I

PRE-/CONCEPTIONS: PROBLEMS OF DEFINITION AND HISTORIOGRAPHY

> Intellectual disability means a significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence). This results in a reduced ability to cope independently (impaired social functioning), and begins before adulthood, with a lasting effect on development. Disability depends not only on a child's health conditions or impairments but also and crucially on the extent to which environmental factors support the child's full participation and inclusion in society.[1]

This is the World Health Organisation's definition of intellectual disability, which incorporates social and environmental factors, and is one attempt at an inclusive definition of a notoriously ambiguous conceptual category – variously called mental retardation, cognitive disability or, most recently, intellectual disability (ID). The terminology immediately prompts a series of questions. What is ID as applied to the Middle Ages? Would a person whom our modern society diagnoses as autistic have been noticed as someone different from the 'norm' back in the Middle Ages? Could one, then, even say that autism existed as an illness in those times? And in more general terms, if we do not have a category or label for an entity such as a disease, does that disease exist? Do these different words (medieval versus modern usage) in actuality express roughly the same underlying 'true' or 'real' concept? Or do all these different terms mean many, just as different concepts? Are medieval medical texts as concerned with establishing strict biological or psychological categories as modern ones? What cultural factors fed into the generation of statements surrounding mental disability in medieval medical texts; e.g. can we say the development of a forensic process in the medieval judicial system (by questioning people as to their mental capacities) had an impact on the way medical professionals described mental disability? The present volume tries to put some of these modern assumptions to the test against medieval evidence.

For this purpose, the conditions defined in modern medical terms as IDs will be the focus of interrogation for their medieval counterparts.

While physical disability in the Middle Ages (c. 500 to c. 1500) has become a rapidly emerging topic for scholarly engagement since the mid-2000s, mental or intellectual disability has not yet been adequately researched. 'Even the most radical historians have only ever treated "intellectual disability" either as a footnote to the history of *mental* pathology dominated by mental *illness*, or of disability dominated by the *physical* disability.'[2] In part this lacuna has been due to a lack of interest among both medical and social/cultural historians, but also due to the difficulties of uncovering narratives of ID in medieval sources. Since the medieval fool, for argument's sake the approximate equivalent of the person with ID, often had lifelong mental limitations and hence no fluctuating changes from sanity to insanity, no recoverance of mental faculties, the fool and the madman might frequently be linked,[3] but the overarching interest of historians has been in the more glamorous acquired madness rather than folly or idiocy. Research is also hampered by lack of documentation, especially institutional records, pertaining to ID – unlike the mad, the mentally disabled were rarely locked up. For early modern Britain it has been claimed that the absence of institutions for what was then often called 'idiocy' was less about lack of diagnostics or distinction from insanity; 'It was also a result of prevailing policies towards the disabled, which designated idiots (and other groups deemed to be chronically disabled or ill) as unfit for therapy and incarceration because untreatable and harmless.'[4]

In his study of madness in late medieval English literature, Harper concluded that 'the tendency of critics to conflate the concepts of madness and folly has led to alarmingly widespread disagreement about the meaning of madness'; all too many historians regarded madness as synonymous with folly, whereas, in fact, a closer look at medieval legal, theological and literary sources demonstrates quite clearly that medieval authorities 'distinguished madness from folly in all of its forms', with madness more commonly implying mania or melancholia.[5] The whole question as to whether mental afflictions are categorised as illnesses or not is of course a crucial one. Mental illness, although now a medical category in the modern Western world, was not always such, and was, and to an arguable extent still is, a social construct, based on social ideas about acceptable and unacceptable social deviance. Even with a modern medical knowledge base, it is not entirely clear whether mental illnesses fall into the category of diseases (which can be remedied by giving medicine) or of problems of individual socialisation and perception, which might be remedied by counselling and therapy.[6] Even should we successfully untangle folly from madness in medieval sources, we are still left with the fool overshadowing the

person with ID. We still know comparatively little about mental disability in the pre-modern past because 'scholarship has remained so preoccupied with the literary figure of the "fool" and the cultural meanings of "folly", tending to eschew hard analysis of the social problems of the mentally disabled'.[7] Unfortunately, for the medieval period, the evidence that would permit such 'hard analysis' is elusive, to say the least. The historian's problems 'are multiform when it comes to actually identifying the mentally disabled amongst the ranks of all those described as having some sort of mental defect or affliction'.[8]

