Superintendent's Report for 1958," KKA, no record number available.

also probably more difficult to assimilate into the community's particular cultural and religious life, in which participation was mandatory. Households participated in Sunday services, domestic religious rituals, and seasonal festivals as a unit—opting out was not an option, regardless of one's religious background.[80]

Finally, the communities usually offered too little support for those who needed a high level of personal care.[81] This likely had as much to do with staffing as with the inability of such children to fit into Camphill's way of life. The communities got by financially with a combination of fundraising, tuition from parents, and, in cases where the state had referred the child, public funds.[82] In the early decades, money was tight and Camphill usually could

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[80] In 1947, half of the children discharged to their parents were removed against Camphill's wishes. While it is impossible to know the exact circumstances, one wonders whether some were children who articulated dissatisfaction to their parents. See "The Superintendent's Report for 1947," KKA, no record number available.

[81] For example, the Macmillan family purchased Camphill Estate for König's use in order for the community to have space for their disabled son, but his needs turned out to be too complex. And the photographs for the 1949 *Picture Post* profile on Camphill mentioned above were taken by photographer Edith Tudor Hart, whose son was also briefly in Camphill until it was decided that his needs were too great. Conversation with Camphill archivists, May 2019.

[82] In 1949, one-third of the 180 children in Camphill were referred by the state. Fees for private patients were determined on a sliding scale based on means. Robertson, "A School Where Love Is the Cure" (n. 23), 31.

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not care for children with profound intellectual disabilities who also had other impairments and medical conditions, though there were exceptions. Camphill already had a high staff to child ratio (1:2.4 in 1949); a ratio of two staff members per child was too expensive, and the facilities could not accommodate such numbers anyway. As noted above, at least into the 1950s, young co-workers were sharing rooms with disabled children because there was no space for private accommodation.

Thus what started as an idealistic, even utopian vision to embrace all of society's "social refugees" turned out to be a very specific therapeutic environment well suited to a particular audience. Though König envisioned anthroposophical curative education as applicable to all children who faced exclusion in mainstream society, in practice Camphill's home life evolved into a form that accommodated children with a fairly specific profile. By the 1960s, the communities were accepting mostly children with intellectual and developmental disabilities who did not have severe physical impairments or major personal care needs. Some needed assistance with bathing and dressing, but most could walk and toilet independently. Some were nonverbal and others fully articulate, but most fell somewhere in between. Most had some behavioral issues, but these tended to be mild. They required "patience, equanimity, and compassion," but not complex medical care or behavior management.[83] I suggest that Camphill came to focus on intellectual and developmental disabilities not because its founders identified a particular need in options for children with cognitive disabilities but because it became clear that these children integrated best into the very specific home life in Camphill villages. But to its specific audience, Camphill offered a

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[83] König, *Camphill Movement* (n. 19), 9–10.

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quiet, ordered, routinized environment in a beautiful setting. Just as importantly to the children's parents, it also seemed to offer something ineffable but precious: a sense of home and belonging, qualities that even the most benevolent among elite Victorian institutions had lacked. The fact that Camphill was staffed by volunteers who were motivated by a spiritual mission and who also called the community home made all the difference.

Conclusion

In our own moment, we often analyze disability via two models, the medical and the social.[84] The medical model defines disability in terms of defect(s) inherent to the body of the disabled person. The social model—introduced by activists in the 1960s and 1970s—sees disability as a social construct and conceptualizes the source of disability not as a person's impairment(s) but as ableist society's exclusionary social and built environments. This model underpins contemporary activism and legislation that seek to lift barriers to full citizenship, justice, and belonging for people with disabilities.

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[84] The cultural model most often employed by scholars of literature and culture studies is less relevant here. For an overview of its emergence and core concepts in the English- and German-speaking academies, see Linda Leskau, Tanja Nusser, and Katherine Sorrels, "Disability Studies in German-Speaking Europe, an Introduction," in *Disability in German-Speaking Europe: History, Memory, Culture*, ed. Linda Leskau, Tanja Nusser, and Katherine Sorrels (Rochester, N.Y.: Camden House, 2022).

