Imagining Archaeologies without Ableism

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Writing in June of 2020, it is impossible to understand how we might be situated within the COVID-19 pandemic. Are we past the crest of the first wave and entering a period of calm; or, as evidenced from Arizona, Florida, Oklahoma, Texas, and southern California, are we still in a first wave that is breaking differentially across our shores? My sheltering in place has been more than a physical circumstance. As an academic who was on sabbatical when the outbreak began, I have been protected (so far) economically from the ravages of the disease, have only known people who are ill (so far) through friends, and have even been protected (so far) from teaching on zoom.

In the days between the identification of the disease in late December and the closure of the nine counties of the Bay Area on March 16th, I had a busy travel schedule: Boston for the SHAs, where I don't recall us talking about the outbreak, New Haven for archival research, where there were also no concerns. By early February, when I went to South Carolina to give a talk, the new disease came up, with rumors already flying about whether there were cases in the area or not, but bars and restaurants were humming and no one was worried. At the end of February, I went to Mardi Gras, and my friends and I went to quiet bars, avoided crowded parts of parade routes where tourists hang out and washed and sanitized frequently. In line for security at Louis Armstrong Airport, I looked at the long lines and thought, "I have a bad feeling about this."

I had an early March Viva scheduled in Iceland, by then cases were concentrated on the west coast, and my flight had me transfer in Seattle, the nation's COVID hotspot of the moment. I asked my hosts whether they thought they would cancel, they assured me there were cases in Iceland but they had it under control—and they did. I think of that trip to Iceland, and the extra two days I stayed there, as the last of my normal. Despite the presence of hand-sanitizing stations everywhere, cafes, restaurants and museums were open. I spoke to visitors from across Europe at that point,

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and all were aware of the disease and watched what was developing in Italy with concern.

Normal ended at the airport. For my return to the US, I had changed my seat to the window seat of the last row of the plane, realizing it was unlikely to be full because it was mistakenly listed as having no reclining seats. I had a middle seat empty, and on the aisle seat was a lovely academic returning home to the US—her university had evacuated her and her study abroad students from northern Italy. She had stayed for a week after her students left with friends, in isolation, trying to determine whether or not she would develop symptoms before heading home to a multi-generational home. She told me five days from exposure to symptoms were found to be the norm, and she was reasonably certain she was clean. She was armed with sanitizing wipes and hand sanitizer and together we scrubbed down our row before take-off. Customs and immigration at Seattle were quiet, with no hand sanitizer to be seen. Most restaurants were now closed to table service, and people flying were nervous. I was six days past my return (during which time I constantly self evaluated how I was feeling) when I was part of an oral exam committee, the first where we socially distanced and did a zoom hybrid exam. During the exam, the stay-at-home order was texted to all of us through the emergency alert system. We then entered COVID time—a form of "crip time" that now all of us have experienced to some degree (Heath-Stout, this volume).

Imagining Archaeologies of Disability

It is impossible to think about these papers without seeing them through the recent lens of the COVID-19 pandemic; and perhaps, due to this, the time is right for calling for a dramatic reframing of how archaeologists approach research examining health care in the past (and by extension, the present) by embracing disability theorizing within the discipline. This volume of papers represents important initial steps in that process, with a number of papers directly engaging with disability (or "crip") theorizing (see in particular, Heath-Stout; Scott; Surface-Evans; and Wooten, this volume), and others thinking deeply about issues of medicalization and ideologies surrounding health care (Barnes; Komara; Kuglitsch; Veit et al., this volume).

Archaeology, as detailed by a number of these authors, has a rich history of looking at the materialization of health care practices and systems through a range of theoretical frames, be in consumerism (e.g., Larsen 1994); understanding disparities in access to health care (Hosken and Tiede 2018; Psota 2011; Rathbun 1987); continuities in particular ethnomedical traditions (e.g., Fennell 2010; Linn 2010; Lun 2015; Wilkie 1996a, 2000), the politicization of reproductive health (e.g., Barnes 2021; Carnevale et al. 2016; Kozub 2018; Wilkie 2003, 2013); community approaches to health care (e.g., Fisher et al. 2007; Geismar and Janowitz 1993; McCarthy and Ward 2000); or the politics of institutionalization (e.g., Beisaw and Gibb 2009). Within this wide range of approaches to understanding healthcare have emerged issues of race, class, sex and gender, yet seldom has disability theorizing entered into archaeological discourse—with bioarchaeology only recently thinking about impairment and disability rather than

paleopathology (see Byrnes and Muller 2017; but especially Kincopf 2020) and archaeological works discussing disability not necessarily engaging with disability theory (e.g., Psota 2011; Spence et al. 2014; cf. Wilkie et al. 2021). A fully actualized archaeology of disability needs to rethink not just frameworks of theorizing about bodies, but methodologies themselves. As Kincopf (2020:1) notes, "Disabled bodies are themselves disruptive, subversive and their refusal to conform with normative standards of analysis and narrative is a potent site of discussion."

Tobin Seibers (2008:8) has argued that one of the strongest unquestioned ideologies shaping human societies today is the ideology of ability:

The ideology of ability is at its simplest the preference for able-bodiedness. At its most radical, it defines the baseline by which humanness is determined, setting the measure of body and mind that gives or denies human status to individual persons. It affects nearly all of our judgments, definitions, and values about human beings, but because it is discriminatory and exclusionary, it creates social locations outside of and critical of its purview, most notably in this case, the perspective of disability.

Seibers sees disability not at the periphery of human experience, but a mode through which difference is constructed and social critique made possible. It is no coincidence, argue disability theorists, that disability imagery and language is often evoked as a means of dehumanizing or rendering as "less than" groups of people—women who are "hysterical," the pathologizing of queer people, the reduction of an enslaved man to the scars on his back, the equating of political opponents as "idiots" or "blind" (e.g., Chen 2012; Knadler 2013; McRuer 2006; Oliver 1983; Quayson 2007; Seibers 2008, 2010; Sontag 1977; Summers 2001).

It is important to emphasize that disability theorists recognize the lived realities of impairment: they consider how a given society understands and treats human diversity. Disability theory, therefore, has a crucial contradiction within it that disability is simultaneously a political and activist shared identity, but disability itself is experienced in a range of diverse lived and embodied ways. This seeming disjunction is ultimately a strength of disability theorizing, for taking a disability perspective allows for active disruptions of multiple narratives about sex, gender, race, and class (Hammer 2014; Knadler 2013; McRuer 2006; Seibers 2008). The disability rights movement is intrinsically entangled—historically, politically and theoretically–with other civil rights movements and intellectual histories, drawing on and contributing to queer theory, critical race theory, and feminist thought (Hammer 2014; Seibers 2008; Snorton 2017).

Early disability theorizing argued that disability is better understood as a social construct than a medical one (e.g., Oliver 1983, 2013; Shakespeare 2010; Shakespeare and Watson 2001). The social understandings of the body define what is disabled. Ato Quayson (2007:6–7) describes Isidore of Seville's Middle Ages' taxonomy of monstrosities (dating to the sixth-seventh centuries CE), as an example of such a socially constructed understanding of disability. Isidore recognized limb loss, surplus limbs, bodily atrophy, mixtures of animal and human parts, and

bodily hypotrophy as categories of monstrosity, and equated such monstrosities with "a moral map of the corporeal body" (Quayson 2007:6). Within Christian theology of the time, disease was understood as the cause of disability and was a moral judgment, yet the church simultaneously demanded the disabled be objects of charity (Quayson 2007:6–7). Clearly this is a constructed understanding of the body framed within particular moral frames. These constructions also limited the ways that "monsters" could interact within broader society—as objects of fear or charity. When we consider the roots of many disabling metaphors in the nineteenth century, when illness and disability were still framed by many within morality narratives (see Kuglitsch, this volume), the work such metaphors do is manifest.