Medical and psychiatric definitions

The main focus will be on concepts and categories of ID as used in the medieval period. As part of this, the book will highlight the problem of imposing modern definitions of cognitive/intellectual/mental disability onto the past. Hence a few words about modern definitions are in order. It has been claimed that the modern concept of ID, as 'perceived by cognitive, developmental and educational psychologists and in much everyday thinking', is defined according to five criteria:

> (1) It is a deficit in the 'intelligence' specific to humans, defined more or less as an (in)ability to think abstractly. (2) This deficit occurs in the mind, as a natural realm distinct from the body; in this sense it differs from physical or sensory disability. (3) The deficit is incurable and thus defines the person, from birth or an early childhood onset until death; in this sense it differs from mental illness. (4) The people thus identified are a tiny, abnormal minority at the lowest extreme from the norm of intelligence. (This holds true whether or not the norm is measurable, by IQ for example.) (5) The causes of the deficit are natural in a deterministic sense, i.e. 'nature' implies 'necessity'. (This holds true whether or not nurture is perceived to have an influence.)[9]

This stands in contrast to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which since the mid-twentieth century and over successive editions has become a standard reference for clinical practice in the mental health field. This 'bible' of modern psychiatry classifies cognitive disorders according to neurodevelopmental and neurocognitive disorders. Neurodevelopmental disorders cover broadly what tend to be called IDs, as well as communication, autism spectrum, attention-deficit/hyperactivity and motor disorders, plus the very modern educationalists' concept of specific learning disorders relating to reading, writing and mathematics. For the sake of argument, my study focuses on disabilities related to this broad category of neurodevelopmental disorders. The one thing in common, regardless for the moment of the question of how applicable these

disorders might be for the medieval period, is that they are all developmental, in other words either congenital or connected to specific developmental stages of infancy, childhood or adolescence – they all manifest before adulthood and then remain with the person for life. In medical language, they are 'nonprogressive' (although in some genetic disorders such as Rett syndrome there are periods of worsening followed by stabilisation, and in San Phillipp syndrome progressive worsening of intellectual functions).[10] The two most common and well-known IDs today are autism spectrum disorder (formerly Asperger spectrum) and Down syndrome. In French, Down syndrome is referred to as *trisonomie*, after the triplication (usually spontaneous) of chromosome 21, which causes the syndrome. Down syndrome is the most common genetic cause of neurodevelopmental disorder, with around one in every 600 live births affected.[11] Today, around 50 per cent of infants with Down syndrome are born with 'significant congenital heart defects', which require life-saving surgery.[12] That was obviously not available in the past, so it is likely that if similar incidences of heart problems occurred in the past, then at least half of all infants with Down syndrome would have died during infancy. However, turn this statistic around, and it follows that about half of Down syndrome babies do not (and did not in the past) have heart problems, so one can assume that this half of the infants could survive into adulthood. With regard to autism spectrum, it has been observed that making psychiatric distinctions between the phenomenology of autism and the pathologies and behaviours of persons with (severe) ID is very difficult in those people with genetic syndromes of ID, since 'complex cognitive, communicative, behavioral, emotional, and physical difficulties … may mask or emulate' autism, but according to '*a pragmatic perspective, the etiology of the behavior presentation is, arguably, unimportant*'[13] [emphasis added]. Mental retardation can be associated with major chromosomal abnormalities or single-gene disorders such as fragile X and Williams syndromes. But again, the range and categorical diversity is rather stunning, and, interestingly for the medievalist familiar with 'loose' categories and nebulous ('unscientific') definitions, around two-thirds of the people diagnosed today as having some form of ID cannot be squeezed into any of these scientific or medical categories other than one of a general 'sub-standard' level of intelligence.[14] Somehow the inability of modern science and medicine to precisely label and categorise ID, despite the enormous advances since the 1990s, with even monthly developments, in the biological sciences in general and genetics in particular, appears worrying and troublesome to researchers and medical specialists.

