

Reproductive Citizenship: Women of Color and Coercive Sterilization in North Carolina

1950-1980

by

Serena Sebring

Department of Sociology
Duke University

Date: _____

Approved:

Eduardo Bonilla-Silva, Supervisor

Linda Burton

Wahneema Lubiano

Phil Morgan

Suzanne Shanahan

Dissertation submitted in partial fulfillment of
the requirements for the degree of Doctor of Philosophy in the
Department of Sociology in the Graduate School
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ABSTRACT

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Abstract

This dissertation develops an original theoretical framework of reproductive citizenship using a historical case study, which explores the history of coercive sterilization of women of color in North Carolina between 1950-1980. It traces the ideological, political, economic, and social factors that led to a neo-eugenic sterilization campaign impacting over 3,000 women of color who were sterilized under state order. Data was drawn from historical sources including: the records of the North Carolina Eugenics Board, policy documents and statutes, trial records, articles in contemporary periodicals, manuscript records of social service providers activist groups, and recorded statements of coercive sterilization survivors. The study employs two comparative historical methodological strategies: first, a time-period comparison contrasting the periods 1950-1964 and 1965-1980; and second, a group comparison highlighting the similarities and differences between black and American Indian women along three theoretically-significant dimensions.

The comparisons revealed important distinctions in: (1) how each group was framed within contemporary popular discourse regarding race, reproduction, and welfare provision; (2) the relationship of each group to the state welfare system; and (3) how each group was affected by the neo-eugenic sterilization campaign led by the North Carolina Eugenics Board. My findings show that for the first time period regarding ideological discourses women of color were framed through discourses of social threats, particularly surrounding paternalistic discourse of feeble-mindedness,

and they were increasingly subject to the surveillance and control of the public welfare bureaucracy. The consequences of these discourses and welfare institutional forces, was that they were affected at the most basic level through the body. For the second time period the ideological discourses shifted from feeble-mindedness to parallel narratives surrounding fears of overburdened welfare services and overpopulated cities. Women of color were subject to sterilization based upon their perceived undeserving dependence on the welfare state and for burdening society with illegitimate children. Whereas women of color in the second time period were still impacted at the level of the body, alternative narratives and actions also rose that challenged the State's form of reproductive citizenship, which ultimately increased reproductive autonomy by changing the institutional structure of the welfare state.

The improvement in the quality and character of reproductive citizenship for women of color in North Carolina was specifically supported by four important mechanisms: (1) a public outcry and judicial consideration of reproductive rights generated by a series of high-profile legal cases involving women of color seeking legal redress after experiencing coercive sterilization; (2) shifts in popular understanding and discursive frameworks led by emergent national coalitions of feminists and women of color advocating for reproductive and welfare rights; (3) increased political representation as more minorities, and women of color in particular, attained elected office as a result of the Voting Rights Act; and (4) the implementation of state and federal policies protecting reproductive autonomy.

Dedication

For Deborah Sebring, Geneva Clarke, Mary Emma Young, and all of my mothers.

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1. Introduction

In 1965, eighteen-year-old Ruth Nial Cox lived with her mother, Devorah, and six younger siblings in rural Plymouth, North Carolina. In order to maintain eligibility for welfare benefits, which at that time were the family's sole source of support, they received regular home visits from social worker Shelton Howland of the Washington County Department of Public Health. When Howland learned that Ruth was pregnant with her first child (and that the father of the baby was not planning to marry her) he began to verbally pressure her to undergo surgical sterilization. This pressure continued for several months after her baby was born, despite the fact that Ruth was not at that time receiving any welfare support for her newborn daughter - eventually culminating in a threat that unless consent was given for the irreversible procedure, the entire family would be stricken from the welfare rolls (*Cox v. Stanton*, 529 F. 2nd 47, 4th Cir. [1973]). Howland then filed a sterilization petition with the North Carolina Eugenics Board (a five-member panel which made official decisions regarding involuntary sterilizations) describing Nial as "argumentative and lazy," incapable of assuming the "responsibility of supporting all the children she would bring into this world," and assuring board members that, ". . . [O]ur agency is thoroughly convinced that the only way to keep a family of this type from reproducing itself is to rely on sterilization" (Begos and Railey 2002).

Faced with the total loss of her family's benefits, Devorah finally agreed to have Nial sterilized only after being deceptively reassured that the contraceptive results of the operation would be temporary ("Sterilized: Why?" 1973). Nial was never tested for any

of the mental afflictions indicated in the eugenic statute, which authorized her involuntary sterilization.

1.1 Research Questions and Findings

Citizenship and reproduction are important sites in which race and gender relations, meanings, and identities have been both historically constituted and contested. Traditionally located at what might be seen as a disciplinary intersection – of sociology, history, and political science – scholars in the field of comparative historical study have developed a large body of literature and increasingly critical analyses of the ways ideologies of gender and race have been key influences in the development of social citizenship and welfare programs – both in the US and in international perspective (Amott 1990; Gordon 1994, 1990, 1976; Fraser and Gordon 1994; Mink 1990, 1998a, 1998b, 1999; Orloff 1993b, 1993a, 2002; Parham, Lori and Quadagno 2000; Quadagno 1996; Skocpol 1995; Blekesaune and Quadagno 2003). The historical record of North Carolina, in particular, is full of stories, which illuminate some key aspects of the interplay between citizenship, race, gender, and reproductive rights.

My study engages this history through the use of two comparative historical methodological strategies: by comparing the time frame 1950-1964 with the period 1965-1980 and by drawing observations about the similarities and differences between how black and American Indian women in this state were: (1) understood in popular ideological discourses about race, reproduction, and welfare; (2) the relationships of these two groups to the state welfare system in each of the aforementioned time periods; and

(3) how each group was affected by coercive practices regarding family planning programs within the state system of health and welfare provision, and particularly how they were impacted by the practices and legal orders issued by the North Carolina Eugenics Board. Data was drawn from historical sources including: the records of the North Carolina Eugenics Board, policy documents and statutes, trial records, articles in contemporary periodicals, manuscript records of social service providers and activist groups, and recorded statements of coercive sterilization survivors.

Studying the history of legal rights and restrictions, social welfare policies, ideologies, and the experiences of reproductive citizenship for women of color in North Carolina has afforded an opportunity to examine a microcosm of the larger national and international histories in this area, and also to develop an appreciation for the national and international influence of North Carolina in the events and processes which comprise a terrain of reproductive history within the United States more generally. This study began with the question: “what do the coercive federally-funded population control and family planning programs that peaked in the United States between 1960 and 1980 - programs which primarily targeted women of color - reveal about the nature and character of reproductive citizenship for women of color in the post-civil rights era?” In the pages that follow, I address these patterns as well as their implications for reproductive citizenship among women of color in North Carolina, more specifically.

However, during the time elapsed since this project was initially proposed (with a much larger scope comparing the histories of coercive sterilization experienced by three

other groups of women of color in various locations around the United States), I have noticed that the questions I found most compelling have become increasingly local and immediate as well. I have asked: why North Carolina? What were the *factors* (ideological, political, economic and social) that so powerfully aligned between 1950 and 1980 - when progressive social welfare workers, reformist politicians, and medical caregivers (in every one of North Carolina's 100 counties), unabashedly went about the work of surgically sterilizing over 3,000 black and brown women and girls with very little opposition or resistance from anyone? Is it a sufficient explanation to attribute this neo-eugenic campaign to old-fashioned racism, or to the "peculiarities" of race relations in the Jim Crow South?

Similarly, what were the *mechanisms of change*, which led to an apparently rapid decline and near erasure of knowledge regarding these policies and events from popular social memory, until just a few years ago? And, to what degree have the *ideologies* and *practices* – which combined to result in the denial of fundamental rights to choice and bodily integrity for thousands of North Carolina citizens - actually disappeared from the contemporary experiences of women of color as reproductive citizens of this state and nation? I wonder, in this moment – when the popular news media and political leaders in contemporary North Carolina are expressing outrage and contrition about the history of the State Eugenics Board – how are we to understand such a brutal chapter in the history of black and brown women in North Carolina? What was *the role of academics and intellectuals* – and in particular what role did sociologists play – in the planning and

justification of such violence? What are the practical consequences that follow from the application of sociological knowledge once it extends beyond the walls of the University and pages of academic journals?

The findings show that for the first time period regarding ideological discourses women of color were framed through discourses of social threats, particularly surrounding paternalistic discourse of feeble-mindedness, and they were increasingly subject to the surveillance and control of the public welfare bureaucracy. The consequences of these discourses and welfare institutional forces, was that they were affected at the most basic level through the body. For the second time period the ideological discourses shifted from feeble-mindedness to parallel narratives surrounding fears of overburdened welfare services and overpopulated cities. Women of color were subject to sterilization based upon their perceived undeserving dependence on the welfare state and for burdening society with illegitimate children. Whereas women of color in the second time period were still impacted at the level of the body, alternative narratives and actions also rose that challenged the State's form of reproductive citizenship, which ultimately increased reproductive autonomy by changing the structure of the welfare state.

The improvement in the quality and character of reproductive citizenship for women of color in North Carolina was specifically supported by four important mechanisms: (1) a public outcry and judicial consideration of reproductive rights generated by a series of high-profile legal cases involving women of color seeking

legal redress after experiencing coercive sterilization; (2) shifts in popular understanding and discursive frameworks led by emergent national coalitions of feminists and women of color advocating for reproductive and welfare rights; (3) increased political representation as more minorities, and women of color in particular, attained elected office as a result of the Voting Rights Act; and (4) the implementation of state and federal policies protecting reproductive autonomy.

1.2 Reproductive Citizenship

Scholars have identified intricate and powerful relations between reproduction and nation building as fundamental components of the rise of modern citizenship (Richardson and Turner 2001:336). Here, I employ the concept of reproductive citizenship in order to consider citizenship as formal status (which confers certain social and reproductive rights), and citizenship as a de-facto practice (in which there are systematic variations in the ways that rights of citizenship are filtered, conferred, and withheld within lived experiences) (Richardson and Turner 2001:335-336; Boris 2005:85; Dwyer 2004:167; Hanafin 2007:81). This extends the traditional scope of the sociological study of citizenship by directing attention to the relationships between reproduction, race, gender, and social entitlement.

The original conceptual framework of reproductive citizenship that this study develops is, I believe, useful in gaining greater scholarly and practical understanding of how the State of North Carolina's commitment to particular types of population and welfare policy over time birthed the social structure in which we live today. Certain

political and social strategies – protective legal statuses, punitive measures, and targeted incentives – shaped and continue to shape the experiences, families, and possibilities of generations to come. Specifically, the welfare programs of North Carolina have been implicated in relations of reproductive citizenship through: educational outreach programs that in many ways came to define the boundaries and discursive terrain underlying ideologies of choice, family, population and what it means to be a member of society. In addition, unequal access to the rewards of citizenship – the benefits, opportunities, and entitlements this status affords – have influenced popular belief about who deserves such rights as well as individual preferences with regard to reproductive health and family planning. Access to reproductive options, statutory protections that determine the limits of the right to bodily integrity, and freedom from many of the institutional forms of pressure or coercion attached to social provisions, remain unavailable to those who are understood to be outside of its bounds (Dwyer 2004:167; Turner 2006:70). In delineating a theoretical framework of reproductive citizenship, I begin with Richardson and Turner’s definition of it as: a political status encompassing legal and socioeconomic arrangements, choices, and behaviors that both expand and limit the reproductive autonomy of women of color (2002:20).

1.3 Neo-Eugenics

Eugenic involuntary sterilization programs in the United States peaked in the early-mid twentieth century. Unlike the time period which will be the focus of my study, the Eugenics Movement labeled various segments of the poor white population

genetically, mentally, or otherwise “inferior” breeders – subjecting approximately 64,000 men and women to forced surgeries in accordance with compulsory sterilization laws in thirty-two states (Largent 2008:25). However, beginning in the 1960s poor women of color in many areas of the United States, like Ruth Nial Cox, became primary targets of involuntary sterilization practices through state sponsored and federally funded family-planning programs (Chase 1977:16; Gutiérrez 2003:383; Stern 2005:1128). According to historian Rebecca Kluchin, the sixties ushered in a period of “neo-eugenic” sterilization programs which focused on poor women of color, and advocated for increased use of female surgical sterilization in federal family planning programs as a cost-effective strategy to reduce the welfare rolls and shrink the population of “unfit” citizens (2004:6).

Changes in civil rights law, popular discourse, and welfare funding early in the 1960s signaled a key turning point – a neo-eugenic transition (Abbott 2001) in the history of state-sponsored sterilization in the United States. Neo-eugenic ideological discourses represent “the consolidation of a rationale for reproductive surgery that was linked to fears of overpopulation, welfare dependency, and illegitimacy, [which] set the stage for a new era of sterilization abuse” (Stern 2005:1132). Large-scale family-planning and population control programs around the country sought to limit the fertility of certain populations of women: poor and working class black women, American Indian women, Puerto Rican women, and women of Mexican descent (Gutiérrez 2003:379). Beginning in the 1930s, throughout the South, hundreds of state-funded birth control centers were established in black communities; the number of black women sterilized involuntarily

rose exponentially and continued to rise over the next 4 decades (Kelley 2003).

“Teaching hospitals performed unnecessary hysterectomies on poor Black women as practice for their medical residents. This sort of abuse was so widespread in the South that these operations came to be known as ‘Mississippi appendectomies’” (Roberts 1997:90).

Table 1: Comparison of Eugenic vs. Neo-Eugenic Sterilization Programs

	Eugenic Sterilization	Neo-Eugenic Sterilization
Time Period	1869 – 1950s	1960 – 1980s
Target Population	Institutionalized, poor, white men and women	Non-institutionalized, poor women of color
Underlying Logic	Bio-determinism: genetic inferiority reproduced through breeding of unfit individuals	Cultural determinism: persistent intergenerational reproduction of cultural characteristics associated with poverty, dependency, irresponsibility, criminality, and illegitimacy
Goal	Selective breeding: enhancing the health of the population by preventing reproduction among unfit individuals	Limit risks associated with overpopulation, welfare dependency, and dysfunctional family formations by limiting fertility of certain populations of women
Funding	Wealthy philanthropists, such as, the Rockefeller, Carnegie, and Kellogg families	Federal family planning services provided through: the Office of Economic Opportunity (OEO), the Department of Health, Education and Welfare (DHEW), and the Public Health Service (PHS)
Key Words /Discourses	“feeble-mindedness” “degeneracy” “defectives”	“welfare queens” “pregnant pilgrims” “irresponsible reproduction”

Source: Kluchin 2004; Kline 2001

In California, it is estimated that 20,000 non-consensual sterilizations were sanctioned by state law between 1964 and 1979. These operations were performed on patients in state-run homes and hospitals and funded by family planning initiatives of the War on Poverty, launched by President Lyndon Johnson in 1964 (Stern 2005:1128). In North Carolina, welfare officials were permitted by state law to petition the court for the sterilization of their clients (Schoen 2001:135). In 1973, the National Abortion Action Coalition revealed that fourteen states were debating legislation designed to coerce women on welfare to undergo sterilization (D’Emilio and Freedman 1988:315). In all, it is estimated that during the 1970s in the United States, federal money funded between 100,000 – 200,000 coercive or nonconsensual operations per year (D’Emilio and Freedman 1998:315).

The racial pattern of North Carolina’s eugenic sterilization orders fits within this national shift or transition in genetic sterilization practices. As indicated above, there was a dramatic shift after World War II. From the program’s beginning in 1933 until the early 1950s, whites comprised the vast majority of sterilization orders. Then from the late 1950s onward the number of black women sterilized by Eugenic Board order climbed quickly (see Figure 1).

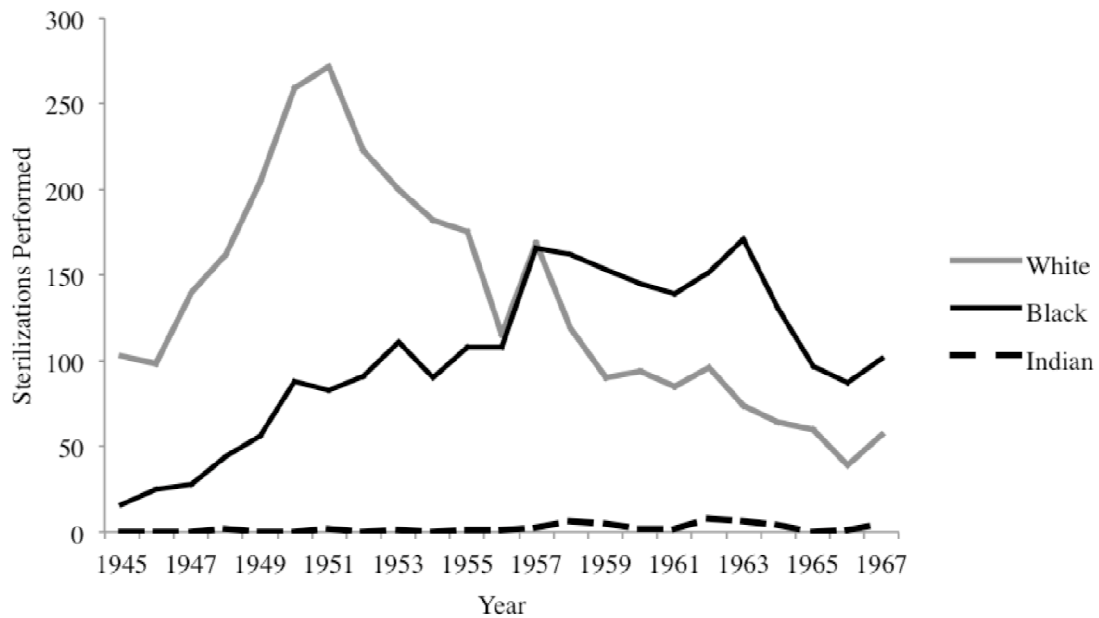


Figure 1: Women Sterilized by Eugenic Board Order, 1945-1967

1.4 Literature Review

1.4.1 Coercive Sterilization and Women of Color

The first sociological study of neo-eugenic sterilization abuses of women of color in the United States was Thomas Shapiro’s (1985) *Population Control Politics*, a mixed-methods examination of the influence of population control ideology on family-planning policies and programs in the United States. Though his quantitative analysis was flawed by its reliance on a model which only indirectly measured sterilization abuse, Shapiro’s findings continue to have significance for the historical study of coercive sterilization – women receiving public assistance had significantly higher rates of sterilization than those who were not on welfare, even when age and parity were held constant. This indicates a particular impact of welfare state

programs on reproductive rights among low-income women. Following Shapiro's early work, the topic of sterilization abuse of women of color in the neo-eugenic era was not addressed in the mainstream sociological or historical literatures for a number of years (Kluchin 2004:3) and only re-emerged within the mid-nineties.

Over the last decade, there has been a growing body of literature addressing the sterilization abuses that occurred during the 1960s and 1970s (Schoen 2001; Bruinius 2006; Hartmann 1995). Much of this research has taken a qualitative approach and has been conducted by feminist scholars and historians using archival records, other primary source materials, and interview data to document sterilization abuse committed against black women in Southern states (Schoen 2005; Roberts 1997; Washington 2006), and Mexican-American women in California (Gutiérrez 2003:2008), American Indian women in the Southwest (Smith 2005), and Puerto Rican women living both in the mainland U.S. and on the island (Lopez 1997; Briggs 2002).

This body of literature highlights the impact of discourses, which have depicted poor women of color as "internal enemies" who were scapegoats against rising popular fears about domestic and global overpopulation, and the expansion of welfare (Gutiérrez 200:383). Although they were clearly pervasive within national public discourse, racialized stigmatizations of the reproductive behaviors of women of color were not uniform across groups. In differing ways, these discourses painted women of color (poor women of color in particular) as "irresponsible" and "uncontrolled" reproductive citizens. In addition to scholarship which directly addressed the sterilization abuses against

women of color, another emergent body of historical literature documents the women's movement and the materialization of reproductive rights discourse which also occurred during this same time period (Baxandall 2001; Roth 2004; Breines 2006).

1.4.2 Studies of Coercive Sterilization in North Carolina

In her study of the history of abortion in this state, Rosalind Petchesky noted the unique value of North Carolina's welfare and reproductive policy history in illuminating "the tension between the principles of individual control and collective responsibility over reproduction" (Petchesky 1984:395). The reproductive policy history of North Carolina is unique in that it was among the first states to integrate reproductive technologies into its public health and social welfare programs. With the financial backing of Clarence J. Gamble, Proctor & Gamble heir, this state introduced the nation's first state-supported birth control program in 1937 (Roberts 2010:48). Although many states had very active eugenic sterilization policies in the 1920s and 1930s, North Carolina's history with compulsory sterilization is unique in several regards.

After World War II, most state sterilization programs declined in popularity because of the desire to dissociate from an ideology that had come to be associated with Hitler and the Holocaust. However, North Carolina's sterilization program took a different direction – it was growing. As one would expect from a state with a reputation for being a more "moderate" or "progressive" area of the South, North Carolina does have a history of comparatively liberal reproductive policies – during the 1960s it was among the first states to pass a voluntary sterilization law and to reform its abortion law

(Schoen 2005:7). At the same time, it became home to one of the largest and most enduring state sterilization programs in the nation. Although the scholarly literature on eugenic and coercive sterilization in North Carolina remains a relatively new and emergent body of work, interest in this history is quickly expanding what is known about race, gender, and class in the South.

The academic work in this area has been advanced most recently by the unusual situation and resources created when the records of the North Carolina Eugenics Board were available (unfortunately only temporarily) for academic study and public use in between 2002-2004. For social and historical researchers (myself included), an opportunity to investigate a little-known archival collection of primary source documents produced by a eugenics program, operating under the auspices of social welfare in the Jim Crow South is clear. Drawing on this important and unique resource, as well as the recently opened historical resources regarding the coercive sterilization of Mexican and Mexican American women in California, scholars from a number of disciplinary locations – including historians (Briggs 2002; Castles 2002; Gutierrez 2003; Schoen 2005; Kluchin 2009), economists (Price and Darity 2010, 2011), and feminist scholars (Gonzales, Kertész, and Tayac 2007) among others, have produced important works in this area.

However, there has been two previous eras of intense interdisciplinary scholarship in the reproductive policies of North Carolina's Social Welfare programs – one during the 1920s and 1930s when sociological attention, in particular, was focused on the racial

characteristics and lineage of the Lumbee Indians of Robeson County and also the perceived feeble-mindedness of many of the State's poor black children. Another era of interest in North Carolina's history and practices around reproductive rights and welfare provision occurred during the late 1960s and early 1970s when progressive and radical legal scholars and sociologists joined national and local welfare rights organizers, whose protests and advocacy called attention to the demeaning and oppressive nature of the newly implemented programs of social provision available to southern blacks during Johnson's War on Poverty (Morrison 1965). Also, among legal scholars there were many publications addressing the key court cases regarding North Carolina's compulsory sterilization program – including, *Cox v. Stanton* (1975) and *North Carolina Association for Retarded Children v. State of NC* (1976) (Roberts 1991, 1997; Zumpano-Canto 1996; Quadagno 1994).

More recently, from an economic perspective, Price and Darity (2010) found that between 1958-1968 the probability of non-institutional and total sterilizations was positively related to a county's black population share. This effect was not found for any other racial group in the population. Furthermore, this effect was not explained by the proportion of people living in poverty (which would indicate a motivation to minimize the incidence of poverty and maximize the incidence of wealth – according to eugenic logic both poverty and wealth are driven by heritable biogenetic traits) or the number of individuals in a county served by either a state psychiatric hospital or mental retardation center (which would indicate a motivation to reduce the population share of individuals

determined unfit due to “feeble-mindedness” or some other heritable mental health deficiency). They conclude that eugenic sterilizations were authorized and administered with the aim of controlling the black population share. They write, “North Carolina’s eugenic sterilization policy was not only biased but genocidal” (2010:268). A follow up study (2011), extends these findings – demonstrating that, for profit maximizing firms in North Carolina, the state-supported genocidal sterilization policy which targeted blacks: (1) served as a worker discipline device, and (2) enabled a principal-agent equilibrium that minimized wages, and maximized worker effort (2011:17).

1.4.3 Citizenship, Motherhood, and Biopolitics

The concept of citizenship can be most broadly defined as “an overall concept which sums up the relationship between the individual and the state” (Yuval-Davis 1997:68). In *Class, Citizenship, and Social Development* (1964), British sociologist T. H. Marshall developed an innovative framework for understanding citizenship relations that fundamentally recast the sociological study of citizenship and became “a touchstone” for most current analyses of democratization, citizenship, welfare states, and market transitions (Somers 1993:590).

According to Marshall’s definition, social rights of citizenship are institutionalized through systems of public education, social entitlements, unemployment insurance, welfare provisions, workers compensation programs, and federally funded health care services (Somers 199:590; Quadagno 1996:18). Importantly, Marshall posited that these social rights of citizenship are foundational to the full realization of

civil and political rights of citizenship – citizens must have the actual ability to exercise rights to which they are formally entitled, and states must act to enforce formal citizenship rights in order for them to have democratic potential (Glenn 2002:53). Marshall’s observation that “... citizenship has itself become, in certain respects, the architect of legitimate social inequality” (1964:70) illuminates the role of citizenship status in creating and reproducing economic and social inequalities, and is a key feature of his framework for the study of women of color and citizenship. Despite well-founded feminist critiques of gender-blindness (Orloff 1993:322), Marshall’s attention to social context and inequality has opened a space of inquiry between formal citizenship as embodied in law and policy, and substantive citizenship as indicated by the capacity of citizens to enjoy their constitutionally protected rights. For instance, Evelyn Nakano Glenn expanded on Marshall’s insights to illuminate the ways that, “racialized and gendered citizenship is created when theoretically universal citizenship rights are differentially enforced” (2002:53).

Comparative historical sociologists (Orloff 1993; Somers 1993; Quadagno 2000b) and feminist scholars (Pateman 1992; Young 1989; Okin 1994) have provided detailed historical analyses of the racialized and gendered characteristics of U.S. citizenship. These works have built new understandings of citizenship, which capture the ways in which citizenship status has been historically organized around race and gender ideologies, and also the ways that citizenship has been constitutive of the cultural meanings and ideologies attached to race and gender differences (Glenn 2002:18).

Comparative historical welfare state researchers in particular have demonstrated how programs of the modern welfare state differentially advantage various social groups – reinforcing unequal gender relations (Skocpol 1992; Gordon 1990; Orloff 1993) and race (Quadagno 1994; Boris 2005; Amott 1990).

Welfare state programs, as institutions of social citizenship, are manifestations of the rights of citizens to a degree of economic welfare and security, to share to the full in the social heritage, and to the life of a civilized being according to the standards prevailing in society. As such, they “help determine the articulation of social solidarity, divisions of class and status differentiation” (Esping-Anderson 1990:55). Welfare state programs have both regulatory and emancipatory potential – they are capable of creating, alleviating, or reinforcing social cleavages among citizens. By providing public access to health care services, welfare state programs offer a measure of economic security to citizens and also, more indirectly, facilitate their full political participation in the civic life of a democratic nation. Especially for women of color, welfare state provisions which increase access to reproductive health care are an area in which the state and citizenship status can have profound effects on social stratification (Orloff 1993:307; Ehrenreich 2008:5). Subsidized reproductive health care programs are potential mediators to historical patterns of gender inequality by providing women with increased personal autonomy (specifically, reproductive liberties and greater control over their bodies and bodily capabilities) states can act to support the self-determination and political agency of women in society (Petchesky 1983:3).

However, the inverse has also proven true – welfare state programs have functioned in ways that created and reinforced inequalities of class, race, and gender within the reproductive lives of women of color. For example, New Deal welfare state programs further entrenched racial and gender inequalities through the structure of eligibilities and benefits, which were based on assumptions about “mothers’ needs” and women’s economic dependence on men, and through the exclusion of non-whites from eligibility (Mink 1990:113). These early mothers’ aid programs, which came to form the original basis of the U.S. welfare state, embodied the contemporary racialized conceptions of motherhood and embedded them within popular political ideologies of economic independence, family formation, citizenship, and nationhood (Mink 1990:96-97; Williams 1991:147-151). Beginning in the 1960s, as a result of civil rights legislation and key court rulings, which made many official forms of racial discrimination illegal, women of color had unprecedented access to welfare state programs (Amott 1990:288). One unintended consequence of this newly expanded access was a heightened vulnerability to a wave of sterilization abuses, as many more poor women of color received state-funded reproductive health care services.

While citizenship is often discussed in abstract or theoretical language, stories of sterilization abuse indicate that citizenship is both a discursive category and an embodied status – the effects of citizenship designations and welfare state programs often occur at the level of the bodies of individual citizens. Michel Foucault’s theory of state power in the practices of governance provides a framework that helps to clarify the theoretical,

discursive, and bodily relations between race, gender, the welfare state, citizenship, and sterilization abuse. Modern state power, for Foucault, is constituted and exercised through practices of biopolitics – in which states act as managers of the life and survival of their citizens and are therefore imbued with “the power to foster life or disallow it” (Foucault 1997:137). In the interest of managing the health and vitality of the population, states have increasingly engaged in “permanent interventions at the level of the body, conduct, health, and everyday life” (Foucault 1997:149). Thus, state funding for population control programs promoting surgical sterilization can be understood as a manifestation of the biopolitical mandate of the modern U.S. state – a permanent intervention at the level of the body.

In a series of lectures delivered at the Collège de France in 1975-1976, Foucault addressed the function of racism in the state and the specific techniques of power associated with it (Feder 2007:63). Biopolitical forms of governance create “biological” distinctions within the population, which form a hierarchy whereby “certain races are described as good and . . . others, by contrast, are described as inferior” (Foucault 1997:255). Racism is therefore, “internal to the biopolitical state, woven into the web of the social body, threaded through its fabric . . . not an effect but a tactic in the internal fission of society into binary opposition, a means of creating ‘biologized’ internal enemies, against whom society must defend itself” (Stoler 1995:59). Feminist and critical race scholars have employed this concept of biopolitics as a way to more effectively “think together” multiple categories of identity without distorting or

conflating the specific mechanisms and production of each (Luibhéid 2004; Giroux 2007; Feder 2007). In this project, I adopt Foucault's framework and genealogical approach in order to critically address the historical contingency of categories of race, gender, and citizenship – to examine not only their pragmatic effects, but also how they took shape and became meaningful at particular times, in specific geographic locations, social, and political contexts.

In order to offer basic and legal understandings of the concepts that will be employed throughout the dissertation, the next section defines three key terms: consent, coercion, and intellectual disability. The specific reproductive technologies discussed will then be introduced for the sake of clarity – tubal ligation, hysterectomy, vasectomy, and castration. The purpose here is to explicitly acknowledge the physical realities of coercive sterilization practices, and to facilitate a historical analysis of reproductive citizenship attentive to its effects at the level of the body (Rose and Novas 2008; Collins 2000; Roberts 1998; Stoler 1995; Foucault 1977).

1.5 Key Terms

1.5.1 Consent

Consent refers to the act of compliance in, or approval of, something done or proposed by another person. Specifically, in the legal context it indicates: “voluntary agreement or acquiescence by a person of age or with requisite mental capacity who is not under duress or coercion and usually who has knowledge or understanding” (Merriam-Webster's Dictionary of Law). There are several different legal contexts in

which the concept of “consent” holds slightly different meanings (e.g., rape, search and seizure, experimental research, etc.). In the context of medical consent, North Carolina law recognizes the patient as the only person with legal authority to consent to medical treatment. However, there are some important exceptions to this general standard which include: minors – for whom parents are authorized to give consent; and people who not have the decisional capacity to consent – in which case, either an identified guardian or the state (in *parens patriae*) is authorized to give consent. There are two legal forms of consent to medical treatment: (1) personal consent, in which a person directly communicates their own authorization for treatment; and (2) substituted consent, in which another party provides authorization on the behalf of a person who is considered incapable of providing personal consent. The standard ethical practices of medicine stipulate that in order to be considered voluntary, consent must be given freely without coercion or duress.

1.5.2 Coercion

Coercion is generally understood to describe the use of threats, violence, physical force, sexual force, or other intimidation tactics in order to compel another person to do something, or stop doing something, against his or her will. Coercion has three main varieties: (1) physical – this involves physical injury or threat of violence on a person or a person’s loved ones; (2) psychological – psychological coercion includes forms of non-physical forms of pressure, including actions such as a person using bullying, pleading, begging, or guilt to obtain his or her objective; and (3) economic – this form exploits the

economic insecurity and lack of financial resources to convince a desired outcome (Sullivan 2009:81).

Although there is not a singular definition of coercion within the North Carolina statutory law, reference to two significant rulings of the North Carolina Supreme Court offers indications of how the legal concept of coercion has been interpreted and applied. In both *Bumper v. North Carolina* (1968) and *Shnechneckloth v. Bustamonte* (1973), the North Carolina Supreme Court has established the mutual exclusivity of coercion and consent under the law – finding that consent arising as “the result of duress or coercion, express or implied” is invalid, that acquiescence to a claim of lawful authority does not constitute legal consent. Within the law at least, the distinction between consent and coercion is quite clear: “[w]here there is coercion, there cannot be consent” (*Bumper v. North Carolina* 1968).

