Global Journal of Intellectual & Developmental Disabilities
ISSN: 2575-8586

Review Article
Volume 14 Issue 3 - October 2025
DOI: 10.19080/GJIDD.2025.14.55590

Glob J Intellect Dev Disabil

Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony

Edward A Polloway*[1] and Michael L Wehmeyer[2]

[1]*Department of special education, University of Lynchburg, USA*

[2]*Department of special education, University of Kansas, USA*

Submission: October 06, 2025; **Published:** October 23, 2025

***Corresponding author:** Edward A Polloway, Department of special education, University of Lynchburg, University of Lynchburg, Woodland Ave Lynchburg, Virginia, USA, Email: polloway@lynchburg.edu

Abstract

This article centers on two main areas of focus. First, it explores the institutional movement in the United States, examining the varied purposes of residential facilities and tracing their historical development and transformation over time. The second section presents a comprehensive history of the Virginia Colony and Lynchburg Training School. Over the course of more than a century, the Colony admitted and housed over 13,000 people classified as disabled. Throughout its existence, the institution underwent four name changes, becoming the Lynchburg State Colony, the Lynchburg Training School and Hospital, and eventually the Central Virginia Training Center. This historical overview serves as a case study of the facility's founding, evolution, and eventual closure. It also sheds light on the practices associated with the institution, including involuntary commitment, segregation, involuntary sterilization, unpaid labor, and educational programs.

The American Institutional Movement

Residential institutions in the United States served as placements for individuals people with diverse backgrounds and a range of disabilities. These facilities admitted people of all ages who might have experienced cognitive impairments, epilepsy, significant physical disabilities, chronic mental health conditions, minor criminal histories, and poverty. Admission often occurred at the request of family members or through intervention by community agencies [1]. While individuals people with different challenges disabilities and impairments were considered for admissions, the primary focus became focused on individuals people labeled as feebleminded. Feeblemindedness was an invented term associated with so-called mental deficiency (precursor to mental retardation and, eventually, intellectual disability). When first used, feeblemindedness was differentiated from the terms of idiocy and imbecility, and those deemed feebleminded might be were considered 'higher functioning' than the people with the most disabled extensive impairments -– labeled as "idiots", and those people who would were be less impaired-labeled as "imbeciles". Eventually, however, feeblemindedness became an overall concept global term embracing overarching all subcategories other wise being used. Thus, institutions would serve those people with feeblemindedness-across ranges of functioning as well as others seen as developmentally disabled [2].

In the early to mid-1800s, feeblemindedness was seen as attributable to sin and moral failures. By the latter half of the 19th century, feeblemindedness was considered hereditary in nature. The first institutions in Europe began with a positive purpose: to serve these individuals and provide them with opportunities for an enhanceda better life. The initial, broadly reported, facility reflecting such a focus was the Abendberg, established in 1841 by Johann Jacob Guggenbühl. Situated in the mountains of Switzerland, it was intended to take advantage of the presumed benefits of sensible diet, clean water, pure air, and positive sensory experiences for those housed there. The Abendberg sought to either cure feeblemindedness or to at least to diminish the impairment person's impairment so that persons they could be successfully returned to their home communities. It became the initial model for people who were feebleminded to have new life opportunities, particularly if they had been neglected, or mistreated and abused, within their home communities [3,4].

The trend toward residential programs accelerated quickly in the United States. The first American public state school (the Massachusetts School for Idiotic and Feebleminded Youth) opened in 1848 in a wing of the Perkins School for the Blind in Boston. Within a decade, five additional facilities had been established and an additional nineteen facilities by 1888 [5]. In 1880, a total of 2,429 persons lived in residential facilities, but the number would exceed 20,000 within three decades [6,7]. The rationale of these institutions was stated by Isaac Kerlin (1877), Superintendent of the Pennsylvania School for Idiotic and Feebleminded Children, at the time of the initiation opening of the first facilities in the United States. He noted that <these persons>: "should be treated distinctively from all other classes, they cannot to their advantage be placed in ordinary schools, they ought not to be associated with the insane asylums, they should not be incarcerated in penal institutions, they should not be congregated with paupers in almshouses, and in the great majority of instances they are better and more successfully treated in well-organized institutions than is possible in their own homes" (p. 21) [8]. Wolfensberger characterized this early halcyon period as an effort to "make the deviant, non- deviant."9 This inelegant phrase reflected the fact that the pioneers developing these facilities were claiming to make their patients or inmates as "normal" as possible through educational and treatment interventions. It was a bold promise, and it would not be readily achieved.