All these just-cited conditions fall under what the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* [*DSM-5*] termed neu-

rodevelopmental disorders. In contrast, I will not be discussing neurocognitive disorders, which not only tend to manifest in adulthood, but are due to disease (e.g. Alzheimer's, Parkinson's, Huntington's), intoxication (alcoholism) or traumatic brain injury – these are all conditions that may affect a person much later in life and have a fairly clear causality. There is of course scope for an overlap between neurodevelopmental and neurocognitive disorders: 'Intellectual disability may result from an acquired insult during the developmental period from, for example, a severe head injury, in which case a neurocognitive disorder also may be diagnosed.'[15] As aetiologies for ID, *DSM-5* lists genetic syndromes, congenital metabolic disorders, brain malformations, maternal disease and environmental influences such as alcohol, toxins and teratogens, all of which would have been likely risks during the medieval or any other periods. Similarly, problems during labour could lead to neonatal encephalopathy in all times and places. 'Postnatal causes include hypoxic ischemic injury, traumatic brain injury, infections, demyelinating disorders, seizure disorders (e.g., infantile spasms), severe and chronic social deprivation, and toxic metabolic syndromes and intoxications (e.g., lead, mercury).'[16] All of these are scenarios that are more than plausible for the medieval period, too. *DSM-5* presents a summary argument for the *physicality* of some IDs, and the reason why it is highly likely, in the absence of evidence to the contrary, that the same kinds of genetic disorders occurred in the Middle Ages, and probably in the same proportions to the rest of the population as in the early twenty-first century. If we assume that humans have been anatomically modern for at least 30,000 years, then surely during the past 1,500 to as recent as 500 years they were equally as 'modern' in the anatomical sense. Therefore similar disease and developmental patterns will have been in existence in the Middle Ages. The genetic and physiological causes of ID will have changed little, historically, thus ID cannot simply be dismissed as a purely 'modern disorder'.

Social constructionism and ID

At this point it is apposite to briefly introduce a philosophical critique, primarily expounded by Hacking, of the preponderance in Western academia to claim that nigh on everything, whether people, objects or ideas, is socially constructed. The question of social constructionism in medical history elicited two important articles by Jordanova and Harley, the latter arousing a lively debate, all in the journal *Social History of Medicine*.[17] Jordanova argued for the usefulness of social constructionism for medical history, considering the link between cultural history and medical history especially fruitful. Harley in turn emphasised semiotic frames of reference as lying at the heart of medical

diagnosis, therapy and prognosis. Though of course they were important contributions in their own right to the field of the social history of medicine, these articles had little concern with disability. In contrast, Hacking devoted considerably more space to disability in general and psychiatric phenomena in particular.

In a nutshell, Hacking's critique is initially directed at sloppy semantic usage by the social constructionists, but he makes some important points concerning the apparent physicality and permanence of ID, as opposed to the transience of mental illness. With regard to 'disability' as a concept, Hacking criticises that many authors who write on disability as socially constructed do not distinguish sufficiently or rigorously enough between product and process. Presumably, in my attempt to simplify Hacking's analysis, 'disability' is a product, while discrimination is a process that creates 'disability'. Where it gets really interesting is in Hacking's chapter on madness, asking if it is a phenomenon that is biological or constructed. Pertinent to the theme of ID is that what Hacking calls 'transient' mental illnesses may be contrasted with conditions such as schizophrenia or mental retardation. Transient illnesses, in his definition, do not just mean 'that they last only for a time in the life of an individual' but that 'they show up only at some times and some places, for reasons which we can only suppose are connected with the culture of those times and places'.[18] The classic example he gives is late nineteenth-century hysteria from France, or anorexia in contemporary Argentina. Unlike such an illness, Hacking asserts, conditions such as mental retardation are in effect constant, immutable and 'real'.

