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'She was frightened while pregnant by a monkey at the zoo': Constructing the Mentally-imperfect Child in Nineteenth-century England

Steven J. Taylor*

Summary. Classifications and concepts of insanity during the nineteenth century were constructed by numerous professional, quasi-professional and lay observers. Consequently, ideas of mental ill health and its causes were varied. This article explores how 'insanity' in children was observed, explained and evolved following 1845. It focuses on medico-cultural exchanges between families and doctors to plot shifts in how child mental health was understood. Numerous causes of insanity were given at admission including terrifying dogs, out of control lunatics and even visits to the zoo shocking expectant mothers so severely that they produced mentally-imperfect children. Such narratives were superseded by a dialogue that still included the family and their ideas, but also served the professional and intellectual agenda of medical men in consolidating their expertise over the insane. The article examines varied ideas of insanity, highlights the importance of the family in influencing medical understanding and introduces the experience of asylums for children.

Keywords: insanity; children; asylums; psychiatry; family; mental disability

Introduction

Children formed a distinct patient population in the pauper lunatic asylums of nineteenth-century England and their diagnoses were markedly different from those of insane adults.¹ Yet how they experienced mental illness and disability has only featured briefly in the historiographies of psychiatry, asylums and childhood.² The nature of child

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¹D. Wright, *Mental Disability in Victorian England: The Earlwood Asylum, 1847–1901* (Oxford: Clarendon, 2001); M. Jackson, *The Borderland of Imbecility: Medicine, Society and the Fabrication of the Feeble Mind in Late Victorian and Edwardian England*, (Manchester: Manchester University Press, 2000).

²J. Melling, R. Adair and B. Forsythe, "'A Proper Lunatic for Two Years': Pauper Lunatic Children in Victorian and Edwardian England. Child Admissions to the Devon County Lunatic Asylum, 1845–1914', *Journal*

of Social History, 1997, 31 371–405; A. Rebok Rosenthal, 'Insanity, Family and Community in Late-Victorian Britain', in A. Borsay and P. Dale, (ed), *Disabled Children: Contested Caring, 1850–1979*, (London: Pickering and Chatto, 2012), 29–42; S. Taylor, "'All His Ways are Those of an Idiot": The Admission, Treatment of and Social Reaction to Two "Idiot" Children of the Northampton Pauper Lunatic Asylum, 1877–1883', *Family and Community History*, 2012, 15, 34–43; Taylor, 'Insanity, Philanthropy and

insanity and how it was constructed by medical men and institutions during the second-half of the nineteenth century has featured even less. Melling *et al.* have recognised the importance of physicians exerting their influence over the insane through the process of diagnosis, but in the context of the Devon Asylum they argue that dealing with insane children was ultimately an issue of how to cope with challenging adolescent male behaviour.³ This article demonstrates that 'insanity' in children was a more complex issue and emphasises the importance of familial involvement during the certification process. It explores negotiated constructs of insanity for children, draws wider conclusions about how childhood was understood during the period, and traces how medical approaches towards children shifted.

By taking under-examined child populations of asylums as a historical prism, this article examines how child mental ill-health was constructed by the legislative and administrative processes of certification. Aetiologies of mental illness feature heavily in this discussion and a causative framework will be developed that explores the lay and medical observations that took place during diagnosis. This examination stresses the importance of non-medical input and demonstrates the increasing medical dominance over child mental health as the period progressed. The article then goes further and considers the children confined in asylums, revealing a conflict between the dual medical discourses of the asylum and Poor Law that further highlights the subjectivity of diagnostic processes.

Familial involvement in the confinement of individuals has been explored by numerous scholars. Michael Ignatieff has suggested that nineteenth-century carceral institutions were partly 'creations of those classes which they are intended to control'.⁴ Developing such an argument, Mark Finnane has argued that the Irish lunatic asylum was a specific intervention in family life and its uses were more complex than relieving just the deviant or dependent poor.⁵ This is a view supported in England by John Walton, who stated that families, communities and authorities resorted to asylums as a last resort for individuals who were deemed 'impossible' and not just for the inconvenient.⁶ Similarly, in the North American context, Nancy Tomes' argued that asylum admission was usually preceded by some form of crisis in domestic circumstances.⁷ Such viewpoints have led David Wright to conclude that asylum confinement was 'a pragmatic response of households to the stresses of industrialization'.⁸ An argument developed by Cathy Smith who has proposed that the poverty and material deprivation suffered by families of the poor meant that the asylum was accessed to alleviate domestic pressures during times of

Emigration: Dealing with Insane Children in Late-Nineteenth-Century North-West England', *History of Psychiatry*, 2014, 25, 224–36.