1.5.3 Intellectual Disability

“Intellectual disability” is now the preferred terminology over the previous term, “mental retardation.” This change was prompted by the efforts of activist and advocacy groups who argued that: (1) the term “mental retardation” did not communicate appropriate dignity or respect for affected individuals, and (2) had too often been used frequently as a term of devaluation. Thus, “intellectual disability” has increasingly become the standard term used by professional organizations, journals, agencies, published research, and government programs (U.S. Equal Employment Opportunity Commission 2011). Specifically, intellectual disability refers to a condition

“characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical skills. This disability originates before age 18” (Schalock et al., 2010). The language used in the time period under study here (1950-1980) to describe the group of individuals who comprise this group has changed substantially – terms like “moron,” “idiot,” and “feeble-minded” are used within the historical documents and contemporary publications I reviewed. In the interests of clarity and respect, here forward I will retain the use of such historical terms in official labels and as recorded within direct quotations, but will refer to the group designated as “people with intellectual disabilities” as a general practice.

1.5.4 Relevant Reproductive Technologies

In the chapters that follow, there are five main reproductive technologies that were used in family planning clinics, medical and correctional institutions, and hospitals to render patients either temporarily or permanently infertile: intrauterine devices, salpingectomy, ovariectomy, vasectomy, and castration. The focus of this study is on the coercive use of such procedures, however, it should be noted that there is no intended implication of anything inherently problematic or oppressive about the technologies themselves. As will be discussed below, the development of each method of long-term contraception has offered new choices that have used millions electively in directing their own reproductive health. However, when used without the patients’ authentic consent, such medical procedures represent substantial violations of bodily integrity. They are each described briefly below:

1.5.4.1 Intrauterine Device (“Lippe’s Loop”)

The Lippe’s Loop intrauterine device (IUD) was a long-term fertility control implement, which became very popular among federally-funded family planning clinics both nationally and internationally in the mid-late 1960s. The device cost only a few pennies to manufacture, could be non-surgically inserted into the uterine cavity, and remain in place until menopause. This type of IUD works by stimulating a “foreign body inflammatory reaction” in the uterus, similar to the body’s reaction to other foreign bodies (i.e., splinters). Once a foreign body is recognized, a concentration of white blood cells, prostaglandins, and enzymes collect in the area of the device with two results: (1) prevention of sperm travelling through the uterus and fallopian tubes, and (2) creating damage to both the sperm and ova – which prevents fertilization (Bullough 2001:151).

The specific types of IUD which were available to women in the 1960s and 1970s through North Carolina county family planning clinics, were removed from the U.S. market in 1985, following the filing of over 200 lawsuits against its maker Johnson and Johnson (Lewin 1986). In a 1973 study of patients’ experiences with the Lippe’s Loop in family planning clinics, researchers found that during the first twelve months following insertion of the device one-fourth of women experienced involuntary expulsion of the device, accidental pregnancy with device in place (50 percent of which led to spontaneous abortion), or removal for excess bleeding or pain (Orlans 1973). Later studies found an increased risk of damaged fallopian tubes resulting from pelvic inflammatory disease associated with IUD use. Users of plastic IUDs (such as the Lippe’s Loop) experienced a 50 percent increase in the rate of permanent infertility

following device removal, when compared to women who had never used the device (Bullough 2001). This was the preferred contraceptive measure within the Robeson County Family Planning Clinic.

1.5.4.2 Salpingectomy

A salpingectomy is a surgical procedure in which the fallopian tubes are either partially or entirely removed (see Figures 2 and 4). Although the side effects and risks for tubal sterilization by salpingectomy are generally considered low, the procedure is major surgery, which must be performed under general anesthesia. Furthermore, there is evidence of substantially elevated risk of hysterectomy among women who had previously had a tubal ligation. Among a national sample of women who had been sterilized they were 3.4-4.4 times more likely to have a hysterectomy than those who had not (Hillis et al 1998; Goldhaber et al 1993). Women who undergo hysterectomy report: “sexual dysfunction and disinterest, a loss of libido, pain during intercourse due to a lack of vaginal lubrication, loss of hair, bone loss, weight gain, an increase in facial hair, intense menopausal symptoms such as hot flashes, night sweats, dry skin, and a change in skin odor, as well as increased risk for heart disease” (Davis 2009:1307). Between 1950-1968 the North Carolina Eugenics Board ordered 4,139 people to have this procedure.



Figure 14. The Operation of Salpingectomy

Source: Laughlin 1922

Figure 2: Laughlin Drawing of Salpingectomy

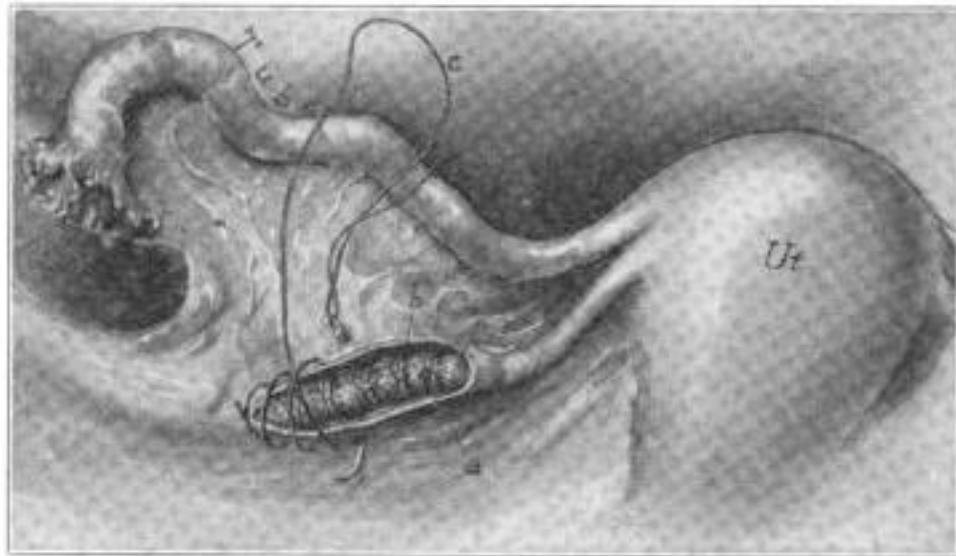


Figure 13. The Operation of Oöphorectomy

Source: Laughlin 1922

Figure 3: Laughlin Drawing of Oophorectomy

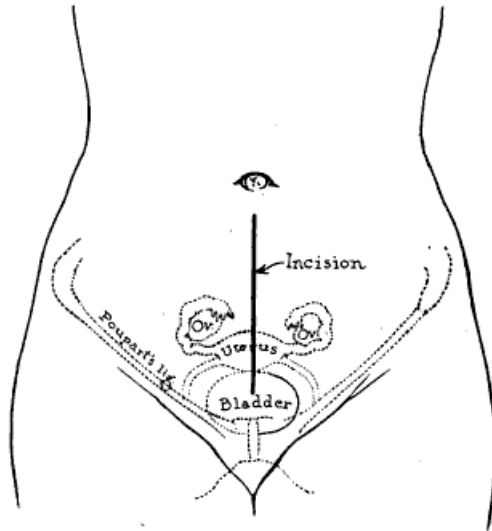


Figure 12. The Abdominal Incision Used in Salpingectomy and Oöphorectomy

Source: Laughlin 1922

Figure 4: Laughlin Drawing of Incision Point for Salpingectomy and Oophorectomy

1.5.4.3 Ovariectomy

Commonly referred to as “oophorectomy,” an ovariectomy is a surgical procedure, which removes one or both ovaries (see Figures 3 and 4). It eliminates the menstrual cycle, and because it drastically reduces the presence of female hormones in the body, it is considered the biological equivalent of castration (or orchiectomy) in males. This has been a fairly common procedure usually performed at the same time as a hysterectomy as a treatment for ovarian cysts, endometriosis, or as a preventative measure for women at high risk of ovarian cancer. However, its clinical use is declining as a result of recent studies, which indicate multiple negative effects on women’s long-term health and wellbeing, and substantial decreases in long-term survival rates among women who have had the surgery. These negative effects include: a rapid decline in the circulation of key hormones (estrogens and androgens) that often leads to hot flashes, sleep disturbance, mood alteration, and sexual side effects. The surgery is associated with higher risks of coronary heart disease, hip fracture, Parkinsonism, dementia, cognitive impairment, depression, and anxiety (Parker et al. 2009). Between 1950-1968, the North Carolina Eugenics Board ordered 40 people to have this procedure.

1.5.4.4 Vasectomy

Considered a minor surgery, and usually performed under local anesthesia, a vasectomy procedure involves cutting the vas deferens, preventing sperm from moving out of the testes. In the vast majority of cases there are no serious complications or negative effects reported. Vasectomy has no effect on the balance of male hormones, male sex characteristics, or sex drive. Testosterone continues to be produced in the testes

and delivered into the bloodstream. In approximately 1 out of 1000 men, there is continuing chronic pain following a vasectomy. No deaths resulting from a vasectomy have ever been reported in the United States (Jaret 2008). Between 1950-1968, the North Carolina Eugenics Board ordered 591 people to have this procedure.

1.5.4.5 Castration

Typically referred to as “orchietomy,” this is a surgical procedure in which both testes are removed in their entirety, causing an immediate reduction of 95 percent of circulating testosterone from the body (Laughlin 1922). It is currently performed in the treatment of prostate or testicular cancer (Albala et al. 2011) and gender reassignment (Etter 2007). There are serious negative side effects, which include: sterility, loss of sexual interest, erectile dysfunction, hot flashes and sweats, weight gain and obesity, gynecomastia (development of breasts), anemia, cognitive changes, metabolic syndrome, and osteoporosis. Between 1950-1968, the North Carolina Eugenics Board ordered 5 people to have this procedure.

2. Data and Methodology

This study of welfare and reproductive history employs comparative historical methodologies to analyze primary source materials pertaining to welfare and family planning policies in the state of North Carolina. Analysis of these documents was conducted using a mixed-method approach which proceeded in three steps: (1) content and discourse analysis of primary source materials; (2) time-period and cross group historical comparisons; and (3) the construction of a synthesized historical narrative using theory-guided process tracing. In this chapter, the data used and process of collecting it will be described, and the methodological strategies employed will be explained.

2.1 Primary Sources

Data for this study was drawn primarily from historical sources including: the records of the North Carolina Eugenics Board, policy documents and statutes, trial records (transcripts and rulings), contemporary newspaper and magazine articles, organizational documents from social service providers and activist groups, the statements of coercive sterilization survivors that were available within archival collections, and a video recorded “listening session” with survivors (see Appendix A). These sources were selected because together they provide a multi-dimensional and broadly inclusive body of information regarding the institutional factors, discursive effects, forms of resistance, and authentic voices of women who were coerced into accepting sterilizations. In addition to the primary source materials, demographic and

statistical data and contemporary and current scholarly research was also consulted in order to provide context for information contained in primary sources.

Previous historical research about sterilization programs has been criticized for a theoretically problematic over-reliance on institutional records of procedures and decision-making processes (Kluchin 2007:132). This over-reliance is likely due to the relative scarcity of documents written from the perspective of those who have experienced sterilization abuse, and the fact that those records which do exist can be more difficult to locate than institutional records. Historians seeking to recover and accurately represent the experiences of the sterilized have often faced a lack of access to primary sources containing the authentic voices of survivors (Briggs 2007:205).

Recently, historian Rebecca Kluchin suggested that the use of newspaper data, court cases, trial transcripts, depositions, and legal dockets along with available medical records, provides previously untapped sources for hearing the authentic voices of survivors as well as important additional information about the social conditions, institutional factors, contextualized circumstances, and power relations under which such sterilizations occurred (2007:136). The data for my study was selected in accordance with this approach – to capture glimpses of the embodied experiences of sterilization abuse as described by survivors quoted in newspaper interviews, legal testimony, and other public statements – as well as the legal, institutional, political, cultural, social, and medical discourses and structures that facilitated and resisted coercive sterilization practices.

2.1.1 Eugenics Board Records

The records of the North Carolina Eugenics Board were the central source of information regarding the coercive sterilization practices and procedures reviewed in this study. The records analyzed here include: pamphlets and publications of the Board; forms used by the Board in the process of ordering sterilization procedures; meeting minutes; and individual case summaries used by the Board in deliberating cases to recommend for sterilization orders. Although these documents were technically classified as public records (as are the documents of North Carolina's Departments of Health, Human Resources, Education, Sanitation, etc.), and at the time this study began, were officially located in the North Carolina State Archives listed on the library website as available to researchers for review upon request, the process of actually accessing them was difficult and very slow.

Some of the Eugenics Boards Records were easily available for review – including organizational manuals, reports, forms, and pamphlets – at the State Archives located in Raleigh, and through North Carolina Digital Collections. However, the record group I was most interested in reviewing had been removed from public access. This collection contains the meeting minutes and reports of the decision-making body responsible for issuing and enforcing sterilization orders within the state of North Carolina. Every case reviewed by the Eugenics Board during my selected time period is in this collection (over 7,000). Following the publicity generated by the *Winston-Salem Journal* series (2002) and Schoen's publications, the State of North Carolina de-accessioned the majority of Eugenics Board records and transferred them to the custody

of the Department of Health and Human Services in 2005. They have been closed to researchers ever since. The value of these documents (case histories, detailed descriptions of the social, economic, racial, medical, and psychological characteristics of women ordered to be sterilized, justifications for these orders, information about the internal procedures of state institutions, the outcomes of sterilization orders, etc.) to my research project simply cannot be overstated. They contain a unique source of qualitative data – discursive evidence that is foundational to gaining a deep understanding of this phenomenon, and building a theoretical framework around reproductive citizenship.

For over a year and a half I communicated with a variety of state officials requesting the records, and although I was never told “no” I would not be permitted to review them. I also was never given access. Despite this apparent dead-end, I was fortunate to receive the generous assistance of a scholar who had previously worked with and digitally scanned the redacted original records. In this way, I received digitized copies of the Eugenics Board’s redacted meeting minutes – which to my knowledge, is the only existing copy of these records that exists outside of the North Carolina State Department of Health and Human Services.

Unfortunately, by the time I received copies of the approximately 4,000 case summaries that concern petitions handled between 1950-1980, both research time and funding for the project were in short supply. The Eugenics Board met monthly to review cases, and during the peak years of its operation they typically reviewed approximately 30 cases per month. Given that it would be impossible to review and analyze such an immense collection of documents in the timeframe available, I employed a two-stage

stratified systemic sampling method (Hughey 2009; Babbie 2004; Strauss and Corbin 1998) to create a set of case summaries from the total population of available Eugenics Board meeting minutes.

First, I divided the total population of case summaries within the meeting minutes into three theoretically meaningful sub-groups. These were: records pertaining to black women, white women, and American Indian women. Second, within each group I selected records at regular intervals in order to arrive at three sub-samples, each of which was representative of its respective sub-group population. Since black women represented the largest group of women of color within the Eugenics Board's population, I wanted to have as large a sample of these records as would be possible to analyze given the time constraints. Therefore, I selected the first case summary pertaining to a black woman for each month – yielding 154 case summaries.¹ In order to create a smaller set of records regarding the cases of white women to serve as a source for group comparisons, for every other month I selected the first case summary pertaining to a white woman – yielding a subsample of 79 records. Finally, since the number of case summaries pertaining to American Indian women were more limited (it is estimated that the Eugenics Board ordered sterilization operations to be performed on approximately 47 individuals identified as “Indian” in total), all such cases within the records were selected – yielding a subsample of 26 cases. This sampling strategy was designed to provide a

¹ In order to assess the potential for bias due to selecting the first record (as opposed to case summaries located elsewhere in the month's meeting minutes), I also reviewed an alternative sample comprised of every fourth case summary pertaining to a black woman for the years 1957 and 1967. Comparisons between the alternative and original samples yielded very similar results in terms of the case characteristics, and discursive frameworks represented.

substantial and representative corpus of discursive material for each of the three groups, from the available primary source materials.

The set of Eugenics Board records I received were missing some information from years 1959-1962, and 1968-1973. Using the records available and sampling method described above, I then reviewed each of the 259 cases and entered information regarding the cases into a spreadsheet for analysis. The information recorded for each case included: county of residence, race, age, marital status, diagnosis, type of testing conducted, identity of the official who recommended the case for review, and how the “patient” was described in terms of sexual behavior, home environment, family background, and abuse history. Some descriptive statistics regarding the cases reviewed are located in Tables 2, 3 and 4. At the same time, I searched for discursive patterns and themes within the case descriptions and made note of commonalities and patterns within the records.

Table 2: Sampled Cases, Selected Descriptive Statistics

		Percentage	Observations
Cohort	1950-1964	73%	(190)
	1965-1970	36%	(69)
Race	White	30%	(79)
	Black	60%	(154)
	Indian	10%	(26)
Case Type	Non-institutional	78%	(202)
	Institutional	22%	(57)
Age	10-14	20%	(51)
	15-19	34%	(88)
	20-24	18%	(47)
	25-29	12%	(32)
	30-24	10%	(25)
	35+	6%	(16)
Diagnosis	Feebleminded	88%	(227)
	Epileptic	2%	(5)
	Schizophrenic	5%	(12)
	Mentally Ill-Other	6%	(15)
Marital Status	Single	80%	(207)
	Married	11%	(28)
	Separated	5%	(14)
	Widowed	2%	(5)
	Other/Not Indicated	2%	(4)
Number of Children	0	48%	(124)
	1	17%	(43)
	2-4	25%	(65)
	5-7	8%	(8)
	8+	2%	(6)

Sample Size: n=259

Table 3: Sampled Cases, Meeting Year by Race

Year	White	Black	Indian	Total
1950	7	13		20
1952	7	12		19
1954	6	12		18
1955	6	13	2	21
1956	5	11		16
1957	9	12	3	24
1958	6	12	5	23
1963	6	11	8	25
1964	7	12	5	24
1965	2	6		8
1966	4	10		14
1967	7	10		17
1968	5	10	1	16
1969	2	8	2	12
1970		2		2
Total	79	154	26	259

Table 4: Operations Performed by Time Period and Racial Group, Women 1939-1968

	White	Black	Indian	Time Period Total
1929-1949	1631 (80%)	396 (20%)	0	2,027
1950-1964	1683 (50%)	1669 (49%)	35 (1%)	3,387
1964-1968	213 (33%)	414 (65%)	10 (2%)	637
Group Total	3,527	2,479	47	6,053

2.1.2 Additional Primary Sources

In addition to the Eugenics Board records, I reviewed the following records at the State Archives in Raleigh, N.C.: Governor’s Office Records, North Carolina State Board

of Public Welfare, North Carolina Department of Human Resources, North Carolina Department of Social Services, and the Ellen B. Winston Papers. Unfortunately, I was not able to analyze records of the state legislature because North Carolina does not keep written records of its legislative sessions. These records were used to trace the organizational development and practices of government agencies involved in the activities of the Eugenics Board, provision of Family Planning Services, and procedures involved in the administration of the Aid to Families with Dependent Children (AFDC) program in North Carolina.

To gain better understanding of the legal foundations and support for sterilization orders issued by the Eugenics Board, I reviewed court records pertaining to sterilization suits. These included: *Buck v. Bell*, 274 US 200, (1927); *Cox v. Stanton*, 529 F. 2d 47 (1975); *In re Sterilization of Moore*, 221 SE 2d 307 (1976); *NC Association for Retarded Children v. State of NC*, 420 F. Supp. 451 (1976); *Matter of Johnson*, 263 SE 2d 805 (1980); and *Matter of Truesdell*, 329 SE 2d 630 (1985).

In order to collect data, which would indicate the local framing and public discourses regarding sterilization and family planning in North Carolina during the selected time period, I examined scanned copies of historical newspaper articles. Using a newspaper archive database available at the North Carolina State Archives, I located approximately 150 articles in North Carolina newspapers between 1950-1980. These sources included: *The Daily Times-News* (Burlington, NC), *The Gastonia Gazette* (Gastonia, NC), *Robesonian* (Lumberton, NC), and the *Statesville Daily Record* (Statesville, NC).

Other archival records included the personal papers collections and oral interview transcripts of people and organizations active in family planning work in North Carolina during the time under study. Important collections of such documents were located in the archives of the University of North Carolina at Chapel Hill and Duke University. These sources gave further context to information contained in the state agency records – the rhetoric that justified coercive sterilization practices is recorded in speeches delivered by key figures, the personal perspectives of those involved were reflected in collections of correspondence and notes, the intentional shaping and framing of public discourse surrounding sterilization was documented in the records of the Human Betterment Association of North Carolina, and records of correspondence indicate who had influence over state practices and policy decisions.

2.2 Primary Source Analysis

Discourse analysis of the primary source materials was used to reveal important dynamics of race, gender, and citizenship frameworks within documents pertaining to reproductive politics. As anthropologists Faye Ginsburg and Rayna Rapp have observed, such examinations “can be used to analyze ‘reproduction’ as an aspect of other contests over hegemonic control” (1991:331). Beyond simply studying the words used to describe women of color as reproductive citizens, my approach seeks to understand the relationships between linguistic constructions (such as the “welfare queen”) and the structural conditions within which they have historically emerged. The concept of consent will be a key focus of my analysis of historical documents. If it is true, as Ruth Miller has recently argued, that “the legal concept of consent differentiates full citizens

from partial or non-citizens . . . only full citizens are capable of consent,” (2007:7) the line between coercion and consent has great bearing on my ability to understand the character and quality of citizenship experienced by women of color in North Carolina during the selected time period.

Once all of the records were collected, reviewed, and organized in the primary analysis process, I created a “questionnaire” which was used to “interview” each case summary within the Eugenics Board records (see Appendix A). This allowed for the production of a quantitative representation of this data, by counting occurrences of certain theoretically significant characteristics within the petitions sampled. This process was intended (and has been used) to supplement qualitative analysis by providing a simple way to track trends and patterns of institutional discourse within the documents.

Group comparisons between the descriptions of black, American Indian, and white women – within the popular discourse, reflected in contemporary periodicals; and the institutional discourse comprising the records of the Eugenics Board – offer a unique vantage on the North Carolina sterilization program. Examining similarities and differences between black women’s and American Indian women’s framing within discourses of race, reproduction and welfare, and each group’s divergent patterns of engagement with and by the public welfare system’s family planning programs, allowed examination of the varied impacts of racial, class, gender, and, geographic distinctions on reproductive citizenship.

In 1960, North Carolina’s population included approximately 1.2 million people of color – which represented 25.4 percent of the state’s population. At that time, the

population of Robeson County and surrounding areas in the southeast region of the state was home to approximately 38,000 Lumbee – the largest North Carolina American Indian group. My sample for the years 1950-1964 includes the Eugenics Board records covering cases of 107 black women, 23 American Indian women, and 59 white women.

Robeson County was listed as the county of residence in 21 of the cases included in the sampled set of Eugenics Board meeting minutes I reviewed (N=259). State records indicate Robeson County as the place of residence for 75 of the sterilization ordered by the Eugenics Board and performed during the program’s most active period, between July 1946 – June 1968 (North Carolina Justice for Sterilization Foundation 2011). This places Robeson County 22nd among North Carolina counties, in terms of the county of residence for ordered and performed sterilizations. However, in my sample, Robeson County was the 2nd most frequently listed among counties of residence (see Table 5). This difference is a result of my sampling procedure – to pull all records where the indicated race was “Indian.” State records do not specify tribal distinctions or affiliations (all Native groups are simply categorized as “Indian” in the files). Forty-five percent of North Carolina’s American Indian population lives in Robeson County (mostly Lumbee), where the group comprises 38 percent of that county’s total population (NC State Center for Health Statistics 2010). It is most likely that “Indians” from Robeson County and surrounding areas indicated by the Eugenics Board records refer to Lumbees (Railey 2002). The other counties indicated as a place of residence for “Indian” women within my sample were Cumberland (1) Hoke (3) Scotland (3) and Swain (1).

Within the sampled set of cases I reviewed the following counties were not represented: Alexander, Alleghany, Brunswick, Chatham, Clay, Currituck, Dare, Gates, Graham, Granville, Greene, Hyde, Jones, Pender, Perquimans, Polk, Richmond, Stokes, Tyrrell, Washington, Watauga, Yadkin, and Yancey. None of them were among the counties noted for high prevalence of sterilization orders within the state’s records.

Table 5: Eugenics Board Cases Reviewed, County Statistics

County	Sampled Cases	State Data: Operations Performed	(County Rank)
Mecklenburg	21	485	(1)
Robeson*	21	75	(22)
Rowan	10	120	(7)
Pitt	9	142	(4)
Buncombe	8	139	(5)
Guilford	8	167	(2)
New Hanover	7	72	(25)
Gaston	6	161	(3)
Hoke	6	28	(70)
Iredell	6	104	(11)

* Discrepancy explained by sampling procedure with Indian women

2.3. Historical Narrative Construction

The second step in my research design is the construction of a synthesized historical narrative using theory-guided process tracing in order to bring the cases together, and situate them within a single analytic model. The use of narrative construction (techniques which build temporal sociological explanations by strategically delimiting and theoretically ordering sequences of relevant events) within comparative historical sociology has been recognized as a particularly effective approach to developing causal explanations that are sensitive to context and contingency (Quadagno

and Knapp 1992; Haydu 199:340; Somers 1996; Abbott 1992). Analytic narratives are “theoretically structured stories about coherent sequences of motivated actions,” which locate significant historical events as key causal factors within the unfolding of social actions, political developments, and/or cultural changes over time (Aminzade 1993:26-27). Analytic narratives allow researchers to highlight “typical sequences across [cases] . . . and explore the causes and consequences of different sequence patterns” (Aminzade 1993:108).

Periodization, or the identification of appropriate starting and ending points for a narrative sequence – the organization of time into meaningful “chunks” with defining themes, key events, and salient constellations of social forces – was the next step in the research process (Haydu 199:344; Falletti 200:12). I selected the time period 1950-1980 because it captures historically and theoretically significant social, political, and cultural events and transitions relevance to sterilization abuses committed against women of color. These three decades comprise a time of rapid social and cultural change, relative liberalization in political ideologies, and egalitarian governmental reforms. 1950-1980 was a time during which North Carolina, and the U.S. more generally, underwent a series of significant institutional changes which had direct bearing on race relations and the meaning of citizenship: an end to overt racial discrimination in federal programs, immigration reforms, and an expansion of the U.S. welfare state (Behrens et al. 2003:560). During this same time period there were also key shifts in popular discourses of race, gender, and reproductive rights/responsibilities related to characterizations of women of color and their reproductive behaviors and experiences (Gutiérrez 2003:xii).

3. Theoretical Framework: Towards a Theory of Reproductive Citizenship

The status of “citizen” as a rights-holding member of a society, and the institutions that collectively comprise a welfare state are co-created. Social citizenship rights are embodied in, and also are created by the institutions comprising the welfare state (Marshall 1964). In North Carolina, for most of the State’s history – until the mid-1960’s - women of color were largely excluded from the institutions of social welfare (Rabinowitz 1974; Quadagno 2000). This study shows that between 1950-1980 the activities of institutions of public welfare were shaped by a widespread resentment that pervaded popular and professional discourses surrounding “illegitimacy” and “dependency,” among black mothers. The denial of social citizenship rights (as embodied in and created by social welfare institutions), and the sterilization abuse of women of color by the welfare state programs in North Carolina is at the center of this analysis, as a way of tracing how reproductive rights were implemented. The relationship between consent, bodily integrity, and popular consensus about what constituted the “best interest of the State” also indicates how the reproductive rights of citizenship were distributed.

3.1 What is Citizenship?

As a starting point, citizenship may be defined as a status that marks the boundaries of a national community and structures relationships between the State and those located either inside or outside of membership. In the United States, access to citizenship is conferred through birthplace (rather than by descent, for example). This is

known as *jus soli* – a legal term (Latin: “of the soil”) which means all born here are equally entitled to the rights of citizenship (Barbalet 200:497). However, all people born in the United States do not now, nor have ever had truly equal access to the benefits and protections of *jus soli* citizenship as a status. The idea of a social contract has been foundational to theoretical explanations of the relationship between citizens and the State. Current sociological understandings of citizenship and the State are rooted in the notion of a social contract, a theory deriving from the works of Hobbes, Locke, Kant, Rousseau, and Rawls, which hypothesizes that all members of society join together by choice for their “general will” or common good. In this framework, rationality and autonomy (or independence) is understood as absolutely necessary because the legitimacy of the government is based on the consent – an independent decision – of all citizens to be governed by it. Therefore, if birthplace can be understood to sort “insiders” and “outsiders” to a national community (although clearly it is much more complicated than this) it is through participation in the maintenance of general will and shared investment in the “greater good” that relationships to others within the body politic are formed and reformed. These relationships are shaped by the apparatus of the State, by differential power among citizens, and historical precedent (for example the “grandfather clause” in voting).

The concept of “consent” defined above is central to directly related to the process of seeking consensus. It is also of vital importance to understanding the relationship of coercive sterilization practices and reproductive citizenship. The ability to give or withhold one’s consent, and have this choice honored, is fundamental to

American ideals of citizenship as a status which protects the individual autonomy of members in the national body. Within this contractual understanding of citizenship, great value is attached to individual freedoms and choice, as components of political life and for personal rights (Nakano Glenn 2002, 2004; Lister 2003; Turner 1993). The legal and ethical traditions surrounding practices of informed consent in medical treatment are, thus, firmly rooted in these cultural values which place deference and respect for personal autonomy as expectations in civil society (Faden, Beauchamp, and King 1986).

Despite the fact that these relationships to the State and to other citizens within the national community are constrained to some degree, it is important to note that they are also not static or set in stone. When there have been major shifts in the distribution of citizenship rights among citizens, the political sphere has consistently been important as a site of negotiation among members of society about what constitutes the “greater good” (i.e., the Civil Rights Movement leading to the Equal Rights Amendment, the women’s movement leading to the *Roe v. Wade* decision).

T.H. Marshall’s foundational definition of citizenship defines it as “. . . a status bestowed upon those who are full members of a community. All those who possess the status are equal with respect to the rights and duties with which that status is endowed” (1950:18). Marshall’s vision of equal citizenship, written in England in the wake of the Second World War, stood in provocative disharmony with the reports of lynching, voting rights violations, and school segregation battles which characterized race relations in North Carolina in that same year (1950:18). This contrast highlights one of the most frequent critiques of Marshall’s theory – that it does not adequately describe the

complexity of diverse societies in which groups are differentially situated in relationship to the State, as the Jim Crow South most certainly was (Yuval-Davis 1991; Lister 1997; Boris 2005). In North Carolina in 1950, although black people had held the status of “citizen” for some time, the package of rights that came with black citizenship was clearly unequal to that guaranteed to white citizens.

Full membership in the national community (as defined by Marshall) has not been universally achieved or denied for all groups within U.S. citizenship. Multicultural theorists Charles Taylor (1992) and Will Kymlicka (1995, 2001) have stressed the role of the State and hegemonic groups in wielding power in shaping state politics, which has a major impact on minority group inclusion or exclusion. Citizenship membership is also not binary. In practice, citizenship is a multidimensional concept the constitutive of which is associated with juridical, political, cultural, social, and economic dimensions. Thirdly, citizenship is not necessarily absolutely stable. Especially, social rights (see Marshall’s social element) can change.

3.2 Citizenship, Social Rights, and the Welfare State

Social rights can be seen as a yardstick in measuring how various groups stand in relation to each other with regard to the rights and obligations they enjoy as members of the community. Social citizenship perspectives emphasize the potential of social provision in democratic states, secured at least partially through the political struggles of citizens and others, to counter domination even as they acknowledge that this potential is often far from being realized. The programs of the modern welfare state differentially advantage various social groups, and there is important variation across countries and

programs, as well as over time, in the extent to which the interests of dominant and subordinate groups are enhanced. In short, social citizenship analysts envision social policy as having an emancipatory as well as regulatory potential. Even where emancipation is not a manifest objective, social programs may have unintended “independence effects” (Orloff 1993:305).

Scholars from comparative historical and feminist traditions studying social welfare and citizenship have complicated Marshall’s image of equal rights for all citizens, by examining the institutions, and in particular the services (i.e. education and social services) of the welfare state. Their findings suggest that welfare state services have had powerful effects on women’s material situations, shaped racial and gender relationships, structured political conflict and participation, and contributed to the formation and mobilization of specific identities and interests (Lister 1990; Lewis 1992; Orloff 1993). Feminist welfare state scholars argue that services must be included in analysis of the welfare state to fully understand the gendering potential of the welfare state (Lister 1990; Lewis 1992; Orloff 1993). Attention to the specific institutions within welfare states is analytically important because it is here that citizenship rights can be observed most directly in the form of institutions that support and protect them (Marshall 1964). “The welfare state . . . is, in its own right, a system of stratification. It is an active force in the ordering of social relations” (Esping-Anderson 1990:310). Similarly, reproductive technologies (such as surgical sterilization) can also be both liberating and oppressive – medical technologies and interventions can hold a number of different

meanings simultaneously (Schoen 2005:6). There are factors that enhance the quality of citizenship enjoyed by group members, and factors destructive to it.