But here Hacking is refuting his own observation of a few passages earlier, in that a fair number of psychiatric diagnostic labels are 'not a diagnosis but a disciplinary device'.[19] Why should all conditions subsumed under the label of ID (or learning difficulties, or mental retardation) suddenly be based in biological 'fact', when it is just as likely that many of these are just labels and classifications, and hence subject to social and cultural change? What evidence is there for Hacking's claim that 'there is a widespread conviction that these disorders [e.g. mental retardation, childhood autism, schizophrenia] are here to stay, and were with us long before they were named'?[20] The biological camp would see these as immutable realities, or, as Hacking puts it, 'indifferent kinds' of illness, while the constructionists regard them as changeable and hence 'interactive kinds' of illness. The classificatory concept of the 'feeble mind' is used by Hacking to demonstrate that mental retardation 'was an idea waiting for a social-construction thesis to happen to it'.[21] Despite his sarcasm, Hacking has to concede that the idea of mental retardation carries ideological baggage with it, used to control people perceived as 'difficult'. The historical horizon

in all this discussion is of course limited to the modern period, with its special schools and institutions. Only at the end of his sketch of feeble-mindedness does Hacking draw attention to the belief that only now, in contemporary twenty-first-century science, are we truly understanding ID, while pretending it is an immutable phenomenon. In contrast to this is the biological approach.

> There is a deep-seated conviction that retarded children, schizophrenics, and autistic people suffer from one or more fundamental neurological or biochemical problems which will, in the future, be identified. It is not claimed that every person now diagnosed will have the same problem. … No one maintains that mental retardation is a single disorder, but many believe that specific types of retardation have clear biological causes, to the extent that we can say these disorders simply are biological in nature.[22]

Aside from the ill-judged use of the word 'suffer', the attraction of Hacking's claim here is that it allows some justification for historical inquiry – if we can assume a biological basis for certain phenomena, think Down syndrome, then at least we can assume they existed as phenomena in the not-so-distant past; and in biological terms the Middle Ages are positively contemporary.

In all this, Hacking hits the nail on the head when he points out that 'an issue that troubles many cautious people [is] the idea that something can apparently be both socially constructed and yet "real"'.[23] One may respond that medieval theologians and natural philosophers would have had no problem with such an apparent contradiction, which therefore highlights how a mode of thinking or analysis is itself a product of culture. Hacking felt the need to present a highly complex and incomprehensible 'semantic way for a philosopher to make peace with the dilemma'.[24] Medieval intellectuals had an easier job, by splitting a single monolithic 'truth' into a number of 'truths', according to divine or human, natural or otherworldly modes of understanding. Teleology, the reading and interpretation of texts, primarily the Bible, at different levels, is the prime example here.

In medieval medical language, neurocognitive disorders would have been seen as caused by external factors impinging on and upsetting the internal humoral balance, while neurodevelopmental disorders presented a more puzzling aetiology, which is perhaps one reason why medieval medical texts say next to nothing on IDs as defined in modern clinical parlance. It is reasonably straightforward to make an association between receiving a bump on the head and observing the consequent cognitive changes that come under the modern category of traumatic brain injury, which therefore are reflected in antique and medieval medical texts; the fevers, rashes and other readily observable somatic signs of diseases such as meningitis could also readily be causally linked with

a subsequent mental impairment; and intoxication, too, has well-observed and described cognitive effects in the pre-modern period. The neurocognitive degeneration affecting the elderly, which classical and medieval medicine lumped under the general heading of senility, was equally observed, even if now the differential diagnoses have become more sophisticated. But prior to the advent of modern psychiatry, neurodevelopmental disorders will have been far more difficult to attach to a medical causality, and hence much less prone to medical, as opposed to social or religious, diagnosis.

