B

BABY BOLLINGER (1915–1915)

American victim of infanticide

"Baby Bollinger" (first name: Allen) was born to Anna and Allen Bollinger at the German-American Hospital in Chicago, Illinois. The seven-pound Baby Bollinger was diagnosed with multiple physical anomalies and became the first victim in a string of public infanticides of disabled babies committed by the head of staff at the hospital, Dr. Harry Haiselden. The doctor declared Baby Bollinger a "monster," a "pitiful bundle of semi-life." Anna Bollinger was encouraged to allow her baby to die by withholding life-saving surgery. "I want my baby. But the doctor has told me . . . I want him to live—but I couldn't bear to think of how he would suffer . . . how he would so often curse the day he was born. So I agreed with the doctor." On the day of Baby Bollinger's death, a Chicago newspaper printed the following description of him: "A pink bit of humanity lay upon the white cloth. Its blue eyes were wide open. Its hair was brown and silky, it dug at its face with little fists. It cried lustily as it drew up chubby legs and kicked out. It seemed quite vigorously informed with life."

—Sharon Lamp

See also Eugenics; Infanticide.

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BANK-MIKKELSEN, NEILS ERIK (1919–1990)

Danish reformer

Neils Erik Bank-Mikkelsen, an early champion of normalization, was born in Denmark in 1919 and received a degree in law in 1944 from the University of Copenhagen. During World War II, he joined the Danish resistance movement, was captured, and interned in a Nazi concentration camp. He developed the concept of normalization in response to his perception that institutionalized people with disabilities were treated only slightly better than concentration camp inmates. Following the war, he entered the Danish Ministry of Social Affairs. In 1950, he moved to the Danish Service for the Mentally Retarded, becoming departmental head in 1959.

He introduced the concept of normalization in a piece of Danish legislation called the 1959 Mental Retardation Act. He described normalization as a means to ensure people with this diagnosis the right to the same community-based existence as their peers without disabilities, including clothing, housing, education, work, and leisure. Normalization was seen as a way to ensure that this population received the same legal and human rights given to other citizens. In 1968, Bank-Mikkelsen received the Kennedy Foundation

Award in recognition of his work. In 1971, he became the Director of the Department of Care and Rehabilitation of the Handicapped, Danish National Board of Social Welfare, and was instrumental to the 1980 formation of Denmark's Central Committee on the Handicapped.

—Pamela Block

See also Bengt Nirje; Normalization.

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BARBELLION, W. N. P. (1889–1919)

English naturalist and author

The fledgling scientist and writer W. N. P. Barbellion, born Bruce Frederick Cummings, kept a journal from the age of 13 almost to his death. Earlier parts show the lad's abilities as a naturalist, a largely self-taught thinker, and voracious reader. When he learned in 1915 that the ailments long plaguing him arose from "disseminated sclerosis" (multiple sclerosis), the journal recorded a race against time to achieve some large ambitions before his body collapsed. He was by then married, had had scientific papers published, and held a minor post at the British Museum of Natural History. Barbellion (1984) continued "tinkering about in the Museum," though he found it "excoriating to be thus wasting the last few precious days of my life in such mummery merely to get bread to eat" (pp. 282–283), against a background of the Great War across Europe. A bowdlerized edition of his journal, published in 1919, impressed most of the critics with its freshness and lively acumen. Barbellion died knowing that he had made his mark in the world of human self-knowledge. Ironically, despite republication in the late twentieth century, his work remains practically unknown and unused by the disability movement.

—Kumur B. Selim

See also Autobiography; Multiple Sclerosis.

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BARKER, ROGER GARLOCK (1903–1990)

American scholar and author

Just after World War II, Roger Barker, while on the faculty in psychology at Stanford University, was asked by the Social Science Research Council to conduct a comprehensive review of the psychological literature on physical disability to help meet the needs of returning war veterans with injuries. Not content with an annotated bibliography of the literature, Barker, in collaboration with Beatrice A. Wright, Lee Meyerson, and Mollie Gonick, published an extensive theoretical and research monograph dealing with the social psychology of physique, disability, and illness. The monograph was revised in 1953.