Despite enthusiasm for the new social invention of the institution, not everyone was convinced of the great promises associated with the facilities. Two of the foremost professionals in the field, Samuel Gridley Howe, Superintendent of the Perkins School for the Blind, and Edouard Seguin, who opened some of the first facilities to habilitate people with intellectual disability in France, both expressed concerns about the growth of institutions, their location removed from home communities, and the segregation of persons with disabilities from general society [3,9,10].

Distinct problems were associated with these initial efforts. For any successes that might have been achieved in supporting individuals in order to help them return to the community, there would be new admissions, and these would be individuals that logically would be less likely to be rehabilitated. Family members in some cases advocated for continued stays despite any positive advances by the individuals. The implied conception of the fact that cures would take place had just not been realized [3,9]. Within a short period of time, disillusionment increased concerning the avowed purpose of curing or educating persons with disabilities. With limited returns to the community and continued new admissions, the institutions became larger. And a shift occurred, subtly initially, from commitment to education to institutions becoming a form of charity. As institutions grew, and as philosophy changed, their emphasis on education diminished as they became more oriented toward providing alternative places to live—to "shelter the deviants from the non-deviants [9]." Protection or asylum became the primary focus. With the movement away from training and returning individuals to the community, and with the assumption that institutional stays would be much longer, it became more logical that facilities would be built in isolated areas, where land was plentiful and cheaper. With the change in philosophy, living conditions in residential facilities moved much further away from the original ideals on which they were founded in the 19th century[10,11]

Concern also increased about the impact of such facilities on state budgets. It was not a major step then that the institutional residents would be seen as a resource that could yield positive financial benefits. Consequently, some individuals were reconceptualized as a potential labor force, particularly those who were "higher functioning." Thus, peonage was invented and practiced in state facilities. Being away from urban centers, with land of reasonable cost and acreage plenty, agricultural pursuits would be an obvious option [9,12]. The question came whether institutions could become self-sufficient communities. Institutions then moved to Wolfensberger's third phase, "protect society from the deviant [9]." With this change in philosophy, extended segregation led to the warehousing of individuals in increasingly larger facilities. The popular pseudoscience of eugenics at that time positioned feeblemindedness not only as hereditary and incurable, but advocated for segregation, sterilization, and other forms of social control over people with intellectual disability, mental illness, or epilepsy. Many placed in such facilities were children, and thus the eventuality of long-term stays became a reality [13]. And then, by the 1920s, a new feature of residential facilities emerged in the form of involuntary sterilizations, as institutions had become co-agents for the adoption of the public policy of eugenics.

In 1912, Henry Goddard had published his history of the Kallikak family, which was presented as the study of a family (given a fictional name) that began with a descendant, Deborah Kallikak, a resident of the Vineland State School in New Jersey. Goddard claimed that he had researched the ancestors of Deborah back until the time of the Revolutionary War, where they found two lines of the family descended from Martin Kallikak Sr. Martin was seen as the progenitor of both a "good" strainline of ancestors, leading to upstanding members of the community, and a "poor" strainline of ancestors, that was alleged to have led to the birth of Martin Jr. This "poor" strain line was reflected in negative eugenics and signaled dysgenic population trends [14].

Goddard's work sounded the alarm that the bad strain ancestral line of the Kallikaks, and families like them, presented a menace to civilizationsociety. They were said to be associated with consistent evidence of criminal and immoral behavior while producing offspring with feeblemindedness across multiple generations. Goddard now claimed that he could identify a higher functioning group of persons with disabilities who could be found through the application of the new mental tests. He labeled them "morons" [14]. As Smith and Wehmeyer reported, the Kallikak study was faulty science, was based on invented data, highlighted two -family lines that did not occur as described, and that Deborah also was not at all as Goddard had described. Essentially, the

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

Kallikak family story was created by Goddard and associates to fit their belief in eugenics and the hereditary nature of feebleminded-ness. Nevertheless, the Kallikak study was broadly embraced and provided fuel to the trend toward both institutionalization and ultimately sterilization[15]. Bullard (noted by Wolfensberger) indicated that "girls of the classes described must be cared for by the state. There is no class of persons in our population who… are so dangerous or so expensive to the state and this accepts [sic] no class, not even the violently insane" (p. 14-15) [9].

The eugenics movement that ensued promoted efforts to restrict the births of individuals who would perpetuate this perceived negative trend within the human community. Restrictive marriage laws became common, and institutions sought to ensure segregation by gender to minimize the likelihood of propagation. Institutions changed, from allowing patients to stay (with discharges informal and easy), to individuals being legally committed. They became the vehicle for protecting society from these individuals [1]. Sterilization was claimed to offer a financial incentive as the opportunity to sterilize persons who might subsequently then be "safe" to be returned to the community could produce major savings in the number of persons being housedinstitutionalized.