Socio-cultural reactions to ID

So much for the physiology. What about reactions, especially reactions by the parents of a mentally disabled child? Anthropological studies have rarely looked at disabilities in general, with an equally small number of cross-cultural studies concerned with pre-industrial societies. Based on the Human Relation Area File, ethnographers report that 'in 21 of 35 societies studied, infanticide was attributed to the presence of an infant who was "deformed or very ill"', and infanticide is occasionally justified by allusion to supernatural influences.[25] With regard to the historical myth of infanticide in times past that were infamously 'nasty, brutish and short', one may observe with Berkson that, firstly, 'individuals with mental and physical disabilities have been members of society since the emergence of Homo sapiens and probably well before that'; secondly, the 'development of agrarian societies brought with them an increase of certain diseases and the appearance of new disabilities', and thirdly, 'nonhuman primate societies and human groups vary in their response to individuals with serious disabilities'.[26] Berkson pointed out that in ancient Greece, even when the historiographically much-debated killing of individuals with disabilities occurred, this was limited to the neonatal period.[27] This is an important conjecture, since most cases of ID, and sensory impairments such as deafness, would be observable only weeks if not months after birth. While neonates with Down syndrome, or other developmental defects with concurrent physical discrepancies (foetal alcohol syndrome is one such), may be recognisable at birth, in other cases ID does not become apparent for many years, and thus at life-stages after which the neonate has acquired personhood. As documented for many cultures, both past and present, 'the neonatal child exists as a special category for whom "personhood is imminent but not assured" and infanticide is usually classified very differently to murder. Once a child is older however, no matter how "defective" they may be, killing them is impossible'.[28]

Some general observations from ethnology were summarised in a survey from the 1990s of more than twenty different cultures worldwide. The authors

had looked at mental disabilities, primarily noting that in the understanding of many cultures the interpretation and differentiation of what modern Western society tends to call mental disability/learning difficulty would also include speech defects and psychiatric disorders, while allowing for lack of clarity in the ethnological terminology employed by Western observers. The cultural evaluation of mental disability in the majority of cultures was negative.[29] In contrast to the historiographical stereotype that 'primitive' cultures do not notice mental retardation, the authors observed that even mild disabilities would be recognised, something which they regarded as remarkable – so, ironically, subscribing to that historiographical view, otherwise why would this observation be remarkable. They refer to the Tamang, a people of Nepal, who regarded lack of verbal competence as a sign of mental disability, as well as difficulties with independent actions, and who distinguished between categories of persons as 'stupid' and 'half-stupid' (the latter implying mild mental weakness).[30] The anthropologist Edgerton, who had earlier conducted similar comparative studies, also noted that many cultures recognised even mild mental deficiencies and concluded from that: 'But I would be greatly surprised if even relatively slight degrees of retardation were not recognized and labeled in the great majority of the world's societies.'[31]

Recognition is one thing, reaction quite another. Some ethnic groups had extreme reactions to mentally disabled persons, such as the Araucanians of southern Chile, who killed newborns identified as mentally disabled – presumably this affected only such children whose difference would be visible at birth, such as children with Down syndrome.[32] If severe mental disability became apparent only some time after birth, then that did not negate extreme reactions, which in some ethnic groups could be justified by claiming such persons were totally useless or presented a (real or imagined) danger to others. In contrast, there are other ethnicities who expressly forbid the killing of mentally disabled persons. In just one ethnological study an isolating reaction was observed, where children with microcephaly were tied up in a hut to prevent them injuring others, whereas in the ethnographic literature overall the majority of reports cite help and assistance coupled with limited inclusion into the social life of a group, based on the extent of individual capabilities, as the main reaction towards the mentally disabled.[33] The authors summarise 'reactions' as follows: 'The degree of affection and consideration on the one hand, and restriction or discrimination on the other hand, could vary depending on the severity of disability but also as a consequence of individual decisions.'[34] Depending on such culturally specific variation, they therefore propose to speak of modified or restricted participation of mentally disabled persons in the socio-cultural life of a group. Most importantly, Neubert and Cloerkes

concluded that social competence is regarded highly in all cultures, and that corresponding deficits entail marked disadvantages. The results of their survey permit the observation that while extreme reactions might be shown toward the severely mentally disabled, the majority of cultures display assistance and permit restricted participation, sometimes with clear indulgence of and special protection for the disabled.[35]