In this work, Barker applied Kurt Lewin's field theoretical concepts of new and overlapping psychological situations to problems of physique, physical disability, and illness. He coined the term *somato-psychological relation* to refer to the question of how variations in physique affect the psychological situation of a person by influencing the effectiveness of the person's body as a tool for actions or by serving as a stimulus to the person or others. This pioneering monograph helped to establish the psychology of physical disability and rehabilitation as a research and professional discipline and to the launching of the division on Rehabilitation Psychology of the American Psychological Association.

—Phil Schoggen

See also Kurt Lewin; Psychology.

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BASHSHAR IBN BURD (714/715–783/784)

Arab poet and critic

The renowned blind poet Bashshar ibn Burd spent much of his life at Baghdad. He was probably born blind, though some writers argue that he lost his sight later. Efforts have been made to elucidate the question from his verses. Of the poetry of Al-A'sha and Bashshar, the celebrated critic Al-Jahiz wrote that these two blind men succeeded in catching truths that sighted people failed to discern, and Bashshar in particular excelled in doing so. Bashshar's self-reflexive wit gave rise to anecdotes, as when he broke wind in company and dismissed it as "merely a noise. Don't believe anything unless you see it!" Sometimes the joke turned against Bashshar. He publicly teased another savant, Said the Philologer, for academic fraud, by asking him the meaning of the word *jaranful* among the Bedouin. Said, who had himself invented this bogus word, was briefly silent, then came back, "The *jaranful* is one who has commerce with blind men's wives," causing hilarity among those present.

—Kumur B. Selim

See also Abu 'l-`Ala al-Ma`arri; Abu 'l Aswad ad-Duwali; `Ata ibn Abi Rabah; Jahiz, Al- (Abu Othman Amr bin Bahr); Khalil, Al-; Middle East and the Rise of Islam.

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BEECHER, HENRY KNOWLES (1904–1976)

American anesthesiologist and researcher

Henry Knowles Beecher was an outspoken advocate of ethical standards in human subjects research and a pioneer in the study of pain, analgesia, and the placebo effect. He was also influential in the growth of anesthesiology as an independent medical specialty. Born in Kansas in 1904, Beecher earned his medical degree from Harvard Medical School in 1932. After early surgical training, Beecher was appointed Chief of Anesthesia at the Massachusetts General Hospital, despite having no formal education in anesthesia. In 1941, Beecher was named the Dorr Professor of Research in Anaesthesia at Harvard University, the first endowed chair of anesthesia in the world. Beecher's career was interrupted by service in World War II, when he observed pain responses of battle-wounded soldiers to be quantitatively different from those of surgical patients. Later, Beecher compared morphine and placebo to investigate psychological context in the physiology of pain control. This work has led to Beecher's appellation, "father of the prospective, double-blind, placebo-controlled clinical trial."

Beecher will be remembered most for his stance on human experimentation. He argued for informed consent by research subjects, and he condemned research that did not demonstrate potential benefit to patients as ethically unjustifiable. His landmark 1966 article in the *New England Journal of Medicine* chronicled 22 published studies with ethical infractions and consequently stimulated U.S. researchers to obtain informed consent prior to experiments.

In 1970, Beecher retired and received the Distinguished Service Award from the American Society of Anesthesiologists. Beecher died in 1976.

—Hugh M. Smith

See also Consent to Treatment; Ethics; Pain.

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BEERS, CLIFFORD WHITTINGHAM (1876–1943)

American advocate

Clifford Whittingham Beers developed the concept of mental hygiene, the precursor of our term *mental health* and the basis of much of prevention emphasis.

A Yale graduate who shared his struggles with mental illness openly in his autobiography, *A Mind That Found Itself* (1908), Beers garnered the support of mental health professionals and the public alike in an effort to advance the fledgling sciences of psychiatry and psychology. As founder of the Connecticut Society for Mental Hygiene (1908) and the National Committee for Mental Hygiene (1909), these groups picked up the term *mental hygiene* coined by Adolf Meyer, and developed an educational and reform movement for care of the mentally ill.