A conservative estimate was that it cost about $350 per person per year to provide support at the middle of the 20th century. To show the benefits of an aggressive policy of sterilization, Gamble reported that through 1950, the documentation of 25,303 persons who were deemed to be mentally deficient and had been sterilized had resulted in a savings of "336,000 inmate years" of future institutionalization because the procedures had allowed them to be returned to their community [16]. And, of course, with their community placement they would no longer be inmates. It was further claimed that all the sterilizations that had been performed "had been approved by the patient or by the family [16]." As it turns out, subsequent interviews of with individuals people after they left the institution pointed to the fact that in many instances they had either not been informed, or they had not approved of the procedure. The genesis for the aggressive movement toward sterilization came in the Commonwealth of Virginia, at the so-named State Colony. The Colony provides a prominent example of the concept of institutions in the United States.

Virginia's Institution

The Virginia Colony was established in 1910, initially to serve as a hospital for persons with epilepsy. It was located on a large farm property above the James River. Over the next century, it would grow, change, and eventually be shut down in 2020. It would be referred to within the community, as "the Colony," located just outside of Lynchburg, at 521 Colony Road [13].

Virginia State Colony

In 1906, a local attorney and legislator, Aubrey Strode worked with Dr. Albert Priddy to locate this new facility in Madison Heights, to respond to a perceived need for a placement for individuals people with disabilities in segregated facilities. Designed initially to serve 100 patients with epilepsy, it opened in 1910 with a staff of 33 and Priddy as the only medical staff member.2 The initial patient/staff ratio of 2.8:1 is noteworthy as a basis for considering the changes over the next century[12,17].Within the first year, the Colony had admitted 150 residents.18 Its focus was on individuals people with epilepsy for only a brief period. The perception of state needs soon changed and led to a significant broadening of the scope of the facility. By 1914, the Colony officially had become a state institution, and the name was changed to the Virginia Colony for Epileptics and Feebleminded, the second of what would be five name iterations over 110 years. With the change in focus, men who were said to have mental impairment, those deemed to be feebleminded, would also be eligible to be housed within the facility [1,13]. With Virginia being a southern state practicing segregation, the Colony would only serve individuals who were White, a practice that would not change for over 50 years.

Within two years, women who were feebleminded also were admitted and a new sixty bed building was constructed to house them. Further growth was rapid and by 1919, a total of 508 patients were at the Colony, with 351 diagnosed with epilepsy and 150 identified as feebleminded [12,17]. A large, isolated community had emerged. The campus for the Colony reflected the architecture of many Virginia schools. Buildings were added on a regular basis with the default pattern being red brick, colonial revival. Renowned architect, Stanhope S. Johnson, designed many of the early buildings. The most prominent was the Bradford Building, which was the centerpiece of the campus, a 3½ story building with a tall, central portico and cupola; it housed the hospital that would serve this new, self-contained community [18,19].

By 1926, there were 845 people in residence. Included within that census were 347 males identified as having epilepsy, 164 women with epilepsy, and 334 women classified as feebleminded; the most radical change was the dramatic increase in the number of women being institutionalized.13 The trend toward feeble-mindedness in the population would continue to increase.

In 1926, the annual cost per resident of the Colony was $177 [1,13]. Extrapolating, the institution now operated with an estimated total annual budget of about $150,000. In the 1920s, the Lynchburg Colony became the home of early sterilization efforts. Dr. Priddy, as the first Superintendent, spearheaded the eugenics movement in Virginia, seeking to halt the reproduction of future generations of children under the hypothesis that that would eliminate the birth of undesirables "the unfit" and thus would enhance genetic purity. Priddy himself was reported to have performed about eighty sterilizations in the first decade [1,12].

Priddy and his colleagues were concerned about the legality of these procedures. Consequently, a virtual plot was enjoined hatched to establish a test case in the courts for sterilization. A

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

resident, Carrie Buck, was identified as the perfect test case. It was known that Carrie's mother, Emma, had previously been institutionalized at the Colony. Carrie had a daughter, Vivian, who similarly was also purported, without proof, to have intellectual disability [20]. The initial defendant in the case would be Dr. Priddy. Legislator Aubrey Strode served as the attorney for the Colony; he had recently developed the model sterilization law. A local lawyer served as the attorney for Carrie, although this was a "friendly legal suit.". Key witnesses included prominent people in the eugenics movement who had neither met Carrie nor directly assessed her [11,12,15,20,21].