3.3 Reproductive Citizenship

A theory of reproductive citizenship should offer some explanation of changes in access to reproductive rights. Feminist analyses of citizenship have highlighted sexuality, reproduction, and physical bodies: “Citizenship is defined as a practice of embodied subjects whose sex/gendered identity affects fundamentally their membership and participation in public life” (Jones 1990:786). In this study, factors that eroded the reproductive rights of women of color included: the creation and promotion of social panic, the uses of “scientific” and professional authority, discourses of “protection,” and elite social and political networks.

The creation and promotion of a social panic surrounding the “menace of feebleminded,” set up a popular discourse around unfit mothers as a threat to society that was then easily applied to women of color following the decline of traditional eugenic thinking. “Intellectual disability” can also be understood as a social construction – a label that identifies a category of individuals, whose ability to meet the cultural and social expectations of others in their society is compromised by level of measured intelligence which is comparatively lower than that which is deemed “normal” (Carey 2009:4).

Just as socially constructed labels can categorize individuals by race or gender, labels regarding intellectual capacity are similarly unstable – shifting meaning over time and social context. Thus, there has been substantial changes in which characteristics and abilities are described by categorizations such as: “idiot,” “imbecile,” “moron,”

“feeble-minded,” “mental deficient,” “backward,” incompetent,” “mentally retarded,” “mentally handicapped,” “developmentally disabled,” “cognitively disabled,” and “intellectually disabled” (Carey 2009:14). The boundaries of the intellectually disabled category have also shown substantial variability over time. As Allison Carey’s (2009) social history of intellectual disability notes, in 1930 a White House conference designated the feeble-minded population as comprising 15 percent of the general population, using an IQ score of 85 or below as the upper limit. In 1962, the President’s Panel on Mental Retardation identified just 3 percent of the general population as mentally retarded when it located the lower limit of normal intelligence at an IQ score of 70. Given the national populations at each time, the 15-point change in IQ range results in a difference of roughly 30 million people included or excluded from fitting within the group (Carey 2009:14).

Early in the development of eugenic discourse the concept of feeble-mindedness was linked to a racialized conception of intelligence, according to which elite white people were thought to have normal and above normal cognitive ability, while members of other classes, races, and ethnicities were supposedly far more likely to have subnormal cognitive ability. Intelligence, in this framework, defined cognitive ability as the capacity to make contributions, in a manner appropriate to one’s gender, to the good of the nation (Stubblefield 2007:163). The concept of feeble-mindedness also particularly affected women – significantly more women than men were labeled as feeble-minded, committed to state institutions, and sterilized in the first half of the twentieth century, solely due to their sexual behavior (Stubblefield 2007:163). The classification of people

with differing levels of intelligence became the justification for widespread eugenic sterilization of supposedly mentally deficient white people, which between 1950-1980 gave way to the coercive sterilization of black, Puerto Rican, Mexican, and American Indian women.

In North Carolina, this association of women of color with feeble-mindedness and reproductive threat coincided with a complicated history of progressive social policies regarding reproduction. North Carolina's implementation of a public health birth control program in 1937 (which coincided with the establishment of the eugenic sterilization program under the Department of Public Welfare) and state-supported family planning programs during the 1960s (a time when there was a significant increase in eugenic sterilizations and coercive family planning programs) also produced a system in which class and racial background determined whether women had access to reproductive health care; whether they came into contact with state sterilization and birth control programs; how they were treated by the representatives of these programs; and ultimately how they experienced sexuality and reproduction (Schoen 2005). Even the liberalization of the State's abortion law was motivated in part by the hope that access to abortion would lead to a reduction in births among welfare recipients (Schoen 2005:12).

We see in the history of North Carolina, that there is a double-edged quality to the effects of reproductive technologies: they could extend reproductive control to women or they could be used to control women's reproduction. Women gained reproductive control when NC state officials began to cover birth control through NC's public health clinics and when, several decades later state legislators enacted a voluntary sterilization

law and liberalized NC's abortion law. However, birth control, sterilization, and abortion found legislative support partly because supporters used eugenic rhetoric and arguments for population control to promote them. Women lost reproductive autonomy when social workers threatened pregnant women on welfare with sterilization and attempted to tie offers of financial help to the use of contraceptives (Schoen 2005). While privileged women could seek sterilization from the private physicians of their choice, poor women were forced to seek help from public health and welfare departments. In North Carolina, this meant that poor women who wished to be sterilized had to bargain with welfare officials and petition the members of the Eugenics Board, the same people who sought out "undesirables" for eugenic sterilizations whose voluntary nature was at best questionable (2005:78-79).

The reproductive choices of women of color became framed as a threat in a variety of forms: genetic threat – eugenic, economic threat – welfare dependency, cultural/social threat – breakdown of "the family," environmental threat – overpopulation. The uses of "scientific" and professional authority to objectify, classify, and intervene in the lives of women of color justified a strictly limited form of reproductive citizenship among women of color. Discourses of "protection" signified a paternalistic stance within the law and social policy that justified restrictions on reproductive rights. This discourse means the opposite of what it says – frequently the protection offered by the Eugenics Board amounted to a violation of bodily integrity in the form of a major surgery, without medical necessity in lieu of actual protection from rape and incest. Elite social and political networks facilitated the development of the

North Carolina Eugenics Board and protected the powerful from responsibility for the violations of law and policy.

3.3.1 Controlling Images of Women of Color and Ideological Discourses

Controlling images are cultural representations of subordinated groups that shape social behavior toward and from members of such groups. They are a manifestation of the ideological discourses that perpetuate them. This is a bi-directional process. Popular understandings of raced and gendered symbols comprise the form (but not the substance) of controlling images. The substance of such discursive constructions relies upon and reflects the unequal power dynamics of race and gender divisions within society (Sheron-Zachery 2009:4). Controlling images constrain what dominant group members see and believe about marginalized groups. Thus, when policy makers frame social issues and potential policy responses to them, and when such images are internalized, they can profoundly influence the self-perceptions of subordinate group members.

Controlling images are strategic and malleable constructions, which emerge in the context of an oppressive system – they hold such systems in place in three key ways: (1) they secure the material conditions of subordination by drawing power and resistance potential away from oppressed people, and (2) they provide “ideological glue” in the form of shared narratives that naturalize and normalize inequality and oppression as “natural, normal, and inevitable parts of everyday life” (Collins 2000:69); and (3) they provide a “disguise or mystification of objective social relations” (Carby 1987:22) and align popular thought and behavior with the matrix of domination and thereby create

“docile bodies” of their subjects (Collins 2000; Foucault 1977; Beauboeuf-Lafontant 2009:22). For example,

The image of the welfare mother provides ideological justifications for intersecting oppressions of race, gender, and class . . . Creating the controlling image of the welfare mother and stigmatizing her as the cause of her own poverty and that of African American communities shifts the angle of vision away from structural sources of poverty and blames the victim themselves. The image of the welfare mother thus provides ideological justification for the dominant group’s interest in limiting the fertility of Black mothers who are seen as producing too many economically unproductive children (Collins 2000:80).

The constitutive parts of this image are important – “welfare queen” is an image that connotes economic dependency, immorality, and an unfair burden to taxpayers (Lubiano 1992:337). Despite decades of statistical findings to the contrary, many Americans then and now held black woman as synonymous with "welfare queen" as the same thing as undeserving burden. The reproduction and multiplication of which have been the heart of a moral panic surrounding welfare mothers. Whereas in the previous Eugenic Era the ideological discourse of a "feble-minded menace" placed poor white young women as a potential enemy within – a dangerous element within society that needed close supervision and separation from other citizens – the neo-eugenic era cast black women in this role. “The welfare queen represents moral aberration and an economic drain, but the figure’s problematic status becomes all the more threatening once responsibility for the destruction of the American way of life is attributed to it” (Lubiano 1992:338). Throughout the 1950s, politicians, sociologists, and psychiatrists argued that black women did not have the same morals as other women did (Ziegler 2008:348).

American Indian women have had differing ideological discourses that have manifested in the controlling image of an “Indian princess” and “squaw.” According to

Bird (1999), since the eighteenth century, these relatively stable set of stereotypical and objectifying popular images of American Indian women coalesced over time (Bird 1999; Jiwani 2008:140). The "Indian Princess" epitomized by the legend of Pocahontas became interwoven with a developing sense of national identity as a "nonthreatening symbol of White Americans' right to be here . . . willing to sacrifice the happiness, cultural identity, and even her life for the good of the new nation" (Bird 1999:72). The Indian princess became an image of nature, wholesomeness, virginity, and docility (Merskin 2010:353). For southerners in particular, this Pocahontas/princess figure provided a narrative –an origin myth – a justification for the brutality of white dominance, colonization of native lands, and disruption of indigenous cultures (Tilton 1994:130). The classic image of a bare-breasted American Indian princess (whose provocative attire has no legitimate historical reference) flourished in the nineteenth century – a time when Southern cultural mores and gender etiquette would never have condoned the public display of white women depicted as half-naked and sexually available (Green 1988:593; Portman and Herring 2001:189).

The "Squaw" archetype is in some ways similar to the Pocahontas/princess, but even more overtly sexualized and dehumanized. In this figure, American Indian women were represented as: lazy, lacking in the range of emotions attributed to white women, neglectful of children, filthy, prone to drunkenness, and "very libidinous" (Derounian-Stodola and Levernier 1993:69; Valaskasis 2005:134). According to Francis (1995:121), "Where the princess was beautiful, the squaw was ugly, even deformed. Where the princess was virtuous, the squaw was debased, immoral a sexual convenience. Where the

princess was proud, the squaw lived a squalid life of servile toil, mistreated by her men – and openly available to non-Native men.”

4. Historical Background

4.1 Eugenics, Feeble-mindedness, and Buck v. Bell

Eugenics, the science of selective breeding, was developed first by English scientist Francis Galton in 1883. Galton believed that the children of elites were successful in life because these individuals possessed certain hereditary traits associated with prosperity, that they then passed on to their children. These traits constituted “reproductive fitness” which Galton sought to encourage through practices of “positive eugenics” – the encouragement of reproduction among “fit” individuals. “Negative eugenics” was a similar effort to discourage reproduction among the “unfit,” who could be identified as such by observations about an individual or family’s economic status, race, ethnicity, criminality, illegitimacy, intelligence, and sexual deviance. Eugenics attributed social and economic inequalities to biological differences among classes of people.

Between 1900-1920, the US was in the midst of a number of social transformations – immigration, industrialization, women’s suffrage, WWI, labor strikes, the birth control movement, and a Great Migration of rural southern black people to the industrialized cities of the Northeast and Midwest. The widespread popularity of eugenics was largely due to middle-class, white anxiety about possible changes in the established social order, and the fact when implemented, it seemed to demonstrate findings that were to their immediate social benefit. At a time when Progressive Era social reformers were looking to scientists for rational solutions to the massive economic

suffering caused by the Great Depression, the “scientific” basis of eugenics was very appealing.

Funded by wealthy philanthropists like the Rockefellers, Carnegies, and Kelloggs, eugenicists opened research centers, which became the sites of training centers and laboratories for the development of eugenic practices. Eugenicists were particularly concerned with the quality of white motherhood, the elimination of illegitimate births, and the regulation of women’s sexual behaviors. White women who violated the rules of a prevailing Victorian morality were labeled as deviant, as a result of inferior genetics. Such deviance, Goddard theorized, indicated a “feebleminded” and “unfit” woman – whose uncontrolled sexuality could not be rehabilitated, but rather required segregation from “fit” society in state institutions (Carey 2009). In contrast, “fit” women were urged by politicians and eugenic movement leaders to do their part, by bearing children who could take rightful place in the existing racial, ethnic, and class hierarchies.

Intelligence testing gave scientific authority to beliefs in connection between poverty, criminality, and low intelligence and provided a technique for identifying and categorizing those seen as burdens to society - labeling them “feebleminded,” then institutionalizing and sterilizing them (Noll 1994:34). State institutions were created for the segregation of “feebleminded” women, epileptics, prostitutes, alcoholics, and other “defectives” in order to prevent reproduction among the “unfit”– which eugenicists claimed, was occurring at an alarming rate (Radford 1991; Stubblefield 2007; Carey 2009). In spite of massive institutionalization, eugenicists remained concerned about the spread of loose morality among women. Soon, they were advocating for the sterilization

of “defective” citizens in order to promote social betterment. In 1907, Indiana passed the first eugenic statute, which was soon followed by fifteen other states by 1922. Most of these laws were not applied on a wide scale at first, and many were challenged in court on the grounds that they were in violation of due process and equal protection under the law. However, between 1923-1925, twelve more state laws were passed that included procedural safeguards (mandatory hearings, jury trials, and appeals processes). Many of these laws, including North Carolina’s third eugenic statute, which was passed in 1933, were modeled after Virginia’s sterilization statute. Virginia’s law was very carefully scripted by Harry Laughlin (eugenicist, whose sterilization diagrams appear in the Introduction), and was upheld as constitutional by the United States Supreme Court in the landmark case *Buck v. Bell* (1927).

The *Buck v. Bell* case was profoundly important in the history of coercive sterilization because the Supreme Court’s ruling in the case implemented a legal precedent for sterilizing some citizens on the grounds that their rights to procreation and bodily integrity could be sacrificed for the greater good. The case originated at the Virginia State Colony for Epileptics and the Feeble-Minded in Lynchburg, where seventeen-year-old Carrie Buck was committed by her foster parents upon their learning that she was pregnant out of wedlock. Carrie Buck was herself an illegitimate child, born to a mother who was also diagnosed as feeble-minded and institutionalized at the Lynchburg Colony. Her case was selected by Colony administrators from among the institutional population, as an ideal example in order to test the new state law’s constitutionality. The institution’s superintendent petitioned the state to sterilize Carrie

Buck on the basis of sexual immorality (as indicated by her illegitimate pregnancy and family history of feeble-mindedness).

In a ruling that established the supremacy of the State's interest in the reproductive potential of citizens over their rights to reproductive autonomy, and affirmed Virginia's statute, the Supreme Court upheld Carrie Buck's sterilization order.

Writing for the majority, Justice Oliver Wendell Holmes declared:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes . . . Three generations of imbeciles are enough (*Buck v. Bell* 1927:207).

Holmes' reasoning was clearly influenced by eugenic ideology. It was also significant because, in addition to affirming the State's legal claim to limit citizens' rights to procreate, the ruling indicated limited citizens' rights to bodily integrity – rather than proscribing a non-invasive approach to fertility regulation (such as the supervision of a gender segregated institutional setting should have provided), the Court upheld the State's right to impose a procedure (tubal ligation) that permanently removed the biological potential of procreation. Thus, it was Buck's rights to privacy, parenthood, and bodily integrity that were on trial and found to be illegitimate.

On the basis of her diagnosis as feeble-minded, Carrie Buck was seen as unable to give informed consent (a key element and protection in the civil rights of citizenship), as she was deemed lacking in: rationality, independence, economic productivity, and

morality. The threat to the state of her reproductive autonomy was seen as twofold: (1) that she might “sap the strength of the state,” highlighting her dependence on social welfare for care and survival; and (2) that her children might “starve for their imbecility,” an assertion of her failure to meet the economic norms that society associates with citizenship, framed in the paternalistic framework of protection (Carey 2009).

Recent investigations of the *Buck v. Bell* case, conducted most extensively by Paul Lombardo (2008) have turned up some very interesting information. First, although it was not mentioned in the famous court proceedings, one way in which Carrie Buck’s story is typical among women institutionalized at that time was that she was labeled sexually immoral on the basis of an out-of-wedlock pregnancy resulting from rape. When Carrie Buck’s files were reviewed by Stephen J. Gould (1985) (and others) in the 1980s, he found evidence that she was raped by a relative of her foster parents – and that her family had refused to recognize either her victimization or the true origin of her pregnancy. This “blame the victim” pattern is repeated again and again in the meeting minutes I reviewed, and will be discussed below. Second, both Carrie Buck and her daughter, Vivian, were not feebleminded. Third, Emma Buck, Carrie’s mother was married – Carrie was not an illegitimate child after all.

Carrie Buck’s case both typifies the eugenic coercive sterilization practices of the early twentieth century. However, beginning in the 1960s poor women of color in many areas of the United States, like Ruth Nial Cox, became primary targets of involuntary sterilization practices through states’ sponsored and federally funded family-planning programs (Chase 1977:16; Gutiérrez 2003:383; Stern 2005:1128). According to historian

Rebecca Kluchin, the sixties ushered in a period of “neo-eugenic” sterilization programs which focused on poor women of color, and advocated for increased use of female surgical sterilization in federal family planning programs as a cost-effective strategy to reduce the welfare rolls and shrink the population of “unfit” citizens (2004). Changes in civil rights law, popular discourse, and welfare funding early in the 1960s signaled a key turning point – a neo-eugenic transition (Abbott 2001) in the history of state-sponsored sterilization in the U.S. Neo-eugenic discourses represent “the consolidation of a rationale for reproductive surgery that was linked to fears of overpopulation, welfare dependency, and illegitimacy, [which] set the stage for a new era of sterilization abuse” (Stern 2005:1132).

4.2 Citizenship and Race in North Carolina

At the outset it is helpful to contextualize these sterilizations in terms of North Carolina's racial politics of that time –both blacks and Indians were already second-class citizens in many important respects. The violation of reproductive rights and bodily integrity implied in coercive sterilization practices are in common with other manifestations of inferior citizenship both groups were already experiencing in areas of segregation, limited voting rights, and marriage limitations. Before 1965, most hospitals were segregated and many black hospitals had neither the equipment nor the staff to perform a large number of operations. After *Brown v. Board of Education* (1954) and the passage of the Civil Rights Act of 1964, hospitals were gradually desegregated and there was an increase in the proportion of sterilizations administered to black women. These sterilizations reflected eugenic as well as racial concerns.

Following World War II, the federal government enacted a series of policies that have become known as "Termination and Relocation." The objectives of these policies were to settle outstanding claims made by American Indian tribes against the federal government, to dissolve the reservation system, and move American Indians to preselected locations. It was expected that once American Indians had been relocated from reservations to urban locations they would become employed and assimilated into the mainstream of American society.

4.2.1 Lumbee Indians in North Carolina

The 55,000 members of the Lumbee Tribe of North Carolina reside primarily in Robeson, Hoke, Cumberland and Scotland counties. The Lumbee Tribe is the largest tribe in North Carolina, the largest tribe east of the Mississippi River, and the ninth largest in the nation. Pembroke, North Carolina is the economic, educational, cultural and political center of the tribe (Oakley 2005:52; Brayboy 1999). The Lumbee Indians have a unique racial history. Over the past 130 years they have been known as Tuscarora, Croatan, Cherokee, and Siouan. Their geographic home is located mostly around the town of Pembroke, and the land surrounding the Lumber River, in Robeson County North Carolina. The Lumbee have never received funding through the U.S. Bureau of Indian Affairs or the Indian Health Service, although the tribe has been working to obtain true federal recognition since 1888. By virtue of state recognition, they have received aid from other federal programs for Indians.

4.2.1.1 Tri-racial relations

An 1885 law designated the tribe as "Croatan Indians" and granted them an independent school system, separate from whites and blacks. Anthropologists Karen Blu and Gerald Sider spent almost ten years in participant observation as residents of Robeson County between 1966-1975. Their observations about the tri-racial order of Robeson County describe the in-between position of Indians and how whites perceived each of the two groups at that time. Blu describes the ambiguity of racial identity, and how that gave way to inconsistencies in contacts between the races. She notes that whites did not often agree about the "nature of Indians."

. . . Whites often do not agree about the nature of Indians. Some Whites say that Indians are honest and hardworking; others that they are lazy or dishonest . . . a few Whites have stereotypes of Indians, but the stereotypes differ from one White to another. Other Whites seem not to have developed a stereotype at all" (2001:25).

However, Blu observed whites seemed to have a much more clearly defined image of blacks: ". . . Blacks are patient, childlike, and happy with very little in their 'natural' state, but they are temperamentally unstable, easily led astray, and may exhibit vicious, 'unreasonable' tempers" (2001:26). Whites' views of blacks even included room for distinctions between "good ones" and "bad ones" – good blacks were happy and submissive, while bad blacks were classified as "uppity, assertive, and demanding" (Blu 2001:26).

Lowery proposes that the Lumbee challenged the binary racial logic of the Jim Crow South by expressing multifaceted racial identities and insisting on political autonomy. At times this search for self-determination collided and was positioned by the

Jim Crow system. However, at other times the Lumbee sense of "shared peoplehood" openly coincided (and necessitated partnership) with the Jim Crow racial system; yet, at other times defied the racial expectations of white Americans who sought to subject indigenous peoples to the supposedly civilizing influences of American culture.

As early as 1885 the "Croatan Indians," (as the Lumbee were known at that time) sought to gain "control over some of their own affairs" through access to the American education system. According to the prevailing racial logic, the Lumbee chose a strategy of accentuating their Indian-white ancestry, and distancing themselves from Indian-black lineage (Lowery 2010:21). In order to avoid the stigmatization associated with "blackness" in the segregated South, Lumbee Indians "adopt[ed] segregation to affirm [their] distinctiveness," in essence seeking education and the prospects of socioeconomic opportunity, mobility, and political autonomy at the cost of conforming to a racial hierarchy that forever complicated the internal dynamics of the Lumbee peoples (Lowery 2010:31).

In 1939, Sociologist Guy Benton Johnson who spent time during the 1930s researching in Robeson County noted, "the very existence of such a group is something of an anachronism" (Johnson 1939:518). According to Johnson, whites actively sought to hold:

the Indian population at the bottom of the social hierarchy along with blacks. The Indian is restricted to his own schools, and he is forbidden to marry a white person. He is supposed not to enter a white man's front door. He is not addressed as 'mister' by white people and if he attends a theatre, he has to choose between one which provides a three-way segregation and one which seats him with Negroes. There is not an eating place in the county which permits him to enter the front door and eat with the white people. In numerous subtle ways, by

glances, gestures, and intonations, he is reminded . . . of the unmentionable stigma which attaches to him (1939:518).

4.2.3 Legal Distinctions

Over time, American Indians in North Carolina were grouped along with blacks into an inferior category of citizenship. This shows up most clearly in the limitation of some of the most fundamental rights to citizenship – the right to vote, the right to bear arms, marriage restrictions, and public schools. The 1776 North Carolina state constitution did not specifically prohibit nonwhite free persons from voting, and in some counties, including Robeson, nonwhites apparently voted and exercised other aspects of citizenship. This local custom ended in 1835. Hereafter, they were excluded from the right of franchise as the new law stated, "no free negro, free mulatto, or free person of mixed blood, descended from negro ancestors to the fourth generation, inclusive (though one ancestor of each generation may have been a white person) shall vote for members of the Senate or House of Commons" (State of North Carolina 1835: Article 3, Clause 3). Five years later the North Carolina General Assembly passed a law which made it illegal for free persons of color to own or carry weapons, unless they received a special license to do so (Dial and Eliades 1996:45). Indians responded with resistance to this racial classification, by distancing themselves from any mixed-race ancestry (both black and white), and any social or economic association with blacks - whose mutual association as "free persons of color" they increasingly abhorred (Lowery 2010:15). Lumbees unsuccessfully challenged the restrictions imposed by their classifications as "free

persons of color” in several lawsuits including, *State v. Oxendine* (1837) and *State v. Noel Locklear* (1853).

In 1854 the North Carolina General Assembly enacted a law declaring, "all marriages since the 8th day of January, 1839, and all marriages in the future between a white person and a free negro, or free person of color, to the third generation, shall be void" (North Carolina Code Section 1, Chapter 254).

School segregation in North Carolina was legally established by a set of amendments to the state constitution passed in 1875. Although the law mandated that black and white students attend separate schools, it did not specify which schools Indian students should attend. In Robeson County Indian children were excluded from white schools, and they refused to attend black schools. Attending black schools would have undermined their distinctiveness as Indians and encouraged whites to classify them, legally and socially, as “colored.” In 1885, the North Carolina state legislature passed a law that recognized Robeson County Indians as “Croatan” and provided for separate Indian schools. With schools of their own, Indians proceeded to express their separate identity through education.

Separate Indian schools were established in 1887 and two years later an amendment specified that "all children of the negro race to the fourth generation" were excluded from them. Furthermore, the law declared, “all marriages between an Indian and a Negro or between an Indian and a person of Negro descent to the third generation, inclusive, shall be utterly void: *Provided*, that the act shall apply only to the Croatan Indians” (North Carolina Code Section 1, Chapter 254).

4.2.4 Colorism

According to Johnson, Indians of lighter complexion, "the whiter Indians," appeared less concerned with distancing themselves from identification with blacks.

While they resent any attacks on the "purity" of the Indians as a group, they feel less than the darker people the necessity for personal justification. They travel about a good deal and find that they are taken for white or for Indian-white mixtures. Their very appearance is a badge of security. Indeed, they feel that if all of the Indians were like them there would be no problem. They blame the dark Indians for the stigma attached to the group and they hate them for it, but their hatred must be kept below the surface. The darker Indians, on the other hand, are apt to be more sensitive on the matter of physical features. Their chances for unpleasant experiences are, of course, greater, and they feel more keenly the impulse to "whiten" their ancestry. Furthermore, they are jealous of the whiter Indians. Thus, there is an incipient but never openly admitted cleavage between the darker Indians and the lighter ones (Johnson 1939:523).

But adopting segregation to preserve distinctiveness proved to be a double-edged sword—excluding blacks and whites from their community assured Indians' control over their own affairs, but it also conceded whites' power to govern race relations. Indians determined their social boundaries according to what whites were willing to accept. In 1956, when Congress recognized the Lumbees under that name but accorded them no benefits or services normally given to recognized tribes. Rather than unambiguously affirm Indian identity, this legislation offered a simultaneous inclusion and exclusion, making Indians subject citizens but still affirming their inferior status.

4.2.5 Sterilization, Segregation, and Indian Identity

In a 2003 article for the *Winston-Salem Journal*, journalist John Railey described a case from some of the archival records he had recently been given access to. The 1938 case involved two delinquent girls recommended by Robeson County for admission at

Samarcand Manor: Ellen Brooks aged fourteen, and Lucy Brooks who was fifteen.

Social workers with the Robeson County Department of Public Welfare described the girls as sexually active and of borderline intelligence. State Psychologist Harry Bice's recommendation for Ellen was clear: "since the girl is mentally deficient and persistent in delinquency, she should be sterilized." However, these girls were Lumbee Indians and therefore not permitted to attend Samarcand or any other institution in the state. A 1933 law required that Indians be admitted to Samarcand along with a similar training school for boys, but the Jim Crow South was not a place where such changes happened quickly or easily. Bice's report to the State Board about the admissions controversy described fourteen-year-old Ellen's dark color and broad nose. These were physical characteristics, which he believed complicated her claims to be "anything but a Negro" (quoted in Railey 2003). Furthermore, Ellen was ". . . reported to have kept company with a boy that is recognized as a Negro." The language here suggests that the boy's racial identity was not a settled matter either.

Given these considerations, Bice chose not to send Ellen to Samarcand but instead placed her as a domestic worker in the home of a suitable family – "in color, they are much like the girl," wrote Bice. Older sister, Lucy was admitted to Samarcand against the protest of School Superintendent Grace Robson who cautioning if it would be possible for "her to make a proper adjustment in a school with white girls" (Railey 2003). Although it is not clear from the records if either girl was actually sterilized, according to the psychologist's recommendations, the records do indicate that the Board addressed considerations of Indian perspectives on sterilization, and that it was common practice at

Samarcand during this time to require the operation for discharge from the institution (Cahn 2007:173). The Brooks girls' situation was considered in light of traditional eugenic concerns regarding the classification and protection of discrete racial boundaries, the prevention of “dangerous” sexual behaviors among young working-class women in particular, and the question of what to do with those members of society who did not fit or could not be trusted to uphold the racial, class, gender, and sexual mores advanced through eugenic ideology.

If either or both of the Brooks girls were ordered to undergo sterilization, their identification as Lumbee would not have showed up in the official records of the Eugenics Board's activities. The first time “Other” is present as an option beyond white and Negro as a category of identity was 1948 long after this case occurred (EBNC-BR 1948-1950:26). The question of Indian identity was ultimately resolved by Bice as a matter of temporary relevance, as in his understanding “[w]e have failed to secure any evidence that the Indians have hope of preserving their own race as a distinct one or of preserving any item of their culture” (Railey 2003). According to records of the North Carolina Eugenics Board, between 1948 and 1974 over 50 Indians were sterilized by state order.¹

¹ This number is likely an underestimate because: (1) the racial identities for each case were not self reported and because of the one-drop rule it is likely that at least some Indians were identified as black as per custom; (2) as will be discussed further, it is clear that the Eugenics Board was not the only way women experienced coercive sterilization during the time under study.

4.2.6 North Carolina Welfare History and Eugenics

The transformation of North Carolina's eugenic measures from institutional segregation to a more comprehensive program that included eugenic sterilization reflected similar patterns across the nation. Between 1910 and 1930, twenty-four states passed eugenic sterilization bills (see Figure 5). In general, states turned to eugenic sterilization after practicing institutional segregation for some time. This chronology reflected the increasing acceptance of eugenics ideology, coinciding with increasing concerns about immigrant populations and white "race suicide." Eugenic segregation, however, remained more politically palatable than involuntary sterilization. After the 1930s sterilization would take off, however, with the help of eager public welfare reformers, and their army of state social workers, social science research, the work of the Human Betterment League of North Carolina, and, most importantly, with the institutionalization of sterilization through the advent of the North Carolina Eugenics Board.



Figure 5: States with Sterilization Laws 1910-1940 (Birthright 1947)

4.2.6.1 Social reformers – the role of Ellen Winston

North Carolina's early welfare and eugenics history is a testament to the legacy of early female social welfare clubwomen and reformers (Larson 1995a, 1995b; Krome-Lukens 2009). This legacy could be said to have originated with Kate Burr Johnson who took office as Commissioner of Public Welfare in 1921. During the 1920s social workers in North Carolina and nationally relied increasingly on methods of casework and developed a new emphasis on professionalization that set them apart from the clubwomen also active at that time. Under Johnson's direction the Board began to advocate eugenic sterilization and stricter marriage laws. In her 1922 report to the state legislature, Kate Burr Johnson declared that, "the undesirable elements of society, the delinquent, the defective and the dependent, are parasites—voluntary or involuntary—on the body social and politic" (NCBCPW-BR 1922:10). A recent analysis of this time conducted by Jennifer Krome-Lukens proposes that it was the Progressive spirit of the era which drove Johnson and other public welfare workers to help those less fortunate, and to prevent such people from having children, either through sexual sterilization operations or extended periods of institutionalization.

Kate Burr Johnson left North Carolina in 1930 and the successor as Commissioner of Public Welfare was Annie Bost, who was also a dedicated clubwoman and reformer. Bost encouraged the Federation of Women's Clubs to use her as a resource; the clubs in turn contributed to support her work. As Commissioner of the Board of Charities and Public Welfare, Bost had the additional responsibility of

administering the state's new eugenic sterilization program. Bost expressed support for sterilization as a tool for preventing the reproduction of the feeble-minded and mentally defective. In 1932, she wrote that "[t]he population of our institutions will continue to increase until we do more to prevent the mating of feeble-minded and diseased people who bring their feeble-minded and diseased progeny into the world to fill up Caswell and other like institutions" (quoted in Krome-Lukens 2009:42).

Like her predecessors, Ellen Winston, North Carolina's Commissioner of Public Welfare from 1944-1961 and Chair of the Eugenics Board, sought to create close ties between welfare policy administration, academic social science institutes and researchers, and social workers. Ellen Winston was not the sort of person one might typically imagine serving nearly twenty years at the helm of one of the largest programs of coercive eugenic sterilization in history. She personally identified as a liberal democrat, and is widely remembered and admired as one of the most important figures in progressive social welfare history (Winston 1974:28; Ware and Braukman 2004; Mittelstadt 2005:6; Peebles-Wilkins 2011).

At a time of nearly complete racial segregation and exclusion of black professionals from Southern welfare administration, Ellen Winston encouraged the county departments to recruit, train, and hire more black social workers, and sought to minimize the effects of racial discrimination interfered in the distribution of benefits (Winston 1974:17). Despite occasional difficulties with North Carolina Governor Luther Hodges – who was deeply concerned with the growing cost of public welfare – Winston was a staunch defender of AFDC programs (Winston 1974:37). She felt that one of the

major problems with the program was that it should be available to more people. Specifically, she advocated for the inclusion of a provision allowing families to receive funds in the case of the father's unemployment, rather than limiting support to single parent families (Winston 1974:43). By the late 1950s, this was not a popular position, as public opinion would become increasingly critical of unwed mothers receiving Aid to Dependent Children funds over the course of the time period 1950-1964 (Dobelstein 1973:232).