Beers's emphasis on prevention and his own example of recovery from a severe illness in his early adult life could be likened to the abolitionist efforts against slavery. As an articulate insider of Yale intelligentsia and some of the best-known private and public asylums of his day, Beers crafted a vision of recovery that engaged others and caught the attention of mental health professionals. His autobiography provided a balanced, substantive view into mental illness, allowing others to view compassionately and realistically the struggle of the human mind to come back from this loss. As a businessman and a communicator, he played a major role in formulating mental health policy by establishing a database on mental institutions, counting the number of individuals served by these institutions, and the psychiatrists serving there. Among the legacies of Beers's courage is the National Mental Health Association, formed in 1950. This organization's mission is to continue Beers's goals of "spreading tolerance and awareness, improving mental health services, preventing mental illness, and promoting mental health."

—Patrick H. Tolan
and Karen Taylor-Crawford

See also Advocacy; Autobiography; Mental Illness.

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BEGGING

People with disabilities have begged throughout history and across the world. They have asked for money and other kinds of charity. Peddling, the selling of typically inexpensive items, can be similar to begging. Begging is done by individuals and in more organized ways. Societies have supported and opposed begging by those with disabilities. Begging by those with disabilities reflects their subordinate position in society.

People with disabilities have begged for thousands of years. In ancient Egyptian and Hebrew societies, blind people often begged. The Bible records that Jesus encountered blind people who begged. While individuals born with disabilities in ancient Greece were often killed, those who became disabled later in life were spared. Some who were spared turned to begging, often near well-traveled places such as temples. During the Middle Ages, begging by those with disabilities was widespread. Many works of art have associated disability with begging.

Begging continues today, though it may be more prevalent in developing countries. Most people with disabilities live in developing countries where opportunities for them to earn a living without begging are often few. Begging becomes a means for survival. It may be the most common employment worldwide for those with disabilities.

Similar to begging is peddling. For example, some deaf people sell cards printed with the manual alphabet and other small items at airports and other public places. They may ask the recipients to "spend" whatever they wish. The unskilled playing of a musical instrument by a blind person in order to receive donations from passers-by is comparable to begging.

Begging by those with disabilities has been an individual and an organized enterprise. Adults have enlisted disabled children to beg. They have even maimed children in order for them to beg more successfully. During the Middle Ages as competition among beggars occurred, guilds and brotherhoods were established, including ones for bind beggars. Pensions have been provided to beggars, as they were to elderly, blind beggars in Italy in the fourteenth century. Some deaf peddlers, at times illegal immigrants who do not know well the language of their host country and have little education, have been organized into peddling rings under the control of deaf or hearing bosses.

Communities have supported begging by those with disabilities. Disabled people have often been viewed as the deserving poor. They deserved the charity of those more fortunate. Religions such as Christianity,

Hinduism, and Islam teach their followers to show charity toward those in need, including those with disabilities. In the ancient world, blind people were assigned the role of beggar. Statutes in France from the mid-fourteenth century governed the begging by blind residents for the benefit of their entire community. During the Middle Ages, the church at times supported begging by those who were blind by allowing them to beg near their entrances or on church grounds. Laws restricting begging by nondisabled people sometimes made exceptions for those with disabilities, as did statutes in more than a dozen states in America in the early part of the twentieth century that made exceptions for blind people who begged.

Societies have also discouraged or prohibited begging by those with disabilities. Begging became so widespread during some eras that disabled beggars were viewed with contempt, as dangerous rascals, with suspicion and hate. Laws were enacted to limit begging.

As societies industrialized, begging may have become less accepted. Industrialization emphasized paid work as the way to contribute to society. Work increasingly became a measure of a person's worth. Begging was not paid work that contributed to society. Furthermore, with the development of the Enlightenment, the view spread that people with disabilities could be, should be, educated in order to be productive members of society. Begging was contrary to this understanding of those with disabilities.