Dr. Priddy stated:

"I have ascertained that <Carrie<> is feebleminded of the lowest grade moron class. Her mental age is nine years…. The history of all such cases in which mental defectiveness, insanity and epilepsy develop in the generations of feeble-minded persons is that the baneful effects of heredity will be shown in descendants of all future generations. Should she be corrected against childbearing by the simple and comparatively harmless operation, she could leave the institution, enjoy her liberty in life, and become self-sustaining" (p.44) [20].

On April 13, 1925, the Amherst Circuit Court upheld the order that Carrie could be sterilized.15, 20 After the death of Dr. Priddy, his replacement, Dr. John Bell, became the namesake of the case. In communication with Strode, Bell affirmed his role in stating: "if you are of the opinion that this case should… be carried on in my name, it is agreeable with me as I am in entire sympathy with the effort being made to reach a final conclusion as to the legality of this sterilization procedure" (p. 173) [20]. Buck v. Bell was appealed to the U.S. Supreme Court for final resolution. Associate Justice Oliver Wendell Holmes delivered the majority opinion, indicating that: "Three generations of imbeciles were enough….." He elaborated: " iIt is better for all the world if, instead of waiting to execute degenerate offspring for crime <and> … to let them starve for their imbecility, society can prevent those who are manifestly unfit continuing their kind [13]."

Upon the decision of the Supreme Court, that sterilization could proceed, ,. Oon October 19, 1927, Dr. Bell performed the surgery on 18-year-old Carrie Buck at the Halsey-Jennings building, the early home of such sterilizations at the Colony. Within six years, 1,333 sterilizations would occur throughout Virginia, including onincluding Carrie's sister, Doris [3,20].

Arnold (1938, p, 59, 63) noted:

We do not undertake to sterilize feeble-minded patients of extremely low intelligence-those who have no chance to adjust outside the institution. We do try to sterilize those who could adjust outside the colony and be at least partially self- supporting, but who, if they were not sterilized, would be rather more likely to have defective children. We have been able to place 632 patients sterilized and thereby relieved the state of the burden of their care [22].

The Virginia Colony would export the practice of sterilization throughout the nation and there would be international implications as well. With sterilization confirmed as "constitutional," individuals who were found to be incompetent because of feeblemindedness, alcoholism, insanity, epilepsy, or other factors could be sterilized under the assumption that the practice would prevent the hereditary transmission of such traits. By 1938, 30 other states in the United States had passed sterilization laws, with many of them based on the Virginia model that had been established to be applied at the Virginia Colony [22-24]. The issue of human rights and the practice of sterilization was put into its most unfortunate context by Superintendent Bell in 1933 when he noted: "there was never a more fallacious statement than that all men are born free and equal" (p.13) [25]. This might be seen as a most ironic quote, given that the Colony which he served was located less than 60 miles from Monticello, the home of the author of the Declaration of Independence.

Lynchburg State Colony

In 1940, the name of the facility was changed to the Lynchburg State Colony. Growth continued, unabated. By 1948, there were over 1,700 patients in residence. The rapid growth had outstripped available facilities, and many individuals residents were now sleeping on mattresses on the floor. Individuals Inmates were commonly placed on a ward with up to one hundred others. Bedrooms might be shared with numerous others. Day halls provided large group surroundings for times away from bedrooms. Private showers were typically not provided; many of the 90 buildings were outfitted with large open rooms with multiple showers where up to ten people might be bathing at the same time. The population had exceeded the ability of the facility to serve them. Institutional warehousing had come to the Colony [1,13].

Retaining its focus as an institution with a medical orientation and thus on the treatment of patients who were committed, the Colony also retained its focus on medical intervention with the continuation of the practice of eugenic sterilization. Although the national commitment to eugenics had waned, momentum for the use of the practice continued [12]. By 1938, 27,000 compulsory sterilizations had been performed nation-wide. Specifically in the Lynchburg Colony, there were 1,097 individuals people who had been sterilized within a decade after the Buck v. Bell decision [20]. 4,000 persons would be sterilized from the facility, making up approximately 50% of all individuals people in Virginia, and 15% of all persons people nationwide, who were sterilized. By 1951, Virginia was second (to California) in the number of sterilizations performed across the facilities in the Commonwealth. Nationally, the total number was now over 47,000 persons, either reported as mentally deficient or mentally ill [22,26,27]. As returns to the community became more limited, as admissions continued to

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

grow, and as the facility became larger, concerns for cost became significant at the Colony as it did at many other like institutions. The surplus of land in Madison Heights allowed for the development of a farm at the Colony. Opportunities for work for residents and for potential revenue for the state could be considered. The farm grew soybeans and vegetables, and dairy cows and pigs complemented the agricultural endeavors. The Colony operated the farm through the 1940s and 1950s with the residents running the farm with staff support. During World War II, work staff were supplemented by the service of conscientious objectors to the war, a practice that was occurring throughout the nation in residential facilities [1,12,28,29].