Two pieces of legislation were enacted by the 1959 General Assembly which sought to increase local administrative authority over AFDC: House Bill 631 (Chapter 1210. Session Laws, 1959) required the State Board of Public Welfare to report the names of all mothers who were receiving AFDC funds to local county solicitors. The county solicitor was thereby authorized to investigate each case to determine whether these mothers were "properly" caring for their children, and county commissioners were granted authority to initiate legal actions against mothers who were not deemed to be giving their children inadequate care. House Bill 678 (Chapter 668, Session Laws, 1959) required the local superintendents of public welfare to supervise AFDC recipients' use of assistance funds. The stated purpose of this legislation was to insure that the funds were being spent to benefit the children (Dobelstein 1973:234). Push for the 1959 legislation came from some of the more conservative counties and those with limited tax revenues (in North Carolina welfare funds were supplied by a combination of federal, state, and county contributions – and some poorer counties struggled to pay their share which was

half of the non-federal share of welfare grants) who said that the welfare grants were too high (Winston 1974:40).

Winston staunchly opposed the 1959 laws: "There is a long history in social welfare philosophy and practice, based upon supportive findings from sociology, psychology, and psychiatry that a social welfare agency seeks to help people through sound case work rather than an authoritarian approach" (quoted in Dobelstein 1973:232). The county commissioners, welfare superintendents, and county welfare boards wanted the legislation enforced, Ellen Winston resisted and sought the support of the national office of the Department of Health, Education, and Welfare – the state was then notified that if the legislation were enforced matching funds could not be provided under the Social Security Act. However, after Ellen Winston publicized conflicts with federal aid policy HB 678, it was never implemented (Winston 1974).

Social scientists were an important facilitating factor in the implementation of a neo-eugenic sterilization policy as part of an expanding welfare state in the Post-World War II era. As a result, the influence of contemporary social scientific ideas on public policy and social work practice became increasingly important. Ellen Winston's Chicago School training shaped her perspective and informed her leadership of North Carolina's welfare programs. Following graduate study in Chicago, Winston published several widely cited articles directly challenging the moral panic regarding the supposed dangers of widespread genetic transmission of feeble-mindedness by empirically refuting the validity of such popular misconceptions regarding an increase of mental disorders resulting from urbanization, and purported skyrocketing rates of mental illness in the

United States more generally (Ogburn and Winston 1929; Winston 1935; Mizruchi and Naugle 1960:42).

Prior to her state appointment, Winston was Professor and Head of the Department of Sociology at Meredith College 1940-1944, and her network of academic contacts also was a key component of her professional agenda (Dobelstein 1973:157). She attended the University of Chicago in 1927 during "the heyday of Park and Burgess" (Winston 1974:7) and was taken under the wing of William Ogburn (Winston 1974:7). She was a prolific academic author – her most well-known works included a co-authored article with William Ogburn examining the frequency and probability of mental disease (Ogburn and Winston 1929), research support for Richard Sterner's (1943) in a well respected analysis of the economic and public welfare dimensions of racial inequality in the US, *The Negro's Share*, and the Myrdal study (Winston 1974:12). Winston was close friends with prominent University of North Carolina sociologists Howard Odum and Guy Benton Johnson, and historian Guion Griffis Johnson and frequently sought their advice (Winston 1974:17). Her connections to academic research conducted at University of North Carolina-Chapel Hill (UNC-CH), is particularly, connected to her work with the Board.

For example, in 1950 the American Public Welfare Association (APWA) requested that the Institute for Research in Social Science (IRSS) of the University of North Carolina at Chapel Hill conduct a national survey and program evaluation of the ten-year old federal Aid to Dependent Children Program (ADC). According to a joint statement issued by the APWA and the IRSS, the study's goal was, "to determine the

extent to which the program has fulfilled the original objectives as contained in the Social Security Act and the relative extent to which needs of children are being met by this program throughout the United States” (“Investigate Children’s Aid” 1950). National survey data regarding families receiving ADC funds was drawn from records of the Federal Security Agency, city and county welfare directors, and child welfare caseworkers. Ellen Winston was chairperson of an IRSS special advisory commission, which was established to guide the project. A statement from the director of the Institute for Social Research indicates the collaborative goal of the project. He wrote: “. . . we shall bring together the advice and counsel of administrators in the field, on the one hand, and the research technicians on the other. We are making an interdisciplinary approach to this problem by combining studies in sociology, economics, and social work” (“Investigate Children’s Aid” 1950).

Ellen Winston was also a highly effective bureaucratic administrator with a professional philosophy centered on professionalization, centralization, and strong leadership through the state office, and a particular skill at building political support for her agenda at all levels of government (Dobelstein 1973; Winston 1974:42). As Commissioner of Public Welfare, she established increased state control over North Carolina's county-based public aid programs and put into place new statewide administrative processes and procedures including more regular methods of communication between the county commissioners and the state agency that greatly improved the process of public welfare activities in the state overall (Ware and Braukman 2004:692).

Between 1944-1955, she initiated a massive recruitment campaign among the schools of social work located in the Southeast (Dobelstein 1973:169). In the interest of increasing the labor supply needed for growing the state's public welfare administration, Winston wrote letters to schools inquiring about their graduates, offered summer jobs to social welfare students, created "learning laboratories" within welfare agencies to attract students from local universities (University of North Carolina in particular) who were completing social work training, and obtained scholarship funds from the U.S. Children's Bureau to offer scholarships to North Carolina students who committed to work in public welfare in North Carolina after graduation in social work school (Dobelstein 1973:167-169).

As a result of these extensive recruitment efforts in the early years of her tenure as Commissioner of Public Welfare, she is credited with increasing the number of state and county welfare workers in the state increased almost seven-fold between 1936 and 1956 – growing from 187 in 1936, to 1291 in 1956 (Dobelstein 1973:169). Winston also made substantial improvements in the efficiency and communication of the state's public welfare programs by garnering local interest in public welfare frequent public appearances in local communities, developing a range of advisory groups who contributed to administrative policy making, and by involving local public welfare leaders in leadership roles in state and national public welfare programs (Dobelstein 1973:258).

Winston was active in the State Federation of Women's Clubs, AAUW, PTA, the Business and Professional Women's Organization, the North Carolina Conference of

Social Service North Carolina Governor's Commission on the status of Women, the American Public Welfare Association (Mittelstadt 2005:30; Winston 1974:15). She also had important academic connections, and this network of personal and professional connections was "very useful" in her work as State Commissioner of Welfare because according to Winston, "one could promote one's interests in several organizations and this tended to give increased support" (Winston 1974:15)..

4.2.6.2 Human Betterment League of North Carolina

Even as mainstream science was denouncing explicitly biological theories of race, the influence of the Eugenics Movement was expanding in North Carolina with help from the Human Betterment League (also known as the Human Betterment Foundation and Human Betterment Association). Shortly after World War II, Clarence J. Gamble – heir of the Proctor and Gamble soap company fortune, Harvard-trained geneticist, and philanthropic advocate of birth control and eugenics – became aware of the high rejection rate of military draftees from North Carolina deemed unfit for service due to mental disease or deficiency during the war (Davis 1969:3). Gamble had taken an interest in North Carolina before. From 1937 to 1941 his financial support backed the state health department's distribution of contraceptives through the county health care system. With Gamble's help, North Carolina became the first state in the nation to offer birth control to its poor (Franks 2005:116). However, in return for this sizeable investment Gamble required that the program promote a new form of birth control – a foam powder, which he had recently developed and wanted to test. His goal was to develop the "ideal

contraceptive" that could be used by those who were "least able physically and economically to bear children" (Schoen 1997:98).

In response to the news of North Carolina's high draftee rejection rate, Gamble sent Miss Else Wulkop, a medical social worker, to the state to investigate the cause. Wulkop worked with Dr. A. M. Jordan, an educational psychologist at the University of North Carolina, to test the intelligence level of the school children of a rural county (Orange). The study's test results reported a high incidence of mental problems, both illness and deficiency. This prompted James G. Hanes, then president of the Hanes Hosiery Corporation, to provide financial support for a similar study to be conducted in an urban county (Forsyth) – again they found high rates of mental illness and deficiency (Davis 1969:4).

Two principles guided Clarence Gamble in his work with birth control: a firm belief in eugenics – he promoted contraceptives to reduce the reproduction of the poor, and also offered cash prizes to those Harvard College alumni with the largest number of children – and a desire to stretch his philanthropic financial contributions as far as possible. Gamble believed that the differential fertility between classes was a fundamental source of social disorder – birth control and sterilization were solutions. He supported both eugenic sterilization and the development of simple contraceptive methods (Schoen 2005:34). Gamble argued explicitly for the need to control the reproduction of poor African Americans: “The mass of Negroes, particularly in the South, still breed carelessly and disastrously, with the result that the increase among

Negroes, even more than among whites, is from that portion of the population least intelligent and fit, and least able to rear children properly” (Schoen 2005:47).

Gamble, Hanes and Wulkop formed the Human Betterment League of North Carolina (HBL-NC hereafter) in 1947 as part of a larger national federation of advocacy organizations that sought to promote the study and prevention of mental deficiency through the implementation of eugenic sterilization procedures. From their national headquarters in New York the Human Betterment Foundation (HBF, hereafter) distributed a wide range of pro-sterilization materials to physicians, social agencies, and hospitals. Additionally, the HBF provided doctor referral services, connections to local social welfare agencies, and financial aid programs to cover the cost of sterilization procedures (Cox 1962). HBL-NC promoted eugenic sterilization through a massive public relations campaign, which included the production and distribution of various brochures and pamphlets, networking and correspondence with welfare officials and state institutional staff, newspaper articles and letters to the editor, and eventually films. The League also employed specifically targeted mailings: sending pamphlets, articles, and recent academic findings about sterilization to "upper class university faculty members, graduate students, physicians, nurses, ministers, public officials, welfare workers and civic leaders" (Begos 2002a). Organizational records boast that in the first ten years of its existence the league had mailed over 575,000 pieces of literature across the state.

C. Nash Herndon was the third president of HBL-NC (1955-1959) (see Table 6 for a list of HBL-NC presidents). Herndon played an instrumental role in growth of involuntary sterilization in North Carolina by bringing together: the financial resources of

private philanthropists, the political agenda and influence of the eugenics movement, the authority of science and academia, and a personal network that linked him to people in positions of power within the state welfare administration (Sharav 2005). In 1935, Herndon was named president of the American Eugenics Society, a position he would hold for twenty years (Deaver 2002). Herndon founded the Department of Medical Genetics at the Bowman Gray School of Medicine at Wake Forest University (which is now part of the Wake Forest University Baptist Medical Center) located in Winston-Salem (Forsyth County's largest city and county seat) in 1941. Two years later, along with Dr. J. Roy Hege, Forsyth County's Superintendent of Health, C. Nash Herndon launched and directed an independent eugenic sterilization program which operated separately from the state Eugenics Board. This Forsyth County program operated between 1943 and the mid-1950s, and is believed to have administered dozens of operations outside of the state laws which required Eugenics Board approval of such surgeries until 1963 (Deaver 2003). Herndon's annual report to the Department of Medical Genetics described the program:

In September 1943, a project aimed at eugenic improvement of the population of Forsyth County was begun in co-operation with Dr. J. Roy Hege, Forsyth County Health Officer. This project consists of a gradual, but systematic effort to eliminate certain genetically unfit strains from the local population. About thirty operations for sterilization have been performed (quoted in Deaver 2002)

Superintendent Hege was also affiliated as a practicing physician at Bowman - Gray. Herndon's annual report indicated extensive collaboration between the Department of Medical Genetics at Bowman Gray, county level administrators (J. Roy Hege in particular), and elected officials. "The expense of this project has been borne by

the Forsyth County Commissioners and necessary operations have been performed at the Forsyth County Hospital. Genetic work-ups and medical affidavits have been supplied by this department.” Herndon later described the university-county collaboration more explicitly

I was at the time also director of outpatient services at North Carolina Baptist Hospital. We would see the targeted parents and children there. I.Q. tests were run on all the children in the Winston-Salem public school system. Only the ones who scored really low were targeted for sterilization, the real bottom of the barrel, like below 70 (Goliszek 2003:91).

At a 1949 meeting of the Human Betterment Association, Herndon enthusiastically reported the success of Forsyth’s program indicating that he “had himself performed six operations in the past week and told of the very advanced policy of Baptist Hospital” (Human Betterment Association 1949). Dr. Herndon’s work in Forsyth County was generously funded by two grants offered between 1950-1951 by philanthropist Wickliffe Draper, which together totaled \$140,000.00. This sum, when adjusted for inflation, is equivalent to \$1,219,857.69 in 2011 dollars (Bureau of Labor Statistics). The grant funding was extended through Bowman Gray School of Medicine with specific conditions attached – the school agreed: (1) not to officially advocate interracial marriage; (2) to consider teaching about therapeutic sterilization; and (3) not to dispute the theory of overpopulation leading to food shortages (Deaver 2002). These conditions are illustrative of the shifting imperatives underlying support for coercive sterilization practices between traditional eugenics and a neo-eugenic era: racialized agenda, active promotion of sterilization for non-institutionalized population, and connection with liberal discourses concerned with global overpopulation.

**Table 6: Presidents of the North Carolina Human Betterment League,
1947-1977**

Year	President	Occupation
1947-1951	George H. Lawrence	Buncombe County Superintendent of Public Health
1952-1954	Nat S. Crews	County Attorney, Winston-Salem, NC
1955-1959	C. Nash Herndon	Chair of the Department of Medical Genetics at the Bowman Gray School of Medicine at Wake Forest University, and Head of the Forsyth County Sterilization Program
1960-1963	Mrs. Norman T. Buddine	Winston-Salem Clubwoman and wife of Chief Engineer for R.J. Reynolds.
1964-1965	Nat S. Crews	(see above)
1966-1967	Dr. Guion Johnson	Historian, Odum Institute Researcher University of North Carolina, Chapel Hill. Myrdal study collaborator and wife of University of North Carolina Sociology Professor James Johnson.
1968-1972	John McDowell	Director, Forsyth County Department of Public Welfare, Winston-Salem, N.C.
1973-1975	Dr. Harold O. Goodman	Professor of Medical Genetics, Associate Dean for Biomedical Graduate Studies at Bowman Gray School of Medicine, Winston-Salem, NC
1975-1976	Herbert C. Bradshaw	Associate Editor of the Durham Morning Sun
1977-	Dr. Charles H Hendricks	Professor and Chair of the Department of Obstetrics and Gynecology at University of North Carolina, Chapel Hill.

Source: HBL-NC 1977

4.2.6.3 North Carolina Eugenics Board – creation

The Supreme Court's ruling in *Buck v. Bell* (1927) established the constitutional authority of any state in the nation to pass compulsory sterilization legislation. However, in practice by the starting point of the time period examined here, 1950, eugenics was largely a southern phenomenon. After World War II, the number of sterilizations performed in most areas of the country began a slow decline. In contrast, southern states – such as Virginia, Georgia, North Carolina, and South Carolina – displayed an opposite trend, ordering sterilization operations with increasing frequency. North Carolina's history of eugenic sterilization is unique for several reasons, including: (1) the authorization of large numbers of non-institutional sterilizations; (2) both doctors and social workers could present petitions for sterilization; and (3) its longevity.

At the center of North Carolina's massive eugenic sterilization program, which ordered procedures for 7,528 people in total, was the North Carolina Eugenics Board (Akin 2011). The North Carolina General Assembly of 1929 authorized the governing body or executive head of any penal or charitable public institution to order the sterilization of any patient or inmate when such an operation was deemed to be in the best interest of an individual or for the public good. Additionally, the county boards of commissioners were authorized to order sterilization at public expense of any mentally defective or feebleminded resident upon receiving a petition from the individual's next of kin or legal guardian. Each order for sterilization was required to be reviewed and approved by the commissioner of the Board of Charities and Public Welfare, the Secretary of the State Board of Health, and the chief medical officers of any two state

institutions for the feeble-minded or insane. A medical and family history of the patient or inmate was attached to the order to provide information and guidance for the reviewers.

But in 1932, a lawsuit resulted in the redrafting of the state sterilization statute and the formalization of sterilization procedures. The new law, introduced by a member of the Board of Directors of Caswell Training School, established a state Eugenics Board composed of the Commissioner of Public Welfare, the Secretary of the State Board of Health, the Chief Medical Officers of the State Hospital at Raleigh and of an institution of the feeble-minded or insane, and the State Attorney General. Housed under the Department of Public Welfare, the Board received petitions for sterilization from the states' penal and charitable institutions, or county superintendents of public welfare, and voted on the authorization of these petitions.

The Eugenics Board was first organized in July 1933, under the provision of North Carolina's third sterilization law, which authorized sterilization on the basis of mental disease, "feeble-mindedness," or epilepsy (N.C. Gen. Stat. § 35-7-36). This law was carefully crafted following Virginia's law upheld in *Buck v. Bell*, in order to ensure its constitutionality. North Carolina had two previous statutes which were struck down because they lacked the provision of an appeal hearing: Chapter 281 – "An Act to Benefit the Moral, Mental, or Physical Conditions of Inmates of Penal and Charitable Institutions," was passed in 1919 (there are no documented sterilizations under this law); and the 1929 Act: "An Act to Provide for the Sterilization of the Mentally Defective and Feeble-Minded Inmates of Charitable and Penal Institutions of the State of North Carolina" (there were 49 sterilizations ordered under this law) (Woodside 1950:9). This

law stood until 1977, however there were several amendments that facilitated the work of the Eugenics Board. In 1937, there was a provision for the temporary admission of persons to the state institutions for purpose of sterilization.

Under the 1933 law, the governing body of any state-funded institution, the board of commissioners of all county welfare departments, and the Eugenics Board were directed to act when there was indication that sterilization would be for the “best interests, mental, moral, or physical of the individual concerned; or for the public good; or where children who might be born would have a tendency to serious physical mental or nervous disease or deficiency.” Sterilizations were performed, according to the Eugenics Board’s biannual reports, for the public good. The Board stressed sterilization’s positive aspects and avoided calling sterilization patients (or victims) criminals or delinquents. An effort was made, according to the Board’s reports, to remove any negative stigma from the sterilized. The Eugenics Board believed sterilizations improved the lives of those sterilized. According to the Board, the procedures were not punishments. Sterilization procedures ordered by the Eugenics Board were funded in two ways. For non-institutionalized individuals the surgeon’s fee was paid by the County where the individual resided; for patients in state institutions the institution was required to pay the cost of completing the procedure.

The Eugenics Board was not technically allowed to order sterilizations on the basis of physical or social grounds, or for any other cases of potentially transmissible physical defects (hereditary blindness, hemophilia, deafness, etc.). The mental conditions for which the Board was authorized to order sterilization included “feble-mindedness,”

which was defined by the board as an IQ score less than 70. However, in practice the Board occasionally ordered sterilization in cases where there was an IQ score greater than 70, if they also observed what they considered to be the presence of additional conditions such as psychopathy, or neurotic symptomatology.

In many situations, these exceptions were based more on social or economic factors, than on the presence of additional psychological considerations. For example, Mary, a mother of seven children, was pregnant again and although she scored a 71 on the IQ exam she was given by state psychologist, her petition was still considered within the Board's jurisdiction. Her case summary read, "Her home is very inadequate with three small rooms in poor repair . . . the oldest sister in the home has an IQ of 55" (EBNC-MM Dec.1964). This description is interesting as it moves toward the new cultural and economic paradigm of the neo-eugenics era, while clearly still referencing the family history concerns of earlier eugenic thinking. Despite the stated intention behind North Carolina's sterilization law – to restrict fertility among certain individuals in order to prevent the transmission of mental deficiencies, the Board's belief in the genetic transmission of feeble-mindedness had long dissipated before the peak years in North Carolina. The 1946-1948 Biennial Report quotes a March 1930 publication of Eugenics:

We do not know precisely to what extent mental defects and psychopathic conditions are inherited. But we do know that on the whole, feeble-minded and insane persons who are permitted to propagate their kind, raise families in a most unfavorable home environment (EBNC-BR 1946-1948:9)

4.2.6.4 Eugenics Board practices and process – importance of social workers

The 1929 and 1933 sterilization laws and the creation of the Eugenics Board opened the gates for the official involvement of numerous social workers – mostly women – in the State’s sterilization programs. North Carolina was the only state in the nation to extend the power of filing sterilization petitions to social workers; its eugenic sterilization program represented more clearly than any other the state interest in sterilization. During the 1930s, thirty-five percent of sterilization petitions came from such sources, demonstrating the readiness with which some social workers embraced eugenics as a pragmatic solution to overburdened welfare departments, or even as an appealing ideology.

Female social workers strongly supported the sterilization programs. As the bulk of the State’s corps of social workers, they were responsible for the vast majority of non-institutional sterilizations, most of which targeted women. The language of sterilization petitions suggests that field workers and their superiors were more concerned with the economic costs of caring for the feebleminded and their offspring—and in later decades, caring for welfare recipients and their offspring—than with helping clients control their reproductive lives or, conversely, with purely eugenic ideas (Krome-Lukens 2009). More than racism though, their actions:

Demonstrate the dangers of acting uncritically on the advise of even well-intentioned social or scientific experts. Their political achievements and the challenges they faced reveal the extent and limits of their power within the state – as well as their power relative to the clients of the state’s welfare system. By gaining control over some aspects of the state’s welfare bureaucracy, women social reformers and their community allies brought the force of the state power to back their notions of appropriate behavior for poor and mentally retarded citizens. As a result, poor women who sought social support opened themselves to the

possibility of stigmatization, institutionalization, or sterilization. Eugenics-inspired policies gave reformers more tools to mold society. Yet the cost of the power they claimed for themselves was deducted from the autonomy of their clients (Krome-Lukens 2009:34).

Petitions from county welfare departments followed interactions with social workers in a variety of programs, including: maternal and infant care, immunization clinics, venereal disease control programs, public health nursing and education, etc. Each petition for sterilization included five required elements. First, a statement describing the mental and physical condition of the person, including a diagnosis, and supporting documentation of mental illness (physicians or psychiatrist report) or feeble-mindedness (results of an IQ test). For institutional cases, the description and diagnostic information came from institutional staff. In non-institutional cases psychological tests were conducted by professionals in one of three settings: (1) the two full-time clinical psychologists employed by the State Board of Welfare; (2) by one of eight consultant psychologists located in areas throughout the state; or (3) the psychiatric departments of teaching hospitals or child guidance and mental hygiene clinics.

Second, a social history provided by the county departments of welfare was provided. This listed information included the person's home life environment, any legal history, and the attitude toward sterilization of the person and his or her next of kin for the proposal for operation. Third, a consent form signed by the person to be sterilized, except if the individual is: under 21; an inmate of one of the five mental institutions; or has been declared mentally unsound by a court of competent jurisdiction. If any of these conditions precluded the consent of the individual, the form was signed by: the person's spouse, parent, next-of-kin or guardian; or a guardian ad litem appointed by the court for

the purpose of representing the person's interests in the Eugenics Board Proceedings. Fourth, a statement indicating the type of surgery to be performed (sterilization or asexualization), as well as the name and address of the surgeon who was assigned to perform the operation. Finally, if the required consents were not given, the petitioner (either a superintendent of a state institution, or a superintendent of a county public welfare department) would then schedule a hearing.

At least 20 days prior to the scheduled hearing date, a copy of the petition (omitting the detailed social history information), and notice of the time and place set for the hearing, was then served upon the person to be sterilized. At the hearing, the case and supporting information was presented to the Board, which then approved or denied the petition. If an individual who was ordered to be sterilized did not agree with the decision, they had a legal right of appeal to the Superior Court of their county of residence (N.C. Gen. Stat. § 35-7-48). In reality, only 4 percent of all Eugenics Board cases went to a hearing – of these cases, most were not protesting the Board's order for sterilization, but rather were situations in which the legal guardian could not be located (Schoen 2005:282). The Eugenics Board approved applications for four types of sterilization: vasectomy and castration for men and salpingectomy, and ovariectomy for women. Figure 6 maps out the actors and steps involved in the petition process.

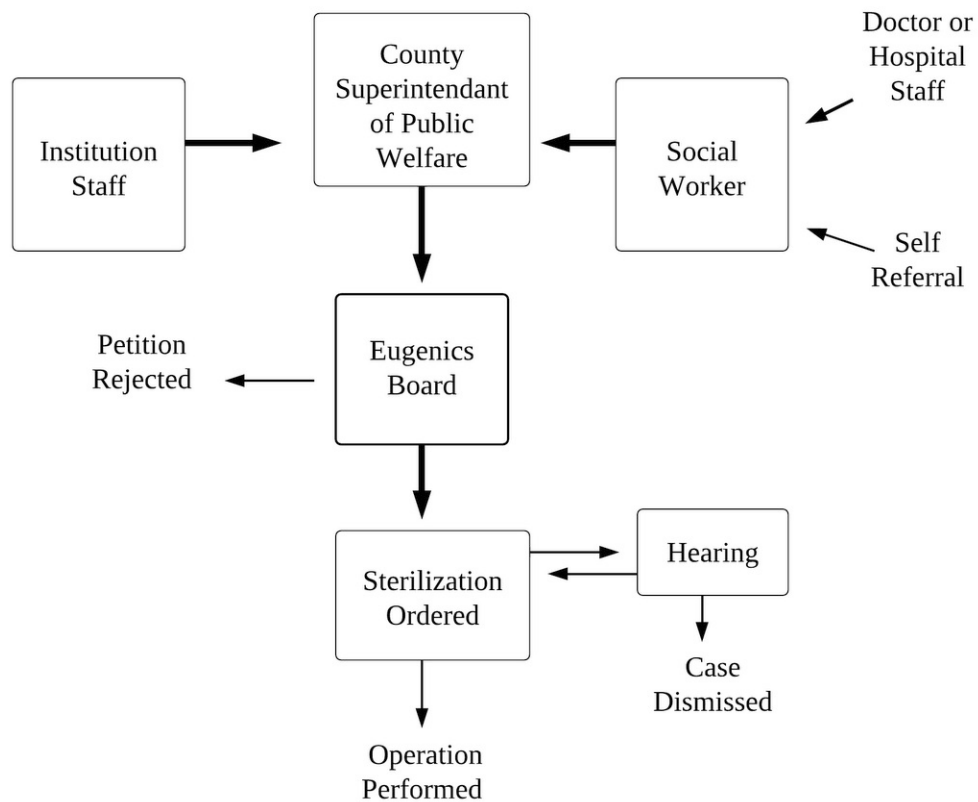


Figure 6: Eugenics Board Petition Process

4.2.6.5 Eugenics Board meetings

The five-member board typically convened on the fourth Wednesday of each month for brief meetings to review the current petitions and discuss program matters. However, in special circumstances the Board would convene for an “emergency hearing” in cases deemed urgent (Eugenics Board of North Carolina 1960). Petitions sent from county departments of welfare and state institutions would be collected by the Board’s executive secretary, who would condense them into one-paragraph summaries for the board’s consideration (the basis of the meeting minutes I analyzed). A “brisk discussion”

would follow the review of each case summary, and the overwhelming majority of petitions were approved. Between 1933-1962 the board approved 98 percent of the petitions for sterilization, and from 1962-1964 92 percent of petitions were approved (Schoen 2005:284).

4.2.6.6 Dissent from the Board

One of the unique aspects of North Carolina's program was that it required the cooperation of high-ranking state officials – both in the form of required attendance for monthly meetings, and the legal obligation to file petitions for those falling within the scope of the sterilization statute. Over the course of the 30-year operation of the Board, there were occasionally members of it who were reluctant participants. For example, Dr. CC Applewhite, represented the Secretary of the State Board of Health on the Eugenics Board during the 1950s. At a 1955 hearing, he challenged the program's traditionally eugenic assumptions about heredity that were driving the consideration of a petition regarding a twenty-one-year-old expectant mother. Applewhite said, "Suppose this baby soon to be born turns out to be a genius. I have been talking with some of these psychiatrists – some pretty smart boys among them. They have their doubts about this matter of heredity" (Begos and Railey 2002).

Repeated absences from the Eugenics Board's monthly meetings was another way state officials displayed resistance to the work. Some board members assigned lower-ranking staff people to attend the meetings in their place. Other members simply did not attend in spite of their expected role. Walter A. Sikes, Superintendent of the State Hospital at Raleigh, attended only four meetings in five years – after which time he was

replaced by the Commissioner of Mental Health (Schoen 2005:284). Although the early 1950s was a time of unprecedented growth in the Eugenics Board's operations, there was no easy acceptance among all of the members regarding the ethical legitimacy of their program. According to Ethel Speas, the Secretary of the Eugenics Board in 1955, the board members "lacked honest conviction for the program" (Speas 1955).

4.2.6.7 Eugenics Board and Human Betterment League's – "educational work"

In addition to its role in authorizing orders for sterilization, the Eugenics Board also promoted public acceptance of sterilization for eugenic purposes through educational work with administrators, public health officers, staffs of social agencies, and others likely to play a part in the referral of cases or petitioning process (Woodside 1950:18). The Human Betterment League of North Carolina also played a key role in "educating" the public about sterilization. This "educational work" included: (1) visits to state hospitals, training schools, county departments of welfare; (2) attendance and participation in civic and professional groups; and (3) publication of pamphlets and materials for distribution to the public. In 1947, the North Carolina General Assembly approved the hiring of a full-time Executive Secretary for the Eugenics Board. The Board's secretary was also charged with "interpreting" the program to people in positions of importance to the Board's work who were less than enthusiastic about its purpose.

For example, the Board expected the cooperation of the staff psychologists at state institutions in conducting IQ tests on inmates who might be considered for petition. The meeting minutes regarding a reluctant staff psychologist at the Women's Prison reflect some of the institutional conflicts that arose in implementing the Eugenics Board's

program. Apparently, “Dr. Cheeve took the attitude that sterilization or the aid of such did not come under his jurisdiction” (NC-EB 1952). Without an IQ score there would be no way to present the petition for a hearing, and without Dr. Cheeve’s cooperation, there was no way for the Board to attain the necessary paperwork. Following the introduction of this problem to the meeting, the recorded minutes then indicate conversation abruptly changed to the topic of increased travel appropriations for the upcoming biennium. To prevent such difficulties, the Board’s secretaries spent a considerable amount of time explaining and re-framing the Board’s work to reluctant officials. For example, in February 1954,

A conference was held with Janet Wein, Chief Medical Social Worker, Duke Hospital, with regard to the attitude of doctors on surgery service at Duke Hospital toward sterilization. This contact was prompted by the fact that one welfare department had the experience of having a patient whose sterilization had been approved, sent home without the operation when the patient responded “yes” to the question as to whether or not she wanted more children. Ms. Wein thought the doctors were very cautious with regard to sterilization. She suggested that Dr. Bayard Carter be contacted in an effort to clear up questions or attitudes in reference to sterilization on the part of the doctors on staff (Speas 1954).

Certainly, it does not seem that all, or even most, of the doctors who performed surgical sterilizations ordered by the Board had moral reservations about doing so. However, the work of managing individual crises of conscience was a task that remained a regular aspect of the program’s operation.

In its early years, HBL-NC also reached out to skeptical audiences and supportive audiences. They explicitly promoted eugenic sterilization through mass mailing campaigns targeted to the medical community, public officials, welfare workers, prominent civic groups, and the public at large. HBL-NC pamphlets explained North

Carolina's Eugenics Law – allowing for the sterilization of the “mentally ill and defective” with the approval of the State Eugenics Board – and urged their audience to support the eugenics program's growth. Specifically, organization records indicate that the group engaged county welfare officials through correspondence reporting the sterilization statistics for other counties and encouraging officials to increase the number of petitions to the Eugenics Board. For instance, notes from a 1953 HBL-NC meeting report, “letters of commendation were sent to all County Superintendents of Public Welfare noting their accomplishments for the year, also their percentage of sterilizations to population and the county's rank within the state, with carbons to County Commissioners and County Welfare Board members.” At the next annual meeting, Gamble re-emphasized the importance of such communications, the secretary's notes read:

Dr. Gamble believes that it would be helpful if each board member would write to Superintendents of Mental Institutions, commending them for sterilizations they have arranged, if any, and urging support of the sterilization procedure when it is indicated. He also re-emphasized the value of personal contact with the county superintendents of welfare, and hoped that members and their friends would be able to make more contacts. He urged the continuation and increase of talks on sterilization before clubs and other organizations (HBL-NC 1954).

To promote their message in the public eye at a wider level HBL-NC also strategically used publications in local newspapers. The League was officially established on March 22, 1947 – the next day an editorial praised the benefits of sterilization in the *Sunday Journal and Sentinel* (Begos 2002b). Board members wrote and circulated articles and editorials to newspapers across the state - *Winston-Salem Journal*, *Raleigh News and Observer*, *Asheville Citizen*, *Charlotte Observer*. The

League's membership included prominent figures, with close family and social connections within the newspaper industry, which facilitated this aspect of their campaign. They also used "letters to the editor" to express a particular concern about the number of "feebleminded" children born in the county (Begos 2002b).

This promotional work of the Human Betterment League of North Carolina had a dramatic impact on the scale of the Eugenics Board's caseload. In 1946, the number of sterilizations ordered by the Eugenics Board reached its lowest point since the program began (Eugenics Board records report 238 sterilizations performed in the 1944-46 biennial period). One year later, in 1947, the Human Betterment Association of North Carolina formed and began promoting the state's sterilization program through public outreach and financial support – contributing to the rapid growth of the program, which doubled in size over the next ten years.