³Melling, 'Proper Lunatic', 377–80.

⁴M. Ignatieff, 'Total Institutions and Working Classes: A Review Essay', *History Workshop Journal*, 1983, 15, 167–73.

⁵M. Finnane, 'Asylums, Families and the State', *History Workshop Journal*, 1985, 20, 134–48.

⁶J. K. Walton, 'Casting out and Bringing Back in Victorian England: Pauper Lunatics, 1840–70', in W.

F. Bynum, R. Porter and M. Shepherd, eds, *The Anatomy of Madness: Essays in the History of Psychiatry*, vol. 2 (London: Tavistock, 1985), 132–46, 141.

⁷N. Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum Keeping, 1840–83* (Cambridge: Cambridge University Press, 1984), 109.

⁸D. Wright, 'Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 1997, 10, 137–55, 39.

extreme need.⁹ While this literature effectively tackles the issues of familial responses to insanity and its institutions, it fails to adequately deal with children, their illnesses and confinement.

Institutional solutions for dealing with the mentally impaired developed in parallel with a changing conceptualisation of what it meant to be a child in Victorian society. The health of working-class children thus came into greater focus and legislation sought to swap the work place for the classroom. Consequently, as they were increasingly viewed through a romantic lens, the state became ever more involved in their lives.¹⁰ Katrina Honeyman observed that in the late-eighteenth century parish apprentices, as young as 8 or 9, were a cheap and abundant source of labour that were essential to the progression of the industrial revolution.¹¹ By the 1830s the situation had changed somewhat and the 1833 Factory Act allowed the inspection of working conditions for children. Furthermore, it introduced education of 2 hours per day and restricted the hours a child aged between 9–13 could work in a day.¹² Further legislation followed in 1844, 1850, 1878 and 1901 that gradually withdrew the young from the workplace. With regards to their development, elementary schooling was established from 1870 and designed to complete the retreat of children from the workplace. However, even after compulsion in 1880, Hugh Cunningham has demonstrated that non-attendance remained common and half time work still persisted in the north of the country.¹³ Despite working-class resistance to schooling, it is in this period that the birth of childhood in what might be considered a 'modern' sense can be observed. The Children Act (1908) solidified the idea of a child as separate from adults and prohibited their detention in adult prisons, made it illegal them for to buy tobacco and enter a public house, and gave local authorities the power to keep pauper children outside of workhouses. Thus the period in question here is of vital importance as we seek to recount the experience of the 'imperfect' child at a time when the prevailing discourse of childhood was very much concentrated on establishing perfection.

To do this, the nature of childhood insanity will be constructed using the surviving patient case-files of children admitted to five pauper lunatic asylums in England during the period 1845–1907. These institutions are Prestwich Asylum near Manchester; Winson Green Borough Asylum that served the city of Birmingham; Berrywood Asylum in Northamptonshire; Three Counties Asylum that offered provision for the rural counties of Bedfordshire, Hertfordshire and Huntingdonshire; and Colney Hatch the second Middlesex county asylum. The temporal period in question covers the dawn of the compulsory asylum era in 1845 and concludes with the creation of the School Medical Service under the auspices of the Board of Education in 1907, and with it the treatment of child mental impairment as an educational rather than medical issue. The records

⁹C. Smith, 'Living with Insanity: Narratives of Poverty, Pauperism and Sickness in Asylum Records 1840–76', in A. Gestrich, E. Hurren and S. King, eds, *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780–1938* (London: Continuum, 2012), 117–43, 118.

¹⁰V. Zelizer, *Pricing the Priceless Child: The Changing Social Value of Children* (New York: Princeton University Press, 1985).