The farm provided some residents with an opportunity for work and productivity during the days. Staff members recalled that the farm was 'a source of pride' for residents [17,29,30]. Further, it was thought that the farm animals could afford a form of occupational therapy. However, having "the patients" working without compensation was a form of peonage, virtual slave labor. Given that problematic concern along with diminished financial benefits, the farm was disbanded around 1957. The cow barn was torn down, the dairy barn was changed into temporary housing, and only a greenhouse remained [1,13].

Lynchburg Training School and Hospital

In 1954, another name change was forthcoming occurred; the facility was now to be called the Lynchburg Training School and Hospital (LTSH). While the hospital notation in the title confirmed the fact that the institution would retain a significant medical focus, the introduction of training in the title promised a change toward other forms of treatment for patients, now referred to as residents. While no longer part of the formal name, the 'Colony' remained a common referent within the community [13]. In 1953, there were 2,291 residents at the facility and 560 staff members (the resident/staff ratio had now grown to 4:1). Funds were appropriated for additional construction, which was intended to relieve some of the crowded living conditions. Working conditions for staff members were said to be better, hours more reasonable, and salary enhanced, and there was to be the addition of a cadre of educators to serve residents, in a way that would not have been done previously for patients. An additional 346 beds were added by 1965 and, although the overcrowding pattern was far from alleviated, there was a limited attempt to slow the rate of new admissions [1,12].

For 60 years, the facility continued to grow annually. Finally, with overcrowding becoming oppressive, it reached its highest census in 1972 with a total of 3,686 residents [13]. As other facilities, most notably the Willow brook State School in New York, were closing, the Training School had become the largest institution in the United States. At this time new admissions were no longer to be considered unless deemed to be emergencies [12]. The practice of sterilization continued through the early 1970s. Dr. Benedict Nagler, the administrator from the late 1950s until 1973, noted that "we turned down lots of requests because we felt that were not justified. The problem was that many times families insisted on sterilizations, which in my opinion were illegal because there was no hereditary disease [1,31]." Sterilizations may not have been as common but certainly this quote re-affirms the fact that the institution had continued to be about the practice of providing these interventions.

In 1980 the broader public finally understood how common involuntarily sterilizations had been. The then superintendent, Dr. K. Ray Nelson, researched records dating back to the 1920s and confirmed that around 4,000 patients had been sterilized at the Colony. They were among the over 60,000 people who were sterilized involuntarily in over thirty states. In Virginia, approximately 8,000 persons were sterilized over fifty years with half of those procedures occurring at the Training School. In Virginia, the segregated Central State and the Petersburg Training School became segregated facilities that would house, serve, and in many cases sterilize, Virginia residents who were Black [13,20,26,32,33].

The practice of sterilization at the Colony was naturally under the purview of medical personnel. Cynthia Pegram reported on a 1980 interview with one such individual person who worked there in the 1950s who stated, "I never saw, nor have I seen, the history of the patient who had been sterilized under false pretenses". He did not know of any patients who had been told they were going to have an appendectomy as a ruse for having her fallopian tubes tied. As he noted, "we had relatively good medical records at the time we were never aware of it." He did however note that if an individual had privileges to travel in town or they wanted to return to the community, they would be given "the choice of having the surgery or having the privilege to do so."31 No doubt this would present an interesting opportunity for making a choice. Individual cases including Carrie Buck and her sister, Doris, present different data on the voluntary nature of the sterilizations [20]. And, of course, it was legal." The success that the Colony had in the Buck v. Bell case had made it so.

The last chapter in the sterilization movement played out into the early 1970s. Detailed research by J. David Smith elucidated the realities of this practice during its final decades. In a 20-year study of individuals who left the institution between 1969-1989, a total of 212 individuals were clearly identified as having been sterilized from among the 2,000+ individuals people who departed during this period. Thus, the data set represents a sample of those persons people who were sterilized before discharge; it does not account for those for whom records were incomplete or inaccurate. The mean year for sterilization procedures was 1950. The last recorded sterilization occurred in 1974. Nearly 70% of those people sterilized were between the ages of 15 and 24; being younger created a greater risk for sterilization, presumably because these individuals were perceived to potentially be more sexually active. While 84% of those people sterilized were confirmed to have "mental retardation", the balance did not [26].