With COVID-19, we have seen a reordering of what constitutes able-bodiedness, or the ability to fully participate within society. As we have watched states reopen in recent weeks, those with "pre-existing conditions," such as people with compromised autoimmune systems, histories of heart disease, diabetes or hypertension, or falling into particular age groups, are seen as no longer capable of participating in society as equals, and are encouraged to stay home, even though the accommodations of case tracing, testing, continued social distancing, masking, and enforced sanitizing regimes would ensure that all could safely navigate back in the world. Instead, a set of people who have identified themselves as low risk have abandoned measures that would allow others to feel safe. Instead, a new model of compulsory able-bodiedness (see Heath-Stout, this volume) has quickly taken root.

The social model of disability emerged out of political activism and the Civil Rights' movements, in the UK and US, and was first named in the writings of Michael Oliver (Berghs et al. 2019; Oliver 1983, 2013). Oliver and others argued that disability was something done to an impaired person by society. For instance, inaccessibility of buildings to wheelchair users is due to disabling architectural choices—the use of stairs rather than ramps or elevators, or narrow bathrooms and hallways, for instance—rather than anything inherent to the body of the wheelchair user. The social model of disability enabled disability rights to be legally understood as a form of civil rights. It is important to note that early activism did not deny the reality of physical or mental impairments that marked some bodily experiences, but emphasized that society created circumstances through which impairments became disabling (Berghs et al. 2019).

We can see within the COVID pandemic and the disabling impacts of policy decisions that fail to imagine the creation of inclusive spaces for individuals who may be at higher risk for contracting the disease. There have even been arguments for creating a system of passports to identify those persons who had been previously exposed to the disease, giving them freedom of movement while preventing the uninfected from fully participating in society. Of course, such a program assumes that those who have had the disease have accrued immunity from reinfection, something that has not been proven. The argumentative power of the social model of disability is clear when recent events around COVID-19 are considered.

The medicalized model of the body that emerges from and enforces the ideology of ability, sees the body as a machine, a sheath, a casing, a biopolitical entity, for which disease or disability are evidence of malfunction. The notion of

compulsory able-bodiedness is a presumption of the medical model's assessment that all bodies that can be, should be mended, and the desired state of all bodies is to be able (Seibers 2008). This is the dominant model of the nineteenth century, and endures to the present in much of Western society. Medical treatment is about curing or fixing ailing bodies or minds, and is a re-emerging theme throughout the papers here. Whether it is the affixing of a "foob" to "fix" a female body fighting breast cancer (see Wooten, this volume), optimizing sunlight, air and diet to affect a cure for tuberculosis (Scott, this volume), toys to sooth grieving and isolated motherless children (Surface-Evans, this volume), braces to ensure a smooth gait (Smith, this volume), patent medicines to soothe a colicky baby (Verstraete, this volume), disciplining one's bowels (Komara, this volume), or ordering one's disordered mind through monitored engagements with a domesticated nature (Kuglitsch, this volume). Even enslavement, in the medicalized model of the world, can be bettered (ameliorated), through the construction of a well-built hospital, designed to treat the truly ill, versus the lazy "fakers" of illness (Veit et al., this volume). The human body can be fixed through engineering, be it replacement limbs (Ott et al. 2002), hernia trusses, medical braces, architectural structures (or elements like "vita-glass"), and shoes or braces.

As I will return to later, disability theorists have felt constrained by these two models, and as Scott (this volume) points out, one of the perceived shortcomings of the two conceptualizations is the loss of the embodied experience of living with impairments, not merely as a social identity, but the phenomenological experiences of pain and fatigue (e.g., Hughes and Paterson 1997). Seibers (2008:25) argues for a theory of complex embodiment "that values disability as a form of human variation," but also "raises awareness of the effects of disabling environments of people's lived experience of the body, but …emphasizes as well that some factors affecting disability, such as chronic pain, secondary health effects, and aging, derive from the body."

Disabling environments do not merely create exclusions from society for certain bodies, but are systems of biopower that explicitly work toward limiting some groups' pursuit of health, well-being, and life. Achille Mbembe (2019) theorized the logical extension of Foucault's concept of biopower (see Barnes, this volume), through his examination of what he calls "necropolitics," or the power of the state to create circumstances that facilitate the life of some citizens, and the deaths of those not deemed as full citizens.

The institutionalized police brutality that consistently facilitates the murder of Black people in the US (see Curry 2017) currently being protested, as well as the higher death rates from COVID-19 being experienced within communities of color and the elderly are raw examples of necropolitical actions at work. The current administration has been blunt in expressing its willingness to risk the lives of some citizens in favor of pursuing particular economic policies. Jasbir K. Puar (2017) recognizes that risks to health are intersectionally experienced, with some bodies carrying greater burdens that disproportionately subject them to risk of debility. Governments do not just kill people as an expression of biopower, they regularly maim citizens (Puar 2017). At Fort Davis, Texas, it is possible to see archaeologically the ways that the military's failure to maintain health standards

for Black soldiers was part of a necropolitical agenda that contributed to higher rates of death during military service, but that also had long term debilitating impacts (Wilkie 2021). This aspect of medical care must be considered in archaeological contexts, particularly within the practices of public health efforts.

Disabled Pasts

The rest of my comments will focus on the following themes: (1) How the papers demonstrate the strength and pervasiveness of the medical model of disability; (2) The necessity of taking an intersectional approach to understanding constructions of health and care-giving; and (3) The advantages and challenges of adopting a framework concerned with "well-being" as a means of decentering the able/disabled conceptualization of health.

Archaeologies of the Medical Model

A number of different approaches to medical intervention are observed in these papers, but papers dealing with institutional settings provide the clearest evidence of how the medical model shaped the embodied experiences of those in institutional settings. While the institutions discussed in these chapters are varied in their temporal occupation and the nature of their patients' impairments, they share an attention to the ways that treatment was constructed. Whether returning an ailing enslaved laborer to their work (Veit et al., this volume), imagining future employment for those currently unable to care for themselves (Smith, this volume), curing a consumptive (Scott, this volume), ordering a disordered mind (Kuglitsch, this volume), each of these institutions saw themselves as participating in treatment. The bodies under these institutions' care were seen, as long as the patient put in the proper effort (even if that effort was "resting as hard as they could," see Scott, this volume), a cure was within reach.

The archaeology of the Orange Valley slave hospital is still in its early development, but Veit and co-authors paper demonstrates the rich possibilities of examining the site of a plantation hospital as a debilitating institution parading as a space of healing. Knadler (2013) has argued that enduring narratives from enslavement and in later racial uplift movements were inherently coached in disabling rhetoric, "At the end of the nineteenth century, disability was recruited as a medicalized biopolitical sign of the legal child-like dependence of African-Americans" (Knadler 2013:101). Veit and co-authors place the construction of the Orange Valley hospital within the Amelioration Movement that served as the response to growing abolitionist pressure within the British Caribbean. Counteracting the physically debilitating circumstances of enslavement was to be somehow ameliorated through better health care. As the authors demonstrate, the physical presence of the hospital was designed to create a visual impression of committed health care for the unfortunate. The visual appearance of the hospital also communicated to knowledgeable viewers health principles of the time: good health required the circulation of fresh air to prevent the

accumulation of harmful and disease-causing miasmas. Large windows and a hipped roof that both served as protection against hurricanes as well as ensuring circulation of air throughout the second floor. This was not a structure that would easily lend itself to the description "hot house," despite the fact that controlled sweats were an element of late eighteenth- and early nineteenth-century medicine. Further, the new hospital carefully kept the two sexes separate from one another. The predominant medical paradigm of the time, known as heroic medicine, was based on the notion that the human body was composed of four primary elements (humors), earth, wind, fire, and air (Hudson 1987). Men's and women's bodies were understood to have different bodily composition, and treatments could vary.