¹¹K. Honeyman, *Child Workers in England, 1780–1820: Parish Apprentices and the Making of the Early Industrial Labour Force* (Aldershot: Ashgate, 2007), 7.

¹²P. Kirby, *Child Workers and Industrial Health in Britain 1780–1850* (Woodbridge: The Boydell Press, 2013), 3.

¹³H. Cunningham, *Children and Childhood in Western Society since 1500* (London: Longman, 1995), 140.

accessed will all be of individuals aged 13 and below at admission. In total, this equates to 773 cases of child insanity spread across the selected asylums.

The argument is to be divided between three further sections. The first explores the medical, legal and social context in which children were certified. The second examines perceived causes of child insanity and develops a causative framework for classification that is divided between three strands (acquired, hereditary and developmental). The final section considers the circumstances that led to the confinement in the asylum and compares case-file observations to admission documentation in order to further explore the nature of diagnosis and asylum confinement.

Certifying the Insane Child

An initial attempt at regulating the insane as a specific group in England was introduced with the County Asylums Act of 1808. In the years prior to this legislation individuals perceived as mad or deviant were dealt with in a piecemeal system of for-profit mad-houses and charitable hospitals.¹⁴ Counties were given the option to erect public asylums to confine their insane, but by 1828 only 10 of 52 counties had done so.¹⁵ The permissive nature of the Act meant that provision remained fragmented and regimes of care could differ vastly according to location.¹⁶ It was only with the 1845 Lunacy and County Asylums Acts that confinement and inspection of the insane became compulsory in England and Wales.

The 1845 Acts established the Commissioners in Lunacy as an inspectorate of asylums and the insane population inside them. They also outlined a process of certification that was designed to prevent the wrongful confinement of the sane population.¹⁷ Poor Law Medical Officers became the initial assessors of pauper lunacy and within three days of identification they were required to inform Parish Officers. In turn the Parish had three days to notify a Justice of the Peace (JP) who then arranged for the examination of the alleged lunatic with a doctor or medical officer. Following the examination, if insanity was confirmed the doctor completed a Certificate of Insanity and the JP issued a Reception Order directing the individual to be admitted to the asylum. A significant anomaly of this legal procedure was the exclusion of the asylum from selecting its own patients.¹⁸

From the asylum records examined it is evident that this teleological process was not strictly followed for the admission of children. For example, George H., aged 7, was sent directly to the Colney Hatch Asylum in 1863 by the Commissioners in Lunacy,

¹⁴J. Andrews and A. Scull, *Customers and Patrons of the Mad-Trade: The Management of Lunacy in Eighteenth-Century London* (London: University of California Press, 2003); W. Parry-Jones, *The Trade in Lunacy: A Study of the Private Madhouses in England in the Eighteenth and Nineteenth Centuries* (London: Routledge, 1972).

¹⁵L. Smith, *Care, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* (London: Leicester University Press, 1999), 82.

¹⁶*Ibid.*

¹⁷P. McCandless, 'Liberty and Lunacy: The Victorians and Wrongful Confinement', in A. Scull, ed.,

Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era (London: Athlone, 1981), 339–62.

¹⁸R. Hunter and I. MacAlpine, *Psychiatry for the Poor: 1851 Colney Hatch Asylum—Friern Hospital 1973 A Medical and Social History* (London: Dawsons, 1974); P. Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (London: Leicester University Press, 1999); Bartlett, 'The Asylum and the Poor Law: The Productive Alliance', in J. Melling and B. Forsythe, eds, *Insanity, Institutions and Society, 1800–1914* (London: Routledge, 1999), 48–67.

circumventing all local and medical bureaucracy. Perhaps reflecting the Commissioners expertise in diagnosis he was discharged one month later because he displayed 'no evidence of insanity'.¹⁹ Peter Bartlett has argued that for the majority of individuals the attitudes of Relieving Officers and JPs during admission were crucial, and many of the insane remained outside of asylums to be dealt with in less expensive alternatives such as the workhouse or domestic home.²⁰ We can thus observe a number of variables that influenced the admission of children to county asylums: inspectors, Medical Officers and local bureaucrats. The agency of families in the admission of children has not yet featured in the literature.