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

The assumption was that sterilization provided the rationale for returning people to the community and based on past philosophy, protecting the community from the possibility of unwanted children in the next generation. Nevertheless, 19% of these individuals went to other mental retardation or mental health facilities while about 15% went to geriatric facilities. The majority, over 63%, therefore did go to some form of community setting including being released on their own, going to a group home, or living with family. Interestingly, thirteen persons people who were sterilized were discharged because they were going to be married [17]. Not surprisingly, the Training School did not offer housing options for married residents [12,29]. Dr. Nagler presided over 15 years over an institution that had followed the medical model and that had primarily provided custodial care. Upon his departure in 1973, Dr. Nelson became the superintendent and sought to make major changes. While some of these features were no doubt "in play" prior to his arrival, change accelerated with the new leadership. These changes served as a microcosm for the world of American institutions of the 1970s. These facilitiesy shifted from a medical model, providing primarily health care and custodial care, to more of an educational habilitation and education model. The change would also be reflected in the variance in terminology from patients to residents by nomenclature decree [1,13].

There was also a parallel increasing emphasis on trying to achieve normalization within the context of what admittedly was a non-normalized environment overall. This trend, inspired by a model from Scandinavia through the work of psychiatrist Bengt Nirje, [34], directly impacted daily living at the Colony. Normalization took many forms including daily rhythms, life routines, yearly rhythms, and some efforts to enable residents to have choices and preferences considered and respected [13]. Having personal possessions, having access to some financial resources, and being offered at least some level of personal decision-making became recognized. Each initiative contributed to the goal of experiencing a more normalized life. All residents had their own beds; no longer were some having to sleep on mattresses on the floor [1].

Passages of time were now reflected in seasonal celebrations, which broke up the long seasons of residential living. Christmas was a major feature of the calendar, with the annual Christmas parade a significant time for celebration. Thanksgiving and Halloween would become special times. It may be that these celebrations might have had a more normalizing impact on staff members and also might have also served to impress visitors from the state administration, but nevertheless these were important changes in life at the Colony, life at the Training School [29,30]. Activities for residents were expanded. The canteen was available for light meals, beverages and treats where individuals could purchase things with their own funds. Weekly dance events were a highlight. Special Olympics engaged many persons in sports activities. Weekends at Camp Virginia JC provided a respite from institutional life. Trips to Kings Dominion, local baseball games, and other attractions were added to the menu. Opportunities for shopping in the community became more common [1,29].

In the name of normalization, there was an effort to decentralize this large institution into individual centers. Now residents would be living, for example, in the Child Development Center, the Adult Training Center, the Education Developmental Center, the Adult Development Center, the Community Adjustment (Smith) Center, the Social Skills Center, or in the unique deaf-blind program that was initiated. The differentiation reflected considerations such as age, level of functioning, degree of independence, mobility, the presence of medical considerations and related need for skilled nursing, and the presence or non-presence of psychiatric and behavioral difficulties [29,30].

Residential options expanded and alternatives to the existing large, virtual warehouse living arrangements were created. The Community Adjustment Center for adults evoked images of a college fraternity quadrangle with multiple smaller buildings and individual room assignments. It was the highest level of independent living that could be achieved in a place that could not offer independent living in its real sense and promised a step toward life outside the institution [13,29,30]. Of course, there were examples of resistance and concern as the institution changed from a custodial model to an educational and developmental model and as normalization became a focal point. For example, some staff members struggled to understand the fact that the population they served did indeed have human rights that took precedence over staff preferences [30]. Education became a primary focus. A formal school building with regular attendance by many residents-now students- offered relevant curriculum, certified teachers, and, after the passage of Public Law 94-142 in 1975, formal individualized educational programs (IEPs) for individuals under 21. Finishing school programs led to formal graduation ceremonies. While such "commencements" did not offer the promise of moving on to new environments, they did celebrate completion of special education programs. While federal law stipulated requirements for the education for individuals through 21, for individuals over 21, goals and objectives were expected to be part of a habilitation or rehabilitation plan.

The advent of widespread use of applied behavior analysis had a dramatic impact on the daily lives of many persons who had been at the institution for years, and a dramatic impact on the lives of staff working with them. For example, the implementation of the Foxx-Azrin toilet training procedures resulted in many individuals learning how to take responsibility for their self- help skills in this domain, while alleviating the time and cleanup effort by caregivers. These researchers noted that the procedure promised an "effective, rapid, enduring, and feasible solution to the problem of incontinence of the institutionalized retarded [35]." Applied behavior analysis was also a new and effective approach to a variety of behavioral challenges. In day halls that previously were populated by individuals who might have been partially clothed, might have engaged in minimal self-care activities, and might have defaulted to self-stimulatory behaviors (e.g., rock-

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

ing, twirling objects) within an otherwise non-stimulating environment, were gradually being transformed into environments where a more normalized daily life might be obtained [1,13].