Did Camphill anticipate the social model? Its own position is hard to pin down. The movement clearly holds that from its inception, it has been a counterpoint to dehumanizing institutions. But Camphill has its own vocabulary; explicit engagement with mainstream categories is hard to find. Nevertheless, the language of its publicity materials resonates with social model tenets and its recruitment of disability rights leaders like Temple Grandin evinces at least some claim to an allegiance. What little scholarship exists in English suggests that Camphill was, from its inception, the "organizational inverse" of an institution, and that its founders expressed views that we now associate with the social model early on. I have tried to show that Camphill's criticism of mainstream medical approaches to disability notwithstanding, in the 1940s and 1950s, the movement was a product of the medical model. I hold that König's critiques of mainstream practitioners represented a sectarian rift within medicine, not an anticipation of the social model.

Still, those critiques of mainstream medicine, coupled with Camphill's cultivation of belonging, made the communities look anachronistic alongside contemporary institutions that functioned as warehouses. I have argued that to the extent that Camphill stood out against its contemporaries, it did so not so much because it rejected the modern asylum system but because it harked back to that system's more optimistic, reform-minded roots. Camphill bore many of the hallmarks of earlier asylums, which had tried to make long-term commitment palatable by impersonating cozy home and village life.

Even more indicatively, the method by which Camphill promoted belonging did not accord with what would become the method of the social model several decades later. Camphill was not concerned with identifying and lifting barriers to belonging. Its approach was more normative. Camphill's founders set about creating a community of belonging for themselves and including disabled people in that community. Their assumption was that disabled people needed to have belonging created for them, and that nondisabled people

knew how to create the conditions that would allow disabled community members to belong. However, I have also claimed that although Camphill was part of the asylum tradition, its attempt to promote belonging went further because its houses not only resembled homes but were genuinely homes. The result was a network of villages that, in the mid-twentieth century, appeared to some to be entirely out of step (in a good way) with contemporary medical thinking about disability.

By the 1970s some contemporary observers had become more critical. Camphill's model of sheltered environments set apart from the broader community led them to conclude that it was essentially a network of bucolic institutions, a relic of the great confinement that is the medical model's most enduring and traumatic legacy.[85] In one sense I think they were

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[85] Community members were already discussing how to counter criticism of Camphill as practicing "benevolent segregation" or as creating "pleasant asylums" in the mid-1970s. See Margarete von Freeden, "Towards the Forthcoming Village Conference," *Camphill Correspondence*, 1975, 12. For details of these criticisms, especially from state regulators, see Nomi M. Stolzenberg and David N. Myers, *American Shtetl: The Making of Kiryas Joel, a Hasidic Village in Upstate New York* (Princeton, N.J.: Princeton University Press, 2021), 185–87. For an overview of Camphill's responses to state oversight and activist critique in the United States, the United Kingdom, and Europe, see Julia H. Wolfson, "Snakes and Ladders: Emergence of Deep Power in Transformational Change" (Ph.D. thesis, Australian National University, 2013), pt. 3, 149–301; McKanan, *Camphill and the Future* (n. 16), 175–95.

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right. After all, I have argued that Camphill emerged from the asylum tradition and was an expression of the medical model.

But I am concerned about the implications of that critique, because the medical and social models have too often been used merely as shorthand for dehumanizing and progressive outlooks. Nevertheless, recent scholarship has expanded their use. As Andrew Hogan has pointed out, the medical model is not an actors' category—historically, no one claimed to use the medical model, and why would they have? It is a pejorative that describes the oppressive regime against which the social model is conceived. Reference to the medical model tends to flatten the wide variation in approaches to disability that have emerged from medical settings. Indeed, Hogan has shown how in the 1970s, an antireductionist critique of the medical model emerged within British and American medicine. It challenged doctors to pay attention not only to biomedical events as causes of disability but also to disability's social and cultural contexts.[86] For some scholars, such nuance does not merit a reconsideration of the medical model as a category; any approach that continues to frame

[86] See Andrew Hogan, "Social and Medical Models of Disability and Mental Health: Evolution and Renewal," *Can. Med. Assoc. J.* 191, no. 1 (2019): E16–E18, and Andrew Hogan, "Moving Away from the 'Medical Model': The Development and Revision of the World Health Organization's Classification of Disability," *Bull. Hist. Med.* 93, no. 2 (2019): 241–69.

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disability as a medical problem is inherently flawed.[87] Yet others have insisted on the usefulness of a blended social and medical model.[88] As Beth Linker has argued, insights and methods from disability history and the history of medicine are both needed to account for aspects of disability that tend to be lost when medicine is excluded as a matter of principle.[89] Examples are, first, that the experience of disability not infrequently includes regular interactions with the health professions over long periods and, second, that the histories of chronic illness and pain are parts of disability and medical history that cannot be disentangled.[90]

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[87] Hogan himself reaches this conclusion. See Hogan, “Moving Away from the ‘Medical Model’” (n. 86), 266–67.