Incidentally, this separation of sexes would have conformed to understandings of health and the body shared by many West African groups impacted by the slave trade, who saw men and women's bodies as potentially dangerous to one another at particular times, necessitating physical separation, particularly at times like menstruation or childbirth, resulting in families occupying multiple structure courtyards rather than single domiciles. At Clifton Plantation, Bahamas, where married couples were expected to cohabitate in a single structure, there is some evidence that cyclical separation of married couples was practiced through the maintenance of single sex dormitories on the plantation that seem to have served as "men's" and "women's" houses (Wilkie and Farnsworth 2005).

Though not discussed in detail by the authors, hospital ledgers also demonstrate a commitment to heroic medicine. Heroic medicine saw illness as resulting from an imbalance in the body's humors, and health could be restored through a regiment of removing the imbalanced humor. Bleeding (using lancets like those purchased by the hospital, or through the use of leeches), controlled burning (cupping), or purging through the use of strong emetics that caused diarrhea or vomiting were deployed in affecting cures. Antimonal powder was an emetic with strong cathartic properties. Sodium supercarbonate served as an antacid. India Pinkroot was both a laxative and worm remedy. Heated red mercuric nitrate was a mercury powder, also known as calomel, which was taken internally and one of the treatments for yellow fever. Camphor was a topical ointment that treated skin eruptions, having antifungal and anti-itch properties (Culpepper 2016 [1652]; Hudson 1987; Jackson 2001). Thus, in the hospital ledgers one can see drug choices and practices that conformed to Anglo notions of proper health care. Likewise, the presence of alcohol bottles (a medicinal solvent), cast iron pots, and a colander speak not only to the possibility of food preparation in the hospital, but to the preparation of herbal medicines, such as tonics or teas. Certainly, Caribbean "bush" medicines draw heavily on the use of herbal infusions, or teas (Wilkie 1996b).

Yet, despite the appearances of commitment to the health of the "unfortunate," the archival and archaeological record suggests practices did not necessarily conform to the best practices of health care. A former military man, David Kerr, the plantation's doctor, would have been familiar with the idea that the best way to keep troops (or a large enslaved labor population) healthy was to prevent them from becoming ill to start with. Sanitary living conditions, even in the early nineteenth century, were seen as connected to maintaining healthy environments. While the presence of water closets with drainage suggested an intent to maintain the police of

the hospital (to use military parlance), the presence of a large, food waste-filled midden abutting directly to the back of the hospital enforces the idea that the hospital was as much for show as for use. Added to that the diversity of ceramics found at the hospital, suggesting that the enslaved population cared for their own, providing food to the ailing, the hospital seems mainly for show. As the authors note, planters and their representatives remained unconvinced that enslaved people were sick rather than lazy.

Let us consider, then, the evidence from Orange Valley from the perspective of both the enslaved person and the not-so-benevolent planter. Even Anglos who had internalized the ideas of heroic medicine were reluctant to submit to it. It was often a last resort to call the physician. To any sensibility, the notion of submitting to blistering, burning, forced evacuation of the bowels and stomach, and being bled out (the recovered chamber pots could have been receptacles for any number of bodily substances) is terrifying and barbaric. There is every reason to think that a strict adherence to heroic regiments of treatment would be a powerful deterrent from seeking medical treatment in the hospital. Likewise, one has to consider whether the buckles recovered from the hospital represent some use of restraint. In such a way, the planter and his representatives could seek to assure that only the most ill people or birthing women would use the hospital. As the authors note, birthing women were most likely to be overseen by experienced women of the community—and it is easy to imagine them undertaking the preparation of herbal and other remedies. Lay midwifery practices had greater success rates for both mothers' and babies' survival than professionally educated doctors of the time (see Wilkie 2003), and ironically, both the demographic and economic security of the plantation after the abolition of the slave trade was best left in their capable hands.

Yet, there is evidence from the hospital ledgers that suggest there were sincere attempts to treat pain—the presence of opium and hernia trusses. Note, that each of these treatments would allow an injured or chronically suffering laborer to return to work—these are both things used as treatments, not cures. Veit and his coauthors provide a sketch of an institution that may have appeared to be benevolent, but once that superficial surface was scratched (or excavated), the reality was apparent.

The record keeping of the hospital provides one other unremarked upon piece of evidence about the economics of reproduction. The recording of newborns based on racial classification had an economic dimension. In the British Caribbean, "negro" indicated someone of full African ancestry, a "mulatto" had one white and one black parent, a "sambo" had three black grandparents and one white grandparent, while a "quadroon" had three white grandparents and one black grandparent. Unlike the US, where the "one drop" of African ancestry classified a person as racially black, one's skin color had implications for free people of color regarding legal rights (Ryden 2018). The presence of mixed race children attests to the sexual violence regularly perpetuated during enslavement, and belies any attempts at "ameliorating" the conditions of bondage. Instead, we see a space where the systematic debilitation of Black bodies was the norm.

Scott's paper, which examines the Weimar Joint Public Sanitarium of Northern California, embraces a broad disability theorizing approach to her subject, playing back and forth between the social and medical models of disability, while also

engaging with crip theorizing that attempts to understand how social understandings of disability become normalized. She looks first at how "ideas about normative ability and behavior are embedded in the built environment, landscape, artifacts, material culture and daily practices," and argues that the tuberculosis sanitarium was a space that deviated from typical domestic architecture in important ways. Glass, instead of being a conduit through which temperature was regulated, was a therapeutic tool through which TB patients took on healing ultraviolet light.

Scott's discussion of glass explicitly designed to increase ultraviolet light for TB patients has had me thinking guiltily about piles of broken glass panes recovered from domestic sites occupied by impaired persons as well as plant conservatories, where I did not pause to think about the work done by glass, and the ways the glass may have been enhanced for particular functions. Access to sunlight did not necessarily translate into warmth for TB patients, who were also supposed to benefit from brisk mountain air, often being forced to sleep in chilly conditions to become cured. In the early twentieth century, TB, and the notion of the consumptive, was increasingly a gendered illness (Sontag 1977; Summers 2001). Teddy Roosevelt, who by his own descriptions suffered from a weak constitution, cured himself through a rigorous outdoor life, being a living example of the benefits of engagements with wilderness and fresh air (Wilkie 2010). These things were both cure and preventative. Women, not encouraged to engage in the robust athleticism of young men, were increasingly framed, as Scott discusses, in the late nineteenth century, as the living embodiments of consumption. Even healthy women pursued a consumptive look, through tight corseting and the application of whitening makeup (Summers 2001). While Wiemar may have housed members of both sexes, they were kept separate and women outnumbered men.

Disability scholars argue that it was the result of political action begun in the 1970s that led to disability emerging as a shared, politicized social identity; yet, Scott's research, and her consideration of publications and writings by patients and circulated through the sanitaria, demonstrates that patients came to see themselves as a collective of fellow sojourners, who shared the travel to the cure, but recognized they had an impairment that would probably mark them for life, a life sure to be punctuated by other periods of ill health and perhaps repeated institutionalization. If to be "consumptive" was to be seen as having an artistic or intelligent temperament, patients embraced the "superpowers" of their disability (after Seibers 2008), engaging in art, cartoons, poetry, and at Arequipa Sanitarium, the production of Arts and Crafts Pottery that still draws enthusiastic collectors. Just because the modern disability movement developed in the 1970s, we cannot dismiss the possibility that there were not communities who identified themselves as fellow spirits earlier. Their political action may have been limited to the confines of the institutions they inhabited, but we should look for such identities archaeologically.