The institution made other contributions to research. Given the large numbers of people housed there, there were a significant number of individuals who had experienced rare genetic disorders and had been placed at the institution. For example, the national effort to identify and treat individuals with phenylketonuria (PKU) was enhanced by the implementation of screening mechanisms at the Training School that identified individuals previously not known to have that disorder. Left untreated, PKU was associated with severe intellectual disability and related health and behavioral concerns. But as screening mechanisms were developed, newborn children could be assessed for the presence of PKU and, with the implementation of a specialized diet, secondary prevention of the impact of PKU could be achieved [36]. While not of direct benefit to the residents, the screening data obtained from residents would become important for future infants who might be born with PKU [1]. Simply put, the Lynchburg Training School was so large and had so many residents that initiatives undertaken here could impact considerations elsewhere. Uncharitably referred to by some as "the largest institution in the free world," LTSH continued to play an outsized role in public policy, as the deinstitutionalization movement moved forward.

It must be noted, however, that the old adage that you can put lipstick on a pig, but it is still a pig, applied to LTSH and every other large, state run institution of the era. Life was better at such institutions than it had been, the facilities were improved, and procedures were put in place to provide habilitation and education. Still, abuses in these settings were common, and while people had more opportunities for group activities and such, real autonomy and freedom were not part of the equation.

Central Virginia Training Center

In its final reiterationiteration, in 1983 the Colony was renamed the Central Virginia Training Center (CVTC). The new title was intended to signal a more pronounced change away from the medical model and thus the traditional history of the facility. Nevertheless, the on-campus hospital remained a major component of the services, and the percentage of the population with complex health needs increased as individuals perceived as "higher functioning" were increasingly returned to the community [1,12]. In 1986, the census had been reduced to 1.550 people. Serving them were 2,400 employees; the resident/staff ratio had now changed to having 1.5 staff members for every resident, a radical change from the 4:1 ratio three decades earlier (i.e., a 400+% increase in staff size with a corresponding 75% decrease in residents). With an annual budget of $52 million, costs per resident were now estimated to be over $33,000. Given the significant increase in staffing, CVTC had become the major employer for region, a fact that became an important consideration as deinstitutionalization continued to play out [13].

The census for the CVTC fell to 357 in 2012 when it was announced that it would soon be closing. In 2020, the last resident was moved to another setting. With the coincidental closure of the Training Centers of Southside Virginia, Northern Virginia, and Southwestern Virginia, the 'gulag' of institutions throughout Virginia had been reduced to one remaining facility. Nine hundred people moved into the community or were transferred into affiliated health facilities throughout the Commonwealth [13,37]. In an ironic twist in 2023, a proposal was developed to transform some of the CVTC buildings into a nursing home; that was considered an attractive option because they were already used previously for an "assisted living or nursing home-type operation when the training school was still open [38,39]." The Colony had lived through the stages of welcoming people for treatment, protecting them from society, and protecting society from them, before endeavoring to return to a commitment to education and treatment. People who had extended commitments entered as an inmate or patient, lived as a resident, and departed as a client, an individual. While the title of the facility was 'softened,' it had remained "the Colony," a place where individuals could be removed, and segregated, from the community.

References

1. Polloway EA (2023) In and out of institutions: Alice Dupuy Walker and the Colony. Avon Press.
2. Polloway EA & Lubin J (2009) Feeblemindedness. In S. Burch (Ed.), The Encyclopedia of American Disability History. Facts on File.
3. Polloway EA, Bouck E, Everington C (2026) Intellectual disability, autism, and developmental disabilities (2nd ed.) DADD.
4. Kanner L (1964) History of the study and care for the mentally retarded. Charles C Thomas.
5. Wilbur CT (1888) Institutions for the feeble-minded. In Proceedings of the 15th National Conference of Charities and Correction (106-113) (Reprinted from The history of mental retardation: Collected papers, 1(295-301) by M. Rosen, G.Clark R, MS Kivitz, Eds., 1976, University Park Press)
6. Larson SA, Eschenbacher HJ, Anderson LL, Taylor B, Pettingell S, et at., (2018) In-home and residential long-term supports and services for persons with intellectual or developmental disabilities: Status and trends through 2016. University of Minnesota, Research and Training Center on Community Living, Institute on Community Integration.
7. Hirst R, Leber K, Brady H, Imbus, C (n.d.) History of mental institutions.
8. Kerlin IN (1877) The organization of establishments for the idiotic and imbecilic classes. Proceedings of the Association of Medical Officers of American Institutions for Idiotic and Feebleminded Persons. J. B. Lippincott.
9. Wolfensberger W (1975) The origins and nature of our institutional models. Human Policy Press.
10. Blatt B (1987) The conquest of mental retardation. PRO-ED.
11. Blatt B, & Kaplan F (1966) Christmas in purgatory: A photographic essay on mental retardation. Allyn & Bacon.
12. Polloway EA (2026) The Colony and the Training School: A history of Virginia's institution (2nd ed.) Avon Press.
13. Polloway EA, Smith JD (2024) The Colony, the Training School, and the Training Center. Avon Press.