[88] See Nancy J. Hirschmann and Beth Linker, “Disability, Citizenship, and Belonging: A Critical Introduction,” in *Civil Disabilities: Citizenship, Membership, and Belonging*, ed. Nancy J. Hirschmann and Beth Linker (Philadelphia: University of Pennsylvania Press, 2015), 6. An example is how invisible disabilities rely on medical diagnoses to become visible; see Catherine Kudlick, “Comment: On the Borderland of Medical and Disability History,” *Bull. Hist. Med.* 87, no. 4 (2013): 556.

[89] See Beth Linker, “On the Borderland of Medical and Disability History: A Survey of the Fields,” *Bull. Hist. Med.* 87, no. 4 (2013): 499–535.

[90] See Jerome Bickenbach, “Disability, ‘Being Unhealthy,’ and Rights to Health,” *J. Law Med. Ethics* 41, no. 4 (2013): 821–28; Linker, “On the Borderland” (n. 89); Tobin Siebers, *Disability Theory* (Ann Arbor: University of Michigan Press, 2008); Susan Wendell,

In short, for some disabled people, medical diagnoses are valuable not only for securing support, but for validating impairments and making their disabilities visible. The flip side of this empowering interpretation of the medical model is a critique of the social model's scope and inclusiveness. Some scholars and activists have called into question whether the social model is always and necessarily helpful to all disabled people. They have noted that the model—grounded as it is in its founders' experience as physically disabled men from relatively privileged backgrounds—has failed many people with cognitive impairments. For its prerequisites to belonging—emancipation and empowerment—are not always the only or even the most important goals, especially in the case of profound intellectual and developmental disability.[91]

Emancipation and empowerment were clearly not central goals in Camphill in the 1940s and 1950s. Yet Camphill was also not merely a warehouse. It tried to foster belonging, which looks progressive today because we think of belonging as an aspiration that becomes

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"Unhealthy Disabled: Treating Chronic Illness as Disabilities," *Hypatia* 16, no. 3 (2001): 17–33.

[91] For an argument concerning problems inherent to advocacy rooted in liberal egalitarian theories of justice and a proposal for an alternative approach focused on capability equality, see Lorella Terzi, "Cognitive Disability, Capability Equality, and Citizenship," in Hirschmann and Linker, *Civil Disabilities* (n. 88), 186–203. See also Herzog, *Unlearning Eugenics* (n. 16), chap. 3: "Time Well Wasted: Sexual, Political, and Psychological Subjecthood in the European Union, 2000s–2010s," 70–98.

central only after major milestones in rights and access have been reached. Should we assume that because Camphill's attempt to promote belonging was paternalistic, it was inherently misguided? In other words, should we assume that absent emancipation and empowerment it is impossible to create a climate of belonging? If so, nondisabled people clearly should not be in the business of trying to cultivate belonging for disabled people.

These are complex questions that require not only critical reflection on problems of power and paternalism but also on the nature of belonging itself.[92] Camphill serves as a useful case study in this regard. Because the movement made belonging a central, pressing issue from its inception, it offers an eighty-year history through which to interrogate assumptions about belonging as an ideal.[93] It can help us to refine our understanding of current obstacles to belonging for people with cognitive disabilities and to advance more informed goals for the structures and cultures we try to put in place when those obstacles are removed.

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[92] Belonging is often discussed as a vague ideal; we need more on how it works, what it offers, and at what cost. Nira Yuval-Davis's discussion of belonging as involving "an emotional or ontological attachment of feeling 'at home' and in a 'safe space' even when these feelings are not warm and positive" is particularly useful. See Nira Yuval-Davis, *The Politics of Belonging: Intersectional Contestations* (London: Sage, 2011), 10. See also Markus Dederich and Katherine Sorrels, "Inclusion, Emotion, and Disability," in *Disability in German-Speaking Europe: History, Memory, Culture,* ed. Linda Leskau, Tanja Nusser, and Katherine Sorrels (Rochester: Camden House, 2022), 23-43.

[93] I attempt this in my current book project, tentatively titled "On the Spectrum: Refugees from Nazi Austria and the Politics of Disability and Belonging in the UK and US."

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