Maria Smith's paper (this volume), looking at the records of shoe repair at the Syracuse State School for Idiots, shows the randomness of taxonomies of debility that have existed in the not-so-distant past. To be an "idiot" was to have conditions as diverse as deafness, cognitive disabilities, partial paralysis, or any diverse array of conditions that prevented one being able to care for one's self, do useful labor, or to understand the legal consequences of his or her actions. With such a diverse array

of embodied experiences under a single institutional umbrella, it is impossible that anyone could receive appropriate care. The Syracuse School, however, conformed with the medical model of disability—the idea that medical interventions could lead to "curing" the disabled body of its circumstances. As Smith notes, the shoe repair records of the Syracuse school show the ways students' circumstances led to differential forms of gaits. Smith points out there was a shared notion of a typical gait that school attendants attempted to impose on students, no matter their particular physical circumstances.

Katherine Kincopf (2020), in a bioarchaeological study framed through crip theory, termed those individuals whose style of walking would have been visibly distinct to observers as having "unusual gaits," a term that nicely avoids constructing particular ways of moving as normative or non-normative, and in her analysis of a medieval Italian cemetery, notes that any range of social, aging or other health conditions could contribute to variety in ways of moving. The value of adopting a term that recognizes difference without valuation grew out of Kincopf's engagement with disability theorizing, and her desire to avoid rendering a disabling or pathological description of people's movements. I was reminded of Kincopf's work reading Smith's study.

The shoe repair receipts studied by Smith demonstrate the wonderful variations in movement that existed within the school. What Kincopf would describe as "unusual" ways of walking, Smith makes clear, were viewed as unacceptable by the administrators of the Syracuse facility. As someone who is very, very, near-sighted, I have long depended upon identifying people at a distance through the way they move, and I was pleased that Smith evoked the importance of being able to feel sound by deaf residents of the school. The thick, insensitive shoes of the school would have affected the ability of deaf students to fully engage with their environment—and likewise, attempts to control gait styles would have also robbed deaf students of the ability to identify which of their fellows was approaching them without looking—different treads would create different vibrations.

Smith reminds us of the biopolitical dimensions of walking, and the ways that society can express low tolerance for diversity in motion. I found Smith's descriptions of students being forced to wear braces and attempt to relearn to walk horrific. I have an unusual gait myself, due to a congenital condition that has left me with three-fourths of a foot and lacking a big toe. My right foot swings outward when I step, leading to a pronounced wiggle when I walk. I tried to "correct" my gait as a teenager when I was accused of trying to draw attention to myself with my swinging hips. My attempts resulted in several recurrent sprains and a walk that was more "usual" and uncomfortable. I finally gave up at some point and returned to my normal unusual gait (after Kincopf 2020). I can only begin to imagine the pain, suffering and self-loathing experienced by children forced to attempt the impossible work of reprogramming their bodies to walk according to someone else's specifications. As Smith's evidence from shoe repairs demonstrates, this was not a possible task for some students' and their biomechanical realities. We see through Smith's analysis that the Syracuse School for Idiots saw their mission not to protect the well-being of their charges, but to mold their resistant bodies and minds into recognizable forms of future laborers.

The role of plants in the therapies of the Western Washington Hospital, as demonstrated through Kuglitsch's creative consideration of flowerpots, shows a very different approach to disciplining disabled bodies. Mental illness, as Kuglitsch notes, was understood to be on the rise during the late nineteenth century in the United States. While Kuglitsch references sources who blamed increasing urbanism and its alienations from nature, it is worth remembering that the United States, at the time when the hospital opened in 1871, was still dealing with the aftermaths of the Civil War, and the concerns about the anxiety disorders and alcoholism among men may speak to widespread undiagnosed Post Traumatic Stress Syndrome [PTSD] among soldiers (Kinder 2015).

Civil War veterans were politically active in establishing national organizations for the support of disabled veterans, but disability was measured in units of lost limbs or eyes (Kinder 2015). Mental illness was not widely understood to be an aftermath of battle until World War I vets returned from the trenches suffering from what was called "shell-shock." Still, as Barnes notes (this volume), the Civil War also was a catalyst that introduced soldiers to particular kinds of products. While Barnes cites "Dr. J. Hostetter's Stomach" as one such product, working at the postbellum site of Fort Davis, Texas, I saw archaeological evidence that Civil War service may have created a market for "Udolpho Wolfe's Aromatic Schnapps" among Black soldiers who had served in Louisiana during and after the Civil War (Wilkie 2021).

In 1871, illnesses of the mind were understood not through the lens of psychology, but as a physical manifestation of moral failings or anxiety disorders arising from an inflamed nervous system (e.g., Strahan 1885; Waddington 1853). Kuglitsch (this volume) describes patients at western Washington undergoing "moral treatment, an eclectic regime of occupation, recreational and spiritual activities." The pastoral setting of the hospital allowed patients to reconnect with nature, and engagement with the disciplined practices of horticulture, encouraged a reordering of the mind through a reordering of bodily disciplines. Horticulture, as Kuglitsch demonstrates, required patients to become aware of temporalities outside of their own minds and bodily needs—plants demanded different modes of care at different moments in their life cycle, thus tending to plants demanded daily attention, but not rote repetitiveness of action. Merely watering was not sufficient, plants required repotting, trimming, turning, proper warmth and light. Plants demanded human interaction. Plants could serve as avatars of a patient's progress, growing lush and fruitful, or barren and wilted. In institutionalized settings, tracking the passage of time can be difficult, and the clear progress visibly seen literally roots a person to a recognizable passage of time. It is not surprising that during the COVID crisis, we have seen a run on seeds and seedlings as people have sought the centering impacts of interacting with plants.

In her work, Komara confronts the stereotypes of Appalachian womanhood, and provides archaeological counters to narratives of incompetence and willful ignorance. This paper particularly demonstrates Seibers (2008) argument that ideologies of ability ultimately frame other modes of identification. Appalachian women, in the stereotypes discussed by Komara, are toothless, they age prematurely, they exhibit a lack of intelligence and resistance to education, as well as an inability to

care for themselves, that would firmly place them as potential residents of the Syracuse Home for Idiots. These are stereotypes that are completely couched within ideologies of ability. Women are represented as "grannies," again suggesting age and infirmity, Appalachian women, who Komara describes as being represented as "deficient," are actively disabled through their representation, and these representations are used to justify their treatment as less than citizens, less than human, as persons who need the paternalism of the company to be cured of their backwardness. This narrative renders women as unfit mothers, poor wives, less than women. Seibers (2008:187) writes:

> In the absence of ability, gender identity has no future and risks to disappear entirely. Disability effects similar transformations on racial, sexed, and class identities not only because they, too, rely on ability as a marker but also because disability appears at first glance to be so individualizing that it overwhelms any sense of group identity, and without identity, it is nearly impossible to project a future.

Appalachian women were fighting stereotypes that explicitly defined their bodies as sick, participation in medical discourse through consumption and demonstrated fluency in scientific medicine through their consumer choices. Komara argues, "Persistent patent medicine use did not result from economic barriers or residents' mistrust of medical professionals or scientific medicine nor from their ignorance of the 'snake oil' nature of patent medicines. The foundational argument here is that patent medicine occupied a nuanced space, they were an old idea with a modern twist that appealed to women's desire for both traditional and cosmopolitan remedies." Of course, unless women explicitly limited their purchases to the privately owned drug stores in Jenkins or mail order catalogs, their purchasing decisions were not private, but available to the coal company. While Komara focuses on the freedom to express their agency enjoyed by the women of Jenkins, we cannot ignore that these women were consumers within a highly regulated and overseen consumer setting.