Begging expresses a complex relation between people with and without disabilities. It relies on the sympathy, pity, perhaps relief, and maybe fear of the nondisabled donor. It enacts interpersonally the larger social relation of inequality between those with and without disabilities. Yet when people with disabilities beg, they also assert themselves. They make themselves visible instead of hidden and ask, even demand, to be compensated for the inferior position the nondisabled world puts them in. Begging may help reproduce the subordinate position of those with disabilities, but it is also a rational response to limited opportunities. Until societies enable all members to sustain themselves through paid work or other means, some people with disabilities will beg.

—Paul Higgins

See also Charity; Poverty.

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BEHAVIOR THERAPY

Behavior therapy refers to a broad range of theories (hypotheses about factors that contribute to the prediction and control of behavior) and a set of treatments that derive from these theories designed to change behavior that is disruptive to patients' lives and functioning. In 1919, John Watson published *Psychology from the Standpoint of a Behaviorist,* and in his preface he states:

> The present volume does some violence to the traditional classification of psychological topics and to their conventional treatment. For example, the reader will find no discussion of consciousness and no reference to such terms as sensation, perception, attention, will, image, and the like. These terms are in good repute, but I have found that I can get along without them. (p. viii)

Watson proposed that the aims of psychology were the prediction and control of behavior. It is reputed that a major newspaper of the day ran an article with the headline "Psychology Loses Its Mind." Other early contributors to the theory and practice of behavior therapy were Ivan Pavlov (respondent conditioning), B. F. Skinner (operant conditioning), Joseph Wolpe (desensitization), Albert Bandura (social learning theory), and Aron Beck's and Albert Ellis's independent development of cognitive behavior therapy. What characterized these diverse thinkers and their

paradigms was an adherence to the scientific method for establishing principles of learning and functioning that formed the basis of their theories and therapeutic methods.

There are three major disabling conditions from a psychiatric perspective: developmental disability, autism, and schizophrenia. Behavior therapy has developed effective treatment strategies for each of these conditions primarily using the operant paradigm, or contingency management, going back more than 40 years.

Before the 1960s, developmentally disabled people were largely warehoused in residential and hospital settings with very little hope for any other life. With the advent of behavior modification programs focusing on verbal behavior, social skills, and independent living skills, most of this population can live more normal lives working in lower-level jobs or sheltered workshops and living in independent or semi-independent (supervised) settings.

Similarly, Ivar Lovas's pioneering work, starting back in the 1960s, with autistic children using intensive operant conditioning procedures on acquisition of verbal behavior, communication skills, social skills, self-care, and independent living skills has increased substantially the proportion of this population able to live more normal lives (some entirely normal) outside of institutional settings.

Schizophrenia is another area in which major contributions have been made by behavior therapy since the 1960s. Gordon Paul's seminal research showed clear superiority for a token economy treatment program over milieu and standard state mental hospital care. Patients were more functional in terms of symptom reduction, social/communication skills, and independent living skills, as indicated by higher discharge rates and lower relapse rates (ability to function and maintain themselves in the community). Even more impressive is the fact that these results were achieved without the use of medication. More recently, cognitive therapy and behavioral systems therapy are being used effectively with patients and their families to further enhance the patient's ability to live in the community.

In addition to the above three conditions, the crippling effects of severe depression and anxiety can result in disability. Disorders such as major depressive disorder, bipolar disorder, panic disorder with agoraphobia, posttraumatic stress disorder, obsessive-compulsive disorder, as well as other anxiety disorders, have been the focus of a great deal of research resulting in the development of effective treatment protocols. For more than 30 years, Beck and his colleagues have been developing cognitive therapy as a treatment of choice for depression. During the same time frame, Peter Lewinsohn and more recently, Neil Jacobsen with his behavioral activation therapy, have effectively approached depression from an operant perspective. Exposure and response prevention (ERP), which was pioneered by Edna Foa with obsessive-compulsive disorder, and later by David Barlow with panic disorder with and without agoraphobia, has become the treatment of choice for anxiety disorders, producing significant improvement rates of between 70 and 80 percent.