These generalised findings were borne out by a dedicated study. For a further ethnographic comparison it is worthwhile looking at the attitudes to and treatment of persons with ID among a traditional, non-Western, non-Christian ethnic group. A brief summary of the anthropological fieldwork conducted among the Semai (more commonly called the Semang) people of Malaysia was published in the 1960s. Overall, the Semai 'classify the dumbness of severe mental deficiency with the lack of verbal facility'.[36] People with mild mental deficiency were teased, but such teasing had to be interpreted within the wider social context, since the Semai teased anyone with a personal idiosyncrasy. Such persons with mild ID were not told to go away, although in times of scarcity they received inferior goods and food, as compared to the rest of the population. In general, 'normal' people recognised that 'mental incompetence excused behavior that would not be tolerable in other people'. If misdemeanours and/or accidents were caused by persons with ID, their fellow Semai would say, 'What can you do?' The culprit 'is dumb' is the reason given for such inappropriate behaviour. In summary, the anthropologist concluded that the Semai 'seem to find intellectual impairment a "problem" only when … it is associated with antisocial activities'. Most importantly, the Semai 'do not regard intellectual impairment as a disease that can lead to antisocial acts'. This attitude is in marked contrast to the modern Western way of thinking about ID. Additionally, the Semai were more concerned about 'making difficulties' for others than about levels of intellect. 'Therefore, inasmuch as intellectual impairment does not lead to "making difficulties for others", it remains socially acceptable in the sense that harmless idiosyncrasies are acceptable, although funny.' In the modern Western world, especially in the USA of the 1960s, which the author was comparing with his ethnographic data, in contrast, 'intellectual impairment per se violates norms of behavior. The violation is serious, not something to laugh about.'[37] There is a lot going on here. On one level, the author was making an interesting and highly useful contrast between regarding ID as a disease, pathologising the condition, which the contemporary psychiatric and educational discourse still does, and the acceptance of lack of intellectual ability as something that 'just is'. On another level, the author was singing the praises of laughing at or about as a way of defusing concerns over 'difference' (what Dentan called idiosyncrasy). Ultimately, one reading of this

study could be that if only modern Western people laughed (again) at people with ID – as allegedly medieval court fools were laughed at – they would stop pathologising harmless difference. And on yet another level, some of the descriptions given here very temptingly invite comparisons with medieval attitudes, especially the integration (not to be told to go away) into society of people with ID, yet at the same time the mockery (stereotype of the village idiot) and laughter such people may have been subject to.

DSM-5 considers IDs to be part of the broader category of mental disorder, so it is worth looking at what is defined as mental disorder: 'A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.'[38] The key phrase here is 'mental functioning', since at this point one may arguably insert the qualifier 'socially constructed' – different cultures at different time and place had differing concepts of mental functionality. The prime example is the irrelevance of being able to read or write in an illiterate society, in contrast to the *DSM-5* definitions of specific learning disorders which become pathologies only in societies with universal expectations of literacy. Much of what *DSM-5* pathologises will therefore simply not have been relevant to a pre-modern society. However, some of the diagnostic criteria appear to have cross-cultural relevance:

> Intellectual disability (intellectual developmental disorder) is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. The deficits result in impairments of adaptive functioning, such that the individual fails to meet standards of personal independence and social responsibility in one or more aspects of daily life, including communication, social participation, academic or occupational functioning, and personal independence at home or in community settings.[39]

Although the specific definition, scope, range and therefore cultural diversity of expectations of what constitutes 'mental abilities' may vary inter-culturally, as ethnological studies have amply demonstrated, all cultures have expectations, and therefore observations of 'deficits', of mental functioning. The cultural and historical variance of mental functioning is the key investigative strand pursued here. Some of the symptomatology *DSM-5* associates with ID is worth citing, to highlight not just how vague the symptoms might be, but how through this vagueness they can apply to many cultural/historical settings. IDs are sub-categorised as mild, moderate, severe or profound, each of which has different bearings on an individual's conceptual, social and practical