The women of Jenkins reminded me of women I encountered while researching Oakley Plantation (Wilkie 2000), who lived within a similar paternalistic economic arrangement, with the appearance of consumer choice being offered to the tenants, who were able to buy goods on the planters' accounts in multiple stores in the neighboring town. Purchases were monitored by the planters overseeing the accounts, and the racially hostile merchants the Black farmers encountered. These contexts shaped some of the consumer choices in important ways. At Oakley, multiple families purchased Dr. Tichenor's Antiseptic (see Barnes, this volume), a medicine pitched by a former Confederate soldier, and which featured an image of Confederate soldiers running a bayonet through a Union soldier. As a medical product, Dr. Tichenor's composition aligned with several traditional herbal cures used in Louisiana, but its packaging cannot be ignored. In the hands of a white family, Dr. Tichenor's must be seen as advocating for a particular kind of white supremacy, in Black hands, the possibility this product did other kind of accommodationist work in fraught social settings (general stores), must be considered (Wilkie 1996a, 2000).

Lucretia Perryman, a Black midwife whose medical practice ended early in the period discussed by Komara, exhibited a similar commitment to innovatively

assembling medicinal products that spoke to her competence as a herbalist, her knowledge of scientific medical and mothering discourses, and her ability to navigate white-owned pharmacies (Wilkie 2003). I similarly argued that Perryman was engaged in politically motivated and sensitive uplift work for her patients and community. This creative assembling of products was a strategy deployed in many households (see also Barnes, Surface-Evans, and Verstraete, this volume).

When Perryman worked with new mothers and children, the medicalization of childhood and mothering was accelerating. Mothering in the 1900s and teens coincided with a number of social, economic, scientific, and political convergences. Family life in the early twentieth century in the United States was radically reshaped as the state took a more proactive role in oversight of child-rearing particularly through public health movements and public education, replacing the women-driven maternalist projects of the nineteenth-century progressive era (Barney 1999; Litt 1997; Sklar 1993). Health care discourses promoted an increasingly medicalized understanding of a child's physical care, while public education increasingly turned its attentions towards instilling heteronormative and white supremacist notions of citizenship and patriotism in its curricula. Eugenic and social health movements revolved around not only how women should mother, but also, which women should be encouraged to reproduce.

Historians and women's studies scholars looking at mothering during this period note the increased medicalization of motherhood (e.g., Barney 1999; Litt 1997) as evidenced by the growing authority of medical professionals in child health and rearing decisions. Litt (1997:288) argued that mothers engaged with medicalization not just in ways that rendered them subservient to the will of physicians—"for all the cultural control that medical discourse commanded in these years, medicalization also provided a site for women's agency; indeed it enabled mother's to make meaningful—and purportedly scientifically verified—evaluations not only of their own practices but the practices of others." Litt conducted oral history interviews with a number of women of different racial, religious, and socioeconomic backgrounds to understand how they differentially engaged with medicalized motherhood.

At the same time, lay healers were being demonized by the professional medical classes, with women being represented as too old, too senile, too weak; in other words, too disabled to provide medical care. It is noteworthy that Komara notes Lydia Pinkham as a representation of "a grandmotherly figure" in advertisements. At a time when the experiential learning of lay healers, be they midwives, herbalists, or other folk specialists, were being demonized and replaced by book-trained physicians, it is worth wondering if the women of Jenkins were expressly critiquing tropes of medicalization.

While Komara does not address the women as caretakers of their household's health, products like Dr. Pitcher's Castoria were explicitly advertised for the product's gentle effect on young bodies (Fike 1987). Dr. Pitcher's had a long history of production, and in selection of certain products, we may see the influence of generations of Jenkins women. Products were not necessarily bought just for their own use. Similarly, I was a bit surprised that Komara did not discuss the explicit relationship between products like Lydia Pinkham's and cathartics with women's reproduction. While these products were available due to their role in maintaining bowel health,

they have also been long associated with their use for inducing abortions during early pregnancy. While birth control was increasingly promoted as having a role in family planning in the early twentieth century, abortion was increasingly criminalized and undertaken carefully (Carnevale et al. 2016; Kozub 2018; Wilkie 2003, 2013). I note that Komara makes no mention of whether any of the most common medical instruments popularized by the bowel-cleansing movement—the enema kit– product available in multiple varieties and styles through the Sears and Montgomery Ward catalogs, were found at the site. Often provided in these kits were vaginal tubes, which could be used for personal hygiene (and contraception). What was the company stance on family planning or the personal sanitation movement that attempted to crack down on venereal disease transmission?

In the case of the enslaved laborers of Orange Valley, cures were to be effected even if the afflicted person attempted to resist efforts to heal them. The Appalachian women studied by Komara, while not institutionalized, were living within a particular kind of public health system that subjected coal miner's family to a disciplining system of health care that encouraged conformance to a particular set of company dictated health regimes. Like the enslaved laborers of Orange Valley, the women of Jenkin's coal town faced decisions about how to balance their own medical knowledge within the structure of the company's health initiatives. We can see the ways that within structured institutions, be it the plantation, the company town, or formalized hospital institutions, disability is foisted onto particular bodies, is understood as standing in opposition to ableism, and is recognized to require curing through different health and social measures.

Authors of papers in this volume also demonstrate ways that processes of medicalization twinned with the ideology of ability, are internalized within individual households and materialized in artifact assemblages. Barnes and Verstraete's papers both consider the ways that households responded to a changing landscape of medical knowledge that was communicated through popular magazines, proscriptive literature, and a range of advertising.

Barnes frames her analysis of medicinal products against a narrative of the growing medicalization of human bodily experiences, ranging from gas, headaches, fatigue, monthly cycles, and the random soreness that are experienced to different degrees by different persons. As Barnes notes, increasingly, a wide range of symptoms were presented as needing medical intervention. This medicalization drew upon individuals' vulnerability to the ideology of ability, playing upon fears of becoming debilitated, of inhabiting a sickly or aging body. For women, whose bodies were systematically constructed as less than—frailer, weaker, less healthy, less robust—men these fears were very real. For being constructed as less then, as already disabled, had real lived consequences, pains and conditions that were dismissed as hysterical—literally arising from having a uterus. Death rates for women and children were appallingly high and means of controlling one's reproduction were increasingly being subjected to oversight. As waves of immigrants entered the country in the last quarter of the nineteenth century, growing Eugenics discourses emphasized motherhood as the duty of some women, and something to be denied others.

Fear, fear for one's own health, of dying in childbirth, of watching one's children die, was not a remote fear, but a reality, one experienced by several of the families examined in these pages. I read with great sympathy both Barnes and Verstraete's papers detailing the ways that women turned to patent medicines in part, because the advertising and images of wise women and soothed children spoke to them and inspired trust in a way interactions with physicians did not.

I read some of the labels for old patent medicines and think, they are describing perimenopause and its long laundry list of diverse and bizarre symptoms that emerge in individually unique combinations in different bodies that can last for a decade or longer (thinning hair, changes in skin pigment, fatigue, mood swings, headaches, back and lower body pressure and soreness, constipation, depression, weight gain, swelling, and many more. And I think, those poor women, in a time when so many died before being done raising their children, how frightening and strange the "change" must have been. And as clearly demonstrated in these paper, the natural cycles of a woman's life, monthly, during the course of pregnancy and recovering, and longer cycles of the lifecourse, were medicalized, marked as less-than-able by discourses of ability in a patriarchal society that valued only particular women for their youth, beauty, reproductive abilities, and caretaking skills. As Barnes notes, medicinal advertisers were involved in the "careful convincing [of] people that previously non-medical problems, like bad breath or social anxiety, [were] to be redefined in terms of illness or disease."