Other potentially disabling conditions such as attention deficit disorder with or without hyperactivity (ADD and ADHD), substance abuse, and borderline personality disorder have also been the focus of attention from behavioral researchers and clinicians. ADD and ADHD have been treated for many years with incentive programs focusing on academic performance and prosocial behavior, as well as parent training programs. More recently, Joel Lubar pioneered the development of neurofeedback therapy, a form of conditioning therapy focusing on brain wave patterns as a promising treatment for, in particular, ADD. Sophisticated behavioral approaches to substance abuse using a wide variety of behavioral techniques to target the multifaceted problems of this population (e.g., functional analysis of drinking behavior, self-management strategies, social skills, self-soothing and emotional regulation skills training, cognitive therapy, couples' therapy, and relapse prevention strategies) have been developed. Marcia Linehan's dialectical behavior therapy (DBT) and Jeffrey Young's schema therapy are the only psychosocial treatments for borderline personality disorder that have demonstrated efficacy.

Over the past 80 years, major contributions to the treatment of diverse disabling conditions have come from the operant, respondent, social learning, and cognitive paradigms. And over those same years, as might be expected, controversies have arisen. An early controversy involved the symptom substitution hypothesis;

that is, behavior therapy targets superficial symptoms rather than deeply rooted causes, and thus new symptoms will emerge. Another controversy involved the coercive nature of behavior modification programs in hospital and prison settings. The movie *A Clockwork Orange* raised a controversy about the use of aversive conditioning. In actuality, however, the goal was to create a stable disability of sorts (inhibited libido and erectile dysfunction), but if Alec's demonic smile at the movie's end is any indication, the goal was not achieved. Many technologies can be abused (e.g., cars result in a high number of injuries, disabilities, and deaths, as do guns, industrial waste, nuclear energy, and even food). The key here is in ensuring the knowledgeable, compassionate, and ethical use of an effective technology through well-conceived and comprehensive research, training, and monitoring of practice.

—Michael B. Evans

See also Agoraphobia; Anxiety Disorders; Autism; Developmental Disabilities; Obsessive-Compulsive Disorder; Panic Disorder; Posttraumatic Stress Disorder; Schizophrenia; Psychiatric Disorders.

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Association for Behavioral and Cognitive Therapies, www.AABT.org

BEHAVIORAL DISORDERS

Behavioral disorders can be defined as the state in which youths under age 18 behave persistently and repetitively in ways that violate the basic rights of others or major age-appropriate cultural, or ethnic norms. The person is more sick than wicked. When behavioral disorders occur after the age of 18, they are considered to be personality disorders.

There are four criteria to diagnose behavioral disorders. To make the diagnosis, at least three should be present during the past 12 months, and at least one should be present for six months:

1. *Physical aggression:* This includes physically cruel behavior toward people and animals, initiating physical fights, using dangerous weapons such as a knife or a gun against others, robbing, or forcing someone into sexual activity.

2. *Deliberate destruction of others' property,* with or without fire setting to cause serious damage.

3. *Deceitfulness or theft:* This includes breaking into another's home, building, or vehicle; lying; and stealing (including shoplifting).

4. *Serious violations of rules:* This includes often staying out at night despite parental prohibitions (before the age of 13); running away from home overnight at least twice; frequent truancy from school before the age of 13. In many Eastern countries, however, truancy at any age is considered as a behavioral disorder—an example of how differences in traditions lead to different diagnostic criteria.

To fit the diagnosis, these behaviors must also significantly affect performance (academic, social, vocational, or personal skills); hence behavioral disorders are considered to be disabilities. Patients who suffer from behavioral disabilities also are unable to learn or work, and these disabilities are not due to intellectual, sensory, or health factors. These patients also lack the ability to build or maintain satisfactory interpersonal relationships.

Because the diagnostic criteria of behavioral disorder vary widely, its manifestations at different stages differ, and because of differences in the adopted methodology, it is impossible to determine precisely its prevalence. However, it is considered to be a common problem in children and adolescents. In the United States, the condition is more prevalent among boys (6–10 percent) than among girls (2–9 percent). The prevalence is more in urban and suburban than rural settings, and even greater in overcrowded cities.