The HBL-NC also had very close working ties with the Eugenics Board. In 1959, Ethel Speas, Eugenics Board Secretary, was the guest speaker at the annual meeting (HBL-NC 1959). Clarence Gamble also made financial contributions directly to the Eugenics Board. In 1945, he contributed \$6,000 to the Eugenics Board in support of a study investigating IQ among school children in Orange County. The study was conducted by George H. Lawrence: Associate Professor of Social Work, University of North Carolina, former Orange County Superintendent of Public Welfare, and current president of the Human Betterment Association. A year later Gamble financed the cost of publishing and distributing 2,000 copies of the Eugenics Board Manual to social and health agencies in other states (EBNC-BR 1946-1948).

4.2.6.8 Eugenics Board as a source of elective sterilization

For some women, the Eugenics Board provided an alternative route of access to surgical sterilization when they otherwise could not. In Johanna Schoen's study of approximately 8,000 sterilization petitions filed in North Carolina, she found that between 1937-1975, 468 (5.85%) could be considered elective sterilization (where either the clients had initiated the request for sterilization, or they responded enthusiastically when a caseworker informed them that sterilization was available through the Eugenics Board) (2005:113). Only twenty-two were for men while 446 were for women. Three-quarters of these "voluntary" petitions occurred between 1958-1966. The peak year was 1962 when 90 such petitions were reviewed (Schoen 2005:121).

Approximately 70 percent of those seeking elective sterilization were black women. This reflects racial differences in access to both contraception and elective sterilization by private physicians during this time period. The women seeking elective sterilization were on average twenty-seven-years-old. This was slightly lower for black women whose average was 26.5, whereas the average white woman seeking sterilization was twenty-eight-years-old. Those seeking elective sterilization had already given birth to an average of four children; slightly more for black women in this group who had an average of 4.4 children than white women who had an average of 3.4 children. It makes sense that the average woman seeking elective sterilization was twenty-seven-years old, had given birth to four children, and was likely to have limited access to birth control and sterilization through private medical care. These were women who had all the children they desired.

5. 1950-1964: Social Welfare, Racial Politics

This chapter addresses the time period 1950-1964 and begins by identifying some key developments that made the dramatic shift toward neo-eugenic reasoning and made its practice possible in the transitional years to come. I offer an examination of the ideological, institutional, and economic factors, which lead to the dramatic rise and peak of the Eugenics Board's sterilization program and I make a series of comparisons among three groups in North Carolina: black women, white women, and American Indian women. Specifically, I outline the (1) ideological discourses of “threats” and “feeble-mindedness”; (2) a crisis in the state's institutional mental health hospital capacity which led to (3) the shift from 1952 that the Eugenics Board consistently ordered more non-institutionalized people sterilized than from those in institutions, acutely through the welfare system. Concretely, in this time period we see how eugenic coercive sterilization was a key aspect of inferior/second class citizenship of people of color in North Carolina. They had limited to no rights to bodily integrity and reproductive citizenship was defined by exclusion from and the ability to make claims for reproductive rights.

Moreover, these years were characterized in North Carolina, by the emergence of a particular intensity with regard to public and political debate surrounding public welfare and race that would fully take form in the second period. Issues of civil rights, school desegregation, welfare dependency, the “rediscovery of poverty,” and new theories of inequality based in culture and social transmission, profoundly shaped the practices of the North Carolina Eugenics Board. The neo-eugenic transition (Kluchin 2004) described in the Introduction, connects the traditional Eugenics Movement as it was epitomized in the

Buck v. Bell (1927) case, and a new era of coercive sterilization practices. Whereas compulsory sterilization practices during the earlier Eugenics Movement period reflected a biological determinism underlying contemporary understandings of social inequality, new advances in scientific research and developments in the social sciences directly challenged the morality and utility of “selective breeding” programs. Replacing the focus on “genetic fitness,” were new concerns about understanding “feble-mindedness” through its connection to intergenerational poverty, the breakdown of the family, and welfare dependence. However, despite significant shifts in the scientific and popular understandings of race, mental illness and intellectual disability, and hereditary transmission, North Carolina's sterilization program did not decline (as many other states did).

5.1 Key Developments and Trends

Seventy percent of the total sterilizations ordered by the Eugenics Board occurred between 1946-1968 (see Figure 7). The number of sterilizations in North Carolina performed on members of the general public exceeded the number performed on inmates and patients in state institutions for the first time. Key developments that help explain the rise and shape of sterilization during this time period, parts of which were outlined in detail in Chapter 4, include: (1) increased state funding for the work of the Eugenics Board which facilitated the hiring of a full-time secretary and assisted the bureaucratization of the Board and the spread of eugenics beliefs; and (2) the influence of key county public welfare heads; Wallace H. Kuralt, George Lawrence, and the Board Chair, Ellen Winston.

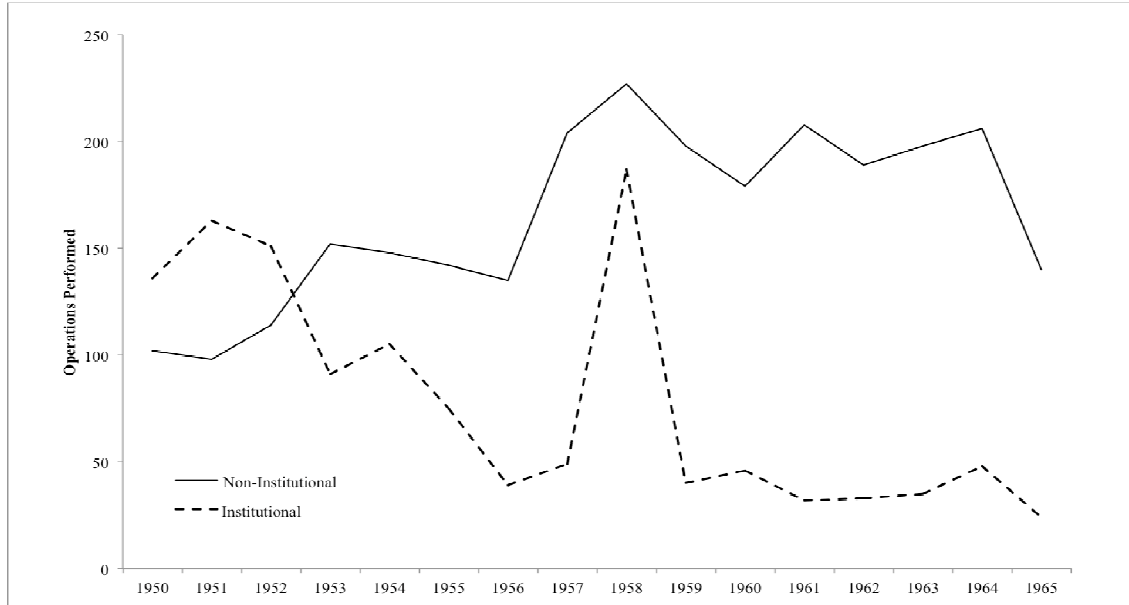


Figure 7: Women Sterilized by Eugenics Board Order by Institutional Status, 1950-1964

Early in 1948 a comprehensive manual was issued interpreting legal provisions and clarifying the policies and procedures of the Eugenics Board. The cost of materials was paid from Federal funds allocated to the Hospitals Board of Control. The manual was sent to persons responsible for initiating petitions: the superintendents of State institutions and county superintendents of public welfare. Through the cooperation of the State Board of Health, manuals were made available to county and district health officers and public health nurses. Clarence Gamble also financed the publication and distribution of 2,000 copies of the Eugenics Board Manual, which made it possible to provide copies to public health and welfare departments and organizations in North Carolina and other states (EBNC-BR 1946-1948:6).

Increased emphasis was placed on the educational aspects of the work of the Eugenics Board during the biennium, which was supported by the role the Executive

Secretary played in disseminating Board procedures. As a means of interpreting the program, the Executive Secretary visited a number of the state hospitals, training schools, and county departments of public welfare and has participated in the programs of various civic and professional groups. A broader understanding of the meaning and value of sterilization to the individual brought about a more extensive use of the operation (EBNC-BR 1950-1952:7-8).

Lastly, two counties public figures, and the leader of the State Welfare Department, had a profound affect and the growth of coercive sterilization in North Carolina. Mecklenburg County conducted the most sterilizations out of any county in the state (485). It is an urban county. The county seat of Mecklenburg is Charlotte. In 1950, the total population was 197,052, compared to 311,522 in 1965. The white population of Mecklenburg County totaled 147,079 in 1950, while those considered “other” comprised a population of 49,973 in that year. In 1965, Mecklenburg’s white population stood at 235,662, and “nonwhite” Mecklenburg residents totaled 75,860. Wallace H. Kuralt was the head of Mecklenburg County public welfare from 1945 until 1972. His son Charles was a famous CBS journalist. Wallace Kuralt got his start in social work in the 1930s, when the welfare system was just starting out. Down in the trenches of post-Depression poverty, he watched women get pregnant again and again when they couldn’t afford to feed the children they already had. He once said that for the poor “sex is their recreation,” a “spontaneous activity, not planned in the same way middle class families plan sex” (Helms and Tomlinson 2011). Kuralt wanted to help them. Kuralt had a rule

that every time his social workers visited a welfare client they had to talk about family planning.

Kuralt drew little public attention during his first decade on the job.

Mecklenburg's eugenic sterilization program remained low-key as well. Records show the department brought only a handful of cases a year to the Eugenics Board from 1937 to 1954 - some years none at all. That changed by the end of the decade. Mecklenburg had by far the most reported procedures – Mecklenburg sterilized 3x more people than the second-ranked Guilford (NCJSVF 2011). In 1955, as sterilizations were starting to taper off statewide, the Mecklenburg Welfare Department got 19 sterilizations of "feeble-minded" clients approved. By 1957 there were 57. The department averaged at least one a week for the next two years. On August 8, 1957, Kuralt, wrote the Human Betterment Association seeking information about the French Loan Fund. Kuralt explained that despite the resources made available by the State Eugenics Board, substantial increases in the number of eugenic sterilizations performed in the county during the preceding months (including many for which Eugenics Board data did not include such as the “numerous cases referred to doctors for sterilization on a therapeutic basis” because such are not reported) had promoted a need to look for additional funding for the procedures (Kuralt 1957).

After 1960, sterilization referrals from Mecklenburg County dropped off.

Between 1958 and 1960 there were 95. Between 1962 and 1964, the number was 48.

From 1966-1968 only 21 sterilizations were performed by the Eugenics Board in Mecklenburg County. Kuralt, however, was always proud of his office's role in

increasing sterilization. He was quoted as saying, “We’ve pursued sterilization of the inadequate parents more actively than any place in the world” (Helms and Tomlinson 2011).

Buncombe was also an exceptionally active western county in the sterilization program. Buncombe had the 5th most operations among the state’s 100 counties (total 159 sterilizations). It is an urban county. In 1950, the total population was 124,403, compared to 133,051 in 1965. The white population of Buncombe County totaled 109,126 in 1950, while those considered “nonwhite” comprised a population of 15,277 in that year. In 1965, Buncombe’s white population stood at 119,531, and “nonwhite” Buncombe residents totaled 13,520. Asheville is located in Buncombe County.

George H. Lawrence was the founding president of the Human Betterment League of North Carolina (1947-1955) and the superintendent of public welfare for Buncombe County (1947-1961). In an article published in the *Henderson Times-News* (“Sterilization Program Use” 1951:8) Lawrence praised the recently released biennial report of the Eugenics Board. He believed that more widespread use of the eugenic sterilization law would result in “greatly reduced costs of operation of the state’s mental institutions.” Lawrence said that the report was “highly encouraging in that it indicates North Carolina citizens are becoming increasingly aware of the advantages of the state’s eugenic sterilization law.” At the time of the article North Carolina was one of 27 states with Eugenic Sterilization legislation.

During the 1948- 1950 biennium the statute was used more extensively than in any previous two year period. Lawrence attributed this to “the fact that it is now

generally understood that no sexual change results from the sterilization, no detectable change except that children are not produced” (“Sterilization Program Use” 1951:8). Lawrence noted that there was a trend toward more operations for inmates of state institutions and attributed much of the increase in number of operations to this factor – between 1948-1950 state inmates had 225 of the 468 operations performed (as compared to 133 of 291 during the previous biennium). One of the cases he recommended suggests that miscegenation was of great concern to him.

Lastly, although Ellen Winston was not a proponent of traditional eugenic ideologies, as Chair of the Eugenics Board, sterilizations peaked. Over the course of her tenure as Eugenics Board Chair she aggressively promoted sterilization as one of several solutions to poverty and illegitimacy, because she was convinced that having too many children was a problem for welfare families and the state (Schoen 2005:88). In her work as Chair of the Eugenics Board, Winston's influence matched her profound impact on North Carolina public welfare more generally. She increased the size of the program in several ways. In 1951, she recommended the expansion of the eugenic sterilization program by following up on AFDC families in which one family member had been sterilized to determine if others could benefit from the surgery – this led to an increase in non-institutional sterilizations, and an increase in the number of women sterilized who had given birth prior to having the operation (Schoen 2005:88). Drawing on a carefully cultivated network of support within state legislature, it was Winston's request for additional funding which procured the budget appropriation for a full-time Eugenics

Board Secretary, a development that facilitated the program’s expansion during the 1950s (Schoen 2005).

5.1.2 Sterilization Comparisons by Racial Group and Counties

By 1950, 1,437 white people and 464 black people had been sterilized, meaning that 32 percent of those sterilized were black - this was roughly proportionate with the state population at the time which was 27.5 percent black. However, over the next ten years this figure would almost double with 59 percent of sterilizations being performed on African Americans between 1958 and 1960 (Schoen 2005:138). See Table 7 for a breakdown of groups by age.

Table 7: Age by Race of Sampled Cases, 1950-1964

	White Women	Black Women	Indian Women
Mean	21.9	20.36	27.35
Median	20	19	29
Range	13-39	11-35	16-40

Each of the three groups of women occupied a distinct and historically significant geographic arrangement (as indicated by county of residence on the petitions) situating each group targeted by the Eugenics Board according to physical arrangements of the population’s economic relationship to the state. For each group, I identified the five counties from which the greatest number of petitions had been initiated. For white women these were: Buncombe (which initiated sterilization proceedings in 8% of cases of white women within the sample); Madison (6%); Rowan (5%); Caldwell (3%); and Iredell (3%). With the exception of Buncombe, all are rural counties, located near the far

eastern, Appalachian region of the state. This pattern supports a continued adherence to the traditional eugenic practice of targeting certain aspects of the poor white population.

Within the petition records of black women included in my sample, the top five counties were: Mecklenburg (14%); Pitt (7%); Lenoir (5%); Gaston (4%); and Guilford (4%). Each of these was the site of a major urban area at the time of the petitions, or was an area undergoing a rapid process of urbanization. The racial discourse of that time, located one source of continuing economic inequalities and racial disparity to the urban “ghetto” culture attributed to the black population as a whole. Thus, it makes sense that in a neo-eugenic framework, the population of urban blacks would be seen as particularly threatening. Finally, the top five counties where petitions for sterilization through the Eugenics Board originated for American Indian women were: Robeson (61%); Hoke (13%); Scotland (13%); Cumberland (4%); and Swain (4%). All but one of these counties is situated on the Southeastern border of North Carolina, comprising the historical home place of the Lumbee. Swain County is the only exception as it is at the far western boarder of the state, where it meets the boundary line demarcating the boundaries of the Cherokee reservation. Although the members of the Eugenics Board had expressed an interest in addressing its services to the population of the Cherokee Reservation, they were informed that the North Carolina Public Welfare Department did not have such jurisdiction. However, the rejection of the Lumbees’ bid for tribal recognition by the federal government (1952) precluded them from setting up independent systems of social provision for education, medical services, etc. As a result, they did fall under the jurisdiction of the Eugenics Board and became the only other

group of women of color (besides black women) to be targeted by the neo-eugenic goals of this program. See Figure 8 for a map of the counties designated by highest rates of sterilization by race [Counties 1-5 (darkest color) represent highest rates sterilization of black women; counties 6-10 (medium color) represent highest rate of sterilization for American Indian women; counties 11-15 (lightest color) represent highest rate of sterilization for white women].



Figure 8: Counties with Highest Sterilization Rates of Women by Race in Sample, 1950-1964

The overwhelming majority, 40 of 46, of Eugenics Board cases involving American Indian women were presented between 1950 and 1965. Within my sampled set

of records there were 23 such cases between 1950 and 1964. It is unclear what factors led to their emergence and then disappearance in the population of Eugenics Board. However, they do align with a legal struggle for tribal recognition by the Lumbee under the Federal Government's policies pertaining to American Indian groups.

For the time period 1950-1964, when compared to the petitions for sterilization of black and white women, the cases of Indian women were unique in the following respects: (1) they were older, on average, than the records reviewed for black and white women. Whereas 46% of white women's, and 29% of black women's petitions originated in institutional settings, none of those for American Indian women did. The lower rate of institutional sterilization petitions among black women during this time period is a product of many factors, racial segregation of public institutions being one of the most important. Lumbee women were similarly excluded from charitable and medical institutions, but their refusal to utilize the limited institutional care arrangements made available to black women is an important part of the racial politics of the 1950s.

However, sterilization for black women was commonly seen through hidden coercive practices. In 1943, Ruby Scott, thirty-three-year-old black woman and mother of four children, from Sampson County, was ordered to undergo surgical sterilization. However, Ms. Scott did not want the operation, and for the next seven years refused to enter the hospital where it was to be performed. Upon learning that Ms. Scott was currently expecting a fifth child, her Sampson county social worker informed the Eugenics Board. The board decided that her post-partum recovery would be an ideal time to proceed with the earlier order. Meeting minutes for her case read: "It was felt that

at the time of the delivery of this child the operation can be carried out” (EBNC-MM Apr. 1950). In another case, Mrs. Bessie R. Lyon, Superintendent of the Bladen County Public Welfare Department, telephoned EB Secretary Ethel Speas to inform the board that eighteen-year- old Angela Daniel (a married black woman) was in labor with her first child and “would be held in the hospital pending the decision of the Eugenics Board” (EBNC-MM Feb. 1952).

5.2 The Ideology Discourses of Reproductive Threats

The sense of reproductive threat inherent in discussions of family planning and population policy at that time can be broken down into three main themes: genetic threat, moral threat, and economic threat. Although they were not separated out neatly in public discourse, analytically it is helpful to look at each individually before examining how they worked together.

5.2.1 Genetic Threat

Genetic threat ideology is seen through how the Eugenics Board followed the children of persons sterilized through the county departments of public welfare and through the threat of miscegenation. Children of sterilized victims, with the expectation that they may be examined upon reaching physical maturity and, if indicated, receive consideration by the Board occurred. Reports of examinations made by the psychologists in the Division of Psychiatric and Psychological Services, State Board of Public Welfare, received by the Eugenics Board were another means of following up on cases to determine whether or not sterilization was advisable (EBNC-BR 1950-1952).

Secondly, particularly in the South, the idea of miscegenation as a genetic threat has a long legacy – dating back at least to the 1860s (Pascoe 2009:3; McGuire 2010:243). In 1950, North Carolina was just beginning to fight a long ugly battle against school desegregation, ultimately culminating in the *Brown v. Board of Education* ruling, which profoundly shaped the racial politics of the region and nation at that time. The neo-eugenic transition was not a sudden shift from one gear to the next, but rather carried ideas about the genetic transmission of racial superiority and inferiority within its framework. Given this, it is easy to identify the anti-miscegenation impulse driving many of the sterilization orders issued by the Board in these years. This impulse took its most punitive form earlier in the Board’s operation, as evidenced by a 1937 order for asexualization (hysterectomy) of a 38-year-old white woman who came to their attention soon after giving birth to a mixed-race child (Begos 2005). During the 1950’s the approach took a more preventative approach.

By the time her petition came to the attention of the Eugenics Board, thirteen-year-old Emma Turner, a young white girl from Mecklenburg County, had spent two long years in the care of the local Welfare Department following a sudden departure of both of her parents. Emma, along with three sisters, had been in the care of a foster family since that time. However, as her case summary indicates, Emma was recently “put out” by her foster mother, although the record does not explicitly specify what events led to this decision. Apparently due to Emma’s recent physical development and “a decided interest in boys for the last year,” her current foster mother was no longer able to provide the kind of intensive supervision these changes required. Although physical

and sexual development are obvious aspects of healthy growth during this time, the recent changes had particularly disturbed her guardian because Emma's new interest in the opposite sex seemed to show "no regard for the man's age, marital status or race."

The foster mother had asked Emma to leave the home, "because of the problems she presents in supervision." The Board's recorded discussion regarding her case illuminates both: (1) the Board's continued legitimizing and adhering to southern racial tradition prohibiting "race-mixing"; and (2) the enormity of what was at stake for young girls and women like Emma, who were compelled to accept an order of surgical sterilization by situations in which housing or employment were conditioned upon surgery. In approximately 20 percent of the 259 case summaries I reviewed, the petitions described mothers as deceased, missing, or neglectful. These cases, usually lacking in any oversight by a concerned adult, were usually the youngest patients, had the briefest descriptions (indicating less necessity for the typical level of rigor in justifying surgery), and were the petitions most frequently authorized by the consent of a court-appointed Guardian Ad Litem. According to the consensus reached at the meeting of the Eugenics Board, Emma needed "the protection of sterilization. This may save Emma's home until such time as she can have other plans made for her" (EBNC-MM June 1963).

While representations of white female vulnerability to black male sexual threat have been the most common expressions of concern for the genetic threats posed interracial interactions, the petition for fifteen-year-old Jonathan Davies' sterilization offers a revealing perspective on this dynamic because of its less familiar gender lens. His case summary was nearly exclusively concerned with establishing the necessity of

sterilization to prevent Jonathan's developing romantic interests in several young black girls from developing into certain disaster.

The family lives in a community occupied by both Negro and white families, many of whom are on a low socio-economic level and there are a number who receive public assistance . . . He is docile and gets along fairly well with the neighborhood children. Arrangements have been made for him to attend Nevins Vocational Training School in Charlotte, and he is very excited over attending and states, "maybe I'll find a girl there." He seems particularly attracted to young Negro girls and describes them as "pitiful" and says they need him to help them (EBNC-MM April 1963).

While there is no documentation of any sexual advances by Jonathan, the caseworker is concerned that his growing interest in sex, his interest in Negro girls, and his docile attitude presents a great potential danger both to him and to the community and it is felt that sterilization would at least prevent any children being born and would also be somewhat of a protection to him in the future.

5.2.2 Moral Threat

A second type of reproductive threat for which compulsory sterilization offered relief was the idea of unwed mothers and welfare dependency as a moral threat. Discussing the rate of out-of-wedlock births among Negroes in North Carolina, one health officer said, "Marriage is very fluid here. It is difficult to check on bigamous unions or the unmarried living as married, and there seems to be no way of bringing these people under any sort of eugenic control" (Woodside 1950:47). The discussion of Janice Tomkins case, originating in rural Pitt County, reveals a discourse of cultural transmission of poverty, which captures the shift from traditional eugenic discourses based in biological, hereditary understandings to a neo-eugenic discourse concerned with

the transmission of inferiority through social and environmental exposure. Her physician's statement indicates the profound sense of risk to society underlying such rhetoric. "The woman is described as very limited in abilities and requiring constant supervision, rendering her incapable of caring for children. The family is described to be of low educational and social standards" (EBNC-MM Dec. 1958). The examining physician states, "that to allow Janice to continue to procreate will be prejudicial to society" (EBNC-MM Dec. 1958).

Clearly, these statements echo Oliver Wendell Holmes' classic eugenic declaration that, "three generations of imbeciles are enough" (Holmes 1927). Throughout the 1950s, politicians, sociologists, and psychiatrists argued that black women did not have the same morals as other women (Ziegler 2008: 348). His words also reflect a growing sentiment among physicians during this time that they bore a social responsibility to balance their attention to individual patients with a moral obligation to encourage fertility limitation among certain clients whose child-bearing was potentially injurious to the best interest of society.

5.2.3 Economic Threat

Finally, a third sense of threat developed over the decade of the 1950s was expressed in explicitly economic terms. In North Carolina, the development of this discourse paralleled the expansion of the welfare program's size and availability to a more diverse population. Fears about the rising cost of the AFDC program in particular, were frequently focused on the reproductive choices of mothers who received welfare support (and in particular black mothers). While the discriminatory welfare practices of

the 1930s and 1940s had largely excluded African Americans from programs like Mother's Pensions and social insurance care, during the 1950s this began to change – a transition with two important consequences for the reproductive citizenship of women of color in North Carolina. First, although racial exclusions from welfare support offered to poor whites often left poor black mothers dangerously without a “safety net” to protect them from the suffering of unmitigated poverty the inclusion of women of color in the benefits of welfare support also came with exposure to the influence of social workers who often, but not always, saw such clients as undeserving burdens to the state. This sense is reflected in Moya Woodside's (1950) study of eugenic sterilization in North Carolina. “It is certainly true that the feeble-minded Negro woman, often with illegitimate children, is a familiar and recurrent problem to health and welfare agencies” (Woodside 1950:6).

This portrayal of the reproductive choices of women of color as an economic risk was also prominent in political discourse over the course of the 1950s. Letters written by citizens to North Carolina Governor Hodges frequently expressed a resentment and rage at the imposition of such financial imposition. “According to this welfare setup at present, we are raising illegitimate colored children to take over our state. In other words they are reproducing like rabbits by having illegitimate children and I cannot have more than two because I cannot afford to have anymore but the colored have them by the dozen and we pay them to have these illegitimate children,” wrote one constituent in 1955 (Kovalchick 1956). The letter's author then proposed a two-pronged solution: (1) limiting the amount of AFDC provisions to support the needs of a maximum of one

illegitimate child per mother, and (2) “Make any person with more than one illegitimate child become sterile by an operation” (quoted in Kovalchick 1956).

Such pleas found state politicians responsive to the concerns of their constituents. In 1963, North Carolina Governor Luther Hodges initiated legislation, which provided for the appointment of guardians for welfare recipients who were deemed in need of supervision by the social workers who oversaw their cases. The goal of Hodge’s proposal was to do something “about mothers who have illegitimate children and then depend on public welfare records for support” (Hodges 1957). In a speech to the southeastern regional conference, American Public Welfare Association, Hodges explained that he was “disturbed about the situation involving illegitimate children whose so-called parents collect welfare money and seem to consider this money a ‘reward’ for their actions” (Hodges 1957).

Others expressed similar concerns with more explicit racial attributions. For example another letter to Governor Hodges, entitled “Comments on the Evils of Bastardy” from the Pitt County Branch of the Patriots of North Carolina Inc. argued in favor of both fines and compulsory sterilization for mothers of illegitimate children who were on welfare along distinctly neo-eugenic lines. The Eugenics Board follows the children of persons sterilized through the county departments of public welfare with the expectations that they may be examined upon reaching physical maturity and, if indicated receive consideration by the Board. Others framed it within the dire consequences that would come from desegregation.

The controversy over segregation has brought to light the amazing fact that 20 percent or more of our Pitt County Negro population is illegitimate and there are

no indications that the tendency in this direction is lessening. The Congressional investigation of the schools in Washington D.C. has revealed that the backward negro child seldom knows who his father is and often does not know his mother and is shunted about among the mother's relatives, friends, or neighbors or anyone at all who will take the slightest trouble to care for him. A child brought up under these conditions will naturally perpetuate and broaden the trend toward wholesale bastardy (Papers of Governor Hodges).

The discursive connections between a virulent racism underlying desegregation struggles in North Carolina, an emerging public rhetoric in which cultural inferiority replaced earlier eugenic thinking, and its expression through a framing of welfare provision for unwed mothers as a particularly economic threat, are especially clear here.

The Board discussed a letter sent by the Superintendent of Public Welfare for Avery County, who wanted to know if the Public Health Department could force a person to consent to a physical examination. A representative for the State Health Officer confirmed that if the person was a "public nuisance" or was thought to be carrying an infectious disease, then the county's public welfare department could force them to have a physical examination (EBNC-MM Apr. 1952). "I plan a tickler file on all persons whose names reach me regardless of age in order that they may be picked up as they reach the child bearing age " (Casebolt, Eugenics board minutes, July 27, 1961) (Begos and Railey 2002).

5.3 Ideological Discourse of Feeble-mindedness - Doctors, and Social Workers

Of the people sterilized between 1950 and 1968 a growing proportion were women deemed to be feeble-minded. In 1954-56, 111 sterilized women had been diagnosed as mentally diseased and 392 as feeble-minded. By 1966-68, when as many as

250 sterilized women were still characterized as feeble-minded, only sixteen were diagnosed with a mental illness (EBNC-BR 1954-1956, 1966-1968). By the 1950s, the scientific validity of “feeble-mindedness” would have been even more in doubt. The feeble-minded women sterilized in North Carolina between 1950 and 1968 were less and less likely to be mentally ill or handicapped. Instead, they were increasingly likely to be single women who were sexually active or who were feared to become so in the future. Describing a patient as sexually uncontrollable, became petitioners’ most predictable strategy for convincing Eugenics Board members of the necessity of sterilization – a growing emphasis by social workers on their clients’ sexuality in order to get sterilizations approved (Schoen 2005:110). Inadequate mothering was used as justification as well. Incompetent mothering (often reflected in supposedly poor home conditions) was not only thought to produce feeble-mindedness in children; it was also considered evidence of mental “deficiency” in adults. The reasoning here sounds similar to a traditional eugenic belief in the heritability of intelligence, however, the social workers’ focus was on the negative impacts of poverty and inadequate home conditions on children (Taylor 1997:146). In 1954-1956, there were 139 married sterilization patients in North Carolina and 364 unmarried patients. By 1966-68, there were only 27 female married patients, and the number of unmarried female patients remained as high as 244 (Ziegler 2008:348).

As *Buck v. Bell* demonstrated, and scholars of social welfare have previously noted (Ladd-Taylor; Gordon 2002; Shoen 2005), the label “feeble-minded,” was used to also silence and shame some victims of violent relationships and sexual assault.

Undoubtedly, some of the young women labeled feeble-minded were difficult and rebelling against the norms of a repressive society, but most were victims of sexual assault and incest or circumstances that denied them of their most basic needs.

Sterilization procedures which were performed for reasons other than mental illness, feeble-mindedness, or epilepsy did not fall under the jurisdiction of the Eugenics Board (EBNC 1948a:19). These were not governed by law, and were performed at the discretion of individual doctors who faced unclear legal liability (Woodside 1950). They were funded in one of three ways - direct payment to private physicians among those with the financial resources to do so (mostly wealthy white families of disabled children), the donation of surgical services by eugenic-minded physicians, or local philanthropic/medical programs such as the one operated in Forsyth County (Severson 2011). It is clear that many sterilization decisions were made by doctors and social workers without even the meager protection afforded by the formal procedures of the Eugenics Board. Woodside's study noted that between 1945 and 1950, there were 200 sterilizations in a single private hospital, most of which were not authorized by the Eugenics Board (219).

5.3.1 Doctors' Authority

Many doctors seemed to operate with impunity, such as Dr. C.V. Tyner who performed an operation of sterilization for Melissa Bingham. A social worker from the Rockingham County Welfare Department informed the Eugenics Board that Dr. Tyner had performed a sterilization operation on Ms. Bingham following the birth of her child prior to receiving the Board's order. In fact he had performed it on November 18 when

the case was not set to be reviewed until November 27. At that point the Board decided to inform Rockingham County that they did not make retroactive orders and that Dr. Tyner would be responsible for the operation. “The doctor found physical reasons that justified this operation and went ahead without getting in touch with the welfare department” (EBNC-MM Nov.1956).

However, the Eugenic Board’s way of dealing with doctors was inconsistent: “A letter of Mary 1, 1954 from Dr. J. R. Gamble Jr. was read which was in reply to our letter of February 25 raising the question with regard to his performing the operation of asexualization instead of sterilization which was ordered by the Board. Dr. Gamble gave in detail the type of operation he had performed and his reason for doing so. He did not indicate that he was aware of the fact that he was not authorized by the board to perform the operation of asexualization. It was the decision of the Board that it would drop this matter. In doing so, it recognized the seriousness of Dr. Gamble’s action (EBNC-MM Mar. 1954).

The Board even agreed to retroactively order sterilization in some cases. In one case, the Eugenics Board decided in favor of issuing a retroactive order for Robeson County sterilization performed two weeks prior to Eugenics Board order issued. A letter from the Superintendent of Public Welfare stated, “The condition of the patient was such that the doctor decided it was advisable to perform the operation at that time” (EBNC-MM Mar. 1954).

At times, the power of the state protected doctors. A staff surgeon at the Goldsboro State Hospital performed a sterilization operation prior to Eugenics Board

action, inexplicably believing that approval had already been given in this case. The Eugenics Board was notified by the Superintendent of Goldsboro State Hospital that this had occurred. On the advice given by the Attorney General's Office, the EB signed a nunc pro tunc (retroactive) order (EBNC-MM Nov.1958).

To protect important people (and families) the EB would just change the rules, refusing to retroactively authorize sterilization: “Dr. Winston asked that the minutes state that the Board refused to authorize sterilization in this instance for the reason that the board does not have legal authority to authorize sterilization retroactive. The minutes of the December meeting are now to the effect that the Board does not follow the policy of making retroactive orders” (EBNC-MM Jan. 1956).