In his study of advertising, Leach (2011) has argued that advertisers were not selling a single product, but a broader idea of a lifestyle—the "good life"—that if the consumer selected the right assemblage of things, they could transform their lives. Medicine hawkers have long recognized that the ideology of ability (and fear of disability) allowed them to literally sell health and the good life in a bottle. These fears, of aging, of being infirm, of being designated as less than able, shaped some of the medical decisions seen in these Arkansas and Illinois households. Hair dyes, skin bleachers, as well as tonics and elixirs that promised to discipline the unruly female body.

Fear shaped other choices, as Verstraete notes, the presence of Mrs. Winslow's Soothing Syrup, in a household linked to an Eclectic physician patriarch seems like a dissonance. Yet, it is possible to see the ways the intersectional pressures of increasingly medicalized womanhood and motherhood (with physicians and beauty narratives increasingly pushing women from breastfeeding and the attendant gastronomic distress that caused in infant digestive systems, increasing colic), manifested in medicine purchasing decisions. In addition, medicalized narratives also identified insomnia as both a cause and symptom of nerve diseases. It becomes easy to imagine a frazzled and exhausted mother deciding the future health of her family and the development of her child's nervous system (a subject I consider further below), would decide that the risk of slipping her child a little morphine outweighed the other considerations. Further, the temporal resolution of archaeological deposits doesn't leave a record of the stages of medicinal approaches; we cannot know if Mrs. Winslow's was deployed after other seemingly less extreme options were undertaken.

Barnes speaks to the privacy involved in the taking of pharmaceuticals, yet, as we saw in Komara's paper, medicinal consumerism could have a very public aspect to it. In the case of the Harris family, Dr. Harris' Eclectic medicinal practice was likely observable to the public. As a herbalist, he was likely to have a visible garden or other features that spoke to his medicinal beliefs. That his daughters quietly dosed their children with a morphine-based patent medicine would have indeed been a private matter that would not have publically undermined the father's work.

Patriarchal and ableist ideologies hurt men too. As mentioned before, while physical scars from warfare marked manly courage, the mental health effects of warfare were ignored. Verstraete's paper plays with the question of how men's health was situated into medical discourses, as provoked by evidence of Mrs. Winslow's Soothing Syrup in boarding house assemblages associated largely with men. The small number of alcohol bottles in this instance associated with the men's garbage is probably a red herring: as a social activity in nineteenth-century bachelor culture drinking often takes place outside the home (Wilkie 2010), so ironically, these items may speak to medicinal uses of alcohol. While archaeologists have generally embraced the anti-patent medicine rhetoric of post-1906, the high percentage of alcohol in these concoctions was typical of herbalist remedies that often used alcohol as a solvent (Wilkie 2003). Recall that early twentieth-century America was poised to outlaw the possession of alcohol. Yet, alcohol was regularly used by physicians in routine and emergency medical treatments, for antiseptic, a reviver, a sedative, and as a nutritional supplement (Hudson 1987). This is not to say that some patent medicines were absolutely not dangerous to consumers—but so were many of the medical school approved treatments of the time. Maternal death from "child-birth bed" fever was literally at the (unwashed) and intrusive hands of medical-school trained doctors.

So while Mrs. Winslow's may not have been a substitute for alcohol, its presence, as Verstraete notes, deserves consideration. One of the increasingly concerning diseases discussed in post-Civil War medical journals through the beginning of the First World War was the condition of "neurasthenia." The condition was notable for symptoms of anorexia, insomnia, melancholy, cardiac problems, dyspepsia, perpetual exhaustion, and panic attacks. James Hurry (1914:1404) noted that insomnia left the neurons unable to rest, and was part of a vicious self-sustaining cycle of the disease. The observed connection between heart and other organ problems emerging from neurasthenia was noted in British medical journals by 1885 (Strahan 1885). As a nerve disease, neurasthenia was understood to be caused by disorders of the nervous system and to have impacts on a man's sexual health and practices (e.g., Hurry 1914; Sinclair 1903; Smith 1903; Strahan 1885). A man could bring on neurasthenia through an active engagement with "vicious habits," and therefore, to be neurasthenic was potentially embarrassing. Nerve tonics, insomnia aids, headache cures, all operated on another level within Victorian society, a level in which sexuality was narrated by ideologies of ability. Verstraete's paper demonstrates that we need to consider how health, gender, and sexuality converged in consumer decision making, and the kinds of multiscalar considerations of context she advocates to understand consumer decisions is well-worth the effort involved.

To what extent did changing narratives about health and medicalization impact families? Barnes' study, with its long temporal reach, provides valuable insights. Barnes can clearly trace the influence of shifts in attitudes and regulation of the medical industry in the consumer choices demonstrated in the household waste from Hollywood Plantation's planter family. While medicinal purchases were shaped by their own particular needs (and fears), the Taylors' medicinal choices show an awareness of changing notions of safety and continued influence of college-trained medical practitioners and professional organizations on health narratives. We can also see the impacts of these shifts on life today—after all the opioid crisis was brought to us not by patent medicine hucksters or even by street gangs—it was brought to this country courtesy of the so-called "ethical" drug companies who used doctors to deal unnecessary prescriptions for pain-killers. Barnes' study reminds us that historical archaeology has a role to play in contemporary discourses on ethics, health care, and the ongoing processes of medicalization.

We can see in these papers the profound ways that ideologies of ability have shaped Americans' sense of their bodies, in ways that not only increased the ways that their experiences of health and their bodies have been medicalized, but also in ways that contributed to social, economic, racial, gendered, and political inequalities. Disability theorizing allows us to examine the processes through which ability is normalized as the normative body, but also the ways that what is "normative" or "able" is historically contextual and socially situated. Given the overwhelming pervasiveness of the ideology of ability, how do we move to archaeological frameworks that allow us to think beyond the able-disabled binary?

Decentering Able-bodiedness with Well-Being

An essential component of this volume is the contributions that consider disabling aspects of our discipline, and the embodied experiences of disability within archaeology (Heath-Stout; Wooten, this volume), as well as papers that consider the issues of health and well-being from an embodied disabled subjectivity (see Surface-Evans, this volume). A barrier to the introduction of disability theorizing in the discipline has been the extremely ableist biases of archaeology. After all, the primary avatar of our discipline remains Indiana Jones, who despite being embodied in the aging body of Harrison Ford, continued to engage in ethically corrupt but physically superhuman feats through four movies. COVID-19's impacts on the film industry may have saved us from a planned fifth installment.

Even though not designed to interrogate questions regarding disability, Heath-Stout's (2019) study of experiences of exclusion in archaeology based upon gender and sexual identities inadvertently revealed persons who also had embodied subjectivities that fell outside of the ideology of ability, driving home disability theorists' assertion that disability cannot be separated from other frames of understanding sexuality, race, and other identifications of difference (e.g., Hammer 2014; Knadler 2013; McRuer 2005; Quayson 2007; Seibers 2008; Snorton 2017). Heath-Stout discusses the rich theoretical linkages that exist between feminist, queer theorizing, and disability theory. She found three interrelated themes characterized the experiences

of archaeologists who have "invisible disabilities," or impairments that are not externally obvious. In a discipline that strongly embraces the ideology of ability, or compulsory able-bodiedness, people are faced with the decision of whether to "pass" (disguise their disability in ways that imply conformance with mandatory able-bodiedness) or disclose disability. Heath-Stout recounts her own difficulties with acknowledging her invisible disability, choosing to come out as queer before disabled. Her decision to pass as able-bodied in her first field school, where Heath-Stout lived without access to her breathing apparatus and risked her health and well-being, demonstrates the oppressiveness of compulsory able-bodiedness.