The 773 children identified were distributed across the five asylums unevenly. There were 95 admitted to Birmingham, 213 to Colney Hatch, 72 were confined in Prestwich, 229 in Northampton and 164 in Three Counties Asylum over the period. Whilst admissions across the institutions varied, diagnosis was remarkably consistent. The mental disabilities of idiocy and imbecility accounted for 76 per cent of all diagnoses with the remainder being made up across a spectrum of mental afflictions such as mania, dementia, melancholy and epilepsy. The dominance of mental disabilities is of particular interest because the county asylums were not established to confine this type of patient. It was thought that the harmless and incurable should have remained outside of the institution, but their admission provides a window to understand how pauper asylums operated and evolved in the second-half of the nineteenth century.²¹

The diagnoses of idiocy and imbecility have evolved out of medical usage and into a derogatory vocabulary in the modern context. During the nineteenth century, however, they were used as labels to describe medical disabilities that often included a broad array of behaviours. The reason that these cases were so unsuitable for asylum care was their incurability. The American physician Samuel G. Howe described the intellectual capabilities of the most severe idiocy cases as being 'much below insects and so little above a sensitive plant'.²² Whilst Edouard Seguin summarised idiocy as being those 'who know nothing, can do nothing, cannot even desire to do anything'.²³ It is thus vital to explore how these 'unsuitable' children were diagnosed in order to understand how they came to be confined in asylums.

The 'Causes' of Mental Imperfection

The pauper lunatic asylums of the nineteenth century have left behind an extensive corpus of records. These include financial documents; architectural plans; correspondence with family, community and government; and medical records. Of interest here are the medical casebooks that detailed the particulars of all individuals confined in these institutions. Some of the information recorded, such as name, address and next of kin, was

¹⁹London Metropolitan Archive (Hereafter LMA), Friern Hospital, Male Patient Casebook 9, H12/CH/B/13/009, George H., p. 92.

²⁰Bartlett, *Poor Law of Lunacy*, 102–3.

²¹On maintaining the harmless and incurable outside the asylum, see A. Borsay, *Disability and Social Policy in Britain since 1750* (Basingstoke: Palgrave Macmillan, 2005), 71.

²²S. G. Howe, 'On the Causes of Idiocy', in M. Rosen, G. R. Clark and M. S. Kivitz, eds, *The History of Mental Retardation, Collected Papers* (Baltimore: University Park Press, 1976, originally published 1848).

²³E. Seguin, *Idiocy and its Treatment by the Physiological Method* (New York: Teachers College, Columbia University, 1907, originally published 1866), 29.

logical. But the case-files also contained detailed medical comments about the causes and nature of the individual's condition and a diagnosis, as well as observations of them conducted sporadically during their confinement. Some of this medical evidence, as noted by Melling *et al.*, was not wholly appropriate and can be used as examples of social, cultural and legal 'transactions' between families, physicians and the institution in the construction of child insanity.²⁴

A substantial number of children had the supposed causes of their mental impairments recorded in the institutional patient casebooks of each asylum. These explanations were heavily influenced by comments and observations from the family to Poor Law Medical Officers in the process of certification. Thorough analysis of the case-files demonstrates that the causes of insanity in children can be divided into three categories. These are hereditary, acquired and developmental. Within the current literature, Laurence Ray has argued that as the nineteenth century progressed, causes of insanity were divided into the moral, physical and 'impaired'.²⁵ In this framework, concepts of the impaired were linked to heredity and incurability, and in turn the moral and physical, in the right circumstances, could recover. Subsequently, for Ray, the asylum was an institution of ambiguities; curative for the non-hereditary and custodial for the chronic and congenital to prevent social degeneration.²⁶ Like almost all of the literature dealing with insanity, this argument was constructed using older patient groups where instances of insanity could be ascribed to life-cycle events such as old age, strokes or lifestyle choices such as intemperance or sexual promiscuity. Children were, however, more difficult to classify and because of their limited life experience require a different set of parameters.