For sterilization procedures authorized by the Eugenics Board, surgeons were exempted from any civil or criminal liability arising from their participation in operations (except in cases of negligence regarding the actual operative procedure). Many doctors were reluctant to perform elective sterilization procedures, as they feared being held liable under North Carolina's mayhem statute (Woodside 1950:58; Deaver 2003). However, the writings of physicians at this time also indicated that they felt a sense of professional responsibility to promote the best interests of society at large. This had important consequences for the ways that they perceived the patients in their care. Whereas previously doctors and health officials in North Carolina focused substantial efforts to remedy the unusually high number of infant and maternal deaths in this state - North Carolina had one of the highest infant mortality rates in the nation (Schoen 2005; SBH-BR 1952:148). Now health professionals were faced with a whole new set of

concerns, increasingly doctors questioned their responsibilities to society with regard to overpopulation. State Health Director Jacob Koomen advocated, “Now the medical profession must look with equal concern to the equality of life and the impact of an increasing number of lives upon our ability to remain viable as a society” (Koomen 1972:7).

Others were more hesitant to cooperate with the Eugenics Board. In one such case, the Eugenics Board sought out the help of Janet Wein, Chief Medical Social Worker at Duke Hospital, after reports from the local welfare department indicated that one of their clients - whose sterilization had been approved by the Board - was sent home from the hospital without the operation after responding “yes” as to whether or not she wanted more children. Wein affirmed that at Duke doctors were “very cautious with regard to sterilization” and suggested that they contact the hospital’s Chief of Obstetrics and Gynecology to “clear up questions or attitudes in reference to sterilization on the part of the doctors and staff” (EBNC-MM Feb. 1954).

5.3.2 Social Workers

Social workers frequently expressed support for the Eugenics Board’s work, which they understood as in line with their responsibilities for overseeing the provision of welfare resources. Contemporary social work practice was heavily concerned with efforts to mediate the negative impacts of poverty and inadequate home conditions on children (Ladd-Taylor 1997). Following the dominant “culture of poverty” explanations for social inequalities, social workers sought to disrupt the intergenerational transmission

of “impoverished and immoral environments” by re-socializing teenage girls who were raised in such environments (Schoen 2005:110).

In a 1989 interview with Johanna Schoen, Elsie Davis a Fayetteville social worker during the 1960s, explained that within the context of the Jim Crow South, many of them came to their work with some level of inherent bias. "The expectation was that in general black people were not able to take care of themselves. They were all illiterate, retarded. So it was consensus that these women don't have any rights. So we can say to them that they can't have any children" (Begos and Railey 2002). Kuralt's assistant recalled in an interview with Schoen: "I remember one of my coworkers whose office was next to mine, and as I said earlier, we had defined services, 60 cases, and I guess, I am embarrassed to tell you that I think he sterilized his entire case load, that all of his caseload, over a period of a year or two years, he got all of the women sterilized. I think that was perhaps a little excessive" (Chapin 1997).

If social workers seemed to overlook the threats facing their clients in navigating themselves out of abusive relationships (or simply existing in spite of them), they most certainly were not exempt from popular discourses, which held threats to national security, the future of democracy, and civilization were immanent. There existed a strong sense of urgency among the social welfare workers at this time to do their part in curbing what were seen as twin dangers of overpopulation and welfare dependency. The rise in such rhetoric, which positioned the reproductive rights of many women of color as potential dangers to society, was an important ideological factor in the rise of neo-eugenic sterilization in North Carolina and elsewhere.

5.3.2.1 Rape/incest

The case summaries which included subtle (and often not so subtle) references to child abuse, rape, and incest, highlight: (1) the difficult family situations social workers were often charged with rehabilitating; (2) the multiple layers and levels of abuse and violation many of these women and girls had already experienced by the time that the Eugenics Board decided their cases; and (3) consistent rhetorical strategies used by men to frame certain women as less deserving of bodily integrity and autonomy. Family violence, extreme poverty, absent and neglectful parents, alcoholism, and addiction ran like a current through many of the case records for women of all races. As Linda Gordon found in her history tracing social workers' understandings and treatment of family violence, victims of incest were often blamed and punished for acts committed against them (2002:215).

Social workers labeled victims (even very young victims) as sexual delinquents, and often charged them with a crime. Mothers of incest victims were also blamed for neglecting their duties to protect and shelter daughters from sexual experiences. Fathers, or male breadwinners, were rarely prosecuted – as the economic dependence of the rest of the family protected men from responsibility, and usually meant that it was the victim who would be sent away. As a result, the most helpless and blameless parties in the situation – children often already burdened with poverty, some abandoned and abused, some with legitimate psychological or intellectual disabilities – were subjected to the most extreme measures of restraint (Horsburgh 1996:573). A troubling pattern emerged early in the process of data analysis – often the caseworkers' narratives in the case

summaries displayed a clear connection between unusually adamant or judgmental descriptions of patient promiscuity in, and indications of rape and incest. For some, grounds for sterilization essentially amounted to a concession that society is unable to protect women from unwanted sexual advances. Instead of attending to their need to limit procreation and ensuring their physical safety, society ignores the injuries women incur in expressing their sexuality and subjects them to social control.

In 1966, above a grocery store in Mecklenburg County, eleven-year-old Kayla Walker shared an apartment with her mother, grandmother, an older sister, and the sister's newborn child. Kayla's mother was an unemployed alcoholic who had been sterilized under state order eight years before. Along with a friend – another young black girl from the neighborhood, Kayla attempted to run away from home. Traveling on foot, the girls were soon picked up and assaulted by a man they had not met before. Kayla returned home after being found by local police, pregnant – although she did not know that right away. The man was charged with attempted rape, and Kayla was placed on probation for promiscuous behavior. The caseworker assigned to their family recommended permanent sterilization for Kayla since “the home conditions are so poor it is felt that this behavior will continue” (EBNC-MM 1966).

5.3.2.2 Rhetoric of protection

The rhetoric of sterilization as “protection” is a consistent theme within the records. Protecting mentally ill or feeble-minded individuals from the burdens of parenthood was often given as a main reason in support of sterilization within the case summaries. One of the interesting discursive contradictions is that it was used to justify

the sterilization of very young children, many as young as 10 years old – who, in both current and contemporary state law, are far beneath the age of consent. “Protection” from the burdens of pregnancy and parenthood in such cases required unnecessary surgical procedures performed on children, and did not protect them at all from the rape and sexual violence indicated by such pregnancies. In 1963, the Eugenics Board discussed a petition regarding a twelve-year-old black girl from Mecklenburg County. Kendra Robinson had to stop school when it became clear that she was pregnant. It was her stepfather’s baby. A sister two years older than Kendra also had a new baby, believed to have been fathered by their mother’s husband who recently had been sentenced to jail for rape. Case notes read, “Her mother is immoral and does not give care or supervision to her children . . . Sterilization will prevent additional children being born into an environment which can offer nothing” (EBNC-MM 1963).

5.3.2.3 Domestic Violence

Professional disinterest in the rights of victims of domestic violence was one of the consistent themes throughout the records reviewed. In some cases, the interaction between a policy preference held by social workers for “keeping families together,” and the coercive approach of the Eugenics Board combined to mutually disempower the women they were charged with helping. Mrs. Sanders was a patient at Cherry Hospital at the time her petition was reviewed by the Eugenics Board. The social history accompanying her petition identified a pattern of problems between Mr. and Mrs. Sanders, resulting from: her jealousy, so many children (7 children, 6 living), her illness, and the husband’s drinking, as well as the actual physical violence which came as the

result of quarrels when Mr. Sanders beat Mrs. Sanders. She reports that Mr. Sanders demands frequent relationships and when she refuses he becomes angry and abuses the entire family. Sterilization will be a protection not only against pregnancy but will reduce the stress in husband and wife, which hopefully will prevent the illness occurring.

The petition for Mrs. Sanders' sterilization listed her husband as the sole consentor on the order for surgery. As she had been admitted to a state institution following diagnosis with "schizophrenic reaction," she was not legally entitled to give or withhold consent under the sterilization law in North Carolina. "Schizophrenic Reaction," was a diagnostic label used by psychiatrists during the time of my study, since 1960 the terminology and science of psychology has progressed substantially. Designations of "schizophrenic reaction, undifferentiated type" are now regarded as too vague, lacking in operational criteria, and the precision necessary for differential diagnoses. However, during the 1960s, specific diagnoses like the one applied to Mrs. Sanders, allowed clinicians "much discretion" and as a result "in the United States, schizophrenia became the diagnosis of choice for psychotic conditions that lacked a clear 'organic' etiology" (Tsuang, Stone, and Faraone 2000:1042).

5.4 Institutional Sterilization – White and Black Divisions

Institutional confinement was a venue for sterilization but manifested along racial lines. During the heyday of the Eugenics Movement's national popularity, North Carolina like many southern states had few institutions for the segregation of feeble-minded children or adults, and there were no institutions open to blacks with mental retardation until after WWII (Noll 1995). Prior to World War II, compulsory

eugenic sterilization laws were typically not disproportionately applied to members of racial minorities when compared to the white population. In southern states (which were thought to be more overtly racist than their northern neighbors, and had the largest black populations) strict racial segregation of medical facilities limited institutional environments for people of color. The facilities that were there lacked the staff and equipment necessary to support widespread use of sterilization procedures (Ziegler 2008:348). Before 1950, only 23 percent of sterilizations performed in North Carolina were performed on blacks although 28 percent of the state population was black (Noll 1995:102). Therefore, one clear contrast between the experiences of white women and women of color with state-funded coercive sterilization in North Carolina, was institutional context.

The need to prevent pregnancy among residents within institutions was, of course, a strong incentive to perform sterilizations. In addition, institutions faced demands from local officials to prevent residents on vacation or newly released into the community from reproducing and creating new problems. Underfunding, overcrowding, and inadequate personnel—universal issues in mental health care that were particularly acute in the South—made sterilization all the more attractive as a quick and easy way to alleviate strain on institutions.

Moreover, under the North Carolina law, Woodside (1950) explained, women did not need to be fully informed about what sterilization meant. At the State Hospital at Raleigh, patients qualified as feeble-minded were not informed about the effect of sterilization, even though the “feeble-minded” included women who had “a history or

likelihood of sexual misdemeanor in the community” who were thought otherwise to be capable of intelligent choice about sterilization. Second, North Carolina officials accepted the “consent” of a family member even if a sterilization candidate herself objected. At Goldsboro and Raleigh “patients were not considered to be intelligent [enough] to consent, and the permission of relatives was considered to be sufficient” (Woodside 1950:71). But if a family objected and the candidate consented, the candidate was almost certainly considered competent to consent, even if she had been diagnosed as feeble-minded (Woodside 1950).

At Dorothea Dix the doctor discusses sterilization first with a patient (if a recovered psychotic or an epileptic of sufficient intelligence) – in cases of feeble-minded patients who are unable to understand, the doctor consults with the relatives only (either in person or by sending them consent papers and an explanation of the petition). Feeble-minded patients are prepared for an operation, but not told what it is or why. Epileptic patients are told about the hereditary nature of their disability and the importance of avoiding reproduction.

Among institutional petitions, there were different patterns by race, which resulted from the segregation of facilities prior to 1963 (less access to institutions) and the unequal funding of existing facilities (white institutions had more resources and therefore could sterilize patients). Eugenics Board reports noted more limited use of the program by state institutions, which served black populations, than by similar institutions for whites. For example, the State Hospital at Goldsboro (for Negro feeble-minded, epileptic and mentally ill) did not have sufficient surgical services to perform these

operations (EBNC-BR 1948-1950:11). However, during the next 2 years there was a sudden increase at that institution as there were 48 procedures performed on these residents (EBNC-BR 1950-1952:7). The important role that black hospitals would play, however, is seen in how they influenced sterilization practices in public welfare officials. Furthermore, with white institutions, like Caswell, where there was a higher probability for sterilization, sterilization was originally conducted under traditional eugenics hereditary discourse and less on neo-eugenics ideological framing, and doctors began to question the acceptability and pushing of sterilization from social welfare professionals.

Although official segregation in North Carolina hospitals occurred in 1963, in practice very little actually changed until two years later when North Carolina's four mental hospitals - Dorothea Dix in Raleigh, Umstead Hospital in Butner, Broughton Hospital at Morganton, and Cherry Hospital at Goldsboro - were integrated according to a drastic reorganization plan designed to (1) avoid liability in federal lawsuits by black families and patients seeking admission to the segregated hospitals; and (2) to bring the state into compliance with the Civil Rights Act – a requirement for continued federal funding of the state's mental health initiatives (Williams 2005).

5.4.1 Caswell Training School

The Caswell Training School (Center) catered to white men and women with an IQ below 70. During 1945 and 1955 the number of residents at Caswell doubled, and a lengthy waiting list for new patients was established (Castles 2002:852). Priority in admissions decisions was given to potential admittees who did not have family members available who were willing to care for them and capable of taking them in, and according

to the assessments of referring county welfare departments and social workers regarding the cases in most urgent need of care. Caswell's population was therefore comprised of young white women from the most socially isolated and impoverished areas in the state (Castles 2002:852).

Scientific developments that demonstrated the limitations of hereditary explanations for mental retardation were slow to penetrate obscure and marginalized places like Caswell, and they were especially irrelevant for the on-the-ground work of social workers and psychologists who collected social histories and selected candidates for sterilization. Superintendents had a very paternalistic stance toward feebleminded girls and young women in their care as they saw the institution as a safe haven for impressionable and vulnerable young women who otherwise could not protect themselves from men intent on taking advantage of such women (Noll 1994:47).

These tensions finally reached the breaking point in 1959, when Caswell's sterilization program underwent a major reevaluation. The debates and conflicts over sterilization at Caswell that occurred during this transitional period are highly revealing. The reappraisal of the program brought to the surface a clear split between the medical professionals of North Carolina's mental health system, who had come to see sterilization as backward and probably useless, and social welfare professionals, who continued to see sterilization as an essential tool for care. The precipitating factor was the appointment of psychiatrist Eugene A. Hargrove, the head of the North Carolina Hospitals Board of Control, to the Eugenics Board. According to the board's executive secretary, Hargrove immediately expressed an interest in developing uniform sterilization policies for North

Carolina's institutions "from a medical view point," employing medical and psychiatric expertise.

It appears that the Eugenics Board representatives from the State Board of Public Welfare initially hoped that the attention, under Hargrove's influence, would result in the expansion of institutional sterilization programs. For some time, certain welfare workers had been frustrated by the declining numbers of sterilizations at state mental hospitals and by the failure of state institutions to sterilize cases referred to them by local welfare departments. They believed that this situation might be remedied through better communication between Hargrove and the Eugenics Board at the state level, and through codification of formal sterilization policies for state institutions (Castles 2002:858-859).

Welfare professionals, however, were sorely disappointed by Hargrove's actions. Hargrove summarily rejected a proposed policy statement, written by the board secretary after discussions with Caswell's psychologist and one other staff member that essentially codified existing practices. The policy statement emphasized the protective functions of sterilization for the individual involved, called for patients to be considered for sterilization beginning at age fifteen, and gave social workers the task of selecting cases to be considered by Caswell's council on sterilization (Castles 2002:859). Instead, after consulting the heads of the medical departments at Caswell and other state institutions, Hargrove concluded that sterilization "is generally unnecessary for persons as long as they have the protected environment of the institution." Sterilizations at Caswell came to a halt immediately. No operations were performed between July 1959 and July 1961.

When the program resumed in late 1961, it was on a much smaller scale, with only two to six operations per year (Castles 2002:860).

Clearly, Hargrove had decided not only to offer a medical point of view, but to place psychiatrists in charge of a process that had previously been dominated by social workers and psychologists. Psychiatrists and other doctors tended to define eugenics in relatively narrow terms, as the attempt to prevent the transmission of undesirable hereditary traits. From this perspective, they were probably more conscious of the questionable scientific basis for eugenic sterilization. As early as 1947, Caswell's medical superintendent had expressed ambivalence about the sterilization program, arguing that sterilization would never lead to the elimination of mental deficiency (as eugenicists had once hoped) (Castles 2002:861). Furthermore, many doctors during the 1950s were wary of tubal ligation under any circumstances, even when a woman actively sought out the operation. An unsigned note in Hargrove's Eugenics Board file asks, "What does the sterilization do to the emotional life--will it lead to behavior disorders, regression, psychosis, emphasize the 'I'm different'?" These were typical concerns for psychiatrists, who viewed women's emotional health as intimately connected with their childbearing abilities (Castles 2002:862).

The resumption of occasional sterilizations at Caswell in 1961, after a two-year hiatus, is some indication of the pressures for sterilization that emanated from both inside and outside the institution. Hargrove's belief that the structured environment of the institution made sterilization unnecessary was, of course, unrealistic. The Caswell staff continued to use sterilization in the early 1960s partly to compensate for the inadequacies

of institutional control. However, the majority of sterilizations in the early 1960s were performed for extra-institutional reasons, especially in cases where sexually active women were about to be released into the community. Caswell had finally linked sterilization with parole, if only on an occasional basis. In addition, staff members acceded to at least one parental request for sterilization (one of only two Caswell cases of male sterilization in the 1960s).

From the 1960s cases it appears that the welfare departments and their successors had won the day in the battle over sterilization. A number of the Caswell petitions noted that "community agencies will find it easier to work with her," or that "social agencies in this girl's community . . . will be more willing to assist and work with her," if sterilizations were performed (EBNC-MM Nov. 1965). Unlike earlier sterilization cases, most petitions in the 1960s were for women with mild or borderline retardation--the women most likely to be released. For the eight patients submitted to the board in 1961 and 1962, the average IQ score was 64, in the upper ranges of mild retardation.

5.4.2 The O'Berry Center

The O'Berry Center opened in 1957 as a school for African-Americans with mental retardation. The facility was integrated in 1965. No sterilizations were authorized for O'Berry residents during the 1950s; between 1960 and 1965 the school performed twelve operations. Between 1965 and 1968 (the last year that the records of the Eugenics Board give detailed information on institutional sterilizations) there were no reported operations (Castles 2002:868; EBNC-BR 1966-1968). Among the cases sampled there were four petitions filed for institutional sterilization at the O'Berry Center

between 1965-1972. Compared to the hundreds of operations at other institutions, the real significance of O'Berry participation in North Carolina's neo-eugenic program is in the extra-institutional influence of certain coercive "recommendation" practices.

Although there were only 12 operations performed at the center, several case summaries within the sampled set examined indicate O'Berry's admission policies were used to compel public welfare officials to recommend potential residents for sterilization before their arrival. For example, one 1964 special meeting case describes the situation of a 15-year old black female prison inmate's situation as follows:

[The] girl is jail in Hertford County on a moral charge. She has been rejected by relatives and no placement could be found for her. She was placed with a family in Wilson County by her mother when she was about four years old, and the Wilson County Welfare Department was contacted as well as the Hertford County Welfare Department because the family believed that [Ida] was sexually promiscuous as well as mentally retarded . . . [they] placed [her] in detention when she was found living with a 17 year old boy. O'Berry Center officials have agreed to accept [Ida] but have requested that she be sterilized before her placement there. The Sherriff of Hertford County is quite anxious to have her removed from detention, therefore, immediate action is requested (EBNC-MM Feb. 1964).

Ida's wishes or feelings about the surgery are not stated within the case record, and her signature does not appear on the consent form. The "consent" for Ida's sterilization was signed by her brother. However, no information was presented regarding the basis of her brother's legal authority in the matter, or if the siblings had a relationship of any substance (seems unlikely given that at fifteen-years-old Ida was described as "rejected by relatives" with nowhere to go, and the fact that she had been in foster care since the age of four), or even if her brother was of age to make such a significant decision on her behalf. In contrast to these silences, the conditional

acceptance extended by O'Berry Center officials and the impatience of the Hertford County Sherriff to have Ida transferred were powerfully loud.

This case typifies the particularly disempowering situations faced by young women (both black and white) who did not have a consistent parental figure present to advocate for them. Especially in cases where housing or other basic necessities were premised upon submission to sterilization orders, young women and girls were left at a substantial disadvantage to exercise reproductive autonomy in the face of a system vested with the power to implement decisions on the basis of institutional efficiency and the convenience of state officials. Here a special meeting of the Eugenics Board was called to facilitate "immediate action" as requested by the Hertford County Sheriff – a law enforcement official without any medical, psychological, or social welfare qualifications to make such a suggestion.

Sometimes the case summaries were quite explicit about the institution's motives – as demonstrated in the summary of a case involving the sterilization order for a fourteen-year-old black girl seeking admission to O'Berry: "the Superintendent . . . has requested that the welfare department assume responsibility for the operation but this will make it easier for his staff to work with Brenda" (EBNC-MM Jan. 1965).

Other case histories similarly indicated the impact of O'Berry's policy requiring sterilization prior to admission. A 1965 case presented to the Eugenics Board describes another fifteen-year-old girl being considered for admission to O'Berry. Her parents were advised by school officials that their daughter needed to have the surgery prior to admission at the institution. In this case, "The parents wish to cooperate fully with the

O'Berry Center, and therefore, are requesting sterilization for their daughter” (EBNC-MM Nov. 1965).

It seems that O'Berry officials also required sterilization prior to release of patients in a clearly coercive manner. Case 1963, "Judy is ambivalent about sterilization, although she accepts the procedure since it will help in placing her outside the institution" (EBNC Oct. 1963). "This 20 year old mother of one child is now at O'Berry School. Her child is in a boarding home as the Department of Public Welfare has custody . . . Is now doing 'day-work' in Goldsboro" (EBNC-MM Oct.1963). Judy was pregnant at the time of her admission to O'Berry, and her child was taken into state custody at birth. Her residency at O'Berry meant that Judy was required to perform unpaid labor ("day-work") and was prevented from parenting her child. This left her in a no-win situation in which the only way she could gain release from an institution that openly exploited her labor, and have the opportunity to restore connection with her child, was to submit to a sterilization that clearly was not her autonomous choice.

5.4.3 Cherry Hospital

Cherry Hospital was founded in 1877 (the hospital has operated under a variety of names: "Goldsboro State Hospital," "State Hospital at Goldsboro," etc.), when the North Carolina state legislature allocated \$40,000 to build an insane asylum for the African American population (Jackson 2005:16). By 1938, there were over 2,500 patients who were attended to by a mere 123 physicians and direct care staff (Wright 1992). Cherry Hospital engaged in the practice (common among Southern prisons and institutions in the early to mid-20th Century) of loaning or leasing out patient laborers (Smith 2009:19;

Jackson 2005; Wright 1992). Such placements were essentially a thinly veiled form of indentured servitude - with long-term childcare, household, or farm labor arrangements in which patients worked without compensation for years in the homes of hospital staff families or other private households in the surrounding areas (Burch and Joyner 2007:67).

Justified by contemporary wisdom regarding the therapeutic benefits of manual labor, Cherry routinely leased-out the labor of its black patients to local white farmers to pick their cotton and other crops, profiting the institution (Jackson 2005). The revenue generated by such patient labor did not benefit the black patients themselves: in 1957-1958 the State of North Carolina spent \$886 per patient at Cherry Hospital, approximately half as much in per capita expenditure of \$1477 to \$1844 at the state's all-white facilities (Wright 1992).

According to Castles (2002), by the late 1950s a clear pattern had developed in the types of justification for sterilization recommendations at Cherry. Cherry Hospital staff described black female patients in ways that bore much more resemblance to the case summaries of non-institutional ADFC recipients than it did to the manner in which white female patients of similar institutions were portrayed. Case summaries for black women routinely emphasized the large numbers of children that the women had already borne, the birth of illegitimate children, and the women's inadequacy as mothers (Castles 2002:869). This pattern stands in stark contrast to descriptions of white female Caswell patients, who were far less likely to have had children prior to sterilization.

For some male patients, they were subject to sterilization as punishment. After being imprisoned for an alleged attempted rape in 1925, 17-year-old Junius Wilson was declared insane and sent to Cherry Hospital in Goldsboro, a state mental facility. The attempted rape charge was then dropped. In 1932, Wilson was castrated in accordance with state law for “mental defectives and feebleminded inmates” accused of sex crimes. He remained in state custody for 67 years. In 1991, he was found not to be mentally ill, just deaf. In 1992, he was officially freed and within two years he was given a three-bedroom cottage to live in on the grounds of Cherry Hospital. Wilson died in 2001 (Burch and Joyner 2007).

Pressures eventually eased the number of sterilizations performed at Cherry. Advocacy by North Carolina Association for Retarded Children a middle-class organization of parents of children with mental retardation, who sought to transform the public's image of mental retardation and secure increased funding for the advancement of medical and institutional care of those with intellectual disabilities (Castles 2002).

5.5 Extra-Institutional Sterilizations

Between 1950-1965, there was a dramatic shift in the institutional status of women sterilized by Eugenics Board order – an increasing percentage of sterilization orders were for non-institutionalized women. In 1950, 57 percent of all women ordered sterilized by the Eugenics Board were institutionalized – by 1965 this number had declined to just 15 percent. The board gradually began to receive more extra-institutional petitions for women in their twenties and thirties, many of whom already had several children. For the most part, then, institutional sterilization of the mentally retarded

remained a white phenomenon, while extra-institutional sterilization was increasingly prescribed for black women (Castles 2002:858). As more and more black families appeared on the welfare rolls in the 1950s, and as the proportion of extra-institutional sterilizations rose, the proportion of black women sterilized increased dramatically (Castles 2002:857).

5.5.1 From Feeble-mindedness to Welfare Queens

Although eugenic science was discredited by the 1940s, the policy goals behind the programs remained. Eugenic sterilization programs continued to offer a medical solution to hereditary feeble-mindedness and to cut welfare rolls by reducing the number of children born to welfare recipients. Thus, as welfare rolls grew in the 1950s and 1960s, eugenic sterilization programs in a few states expanded. Continuing such programs became particularly appealing in the postwar period when sex outside of marriage and rising illegitimacy rates seemed to threaten the stability of the American family. Eugenic sterilization could be used to combat the problem of illegitimacy. The “rediscovery” of poverty in the early 1960s further fueled concerns about the reproductive capacity of poor families and solidified the link between illegitimacy and innate immorality (Schoen 2005:108).

Reviewing AFDC rolls was one way of retrieving names for potential sterilization. On July 1, 1961, Sue Casebolt took over as the executive secretary of the eugenics board. Before the month was over, she was pushing a new agenda that would target girls like Ramirez.

I now propose to have as my objective as Executive Secretary to work to promote earlier use of the (sterilization) program that is, after the first rather than third of (sic) fourth child, which would result in prevention of problems requiring staff time, money, and use of other needed community resources. To this I plan to use all resources available to secure information as to persons who need to be offered the service. A few of these are: Mental Health Clinics. 2. County Health Officers. 3. Public Welfare records such as APTD and ADFC (Eugenics Board minutes 1961).

Many of the women sterilized in the late 1950s came to the public maternity clinic where they were seen by the Health Department's Dr. Elizabeth Corkey. An obstetrician who came to Charlotte in 1955, she emerged as a leader in improving race relations and women's reproductive rights. Becky McNair, a caseworker from 1961 to 1964, remembers Corkey as "a hands-on, caring person" who was central to the sterilization push.

In 1952, North Carolina also restricted AFDC eligibility with an employment requirement policy (Reese 2001:71). Reese argues that welfare boards shaped their welfare policies to suite farmers' needs: "I argue that states were more likely to restrict AFDC eligibility where agricultural capitalism was an important part of the State's economy" (Reese 2001:76). The North Carolina State Board of Public Welfare noted that its newly created employment requirement for AFDC was "expected to be of particular value in counties where there is a considerable amount of seasonal work in agriculture" (Quoted in Reese 2005:50). In 1950, blacks were described as living under conditions of "poverty, neglect, and rural isolation" and that "although the Plantation System has almost disappeared . . . tradition and custom of former days still influence the behavior of the more ignorant people in the South" (Woodside 1950:3).

5.6 Legacies and Reproductive Citizenship

By the time the Board was abolished in 1974, it was virtually obsolete – in part because the N.C. legislature passed the voluntary-sterilization legislation in 1963.

Wallace Kuralt and a number of physicians successfully lobbied for the passage of a voluntary sterilization bill. Kuralt argued that women from all economic backgrounds should have access to a range of reproductive health options, including: contraceptives, sterilization, and abortion. North Carolina became the first state to legally permit voluntary sterilization (Schoen 2005:120).

Today, it is impossible to tease out the exact mix of good intentions and overzealous execution, prejudice and paternalism that let sterilization crusades run unchecked during this time period. But key actors like Wallace Kuralt had no regrets. In writings and interviews throughout his life, he described sterilization and birth control as the key to saving tax money and rooting out poverty among the "low mentality-low income families, which tend to produce the largest number of children" (Charlotte News 1964). In his 1964 piece in *The Charlotte News*, Kuralt noted that one-in-three Negro children was born to an unmarried mother and "These children came into the world with all the odds against them," he wrote, "and their mothers face a blighted life of hopeless struggle just to survive." Compassionate, visionary, and a champion of women and the poor: that is the reputation that Wallace Kuralt built as Mecklenburg County's welfare director from 1945 to 1972. Today, the building where Charlotte's poor come for help bears his name - a name made even more prominent when his newscaster son, Charles Kuralt, rose to fame (Helms and Tomlinson 2011). Regardless of intentionality, because

of the actions of Charles Kurlalt, Ellen Winston, and the Eugenics Board women of color were systematically denied reproductive rights and they were held hostage to the notion that they were deemed unworthy of the rights that are afforded with full citizenship status. They were defined by their reproductive capacity and reproductive citizenship was the axis which solidified their exclusion from reproductive rights and guided the way social workers surveyed and controlled their bodies.

6. 1965-1980: Shifting Social Threats and Rights

This chapter traces new ideological discourses justifying coercive sterilization in extra-institutional settings but also the decline of the North Carolina Eugenics Board and the emergence of the improvement in the quality and character of reproductive citizenship. Whereas reproductive autonomy for women of color in North Carolina between 1950 and 1964 was primarily shaped by progressivism and rapid expansion of a state welfare bureaucracy that in many ways remained deeply rooted in traditional eugenic biologically deterministic discourses about the genetic transmission of feeblemindedness and poverty, from 1965 forward the reproductive citizenship rights of women of color were predominantly affected by the development of parallel ideological discourse narratives surrounding urban overpopulation and concerns regarding cultural transmission of welfare dependence within contemporary discourses of race, welfare, citizenship, and reproductive choice. Ideological discourse fuelled powerful controlling images of women of color associating them with moral and economic threats to the nation, which was considered to be under siege due to the rising rates of illegitimacy. Environmental (as opposed to biological) theories of inequality were used to critique female-headed black families as a locus of intergenerational cultural pathology and enforced growing popular resentment over perceived unjust burdens to tax-paying citizens resulting from the reproductive choices made by poor women of color. These more racially covert ideological discourses, nevertheless, did not end the tenacity of overt racial ideologies, and as Angela Davis rightfully stated, North Carolina at that time was “not the New South.” Genetic fears over miscegenation, overt racial profiling

of Indian women in the Robeson County Clinic, and academic research that attempted to bring back traditional racial biological determinism was also present in this period.

Previously, popular understandings of inherited feeble-mindedness and mental deficiency, and the widespread institutionalization of those so identified had the effect of delegitimizing and silencing the voices of those most impacted (those with disabilities, and poor young women of color) by the coercive programs of the Eugenics Board. During this time period, however, the popularization of mainstream (white) feminist discourse which centered on the fundamental importance of women's rights to reproductive autonomy – most notably in the landmark abortion rights case *Roe v. Wade* (1973) – had an important facilitating role in the expansion of institutionally-protected reproductive citizenship rights for women of color. While the embodied experience of citizenship with regard to rights to bodily integrity and reproductive autonomy for women of color in North Carolina was clearly constrained throughout this time period, ultimately we see a substantial increase in the reproductive autonomy available to women of color by the end of this period.

Expanded access to reproductive rights for women of color in North Carolina between 1965 and 1980 was specifically supported by four key mechanisms: (1) public outcry and legal negotiations shifted access to reproductive rights following a series of high-profile legal cases involving women of color seeking legal redress after experiencing coercive sterilization in the early to mid-1970s; (2) shifts in popular understanding and discursive frameworks prompted by emergent national coalitions of feminists and women of color advocating for reproductive and welfare rights; (3) the

implementation of the Voting Rights Act which dramatically increased political representation as more minorities, and women of color in particular, attained elected office; and (4) the implementation of state and federal policies protecting reproductive autonomy.

The emergence of rights claims to social citizenship benefits (including both financial support from public welfare programs such as AFDC, and increased access to reproductive options made possible by the federal implementation of the Medicaid program) from women of color within the public sphere and political arena profoundly shaped policy responses to contemporary social problems including overpopulation concerns at the national and global level, urbanization, racial desegregation and civil rights unrest, poverty reduction, and reproductive choice. These claims and their impact on prevailing ideologies of citizenship marked an important interruption of the historical exclusion of women of color from cultural and political influence as citizens whose interests had a legitimate role in shaping popular ideologies.