Related to passing is the notion of masquerade, also situated in feminist and queer theorizing. Masquerade is a mode of disclosure that involves exaggeration of an aspect of impairment to render it visible, or emphasizing one aspect of impairment while covering for another. In my experience, as someone with a not-so-visible/not-so-invisible impairment (some people notice it immediately, some take years—so maybe it should be considered a peek-a-boo impairment), even though I am left-handed, I will sometimes perform visible acts with my right hand as a form of disclosure, sticking it out to receive objects, clumsily picking things up with it, or waving it in an ironic fashion. These disclosures are used to warn people who may notice my limb difference as a result of a handshake or during social interaction, as a way to try to circumvent exaggerated double takes, shocked looks, or conversations that start with questions like "what is wrong with your hand" or "what happened to your hand?" As I've aged, I'm significantly less polite in responses ("nothing, what's wrong with yours?" or for the second question "the womb" or if I'm particularly irritable, "shark attack," "acid bath," or "garbage disposal malfunction, don't ask.") Yet still, I have at different times felt that representing my difference as disabling or an impairment was inappropriate, having internalized the ableist notion that some impairments are "worse" than others, and indeed, recognizing the amniotic banding syndrome that shaped the formation of my right hand and foot does mark me as disabled, and identifying as such, is clearly a political act, as recognized by Heath-Stout, Wooten, and Surface-Evans in these papers.

Heath-Stout's paper clearly demonstrates the importance of archaeologists with disabilities being forthright about their embodied experiences and bringing their subjectivities to bear on the practices and interpretive gazes of archaeology. Too often, the ableist assumptions of archaeologists are frustratingly grafted on the past. A particularly disturbing example being an article published in the flagship (for some archaeologists) journal of *American Antiquity* (Spence et al. 2014), where identification of a congenital hearing defect within a prehistoric population was hypothesized as a contributing reason for the community "dying out," since their ability to communicate with other groups would have been limited. How no one in the review process protested these clearly ableist interpretations astounds me.

This leads to Heath-Stout's final important discussion point, the notion of "crip time." "Crip time" recognizes there is no single temporality that works for all bodies—whether the disability is invisible or not. For people who live with invisible disabilities, however, archaeological practice, be it in CRM, heritage studies, or university settings, is extremely intolerant of failures of practitioners to conform to particular ableist constructions of time. Journals demand adherence to deadlines,

advisors measure progress in semesters, discussants expect papers certain times before a conference, and field archaeologists expect a certain number of holes to be dug in a particular time frame. For those on the tenure-track, interruptions to schedules, be they due to sickness, pregnancy, impairments, or care-giving demands can be career destroying. Yet, intolerance of crip time is instilled at the university level. Those who teach in universities, have probably heard colleagues complain about students given scholastic accommodations that reflect the lived realities of crip time—time and a half on exams, extra time to meet assignment deadlines—stating in exasperation, "how do they expect to succeed in the real world." The "real" world, however, is structured around the notion of compulsory able-bodiedness.

So, for full disclosure, I witnessed both times Dr. Dr. Maria Zolezzi Garibaldi and Ms. Wooten presented their Color Pink research, and both times, I laughed and wept. It is a brave, funny, and honest presentation of the embodied experience of breast cancer, the complicated engagements between ideologies of ability and the ways certain bodies are categorized as disabled no matter how the person living within that body sees themself. Dr. Dr. Garibaldi's research into ritualistic practices surrounding breast cancer provides a satirical critique of the ways female ills are trivialized (Wooten's future-self explains to Dr. Dr. Garibaldi in 2037 that breast cancer isn't pink, it's a hairy monster that eats you up), as well as the ways normative notions of a proper female body are policed with the pressure to conform to a two-breasted body. It is hard to think of a less mechanically useful but symbolically important prosthetic than the FOOB (for humans, for companion animals, nothing compares to the "neuticle"). Wooten's lived experiences, and her consideration of how future archaeologists may come to understand our reification of the breast as related to cancer, clearly demonstrates the ways that processes of medicalization and ideas that the female body, even when fighting cancer, creates a perception of the female body as somehow less-than; even one of the deadliest cancers for women is somehow cute and feminine, and not at all masculine.

Wooten also expresses the ambivalence that comes with trying to understand whether "disabled" is the appropriate term for what one has endured and its ongoing legacies. Wooten (this volume) writes,

> Am I disabled? No, I reserve that label for someone one with a more serious condition. I am sure other people whom I might consider disabled do not think of themselves as such either. But my health has been impacted, both mentally and physically, by my illness. While some of it was temporary, other impacts linger and I will have to manage them for a lifetime. It is not surprising that I live with more anxiety and depression than I had prior to being diagnosed with cancer. This can impact my ability to work in a typical, linear way, but after years of working in this fashion, it is my normal.

Disability activists like to state that able-bodiedness is a temporary state. Whether through illness, injury, aging or other debility, all human bodies enter into periods of impairment, and are at risk of being subjected to disabling treatment. Wooten's experience of cancer, treatment, and recovery, speaks to the unexpected ways impairment can suddenly enter one's life.

Wooten refuses to conform to forces of medicalization that would seek to disable her, and while she personally resists taking on the mantle of a politicized disabled identity for herself, Wooten's work and stance is an essential component of critiquing ableist ideologies and drawing attention to circumstances through which able-bodies become impaired and subjected to disabling. Reactions to her presentations, like Heath-Stout's survey, demonstrate there is a strong desire within the discipline to have these discussions, and to provide opportunities for archaeologists to question the compulsory able-bodiedness of our discipline.

Then how do we move forward and consider ways of thinking about the past that recognize the influences of the ideology of ableism without falling prey to it? There are no easy answers, just as there are currently no clear answers about resolving theoretical distances between the social and medical models of disability.

Surface-Evan's paper, working though the idea of well-being, is an example of a very successful attempt to think more broadly about differences in embodied experiences that avoid disabled-abled binaries.

Surface-Evans, who discusses that her desire to avoid abled/disabled binaries in interpretations of health emerged out of her own experiences of impairment, suggests that archaeologists might consider thinking of "well-being." Her construction of well-being grows out of disability theorists' critiques that too often processes of medicalization lead to healthy bodies being seen as the default human body. Well-being, Surface-Evans argues, allows for the possibility of seeing disabled bodies as potentially happy and well, as well as recognizing that diseased persons can enjoy a sense of well-being. Her notion of well-being avoids automatically constructing healthy/unhealthy or disabled/able bodied dualities that emerge out of medical models of the body. It also accomplishes something that is too often missing from archaeological studies of health—a holistic approach to the archaeological record.

The lighthouse keeper households studied by Surface-Evans were expected to undertake a range of physically strenuous activities as part of caring for the lighthouses and ensuring their functions were not interrupted. While the duties of lighthouse keeper were presumed to be concentrated within one person, as Surface-Evans notes, the realities were that the extended household, including wives and children, were presumed to be uncompensated labor (a situation that continues in many contexts today). Families were also important due to the isolation of many of the lighthouses. Family members were necessary sources of mutual support and caregiving. Deposits at 40-mile point included canned goods, and evidence of the same kinds of purgatives discussed by Komara. The dependence of keepers on canned rather than fresh fruits and vegetables may have encouraged their use of medicines to regulate digestion. The canning process breaks down naturally occurring fiber in fruits and vegetables that would otherwise aid regularity. The presence of throat medicines, including one manufactured by Vicks, speak to the conditions of living through cold winters on the Great Lakes. Wood and coal heating create particulate matter and throat drying heat, potentially requiring soothing throat remedies.