Of the 773 children identified across the five institutions there were 313 (41%) with a specific cause stated for their mental illness or disability. This is a significant total, but the majority fell outside of the framework developed here and perhaps signifies how busy these institutions were.²⁷ Those without explanations usually had the cause of insanity recorded as 'unknown', 'congenital' or due to epilepsy, and 52 per cent of these children, a smaller proportion than the sample considered collectively, were diagnosed as idiots, imbeciles or epileptics from birth.

It was a common belief among medical men in the nineteenth century that the intellectual disabilities of idiocy and imbecility resulted from hereditary causes. The aforementioned Samuel Howe believed that idiocy occurred in children because their parents had 'violated the natural laws of man'.²⁸ Examples of such violations were illegitimacy, intemperance, vagrancy, criminality, intermarriage and attempted abortion, all considered actions and behaviours of the 'undeserving' urban poor.²⁹ In a similar fashion, Seguin also thought that parents were the root of the problem, but he believed that idiocy was caused by the mother being 'under-fed [and] in poverty herself'.³⁰ Amongst the proportion of children with a recorded cause for their insanity 53 per cent of cases

²⁴Melling *et al.*, 'Proper Lunatic', 378–9.

²⁵L. Ray, 'Models of Madness in Victorian Asylum Practice', *European Journal of Sociology*, 1981, 22, 229–64.

²⁶*Ibid.*

²⁷C. Cox and H. Marland, "'A Burden on the County": Madness, Institutions of Confinement and the Irish

Patient in Victorian Lancashire', *Social History of Medicine*, 2015, 28/2, 263–287).

²⁸Howe, 'On the causes of idiocy', 34.

²⁹A. Davin, *Growing up Poor: Home, School and Street in London 1870–1914* (London: Rivers Oram, 1996), 29–38.

³⁰Seguin, *Idiocy*, 31.

were said to have been hereditary. These could have been close links to insanity such as a parent or sibling suffering a mental impairment or they might have been more obscure like a great aunt or uncle who had suffered dementia in old age. Regardless, any familial connection to the pauper lunatic asylum resulted in the child being given a hereditary cause for their condition.

It is apparent from Figure 1 that the majority of causative explanations occurred in the years following 1883. Looking more closely at hereditary causes, we can observe that they almost mirror the total number of children admitted in terms of spikes and dips. There are points in the 1880s, however, where it is evident that hereditary diagnostic explanations accounted for a greater proportion of child entries than either before or after. The reason for this increase reflects the emergence and growing influence of the eugenics movement. Sir Francis Galton, who first coined the term eugenics, had been heavily influenced by *On the Origin of Species* published by his cousin Charles Darwin in 1859. He argued that the weak should be prevented from reproducing in order to create a strong human race.³¹ It was from this school of thought that the pioneering psychiatrist Henry Maudsley suggested that the problem of insanity could be combatted through selective breeding.³² From the sample of asylum children identified, it is clear that the increase of hereditary causes for child insanity in the 1880s reflected the growing influence of eugenics ideas and the enthusiasm of medical professionals to control this particular patient population.

British doctors dealing with what became the eugenically defined 'deficient' child continued with similar causative assessments. George Shuttleworth, who was Medical Superintendent at both the Royal Albert Idiot Asylum in Lancaster and the Earlswood Asylum, suggested that 'parental intemperance' and 'ill assorted marriages were a frequent cause of mental defect in offspring'.³³ However, he also began to recognise a range of wider environmental factors that might influence a child's mental development. This caused his attention to turn towards 'placing them under the best hygienic conditions possible' which inevitably involved removing the young from parents who were 'often very unsuitable Guardians of their own children'.³⁴ Despite increased recognition of external factors, medical men, such as Shuttleworth, were still heavily influenced by the earlier teachings of physicians such as Seguin. In 1895 he reinforced these principles by declaring that 'all meaningful teaching of mentally deficient children must proceed on physiological principles'.³⁵ Thus we can see that by the late-nineteenth century the methods and techniques used to 'improve' or 'train' the mentally disabled had changed very little.

The hereditary explanations assigned to children were often closely related to eugenic philosophies. It was thought that by regulating the freedom of the mentally weak and by removing them from society it would be possible to curb their reproduction and thus

³¹F. Galton, *Inquiries into Human Faculty and its Development* (London: J.M Dent & Company, 1883).