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890

14. Goddard HH (1912) The Kallikak family: A study in the heredity of feeble- mindedness. Macmillan.

15. Smith JD, Wehmeyer ML (2021) Good blood, bad blood: Science, nature, and the myth of the Kallikaks (2nd ed.) American Association on Intellectual and Developmental Disabilities.

16. Gamble CJ (1951) The prevention of mental deficiency by sterilization. American Journal of Mental Deficiency 56: 192-197.

17. Sidener C (2019) Local storied history of Central Virginia Training Center to come to a close in 2020. The News and Advance.

18. Virginia State Colony for Epileptics and Feebleminded.

19. Lee AC (2012) Central Virginia Training Center (State Colony for Epilieptics and Feebleminded) SAH Archipedia (G. Esperdy & K. Kingsley, Eds.)

20. Smith JD, Nelson KR (1989) The sterilization of Carrie Buck. New Horizons Press.

21. Brookwood M (2021) The orphans of Davenport: Eugenics, the Great Depression, and the war over children's intelligence. Liveright.

22. Arnold GB (1938) A brief review of the first thousand patients eugenically sterilized at the state colony for epileptics and feebleminded. Annual Meeting of the American Association on Mental Deficiency, Richmond Virginia, April 1938.

23. Pegram C (1980) 19th century theories pave the way for sterilizations. The Daily Advance.

24. Pegram, C (1980) Sterilization was seen as a simple solution to social ills. The Daily Advance.

25. Bell JH (1933) Report of the Virginia State Epileptic Colony. Richmond: Virginia State Epileptic Colony, Division of Purchase and Printing.

26. Smith JD, Polloway EA (1993) Institutionalization, involuntary sterilization, and mental retardation: Profiles from the history of practice. Mental Retardation 31: 208-214.

27. Harshman LP (1951) 19 years' experience with a special sterilization impact in Indiana. American Journal of Mental Deficiency 55: 377-380.

28. Taylor SJ (2009) Acts of Conscience: World War II, Mental Institutions, and Religious Objectors. Syracuse University Press.

29. Mattox H (2023) Personal correspondence Notes to Edward Polloway.

30. Merryman R (2023) Personal correspondence to Edward Polloway. Notes to Edward Polloway.

31. Pegram CT (1980) Doctor says patients consented. The Daily Advance.

32. Booker B (1980) More than 8300 sterilized at institutions in Virginia. Richmond Times-Dispatch. February 23, 1980.

33. Pegram (1980) Parents don't see sterilization as "academic question" The Daily Advance Tuesday, April 1: 1980.

34. Nirje B (1969) The normalization principle and its human management implications. In

RB. Kugel & W Wolfensberger (Eds.) Changing patterns in residential services for the mentally retarded (pp. 179-195) President's Committee on Mental Retardation.

35. Azrin NH, Foxx RM (1971) A rapid method of toilet training the institutionalized retarded. Journal of Applied Behavior Analysis 4(2): 89-99.

36. Messner DA (2012) On the scent: The discovery of PKU. Distillations: Using Stories from Science's Past to Understand Our World.

37. Central Virginia Training Center Closes. April 2, 2020. Message from Commissioner Alison G. Land.

38. Falconer J (2023) Measure could pave way for nursing home facility at site. The News & Advance.

39. Faulconer J (2023) Va. Senate Oks bill to bring nursing home to CVTC site. The News & Advance.

DOI: 10.19080/GJIDD.2025.14.555890

How to cite this article: Edward A P, Michael L W. Institutions for Persons with Intellectual and Developmental Disabilities: A Case History of Virginia's Colony. Glob J Intellect Dev Disabil. 2025; 14(3): 555890. DOI:10.19080/GJIDD.2025.14.555890