As Surface-Evans notes, thinking about well-being requires us to put aside our own biases. While to many readers today, smoking tobacco is seen as clearly jeopardizing a person's complete health (as defined by the World Health Organization), the activity was seen as having healthful benefits in different times. In addition,

smoking, just like the consumption of alcohol, was considered to create a feeling of warmth in the body, and was/is used in cold climates to combat chill. In this way, we can also see the use of morphine-based drugs, whether used for children or by adults needing soothing, were used for creating a sense of well-being.

It is in Surface-Evan's McGulpin Point case study, however, where the full implications of using a well-being framework becomes apparent. Although there are few artifacts related to what may be considered health, the evidence of materials that supported well-being are wide-ranging. The archaeological remains are traces of the Davenport family's life at the lighthouse. The Davenports suffered a fate feared by many of the families considered in these papers—Madeline Davenport died in childbirth, leaving her husband John to raise their nine children on his own. A mere eight years later, the family lost another member when one of the sons drowned in icy waters. What is seen in the archaeological traces left by the Davenports is not a record of tragedy, but an assemblage of practices that speak to John Davenport and his family's pursuit of a good life: an engagement with the environment that included caring for plants and trees to the extent that surplus was canned and consumed over the winters, forays into the wilderness to hunt (despite hunters' claims, much of hunting involves enjoying the outdoors rather than successfully killing things), fishing, and closer to home, animal husbandry, all activities that provided routines and purpose beyond the duties of lightkeeper. Even more, Davenport kept his children supplied with toys, like dolls and teasets, that encouraged imagination and creativity, as well as objects used for communal play like marbles. In what could have been a household shaped by grief and isolation, Surface-Evans has revealed the story of lives well and fully lived.

In other papers, we see similar archaeological expressions of well-being, the creative works of the TB sanitaria patients, the plants tended in the Washington Mental Hospital, the ingenuity in consumer practices of the Hollywood plantation, Jenkins company town, and residents of Springfield, Illinois. We see in the mixture of ceramics at Orange Valley, the efforts of the enslaved community to care for their own. In the works of Heath-Stout and Wooten, we see acts of contemporary caregiving, work that imagines an archaeological discipline more attentive to the well-being of its members.

Still, these works represent first-steps in the creation of a fully-theorized and actualized archaeologies of disability and wellness. Wellness complements, but cannot replace the important critique raised by disability studies literature and the concerns of disability theorizing. These papers demonstrate that we need to interrogate the ways ideologies of ability shaped the contexts we studied. Medicalization and other processes of debilitation have to be critically examined, for these are processes that create marginalization and naturalize social inequalities.

Disability activists also demonstrate areas that we have yet failed to consider. For instance, disability activists note that ablest ideologies seek to squelch sexual desire and reproduction among the impaired. Kara Ayers (2020; Andrews and Ayers 2016) speaks eloquently about the ways that disabled persons are denied and stymied in their contemporary efforts to parent. Bringing a disability lens to contemporary issues disrupts narratives on what constitutes reproductive rights. Likewise, the institutional settings described in these papers deployed housing arrangements and

spatial layouts that denied privacy or the opportunity to pursue romantic or sexual relationships. Even more importantly, particular expressions of sexuality were themselves rendered as evidence of disability. Komara notes that Dr. Pierce's literature accompanying his patent medicine blamed poor digestion for the terrible habit of female masturbation and promiscuity! The "idiots" and "insane" patients at Syracuse and Washington no doubt included patients who had been committed for the sin of "self-violence," sexual relations that did not meet community standards, out of wedlock births, or homosexual desire.

As I mentioned earlier, the "nerve" disorders suffered by men were said to be both caused by abnormal or excessive sexual appetites and in turn, cause further sexual debilities (Parsons 1977). Nineteenth-century medical journals are filled with articles describing the madness of masturbators and the horrendous punishments bestowed upon them. Bromides, such as those that were the active ingredient in popular "nerve" or "headache" cures like Bromo-Seltzer (among the drugs recovered from Jenkins and Hollywood Plantation) were used to dampen a person's sexual drive and were prescribed in insane asylums to chronic masturbators. An 1899 article, called "Notes on the Castration of Idiot Children," lamented that a physician in Kansas was being criticized for treating masturbation with castration (Flood 1899). The six boys were described as "chronic masturbators" who were treated for five years by another doctor with no effect. "Dr. Pitcher, taking a rational view of the subject, performed the operations for the same reason that he would perform any surgical operation—for its curative effect" (Flood 1899:297). The article details castration being used to treat kleptomaniacs and epileptics, with bromides and cod liver oil continuing to be provided following castration.

An 1866 article in a British journal argued that there was no therapeutic benefit to performing clitoridectomies on women in cases of madness, hysteria, epilepsy, or other nervous diseases of women (West 1866), yet the procedure continued to be widely used through the early twentieth century (Rodriguez 2008). Sexual violence wielded by doctors to police sexual expression is well-documented (see Roberts 1998, for history of racialized violence within medicine), and the archaeological evidence presented in papers here provide insights into the ways discourses on medicalization enforced heteronormative and misogynistic policing of sexual desire and practice. The medicalization of sexual desire, reproduction and the sexed body deserve our consideration, for is not the pursuit of fulfilling and loving relationships part of well-being?

Imagining Different Futures

These papers collectively present demonstrations of how archaeology may benefit from disability theory, and through a consideration of the pervasiveness of the pervasiveness of the ideology of ability—in the past, for the households and institutions we study. Understandings of the medical and social models of disability allow us to interrogate how diverse bodies were understood, classified, and policed, while concepts like "well-being" allow us to examine how relationships of nurturing, caregiving, and community building materialized in the past.

What must not be lost in archaeological studies of impairment and disability, however, is the political activism intrinsic to this field of study. Deconstructing ideologies of ableism are not mere intellectual exercises, they are debates that have extraordinary bearing on the lived experiences of millions of people in the US alone. The passage of the Americans with Disabilities Act (ADA) was only possible through theorized activist rethinkings of the nature of impairment and disability and the role that society plays in creating debility. This is an area where archaeologists have much to offer, and there is a broad community deeply interested in understanding these histories to create better futures.

Disability theorists continue to grapple with ways of understanding the gaps between embodiment and social constructions of ability, and archaeology provides the opportunity to understand embodied experiences situated within a broader material world. Recently, new materialist theorizing (see Barad 2007; Bennett 2009; Chen 2012; Coole and Frost 2010:8) provides one potential arena for developing new ways of understanding materializations of disability. Kincopf's (2020) recent dissertation is an outstanding example of how new materialist theorizing creates new opportunities for framing disability theorizing within archaeology, and following her lead, new materialist thought may be a rich source for future disability archaeology. For now, these papers are an important collection that will surely help shape future discussions in the development of archaeologies of disability.

Historical archaeologists have been long concerned with other modes of social inequality, be it sexism, classism, racism (e.g., Delle et al. 2003; Franklin 1997; Mullins 1999), and engaged work with a variety of communities has demonstrated the extraordinary contributions that archaeology can make to contemporary debates. Disability theorists recognize that representations of the impaired and the infirmed have long been used to marginalize a range of groups while simultaneously rendering the impaired themselves less than human or completely invisible. It is time that we turn our attention to fully developing an archaeological praxis that considers the range of bodies and minds that move through this world, and in doing so, participate in conversations imagining a future that embraces a notion of well-being and happiness independent of a compulsory able body.

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