domain. The stark differences between the behaviours of those with mild to moderate levels of ID and those in the severe to profound range have been a recurring theme since the 1960s. Thus, Clarke and Clarke already referred to ID (or 'mental deficiency' in the language of the day) as 'a socio-administrative rather than a scientific concept varying in different countries and within a given country at different times'.[40] For mild ID, *DSM-5* cites impairment of money-management skills, a criterion already identified by fourteenth-century English legal records; the more general 'difficulties of regulating emotion and behavior in age-appropriate fashion', with such difficulties being 'noticed by peers in social situations',[41] can equally apply to a medieval (or any other cultural) setting. Similarly transcultural are these symptoms of moderate ID, which is characterised by a limitation in 'social judgment and decision-making abilities' so that 'caretakers must assist the person with life decisions'.[42] Substitute the term 'guardian' for caretaker, and again medieval legal and social concepts become apparent. From this one may surmise that while social expectations of 'mild' and 'moderate' ID may be inter-culturally similar, the definitions of conceptual and practical mental functionality are far more culturally specific. The symptomatological gap between the modern American culture of *DSM-5* and the pre-modern period narrows much more when it comes to 'severe' and 'profound' ID. Persons characterised as having severe ID have conceptual domain problems with 'concepts involving numbers, quantity, time, and money',[43] which are inter-culturally relevant. To gave a basic example: in a pre-modern pastoralist society, the ability to count or otherwise have quantitative knowledge of one's herd of animals is highly important. And in cases of profound ID, with regard to the conceptual domain 'co-occurring motor and sensory impairments may prevent functional use of objects'.[44] Again, this is inter-culturally relevant; if, for instance an adult person has difficulties feeding themselves due to such motor or sensory impairments, it will have been regarded as problematic in all human societies, as will have been the impairment of verbal communication associated with profound ID in the social domain.

What is interesting, however, is that all these cross-cultural symptoms as defined by *DSM-5* are from the social domain; none is from the conceptual or practical domain. When considering autism spectrum disorder (which is the new, consolidated label for what were previously regarded as the separate disorders of autism, Asperger's and pervasive developmental disorder[45]) the social aspects become even more important to diagnosis, so that levels of severity come to be 'based on social communication impairments and restricted, repetitive patterns of behavior'.[46] These diagnostic criteria are so culturally specific that it really brings to the fore the absurdity of retrospectively apply-

ing such labels to any pre-modern periods. Expectancies of the quality and quantity of 'social communication' vary inter-culturally, so that, for instance, the very behaviour that one society pathologises, another culture may value despite recognising strangeness or difference. (*DSM-5* itself tacitly acknowledges this: 'It remains unclear whether higher rates [of prevalence] reflect an expansion of the diagnostic criteria of DSM-IV to include subthreshold cases, increased awareness, differences in study methodology, or a true increase in the frequency of autism spectrum disorder.'[47]) A case in point would be the behaviour of medieval anchorites, people who voluntarily withdrew from the world, restricted their social interactions and indulged in some very regulated, if not repetitive, behaviours. A modern psychiatrist might be very tempted, in the absence of knowledge concerning culturally specific contexts, to diagnose such a medieval anchorite, or other member of a monastic, enclosed, regular (as in living according to a rule) community, as being on the autism spectrum.

Nevertheless, in general one may surmise that the more severely or profoundly a neurodevelopmental disorder, including ID, manifests, the less relevant inter-cultural variance becomes. Even *DSM-5* takes some account of socio-cultural factors in its generalised definition: 'The essential features of intellectual disability … are deficits in general mental abilities … and impairment in everyday adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers.'[48] In this broad description, ID becomes something that manifests and can be identified in every human society, at all times and places, according to each society's own specific criteria, although in contemporary Western society it is a combined set of 'clinical assessment and standardized testing of intellectual and adaptive functions'[49] that determines diagnosis. While of course much of the modern diagnostic approach of *DSM-5* is simply not relevant to a study of pre-modern society, some of the descriptors are. For instance, *DSM-5* describes gullibility as an associated feature that can support diagnosis. 'Gullibility is often a feature, involving naiveté in social situations and a tendency for being easily led by others. Gullibility and lack of awareness of risk may result in exploitation by others,'[50] a facet of ID regrettably all too often encountered in the medieval (and earlier) sources, especially with regard to legal cases.

Idiocy, madness and historiography

But the historiographic inclination to read idiocy as something internal to an individual, and therefore to treat idiocy as an unchanging phenomenon present throughout time, actually becomes ahistorical. What one society calls 'idiocy' may not be the same for another society centuries later. And if it is not