6.1 Key Developments and Trends

At the national level, the early 1960s brought a number of important changes in federal legislative policies and shifting ideologies that impacted the reproductive liberties of women of color in North Carolina. Within North Carolina, deinstitutionalization of mental health facilities also greatly shaped where sterilizations took place.

6.1.2 War on Poverty and Federalization of Welfare

After President Kennedy's assassination in 1963, the new President Lyndon Baines Johnson (1908-1973) continued and expanded his predecessor's antipoverty

efforts. In 1964, Johnson declared an “unconditional war on poverty in America,” and announced a reform program known as “The Great Society.” The Office of Economic Opportunity (OEO) was established by Congress in 1964, which funded Community Action Programs (CAP), Head Start, and the Job Corps (Schulman 1995). Increases in social welfare provisions under the War on Poverty launched by President Lyndon Johnson in 1964, along with the Food Stamp Act of 1964, marked this year as a time of increasing citizenship rights for poor black mothers, who for the first time in history had access to a system of social provision that historically left them to their own devices.

The “rediscovery of poverty” during President Kennedy’s administration (1960-1963), raised national awareness of persistent, structural poverty in the United States. In the same year, there were substantial changes that resulted in expansion of the ADC program (renamed AFDC). The federal Bureau of Public Assistance (BPA), which ran the ADC program, issued a directive against states’ and localities’ use of “suitable home” rules, that had traditionally been used to keep children of unwed mothers out of the program (Gabe 2011:56). In his statement at the signing of the 1962 Amendments, President Kennedy described it as “a new approach—stress[ing] services in addition to support, rehabilitation instead of relief, and training for useful work instead of prolonged dependency . . . [the] objective is to prevent or reduce dependency and to encourage self-care and self-support to maintain family life where it is adequate and to restore it where it is deficient” (Gabe 2011: 8). In 1962, support of a second parent in a family who was incapacitated or unemployed was allowed, and the program’s name was changed to the Aid to Families with Dependent Children (AFDC) (Gabe 2011:55).

As the War on Poverty simultaneously increased women of color's access to services while also helping to shape new ideological discourses the federalization of welfare and Medicaid funding during this time period gave state bureaucracy less power and made the Eugenics Board less necessary for social workers seeking sterilization of clients (Dobelstein 1973:250). The new availability of federal funding for reproductive healthcare under the Medicaid Act meant that the Eugenics Board's financial provision for sterilization services no longer motivated social workers to petition the Board for sterilizations that could be performed in their own counties with the availability of federal funding. In 1966, the OEO provided guidelines for community-level funding for family planning. A portion of the 1967 Social Security Amendments required state welfare agencies to develop family planning programs and permitted federal grants to voluntary, nonprofit organizations such as Planned Parenthood (Gordon 2002).

In the first period in the 1950s the Federal administration of ADC left states with a lot of autonomy to write their own welfare policies. Some states made cutbacks during this time and some did not – states that restricted ADC eligibility during this time were often influenced by racist whites, concerned with maintaining the racial status quo, and agricultural capitalists, concerned with maintaining a ready sure supply of low-wage seasonal labor. Although reluctant to do so, they could threaten to withhold federal funds if state welfare policies did not comply with the Social Security Act and other federal laws. Yet, in the 1950s, federal welfare officials exercised particularly lax control over ADC, facilitating state-level cutbacks in the program. However, not all states restricted ADC eligibility in this period. Whether or not states restricted ADC eligibility in the

1950s was mainly determined by the nature of their race relations and political economy. The ADC program became more inclusive of unwed mothers and minority families – federal government increased pressure on state officials to stop discriminating against non-white applicants. In response to the 1950s backlash, many states adopted either legislation or administrative decision strict formal eligibility rules for ADC – two most common types “employable mother” and “suitable home” NC instituted an employment policy in 1952.

In 1962, the Bureau of Family Services ordered that state plans for determining eligibility for AFDC “respect the rights of individuals . . . and not result in practices that violate the individual’s privacy or personal dignity, or harass him, or violate his constitutional rights.” Implicitly, states that did not comply could risk losing federal matching funds (Gabe 2011:56). In 1974, the new Social Security Amendments created a Title XX, which expanded eligibility for free or subsidized social services to the non-poor, but with a spending cap, rather than an open-ended matching grant. Title XX further severed the provision of social services from the provision of cash aid (Gabe 2011:58). In 1972, HEW issued a mandate to states to separate the provision of services from the administrative function of determining eligibility for aid. Under the mandate, social services would still be provided at the families’ request, rather than on a routine basis.

6.1.3 Sterilization changes

The War on Poverty, the federalization of welfare systems, the *Brown v. Board of Education* decision, along with the passage of the Civil Rights Act of 1964, on the one-

hand increased women of color's access to services and led to a gradual desegregation of hospital facilities but also collided with the deinstitutionalization trend of mental health patients. These factors led to an increase in the proportion of sterilizations performed on black women in non-institutional settings (see Figure 9) (Ziegler 2008:348).

Beginning in the 1950s, a historical trend toward the deinstitutionalization of people with mental illness represented a massive restructuring of the prevailing models of institutional care, with many large state-run programs closing or at least being rededicated to serve other medical health purposes (Lamb and Weinberger 2001). The new trend was to close asylums and move toward community-based placements for patients who could not be cared for at home. In North Carolina, as elsewhere in the South, institutions for the feeble-minded and mentally ill faced significant financial strains following the Great Depression (Castles 2002:852). These pressures were only exacerbated after 1945 by the legal obligations placed on institution Superintendents by the State's Eugenic Statute along with the Eugenics Board's active encouragement of policies requiring that patients be sterilized as part of routine intake and discharge procedures, all which served to strain an already overburdened system even further. This mirrored a larger national trend, which led to rapid institutional decline between 1955 and 1980 the population of such institutions rapidly declined – falling from 559,000 to 154,000 (Koyanagi 2007:5).

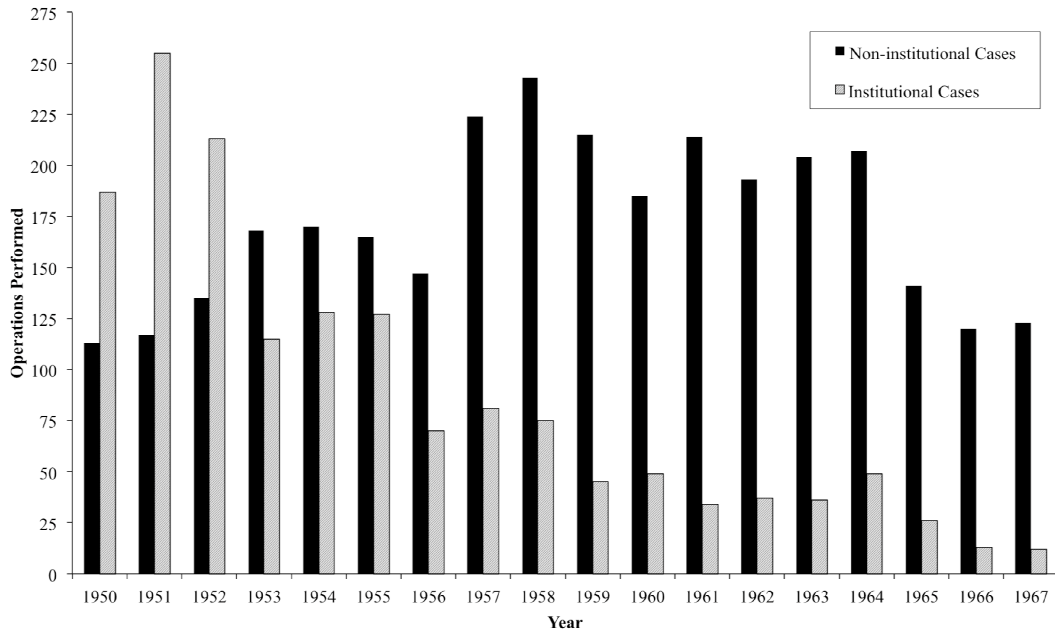


Figure 9: Shifts in Institutional and Non-Institutional Cases

There also were shifts in the ages of women who were considered for sterilization and increased attention given to promiscuity and lax informed consent. The ages of women whose cases were presented to the Board for orders of sterilization declined substantially from the time period prior (see Table 8). This trend reflects the profound impact of a Eugenics Board policy, initiated by Ellen Winston, whereby social workers tracked relatives of those for whom sterilization was ordered in order to follow up with children or younger siblings as they reached adolescence. Between 1965-1970 the average age of white women presented to the Eugenics Board was 19.5, as compared to 21.9 previously. A similar pattern held for black women. Between 1965-1970 the average age of the black women in the cases I reviewed was 17.72. This represents a substantial decrease in the average for women sterilized between 1950-1964, which for black women was 20.36. The only group whose ages did not show a decline was the

Lumbee; however, the significance of this is unclear, due to the limitations arising from small size of this group during the second time period. Between 1965-1970 only three petitions for the sterilization of Lumbee women were presented to the Eugenics Board (EBNC-BR 1964-1966; 1968-1970).

The mention of promiscuity as a justification for sterilization in the cases I reviewed is seen in the following example.

Sexual experiences began when she was eight years of age and was raped repeatedly by her step-father. At age fifteen, two boys supposedly raped her although they claim that she offered no resistance. The Court found her to be promiscuous in September 1964. Because of her promiscuity, the mother is afraid of letting her out of the house alone for fear that she will become pregnant (EBNC-MM May 1966)

Table 8: Ages of Sterilization Victims by Gender

Age Range	Males	Females	Total
10-19	445	2,545	2,990
20-29	368	2,553	2,921
30-39	205	1,229	1,434
40-49	78	91	169
50+	12	0	12
Unknown	2	0	2
Total	1,110	6,418	7,528

Eugenics Board Records from this time period show clear signs of attrition of adherence to program policies and standard practices. One disturbing way that this

pattern shows up is in clear violations of informed consent policies. For example, there was a rise in prevalence of cases where sterilization was ordered on the basis informed consents signed by patient's mothers, who themselves had been previously identified as feeble-minded; or cases where both the mother and the patient signed the forms and both were identified as feeble-minded.

6.2 Ideological Discourses of Population and Welfare Explosions

Whereas between 1950-1964 the institutional ideological discourse reflected in descriptions of women within the Eugenics Board Meeting Minutes had a paternalistic tone, that emphasized the state's responsibility to protect those seen as feeble-minded or otherwise disabled, after 1965 this discourse shifted. The shift was from a paternalistic/protective biologically-framed discourse around the target population during the first time period, toward one that increasingly was environmentally-based and concerned with protecting the state and taxpayers from welfare expense. Eugenics Board and Human Betterment League "educational work" showed new emphases on sterilization as a personal choice and the duty of responsible reproduction and foregrounded the "value of sterilization for the particular individual" (EBNC-BR 1964-1966). For example, one meeting note stated: "While sterilization will not have any effect on her behavior and adjustment, it will stop additional children from being born to become public charges" (EBNC-MM Mar. 1967). The language and actions of social workers and the Eugenics Board was part of the two parallel ideological narratives being employed throughout the nation regarding the threats of population and welfare explosion, intricately tied to racial constructions, and the perceived burden they would

put on the State (and white citizens). The discourses of this time period shows that sterilizations had as much to do with taxpayer stinginess, controlling women's sexuality, and political expediency as with eugenics or the "rationalization" of reproduction (Ladd-Taylor 1997).

6.2.1 Population Explosion

Popular support for federally funded family planning programs increased dramatically during the 1960s – largely driven by growing concern about overpopulation as a threat to political, social and economic stability in the United States and abroad (Critchlow 1999). In 1961, Planned Parenthood formed a new division known as Planned Parenthood-World Population, which worked to build public support for population control as a part of United States foreign and domestic policy (Gordon 2002). Stanford University biology professor Paul Ehrlich's bestselling book, *The Population Bomb* (1968), is considered the classic statement of environmentalist concerns with overpopulation – he warned that future mass starvation and irreparable environmental destruction would result if world population growth was not controlled.

President Johnson's 1965, 1966, and 1967 State of the Union addresses identified world population growth as an issue of increasing concern and urgency. In 1965, Johnson indicated that he would "seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity of world resources." The 1966 address sought to apply this knowledge and dedicated financial resources – Johnson promised, "to help countries trying to control population growth by increasing our research, and we will earmark funds to help their efforts." Johnson's tone in the 1967

State of the Union strikes a note of panic that reflects an increasingly urgent tone within popular and political discourses regarding population control: “the greatest challenge to the human family is the race between food supply and population increase. That race tonight is being lost. The time for rhetoric has passed. The time for concerted action is here.”

However, contrary to the predictions of population control advocates, such as Paul Erlich and Hugh Moore, by 1968 there was a sharp decline in the growth rate of the U.S. as well as many developed nations. In fact, in 1968 the national population growth rate had fallen to 17.5 per thousand – the lowest it had been in the post-war period. This meant that, excluding growth due to immigration, the U.S. was experiencing zero population growth. As a result, public support for heavy-handed population control tactics and coercive family planning programs also began to decline and counter narratives about reproductive rights could emerge (Critchlow 1999:150).

6.2.2 Welfare Explosion

While concerns about “population explosion” shaped U.S. foreign policy and increased popular support for federally-funded family planning abroad; domestically, support for federal population control programs was driven by widespread fear of a perceived “welfare explosion” – linked to the social disruption created by out-of-wedlock births, especially among poor urban blacks (Critchlow 1999). Nationally, this concern with population growth was tied-up in long-standing stereotypes regarding black families, and black mothers, in particular (Jones 1985).

In 1961, there were substantial changes that resulted in expansion of the ADC program (renamed AFDC). Nationally, the number of people on AFDC rose from 3 million in 1960, to 4.3 million in 1965, and to 8.5 million in 1970. In response to widespread public concern about the “welfare problem,” President Johnson initiated federal funding for family planning projects as a part of his War on Poverty. In 1966, the OEO provided guidelines for community-level funding for family planning. A portion of the 1967 Social Security Amendments required state welfare agencies to develop family planning programs and permitted federal grants to voluntary, nonprofit organizations such as Planned Parenthood (Gordon 2002).

Expanding welfare caseloads were beginning to contribute to the perceived “welfare crisis,” by the mid-1960s (Gabe 2011:57). Contributing to the “crisis” was a growing number of families potentially eligible for cash assistance, as the baby-boom generation began entering adulthood, as well as changing social behavior relating to marriage, divorce, and childbearing (Gabe 2011:57). Between 1961 and 1967, the share of families receiving AFDC who were headed by never married mothers would increase from 21 percent to 28 percent (Gabe 2011:57). In addition to an increasing number of potentially eligible families, an increasing share of such families applied for and were granted assistance during the 1960s, with the participation of eligible families in AFDC increasing “from perhaps 33 percent in the early 1960s to more than 90 percent in 1971” (Gabe 2011:57).

The Republican 1968 gubernatorial candidate Mel Broughton Jr. argued that all welfare recipients should “be required to limit the size of their families” out of wedlock.

He described himself as "sick and tired of the waste and inefficiency, the overlapping and duplication of services which runs throughout the entire federal poverty program," if elected he would "use the influence of my office to persuade the federal government to either make poverty programs truly meaningful and worthwhile or to abolish them" (Broughton 1968:2).

The role of social workers in monitoring the reproductive and parenting choices of women increased with the popular criticism of welfare provision and its resultant sorting of women into categories of deserving and undeserving of public support. The policies of social welfare bureaucracies allowed them to closely monitor women of color protecting state resources from the undeserved use of public funds by "welfare queens" through the implementation of punitive and controlling social policies intended to reduce the burden on taxpayers and the American welfare state (Collins 1998:36-37).

6.2.2.1 Illegitimacy and cultural pathologies of black families

In North Carolina in 1965 the *Health Bulletin* stated that 25 percent of teenage births were illegitimate. The author of the article stated: "There is deep concern about out-of-wedlock births, especially among teenagers. Not only because of the unfavorable consequences, their infants and even the putative fathers. But only also for the heavy burden placed upon community health, welfare, and educational and economic resources. In North Carolina, as elsewhere, the number of illegitimate births have been rising...health workers have an opportunity, indeed a challenge, to move more aggressively" (Siegel 1967:5). This was a challenge taken up by welfare workers in various departments. Statewide campaign to address the problem of illegitimacy in North

Carolina grew in this period with programs initiating in Northampton, Halifax, Bertie, Duplin, Pender, Jones, and Brunswick.

Popular concern regarding reports of growing trends of illegitimacy and welfare dependency continued to find reflection in the policies of social welfare departments. In May 1968 the North Carolina Board of Welfare adopted a regulation requiring instruction in birth control for all women receiving Aid to Dependent Children. However, just four months later, the Department of Health, Education, and Welfare required that this policy be discontinued because of its conflict with federal laws permitting such information to be made available but not required (“Familiar Pattern” 1968).

The North Carolina welfare offices also linked illegitimacy and women of color. Eugenics Board Chair, Ellen Winston, suggested that Dr. John R. Larkins, head of “colored work” in the state’s welfare department, call a meeting in Northampton on the problem of illegitimacy. Larkins pointed out that in 1957, 79 percent of the illegitimate children in the state were colored. However, he says, “Just as there are many causes of the problem, so there must be many different kinds of action to alleviate it. The problem stems largely from poverty and ignorance” (Eugenics Commission Record Group). Larkins pointed out that the problem could not be solved by denying children born out-of-wedlock welfare payments and depriving them of opportunity.

Linking blackness, illegitimacy, and culture reached its highest level with Senator Daniel Patrick Moynihan’s 1965 report “The Negro Family: the Case for National Action.” His report popularized social science theories, which attributed racial patterns of economic inequality and persistent poverty to cultural deficiency in black families.

Between 1940-1963, rates of illegitimacy among both white and black illegitimacy increased. Over this thirteen-year period, the number of illegitimate children per 1,000 live births increased by eleven among whites, and by sixty-eight among nonwhites. At that time fourteen percent of black children's families were currently receiving AFDC assistance, while two percent of white children's families currently were. Among white children eight percent would receive welfare assistance at some point in time, compared to fifty-six percent of non-white children's families who would draw on welfare support at some point before they reached adulthood (Johnson 1965).

The report included Moynihan's characterization of black families as bound within a "tangle of pathology," a dysfunctional pattern in his observations of black families. It was to black mothers primarily that Moynihan attributed patterns of intergenerational transmission of pathological dysfunction – a set up for persistent economic inequality and limited life chances facing black men, and a cycle of welfare dependency that had become inseparable from popular perceptions of black women by this time. Drawing on the classic theories about family environments formulated by sociologists such as E. Franklin Frazier in the 1940s and Oscar Lewis, Moynihan adopted a Culture of Poverty perspective on urban poverty and changes in structure among families of color in the United States. It reflected an emerging consensus of liberal social science researchers, which framed unmarried (or "overly dominating") black mothers as a "matriarchy" responsible for the transmission of "loose sexual behavior" and "moral degeneracy" (note: not genetic degeneracy) in their children (Feldstein 1994:269). Black women were blamed for their own poverty, the harsh economic inequalities facing black

people as a group, and even the fate of national public stability (Collins 1998; Lubiano 1992).

The report's findings were controversial but also highly influential – they were quickly embraced and advocated by President Johnson, and it had a large impact on welfare policy. Shortly after the report was released, Johnson gave a speech at Howard University (June 1965) that incorporated Moynihan's framing, and presented prevailing liberal understandings of black families as fundamentally broken and ensnared in a "circle of despair and deprivation" (Johnson 1965). Moynihan argued that, contrary to dominant white social norms, the black family was organized according to a matriarchal family structure (Johnson 1965). As a result of this pathological structure, black males were said to lack appropriate adult role models, and failed to create stable self-sufficient two-parent families. According to the report, in order to reduce demand for state welfare assistance, the state should enact policies and programs to support the economic position of black males.

Moynihan's call to action was a plea for the "restoration" of black male family leadership. He argued that the black family's current matriarchal form violated the very nature of manhood in American thought. This plea was consistent with traditional liberal ideas of citizenship specifically, the independent male breadwinner citizen and a maternalistic citizen-producing ideal of womanhood – this was a narrative of citizenship that left no space for black mothers much less a grounding for reproductive citizenship for women of color.

6.3 Tenacity of Overt Racial Ideologies

The more covert ideological discourses of population and welfare explosion as it pertains to race, as welfare actors tried to frame poverty in environmental and cultural factors tied to race but not caused by it, does not mean that the prevailing overtly racist logic was absent. The fact that North Carolina did not represent a “New South” with regards to racial politics was expressed forcefully on February 19, 1974, when Angela Davis appeared at the Memorial Auditorium in Raleigh as the keynote speaker for a rally sponsored by the multi-racial people of color-led organization, North Carolina Alliance Against Racism and Political Repression. Davis condemned institutionalized racism within the state's correctional system. Davis and other radical blacks protested the P2 Federal Center for Correctional research where behavior modification research was taking place at the State Hospital at Butner. Among feminist women of color, Davis was also an early outspoken, and nationally influential, voice against coercive sterilization practices. In her Raleigh speech she called attention to the coercive sterilization case of Elaine Riddick Trent (who was currently suing the state of north Carolina for a 1968 sterilization ordered by the Eugenics Board). Davis drew widespread attention to the case noting that Trent was only fourteen-years-old at the time of her sterilization and did not even learn of the operation until she was nineteen. The case of coercive sterilization against Indian women in the Robeson County Clinic and the reemergence of academic biological race determinist arguments also represented how overtly racist practices can coexist with dominant cultural interpretations during this time.

6.3.1 Robeson County Clinic and Testing IUDs

In 1965 the Congress of the United States gave recognition to the Lumbee as an Indian group (meaning that they fall within the boundaries of the current definition of who is an American Indian) while specifically excluding them from any benefits or future legal claims against the Federal Government on the basis of Indian status (Davis 1974). In 1966, the OEO provided new guidelines for community-level funding for family planning. Robeson County received its funding through the State Mental Health Fund and the AFDC program because of the portion of the 1967 Social Security Amendments that required state welfare agencies to develop family planning programs. The program's only physician, Dr. Ann Huizinga of the North Carolina State Board of Health chose Robeson County as the setting for a pilot study in family planning. Robeson County Welfare Commissioners eagerly supported the implementation of a family planning program as they hoped to address popular concerns about "the relatively high birth rate in Robeson County" (Davis 1974). From the time of the clinic's inception, the types of contraceptive technologies offered by the clinic, were shaped by Dr. Huizinga's interest in assessing the feasibility of intrauterine device clinics in North Carolina. The clinic was open each Tuesday from 10:00 a.m.-4:00 p.m., and there was no charge to patients for any clinic service (SBH-BR 1943).

A 1974 study, the "Fertility Behavior in a Tri-Racial, Low Income, Rural County" was funded through a research grant by the National Institute of Child Health and Human Development (Davis 1974). The study's findings offered provocative insights into the racial structure of the Robeson County Clinic. According to the public health

investigator's report, "the program operates on the assumption that the average patient is either not intelligent enough or not conscientious enough to use most other methods affectively . . . there is a belief that, especially among the Indian groups, the cultural barriers are insurmountable" (Davis 1974). Therefore, Dr. Huizinga was in the practice of prescribing the implantation of IUD's in 99.6 percent of the clinic's cases. Oral contraceptives were given to less than 1 percent of all patients seen by the clinic. Davis' report indicated that the near-exclusive use of IUD's was according to a preference of Dr. Huizinga. The reason for the almost exclusive use of IUD in the clinic lies primarily with the preference of the family planning clinician. He notes "concern among the public health director and clinic personnel that the clinician's refusal to prescribe oral contraceptives even to women who request the method exclusively" (Davis 1974). The program reports referring "a great many" patients to the local hospital for sterilization . . . the clinician recommends sterilization when a woman has had about four live births, although this recommendation may vary according to the health of the mother, living conditions in the home, and other factors which he considers important" (Davis 1974:142).

In 1972, the Robeson County Clinic served 713 female clients (the clinic only saw women), who were 48.2 percent black, 38.6 percent Indian, and 13.2 percent white. While the program provided an important and unique resource for women of color in Robeson County and the surrounding areas many of whom previously lacked access to private physicians for such services, there were also indications of problems within the program. In 1972 alone, 176 patients left the program. Follow up interviews with former

patients indicate that most of those who left (40.9 percent) requested that the IUD be removed either by the clinic, usually due to undesirable side effects, and an additional 7.9 percent expelled the device (Davis 1974).

When “the pill” became widely available it was adopted by many county health departments. Robeson County's Health Department took the position that something requiring no attention and no remembering would be more effective, in practice, among persons using public services. Instead it became the first health department in North Carolina to implement the IUD, although it had only previously been tested in a "city hospital in another state" ("Conclusion Confirmed" 1965).

In 1970, Robeson County Health Director Marion Pate was planning an expansion for the family planning program because of the belief the population explosion is getting out of hand. She stated that the "department wishes to expand existing program so that more women will be able to take advantage of the services" (Davis 1974:120). Expanded services were to be given in conjunction with the maternity clinic every Tuesday at 1:00 p.m. Robeson county birth rate was 22.7 percent per 1,000 population. White birth rate = 16.4 per 1,000 - nonwhite rate - 26.8. In Robeson County approximately 20 percent of births were to unwed mothers (Halferty 1970). Patronage of prenatal health clinics in Robeson County is 43 percent Indian, 5 percent white, and 52 percent Negro. "The public service of the Health Department are used less extensively by the white population than by other races. The difference is offset by a larger number of visits to doctors' offices" ("Use of Services" 1966).

A Scotland County case summary describing an Indian woman's situation reflects the influence of ideological discourses framing American Indian women on medical and social work professionals. It reads, [she] "is a "work horse," "cutting and hauling wood, and any type of field work. She does not 'go out' with men in the usual sense, but has her relations with them in the fields where she works. She has no guilt about her behavior and says she enjoys it and plans to continue" (EBNC-MM May 1967). Scotland County is located directly west of Robeson County, the historical home of the Lumbee tribe. American Indian women represented moral threats embodied through discourse that personifies the controlling image of the figure of the Squaw.

6.3.2 Biological Determinism Revisited

The prevailing ideological shift toward environmental/cultural explanation did not altogether negate the scientific legitimacy and popular appeal of biological or genetic explanations of inequality – in fact, these became: (1) more closely tied with race (whereas previously the focus was on developmental disability and mental illness among whites); and (2) understood as working in combination with environmental or cultural factors to produce unequal life chances. Berkeley psychologist Arthur Jensen, Harvard psychologist Richard Herrnstein, and Stanford physicist William Shockley (Nobel laureate) argued that racial inequality was a result of blacks' cognitive inferiority and underachievement. Furthermore, they argued that the nation's welfare was threatened by the combination of low IQ scores and high birth rates among the black population (Roberts 2011:46). In a 1969 *Harvard Educational Review* article Arthur Jensen argued against the "social deprivation hypothesis," an environmental theory in favor over genetic

explanation of racial differences in IQ test scores. He wrote, “Is there a danger that current welfare policies, unaided by eugenic foresight, could lead to the genetic enslavement of a substantial segment of our total population?” (1969:95).

6.4 Improvements in Reproductive Citizenship

Although this period personifies increased sterilization of women of color from the previous, by the end of the period there is a substantial increase in their reproductive autonomy. Four mechanisms situate how women of color were able to attain more reproductive control: (1) public outcry and legal negotiations shifted access to reproductive rights following a series of high-profile legal cases involving women of color seeking legal redress after experiencing coercive sterilization in the early to mid-1970s; (2) shifts in popular understanding and discursive frameworks prompted by emergent national coalitions of feminists and women of color advocating for reproductive and welfare rights; (3) the implementation of the Voting Rights Act which dramatically increased political representation as more minorities, and women of color in particular, attained elected office; and (4) the implementation of state and federal policies protecting reproductive autonomy.

Moreover, although the Eugenics Board was active and pursuing sterilizations in non-institutional settings their operations were in steady decline. In 1964 the North Carolina Eugenics Board ordered the sterilization of 256 people. From this year until the program’s closing, the Board’s activities would slowly dissipate. The Board ordered sterilization in fewer and fewer petitions because of dissent from within the Board and internal conflicts regarding their role in controlling reproduction when it was now clear

that feeble-mindedness was of questionable scientific validity and most mental illness was not inherited (Schoen 2005). By 1973, the last year for which statistics are available, 60 percent of cases presented were rejected (see Table 9) (NCSA – DHR 1970). This stands in stark contrast to the previous time period in which prior to 1962, the Board ordered sterilization in 98 percent of all cases presented (Schoen 2005:264).

Table 9: Sterilizations Petitions Reviewed and Ordered by the Eugenics Board, 1965-1973

Year	Petitions Presented	Petitions Ordered	Percent Ordered
□ 1965	226	183	81%
□ 1966	191	161	84%
□ 1967	223	174	78%
□ 1968	193	162	84%
□ 1969	198	162	82%
□ 1970	213	135	63%
□ 1971	165	106	64%
□ 1972	116	71	61%
□ 1973	47	19	40%

After 1965 records indicate that board members questioned the ethical dilemmas posed by their work with increasing frequency. An unsigned note in Eugene Hargrove’s Eugenics Board file asks, “What does the sterilization do to the emotional life—will it lead to behavior disorders, regression, psychosis, emphasize the ‘I’m different’?” (quoted in Castles 2002:873). Robert L. Rollins, superintendent of Dorothea Dix Hospital was a member of the Eugenics Board. Starting in 1967 he chose not to attend most meetings because of his opposition to the program. In the early 1970s, Rollins and board member Ann Wolfe introduced fundamental reforms that eventually culminated in the abolishment of the program (Schoen 2005:284). Another board member, Dr. C.C. Applewhite offered a more direct criticism. He called into question one of the core

problematic foundations of eugenic science – the heritability of feeble-mindedness.

"Suppose this baby soon to be born turns out to be a genius," he said when considering a sterilization petition for a 21-year-old woman. "I have been talking with some of these psychiatrists - some pretty smart boys among them. They have their doubts about this matter of heredity" (Railey and Begos 2002).

Although it slightly predated the beginning of this time period, the 1963 retirement of the Eugenics Board's longstanding leader Ellen Winston was a major internal factor which led to the decline of North Carolina's Eugenics Board over the next few years. Ellen Black Winston, North Carolina Commissioner of Public Welfare, took over the position of Chairman of the Eugenics Board in 1944, and left the Eugenics Board in 1963 to become the United States Commissioner of Public Welfare (EBNC-BR 1962-1964:8). Under Winston's leadership, the program's expansion resulted from her consistent emphasis on professionalization and her extensive social and political network within state government. Although she was replaced by R. Eugene Brown, who had been her assistant for many years, the Board's momentum during the Winston years was never matched in the years following.

6.4.1 Legal Actions/Challenges

In 1973 allegations of coercive sterilization practices by a rural South Carolina obstetrician drew new popular interest and awareness to the imbalances of power and coercive potential that often characterized the relationships between poor black mothers in the South, their physicians, and the Medicaid programs which paid for services to indigent clients. In Aiken County, South Carolina Dr. Clovis Pierce (one of only three

obstetricians in the county) was ordered to stop his policy of conditioning medical care for pregnant mothers on welfare upon their consent to surgical sterilization following childbirth. A series of complaints to the State Board of Social Services prompted an investigation by the State Board of Social Services, which determined that over an eighteen month period ending in July 1973, Pierce received approximately \$60,000 in Medicaid payments for his services. Three of Pierce's former patients charged that while they were in labor, the doctor informed them that he refused to deliver their children unless they immediately signed consent for surgical sterilization. Shirley Brown later testified during a \$1.5 million lawsuit filed by the ACLU on her behalf, that she was forced to leave the Aiken County Hospital following the birth of her third child because she would not agree to the procedure.

Two other women represented by the ACLU, Mrs. Shirley Brown and Mrs. Dorothy Waters, had been intimidated by Pierce's threats – he would refuse to attend their deliveries, deny admission to the county hospital, and use his influence in the community to see that their welfare benefits terminated – unless they submitted to a procedure they did not want. Although a jury held Pierce did violate the constitutional rights of Mrs. Brown, they awarded her only \$5 in damages. During the trial, Dr. Pierce testified that sterilization of poor women after their third child was a policy of his practice. “My policy was with people who were unable to financially support themselves whether they be on Medicaid or just unable to pay their own bills, if they were having a third child to request they voluntarily submit to sterilization following delivery of the child” (“Physician Wins Sterilization Case” 1977).

National attention was also drawn by a 1973 case of African American teenaged sisters, Minnie Lee and Mary Alice Relf, who were sterilized without their knowledge or consent in a federally funded health clinic in Montgomery, Alabama. In 1965 Nial Cox-Ramirez was sterilized in Plymouth, North Carolina. The end of state sponsored compulsory sterilization can be directly traced to the publicity surrounding her lawsuit against the North Carolina Department of Welfare in 1974.

In the case, *re: Johnson* (1980) it was established that inability to care for children is the exclusive ground for sterilizing mentally disabled individuals. A county official petitioned to have Johnson sterilized, offering testimony to disparage Johnson's lifestyle. Although Johnson was classified as only mildly retarded, wanted children, and had been involved with at least one man who wished to marry her, the court held that the petitioner had proven "that...the respondent...had exhibited emotional immaturity, the absence of a sense of responsibility, a lack of patience with children, and continuously adventures with boyfriends" and therefore, Johnson would not "meet any acceptable standard of fitness to care for a child."

6.4.2 Alternative Narratives

At the same time that federal policymakers were calling for birth control as a part of "population control" and domestic welfare policy in the 1960s, the feminist movement began asserting "reproductive rights" (a term which emerged in the late 1960s), as a component of constitutionally protected citizenship. However, black and white feminists took very different approaches to reproductive rights advocacy – each arising from historical positions along axes of race, class, and gender. Black and white feminist

movements had divergent perspectives on reproductive citizenship based on ideological differences in frameworks of family and motherhood and structural differences that situated black and white feminists in particular relation to the welfare state.

While many “second wave” white feminists understood motherhood as inherently oppressive because it doomed (white, middle class) women to a lonely life as suburban housewives, many black women were forced by economic circumstance into low-wage labor and never had the luxury of spending a lot of time with their families. As a result, the interests of black working women centered on access to more reproductive health options and autonomy, supportive policies that would allow mothers to have more time with their children, and more resources to meet their basic needs and those of their families – rather than an outright rejection of motherhood itself (Kelly 2003). As white women demanded greater access to contraceptives and abortion as necessary components of sexual freedom, black women were fighting forced sterilization and family planning policies that sought to limit black births, according to a very different framework – reproductive rights.

The differences between mainstream (white, middle class) feminist approaches to reproductive rights advocacy is captured by the differing approaches to organizing employed by the predominately white, middle class organization, National Abortion Rights Action League (NARAL) and the women-of-color led, Committee for Abortion Rights and Against Sterilization Abuse (CARASA). Although NARAL's organizational efforts, like those of CARASA, sought increased access to abortion, their literature reflects a moralistic and conservative stance toward reproductive rights of poor women

and expresses concerns regarding the “social costs of uncontrolled childbearing” (Allina 2007:25). CARASA also espoused the importance of abortion rights, but only as one element of their efforts which also publicized and staunchly opposed the forced sterilization of poor women - framed as a violent negation of the rights of all women to make autonomous decisions about whether to bear (or not bear) their desired number of children (Luna 2009:351).

6.4.2.1 Women of color claims for their rights in the public sphere

In the 1970s at the national level women of color increasingly laid public claims to rights of social citizenship advocating for the implementation of legal protections ensuring the right to vote and receive public entitlements (Collins 1998:33). This was a key moment and an important intervention into political discourses and popular negotiation of citizenship rights and social welfare provision, arenas which women of color had historically been excluded from. The act of claiming rights as citizens should be recognized as an important first step to having institutional support and protections implemented within the state. Feminist scholar Rian Voet argued that "instead of seeing citizenship as the means to realize rights, we should see rights as one of the means to realize equal citizenship" a perspective that emphasizes women's political participation over the attainment of particular rights, and highlights women's actual ability to exercise citizenship rights within the political sphere (Voet 1998:73).

Specifically, the claim to rights regarding reproduction and motherhood challenged how previous eugenic policy supporters like the Clarence Gamble and members of the Human Betterment League, or progressive reformers like Ellen Winston

and Wallace Kuralt, or liberal academics like Oscar Lewis and Patrick Moynihan had spoken for and about black mothers in ways that restricted, rather than enhanced the autonomy of women of color. Although this was a uniquely important development, it certainly was not historically the first time that black women had connected maternity with calls for recognition of their rights as citizens and legitimate members of the public sphere.

Sojourner Truth's 1881 "Ain't I a Woman" speech was an early example of the first motherhood advocates into public sphere. She argued, "I have borne thirteen children, and seen most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?" (Truth 1881). During the Civil Rights Era, another example was Mamie Till Bradley, the single black mother of fourteen-year old murder victim Emmet Till. She sought to intervene in a public discourse that overtly invalidated the legitimate expectation that the State would protect black citizens when white commentators justified her son's murder on the grounds that her son's violation of racial etiquette – whistling at a white woman – resulted in his violent death (Feldstein 1994).

6.4.2.2 Women of color organizing – reproductive and welfare rights

Black feminists countered Moynihan's framework and findings by: (1) refuting the myth of "black matriarchy;" (2) arguing that blame for unemployment among black men belonged to a racist society that discriminated against them; and (3) asserting that the report "blamed the victim" by scapegoating poor single black mothers. Black women

increasingly became engaged in welfare rights organizing – addressing issues such as health care, housing rights, and childcare (Beal 1970).

Reproductive rights organizations formed by poor women and women of color actively struggled against programs of involuntary sterilization by seeking mandatory waiting periods - intended to allow women greater freedom of choice by allowing women greater time and space to make decisions about sterilization away from the influence of medical providers who frequently pushed new mothers to undergo tubal ligation surgeries during or directly after childbirth. These boundaries were designed to prevent the kinds of postpartum coercion that became widespread in the Eugenic and neo-eugenic time periods (Collins 1998). Furthermore, they sought new written informed consent procedures to make it more possible for women to receive accurate and adequate information about sterilization procedures prior to making a decision one way or another. However, mainstream and middle-class feminists argued against these recommendations because they conflicted with efforts to eliminate barriers to voluntary sterilization and increase access to contraceptive options as necessary elements of reproductive autonomy, as traditionally defined by second-wave feminist organizations (Allina 2007).

Black feminists criticized the mainstream white feminism's support for abortion on demand and immediate access to voluntary sterilization (voiced most prominently by the National Abortion Rights League). The Committee to End Sterilization Abuse, an organization made up primarily of women of color, sought the establishment of federal guidelines that would prevent the practice of obtaining consent for sterilization during labor or immediately after childbirth, or for an abortion under the threat of losing welfare

benefits. They argued that abortion or sterilization on demand did not acknowledge the class and race biases in reproductive policy, the life circumstances that compelled poor women to abort, or the long history of forced sterilization imposed on women of color. Battling forced sterilization and racist reproductive policies was not the same as rejecting birth control.

Black feminists organizing against forced sterilization and other racist reproductive policies often found themselves pitted against black nationalist male leaders some of whom equated *all* forms of birth control with a white plot to eliminate the black community – and espoused large black families as an answer to perceived genocide. For example, in response conflation of all birth control with genocide, Toni Cade Bambara highlighted the invisibility of black women’s rights to self-determination and needs for reproductive options within such discourse, by challenging: “What plans do you have for the care of me and the child?” (Petchesky 1990:137).

Birth control clinics – which served as the point of access for reproductive health care for many black women – became points of contention as male dominated nationalist organizations, such as the Nation of Islam, sought to close them down¹ (Kelly 2003:145). In *Double Jeopardy*, Black feminist scholar Frances Beal wrote about the tensions between understandings of issues of reproductive choice within male-dominated civil rights organizations, and those of black feminist groups whose advocacy work she had been involved with around issues of reproductive autonomy. She also illustrates the wider

¹ For example, members of the Nation of Islam engaged in birth control clinic invasions, and published anti-birth control articles in "Muhammad Speaks" -accompanied by pictures of bottles of birth control pills marked with skull and crossbones, or graves of unborn black infants.

set of protections sought by women of color regarding reproductive autonomy. Beal recalled:

...in the South, there was a sterilization abuse problem amongst black women, and a number of black women found that when they went in to have a baby or after they had had a baby, unbeknownst to themselves, they were sterilized, so they couldn't have children anymore. So we began to talk about it, not in terms of just abortion or sterilization, but in terms of reproductive rights: what right does a woman have to control her own body and not be subjected to political or economic pressures in order for the choices that they make (Beal 2006: 36).

Black women's welfare rights activism beginning in the 1960s resulted in new access to Aid to Families with Dependent Children (Amott 1990). The National Welfare Rights Organization (NWRO) was established in 1967 and developed and promoted the first succinct ideology that linked issues of racial justice with reproductive rights and economic freedom. Black women dominated the ranks of this grassroots organization of welfare recipients, accounting for roughly 85 percent of members by one estimate. Initially the NWRO privileged poverty-related issues, but by 1972 it assumed a more overtly feminist position, broadening its commitment to mothers' rights and personal choice to one of women's rights and reproductive choice. Securing reproductive freedom, defined by the right to bear and raise children with dignity and to have unrestricted access to reproductive health services, became a central goal of the NWRO (Kluchin 2009:174).

The new assertiveness of poor mothers through the agency of the National Welfare Rights Organization served to educate those eligible persons not receiving aid, and to win for recipients, additional benefits to which they were entitled. NWRO had 800 affiliates in fifty states by 1971. NWRO headquarters – Washington DC. Included

540 separate local Welfare Rights Organizations, or WROs from the Brooklyn Welfare Action Council in New York City. Membership in these local groups included a large percentage of African American women with children (Kornbluh 199:67). The four goals: adequate income, justice, dignity, democracy – remained the official goals of the welfare rights movement until it dissipated in the mid-1970s. The overarching goal was to establish welfare, or a minimum standard of living, as a citizenship right and human right (Kornbluh 1998: 67).

6.4.3 Increasing Political Participation and Representation

Rights of citizenship for black people, male and female, were profoundly impacted by the Civil Rights Acts of 1964 and 1965 and with their inclusion in the Voting Rights Act of the same year. These protections led quickly to massive improvements in the political participation of southern black women – among this group the proportion of women who had never voted in an election dropped from 87 percent to 28 percent over the next seven years (Jones 1985:276). In 1973, Rep. Shirley Chisholm D-N.Y. publicly expressed opposition to new sterilization guidelines that were being developed by the state and county offices of the Department of Health, Education, and Welfare (see section 6.5.4). Chisholm sent a letter to Weinberger from the black women members of the House noting that current guidelines did not include all adults, minors, and incompetents (Fogg 1973). She argued that they should because they need one national standard to cover all of the wide variance in state laws (Fogg 1973).

6.4.4 Policy Implementations

In June 1973, the Southern Poverty Law Center brought a legal suit on behalf of three African American girls: Katie, Minnie Lee, and Mary Alice Relf (aged seventeen, fourteen, and twelve, respectively) against the Department of Health, Education and Welfare (HEW) after the two younger sisters were deceived and coerced into being surgically sterilized and all were used as guinea pigs for the then experimental Depo-Provera birth control injections (Davis 1981; Ordover 2003).

Furthermore, reports of sterilization abuse among Native American women in federally-subsidized reservation hospitals prompted Senator James Abourezk (Democrat, South Dakota) to initiate a congressional (GAO) investigation which uncovered that a large proportion (as high as 70,000 out of 150,000) of American Indian women and children were sterilized at Indian Health Services facilities, including a significant proportion of women under age twenty-one (Ralstin-Lewis 2005).

Caspar Weinberger, Secretary of HEW under President Richard Nixon, responded to the Relf lawsuit and the GAO investigation by issuing an immediate mandate to all state welfare officials directing them to immediately discontinue state funding for the sterilization of minors and other legally incompetent individuals. He further required each county to develop a set of specific guidelines within a two-week's time regarding legally incompetent individuals and minors. They were also instructed to develop and implement new guidelines separating the process of funding reproductive health and family planning services from the administrative function of determining eligibility for aid. Finally, Weinberger directed the regional welfare directors to contact governors and

request that they institute new practices to better support the rights of individuals in cases of sterilization.

However, a 1981 Service Plan Manual issued by the N.C. Department of Human Resources notes that:

Voluntary sterilization continues to present problems of non-compliance with federal regulations where federal funds are used to pay for the procedure or where staff of federally funded agencies become involved in helping to “arrange for” sterilization. The recent federal monitoring visit report on the audit of the Division of Health Services and five local family planning providers shows the following most common areas of non-compliance: proper waiting period not observed (no fewer than 30 days; no more than 180 days); required signatures; missing on consent form (person taking consent, patient, physician); invalid consent form used; hysterectomy procedures inappropriately paid for or arranged for sterilization services not reported on the quarterly report (N.C. Dept. of Human Resources 1981).

6.5 Dismantling of Eugenics Board and Reproductive Citizenship

Under the Executive Organization Act of 1971, the Eugenics Board of North Carolina was transferred to the newly created Department of Human Resources (DHR). Although the Board retained its statutory powers and actions regarding sterilization proceedings, the Board’s managerial and executive authority was vested in the secretary of the DHR, a cabinet-level officer appointed by the governor. Under the Executive Organization Act of 1973, the Eugenics Board became the Eugenics Commission. The following five members of the Commission were to be appointed by the governor: the director of the Division of Social and Rehabilitative Services of the DHR, the director of Health Services, the chief medical officer of a state institution for the feeble-minded or insane, the chief medical officer of the DHR in the area of mental health services, and the attorney general. Finally, in 1974 the General Assembly transferred responsibility for

any sterilization proceedings against persons suffering from mental illness or mental retardation to the judicial system. In 1977 the General Assembly formally abolished the Eugenics Commission. However, it is important to recognize that the use of coercive means to secure "consent" to sterilization procedures did not abruptly come to a halt with the Board's extinction, this pattern continued – albeit on a smaller and less public scale.

Citizenship rights have historically been structured and constrained by racial and gender hierarchies, therefore citizenship as a status is not best understood as an all-at-once or all-or-nothing package of rights and responsibilities. For Southern black women, in particular, the surveillance and control of the massive welfare bureaucracy, within which state institutions and the North Carolina Eugenics Board played key roles, only replaced earlier forms of intense surveillance and control characteristic of slave labor and then later domestic work arrangements (Collins 1998:20). The limitations on formal and substantive citizenship rights inherent in the historical rigidity of exclusion from labor market options, educational opportunities, housing options, access to health care, and exercise of bodily autonomy were part and parcel of racial understandings in the United States (Collins 1998:22). Reproductive citizenship, however, was the crucial avenue by which women of color were inherently defined. Control over their bodies through ideological discourses that justified institutional sterilization actions marked women of color as population vessels that threatened the State's version of proper citizen. It is only when women of color entered the public sphere, and demanded their rights as citizens as they understood it, that the State then was forced to expand the definition of citizenship and rights.

7. Conclusion

Over the course of the time period surveyed (1950-1980), there were discursive transformations that reflected ideological shifts underlying popular discourses of race, gender and reproductive rights/responsibilities related to characterizations of women of color and their reproductive behaviors and experiences. In particular, during the first time period (1950-1964) women of color were described with ideological discourses of social threats – genetic, moral, and economic – and in new interpreted meanings of feeble-mindedness that was supported by the increased bureaucratization of the welfare state. During the second time period (1965-1980) the ideological discourses shifted from feeble-mindedness to overlapping frames focused on the fears attributed to the explosive population growth of illegitimate children who would burden welfare provisions. These shifting discourses led to a neo-eugenic sterilization campaign impacting over 7,300 women of color in the state of North Carolina. When women of color fought for their voice and citizenship status, and institutions began to change, we began to see the improvement in the form of reproductive rights.

The marked changes in the ideological alignment of reproductive rights and welfare provision discourses, nevertheless, did not stop how the foundational structures of race, gender, and class continue to constrain embodied experiences and daily practices of citizenship – economic, political, and social – along these axes up to and including the present moment. The powerful role of race, gender, and class in positioning the 7,300 North Carolinians sterilized by Eugenics Board order has shifted, but not declined in

significance for the character and quality of citizenship rights associated with bodily integrity and reproductive autonomy.

For most of the historical period examined in this study, social welfare bureaucracies and officials did not serve their assigned role as public servants to provide for the "modicum of support" set as a baseline responsibility of states to their citizens (Marshall 1950). Rather, through the institution of welfare provision the state of North Carolina treated sterilization victims according to their discursive positioning as threats to the health of the population and financial security of the state and nation. In the process, social workers, medical and mental health providers, institutional officials, and political representatives profoundly negated the legitimacy of citizenship rights among the variously comprised segments of the larger population who were subjected to violence and psychological trauma at the hands of the state.

While *Winston-Salem Journal* writers Kevin Begos and John Railey came to the conclusion that the policies of North Carolina's Eugenic Board were overtly racist – a form of genocide – Johanna Schoen was unconvinced. But another plausible explanation lies somewhere in the middle thinking of racism as a scavenger ideology that in this case was perfectly suited to combine with the growth of rational, legal authority exemplified by the growth of the state bureaucracy and welfare programs. Ellen Winston's focus on professionalization and efficiency became an efficient means to solve what was understood to be a problem of people-minded reproduction and quickly morphed into the problem of illegitimate growth. It was consistent with the growth of progressivism and liberalism beliefs where individuals with perceived best intentions could be convinced of

the necessity of streamlining the population and the state budget. Moreover, this rational, legal authority was not challenged by the traditional advocates for marginalized citizens such as the Catholic church or civil rights leaders.

7.1 Contemporary Reproductive Citizenship and Victim Compensation

In 2002, North Carolina Governor Easley made the historically significant gesture of offering an apology on behalf of the State to its citizens who had experienced harmful and coercive sterilization practices (GECTF 2012). Although several states had eugenic programs similar to North Carolina's the official apology by Easley was unprecedented at the time – he was the first Governor in the nation to apologize for coercive sterilization programs within state systems (Begos and Railey 2002). A decade later, as I write, the state of North Carolina is preparing to distribute a package of financial compensation – including a lump-sum financial payment of \$50,000 and mental health services to all living victims of North Carolina Eugenics Board sterilizations orders through the Governor's Eugenic Compensation Task Force (GECTF 2012:4). This particular package of compensation was implemented according to the recommendations of a five-person committee convened by Governor Beverly Purdue in 2011 under Executive Order 83. The Governor's Eugenic Compensation Task Force met five times over the last year and recently issued its final report.

Indicative of a recognized accountability by the State to these victims the compensation will be offered to living victims along with lifetime freedom from tax liability and the State's commitment to sustained efforts to a) own up to its wrongdoing

and to b) do what is possible now to provide survivors with meaningful assistance and "send a clear message that we in North Carolina are a people who pay for our mistakes and that we do not tolerate bureaucracies that trample on basic human rights"; and c) set their recognition of wrongdoing within the history taught in public school curriculum and cultural preservation through state digital archives and a traveling museum exhibit documenting the actions of the Eugenics Board (2012:1).

Hence, unprecedented popular awareness and outcry over the violence of forced sterilizations made public through Begos and Railey's 2002 newspaper series – along with: legal advocacy by groups such as the ACLU and the NAACP; the institutionalization of rights to bodily integrity and reproductive autonomy espoused by the Governor's Task Force; the newly created North Carolina Victims of Sterilization; the staunch support of North Carolina legislatures; and the State's last two Governor's – indicate a new level of institutionalized support for reproductive rights. These events are a profoundly different relationship between Eugenics Board subjects and the State than has existed historically. The 111 victims who have now come forward to identify themselves have entered the public sphere through publicized hearings and "town hall meetings," news media appearances and hundreds of newspaper articles. Whereas in 1967 the North Carolina Court simply refused to hear the \$1 million lawsuit filed by Elaine Riddick Trent, currently when Trent and other survivors expressed frustration with the Board's initial recommended settlement of \$20,000, the Board responded by offering \$50,000 instead.

Nevertheless, the relationship between the state of North Carolina and these sterilization survivors as subject citizens remains complicated, contested, and subject to change in ways that are not predictably egalitarian as the history traced above reflects. Citizenship is not colorblind. It is structured by class and gender as well. These inequalities are embedded in the relationships of women of color, as subject citizens, to the state of North Carolina through welfare state provisions of basic necessities, including access to reproductive health care. For women of color, this underlying tension imbues the exercise of reproductive citizenship with the continuing potential for reproductive harm. For women of color whose interactions with the welfare state are premised upon their legitimate claim to the social rights of citizenship institutionalized by welfare state services, despite the fact that the same programs and policies of social welfare which are (at least on the surface) associated with citizenship status.

Women of color in North Carolina between 1950 and 1980 held a contradictory relationship to the State as subjects whose relationship fluctuated to state imperatives, which sought to address perceived moral, economic, or social threats. State policies imposed themselves on the bodies of women of color in strategically unstable and shifting ways. Changes in dominant ideological discourses have at times framed state interest and stability as mutually exclusive with the exercise of reproductive autonomy by women of color. The unstable and subtly shifting forms of coercive state power have far more frequently limited than honored the reproductive rights of women of color. The historical record suggests an uncertain future for women of color as reproductive citizens whose participation in the negotiation of rights, obligations, and benefits is fundamental.

Appendix A: Primary Data Sources

MANUSCRIPT COLLECTIONS

Duke University Archives, Durham, NC.
Robin Chandler Lynn Duke Papers
Reproductive Rights National Network Records
Victoria Ortiz Papers
Takey Crist Papers

North Carolina State Archives, Raleigh, NC
Social Services Record Group
Eugenics Commission Record Group

North Carolina State University Archives, Raleigh, NC.
Ellen Black Winston Papers

University of North Carolina at Chapel Hill Archives, Chapel Hill, NC.
Claude Currie Papers
Human Betterment Association of North Carolina, Inc. Records
J.W. Roy Norton Papers
Southern Oral History Program Collection.
Joseph L. Morrison Papers
George Watts Hill Jr. Papers

NEWSPAPERS AND PERIODICALS

Afro-American
Charlotte Observer
Durham Herald News
Ebony
Herald-Sun
New York Times
Raleigh News and Observer
Robesonian
Social Service Review
Time Magazine
Winston-Salem Journal

LEGAL DOCUMENTS AND CASE RECORD

Bowers v. Hardwick, 478 US (1986)
Brewer v. Valk, 204 SE 638 (1933)
Buck v. Bell, 274 US (1927)

Carey v. Population Services International, 431 US (1977)
Cook v. State, 495 P. 2d (1972)
Cox v. Stanton, 529 F 2d 47 (1975)
Eisenstadt v. Baird, 405 US (1972)
In re Sterilization of Moore, 221 SE 2d (1976)
Jackson v. Bumgardner, 347 SE 2d (1986)
Loving v. Virginia, 388 US (1967)
Matter of Johnson, 243 SE 2d (1978)
Matter of Montgomery, 316 SE 2d (1984)
Matter of Truesdell, 329 SE 2d (1983)
Matter of Truesdell, 304 SE 2d (1985)
NC Association for Retarded Children v. State of NC, 420 F. Supp. (1976)
Planned Parenthood of Southeastern Pa. v. Casey, 505 US (1992)
Roe v. Wade, 410 US (1973)
Skinner v. Oklahoma ex rel. Williamson, 316 US (1942)

Appendix B: Eugenic Board Data Sample, Descriptive Statistics

Table 10: Institutional Statistics

	<u>1950-1964</u>			<u>1965-1980</u>		
	White Women	Black Women	Indian Women	White Women	Black Women	Indian Women
Category	59	108	23			3
Institutional Cases	27 (46%)	31 (29%)	0 (0%)	7 (35%)	6 (13%)	0
Non-Institutional Cases	32 (54%)	77 (71%)	23 (100%)	13 (65%)	40 (87%)	3 (100%)
Age						
Mean	21.9	20.36	27.35	19.5	17.72	31.33
Median	20	19	29	16	15	N/A
Mode	N/A	14,19*	N/A	15	14	N/A
Institution¹	Caswell: 6	Broughton: 9	N/A	Caswell: 3	O'Berry: 4	N/A
Counties²	Buncombe 8% Madison 6% Rowan 5% Caldwell 3% Iredell 3%	Mecklen. 14% Pitt 6% Lenoir 5% Gaston 4% Guilford 4%	Robeson 61% Scotland 13% Hoke 13% Cumberl. 4% Swain 4%	Rowan 10%	Mecklen. 9%	Robeson 100%

¹ Institution that presented the most petitions per group, during period in question.

² Counties that most frequently petitioned the Eugenics Board during the period by group.

Table 11: Marital Status, IQ, ADC, Children Deceased

	<u>1950-1964</u>			<u>1965-1980</u>		
	White Women	Black Women	Indian Women	White Women	Black Women	Indian Women
Marital Status						
Single	61%	82%	87%	90%	96%	66%
Married	24%	7%	13%	0	2%	33%
Separated	8%	1%	0	5%	2%	0
Divorced	0	0	0	0	0	0
Widowed	0	4%	0	5%	0	0
Other	7%	0	0	0	0	0
Mean IQ Score	48.3	50.1	43.4	51.7	49.4	44.3
ADC Indicated	17%	38%	8%	5%	22%	0
Children Deceased	7	13	3	0	2	0
Cause of Death³						
Accident	1	1	0	0	0	0
Illness	1	1	0	0	0	0
Starvation/Malnt.	0	4	1	0	1	0
Unknown	5	7	4	0	1	0

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³ If there were any children deceased.

Table 12: Diagnoses

	<u>1950-1964</u>			<u>1965-1980</u>		
	White Women	Black Women	Indian Women	White Women	Black Women	Indian Women
Diagnosis						
Feebleminded	80%	90%	96%	90%	87%	100%
Epileptic	2%	3%	4%	0	0	0
Schizophrenic						
Reaction	14%	4%	0	10%	4%	0
Depressive						
Reaction	2%	1%	0	0	2%	0
Mentally Ill-						
Other	2%	3%	0	0	4%	0
Brain						
Syndrome	0	0	0	0	2%	0
Depressive						
Reaction	0	0	0	0	2%	0
Born out-of-						
wedlock	5%	23%	9%	10%	20%	0
Has illegitimate						
children	17%	62%	70%	35%	46%	66%
Negative descript.						
of community	3%	6%	4%	10%	11%	N/A ⁴
tive Needescript.						
⁵of family	44%	42%	26%	45%	43%	33%

⁴ Community was not described positively or negatively in the case records reviewed for Indian women.

⁵ Negative description of family.

Table 13: Personal Descriptions of Patients

		<u>1950-1964</u>			<u>1965-1980</u>		
	White Women	Black Women	Indian Women	White Women	Black Women	Indian Women	
Description of patient: promiscuity							
Mentioned	29%	38%	39%	70%	67%	66%	
Mentioned > 1	N/A	6%	1%	30%	15%	N/A	
Mentioned ≥ 3	3%	2%	N/A	15%	15%	N/A	
Description of patient's mother							
Mother							
mentioned	24%	35%	13%	45%	63%	33%	
Pos. description	0	1	1	0	1	1	
Missing/ Neglectful Feebleminded	10%	6%	4%				
Description of home							
Condition							
referenced	19%	12%	35%	10%	20%		
Positive	3%	1%	1%	0	4%		
Negative	8%						
Negative characteristics named	overcrowded	Undesirable neighborhood/ area, dirty, overcrowded	Dirty, overcrowded		Dirty, overcrowded, disrepaired	33%	

Appendix C: Eugenics Board Meeting Minutes

4. [REDACTED] - (C) - Resident of Lenoir County

Proceedings instituted by Joseph F. B. McCauley, SPW

Medical history by Dr. Sam L. Parker, Jr.

Sterilization recommended by Dr. Parker

Social history:
This 32 year old woman is a widow and the mother of five children ranging in age from two to nine years. Another baby is expected very soon. The husband died October 6, 1954. She earned an I.Q. of 48 with all subtest scores being low on the Wechsler-Bellevue Intelligence Scale, Form I administered by Helton McAndrews March 1, 1956. The petition is presented on the basis that this woman is mentally deficient, sexually promiscuous, and is unable to care adequately for the children that she has.

Diagnosis: Feeble-minded

Consent: The consent is signed by the patient, the mother, [REDACTED], and the father [REDACTED]

Operation will be performed by: Dr. Fuller and Dr. Parker

Figure 10: Sample of Eugenics Board Meeting Minutes with Redacted Victim Names

Appendix D: Data Sample Questionnaire

Table 14: Questionnaire for Data

Meeting Date:	Diagnosis:
Case Number:	<input type="checkbox"/> Feeble-minded
Race:	<input type="checkbox"/> Epileptic
<input type="checkbox"/> Negro	<input type="checkbox"/> Brain Syndrome
<input type="checkbox"/> White	<input type="checkbox"/> Mentally Ill - Dementia Praecox
<input type="checkbox"/> Indian	<input type="checkbox"/> Mentally Ill - Brain Syndrome
County:	<input type="checkbox"/> Mentally Ill - Schizophrenic
Institutionalized?	<input type="checkbox"/> Mentally Ill - Depressive Reaction
<input type="checkbox"/> Yes	<input type="checkbox"/> Mentally Ill - Manic Dep. Psychosis
<input type="checkbox"/> No	<input type="checkbox"/> Mentally Ill - Other
<input type="checkbox"/> Soon to be	If mentally ill - other, what is the diagnosis
Institution Name (if institutionalized):	Other Diagnostic Information:
Proceedings Instituted By:	IQ Exam Given By:
Age:	IQ Test Type:
Marital Status:	<input type="checkbox"/> Mental Test/ Generic
<input type="checkbox"/> Married	<input type="checkbox"/> Wechsler
<input type="checkbox"/> Single	<input type="checkbox"/> Goodenough
<input type="checkbox"/> Separated	<input type="checkbox"/> Stanford-Binet
<input type="checkbox"/> Divorced	<input type="checkbox"/> Vineland
<input type="checkbox"/> Widowed	<input type="checkbox"/> None Performed/Indicated
<input type="checkbox"/> Other/Not Indicated	<input type="checkbox"/> Other
Number of Children:	IQ Score:
Currently pregnant?	Patient illegitimate?
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	<input type="checkbox"/> No/Not Indicated
	Patient has illegitimate children?
	<input type="checkbox"/> Yes

<input type="checkbox"/> No	<input type="checkbox"/> No
Deceased children? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dceased children,:how many? Deceased children,: cause indicated?
ADC indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Concern with miscegenation <input type="checkbox"/> Indicated <input type="checkbox"/> Not Indicated
Description of community? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Not mentioned	Description of household <input type="checkbox"/> Dirty <input type="checkbox"/> Disrepair <input type="checkbox"/> In undesirable neighborhood <input type="checkbox"/> Too small <input type="checkbox"/> Described Positively <input type="checkbox"/> Not described
Description of Family <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not mentioned	Incest/Rape Indicated? <input type="checkbox"/> Neither <input type="checkbox"/> Rape <input type="checkbox"/> Incest <input type="checkbox"/> Other:
Description of patient - promiscuity <input type="checkbox"/> Promiscuity not mentioned <input type="checkbox"/> Mentioned - once <input type="checkbox"/> Mentioned - twice <input type="checkbox"/> Mntioned - 3+ times	Consent signed by... <input type="checkbox"/> Patient <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Husband <input type="checkbox"/> Guardian ad litem <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Aunt/Uncle
Description of patient's mother <input type="checkbox"/> Missing/Neglectful <input type="checkbox"/> Feebleminded <input type="checkbox"/> Bad housekeeper/unclean <input type="checkbox"/> Promiscuous <input type="checkbox"/> Negative in some other way <input type="checkbox"/> Described positively <input type="checkbox"/> Deceased <input type="checkbox"/> Not described	
<u>Notes:</u>	

Appendix E: Selected Data Queries

Table 15: Ages of Women Sterilized by Race and Time Periods

Ages of women sterilized					
	1950-1964			1965-1972	
	Mean	Median		Mean	Median
White	21.9	20	White	19.5	16
Black	20.36	19	Black	17.72	15
Indian	27.35	29	Indian	31.33	N/A*

Table 16: Mean IQ Score by Race and Time Period

Mean IQ score					
	Period 1: 1950-1964			Period 2: 1965-1972	
White	48.3		White	51.7	
Black	50.1		Black	49.4	
Indian	43.4		Indian	44.3	

Table 17: Relationship between IQ and Reference to Promiscuity

IQ and reference to promiscuity					
	Period 1: 1950-1964			Period 2: 1965-1972	
IQ > 59	(n=32)		(n=14)		
	19 (59%) = Not mentioned		4 (36%) = Not mentioned		
	13 (41%) = Referenced		10 (64%) = Referenced		

	(n=133)	(n=48)
IQ < 60	81 (61%) = Not referenced 52 (39%) = Referenced	17 (35%) = Not mentioned 31 (65%) = Referenced

Table 18: Percentages of ADC by Race and Time Periods

ADC by race			
	Period 1: 1950-1964		Period 2: 1965-1972
White	17%	White	5%
Black	38%	Black	21.7%
Indian	8%	Indian	0%

Table 19: Likelihood of Promiscuity Mentioned among ADC Cases

ADC and promiscuity			
	Period 1: 1950-1964		Period 2: 1965-1972
With ADC (n=53)	32%	With ADC (n=11)	5%
No ADC (n=137)	38%	No ADC (n=58)	21.7%

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Biography

Serena Sebring was born in Boston, Massachusetts, on May 13, 1977. In May 2005, she graduated summa cum laude with a Bachelor of Arts degree in Sociology from the University of Colorado, Boulder. Her honors undergraduate thesis was entitled, “Experiences of White Mothers of Biracial Children: Life at the Crossroads of Race, Gender, and Sexuality.” She completed her master's thesis, “Ties That Bind: A Comparative History of Interracial and Same-Sex Marriage Discourse,” and received her Master of Arts degree from Duke University in Durham, North Carolina, in May 2008. The Duke University Graduate School awarded her a Summer Research Fellowship in 2010. She is the author of two publications, “On the Humanity of Justice: Open Letter to the President,” published in the *University of Colorado Honors Journal* (2005) and “Four Days in Durham,” published in the *Feminist Review* (2007).