³²H. Maudsley, *Body and Mind* (London: Macmillan, 1873), 276; Maudsley, *Responsibility in Mental Disease* (London: S. King & co., 1874).

³³Wellcome Library, G. E. Shuttleworth, 'On the Treatment of Children Mentally Deficient. An

Address to the Union of Teachers of the Deaf and Dumb on the Pure Oral System', 1895, MS. 4579, 17–21.

³⁴Shuttleworth, 'On the Treatment of Children', 21–2.

³⁵Shuttleworth, 'On the Treatment of Children', 22.

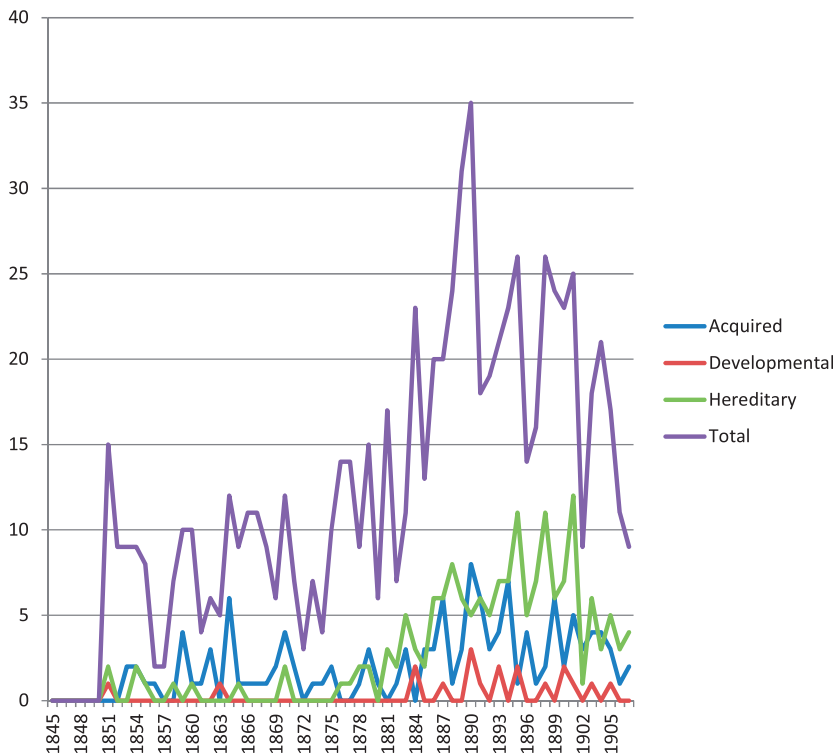


Fig. 1. Instances of admission for those with causative explanations.

Source: Birmingham City Archive (Hereafter BCA), Male Patient Casebooks, MS344/12/2 & 2a, MS344/12/5, MS344/12/7–9, MS344/12/11–14, MS344/12/20–22, MS344/12/27; BCA, Female Patient Casebooks, MS344/12/41–47, MS344/12/49–51, MS344/12/53 & 54, MS344/12/56 & 57, MS344/12/60–63; BCA, Patient Index, MS344/11/1 & 2; LMA, Colney Hatch Male Patient Casebooks, H12/CH/B/13/001–61; LMA, Colney Hatch Female Patient Casebooks, H12/CH/B/11/001–085; Northamptonshire Record Office (Hereafter NRO), Male Patient Casebooks, NCLA/6/2/2/1–12; NRO Female Patient Casebooks, NCLA/6/2/1/1–13; Greater Manchester County Record Office (Hereafter GMCRO), Male Patient Casebooks, ADMM/2/1–16; GMRCO, ADMF/2/1–21; Lancashire Record Office (Hereafter LRO), Male Patient Casebooks, QAM/6/6/1–34; LRO, Female Patient Casebooks, QAM/6/6/1–34; Bedford and Luton Archives Service (Hereafter BLAS), Male Patient Casebooks, LF31/1–12; BLAS, Female Patient Casebooks, LF29/1–12.

prevent the degeneration of society. In this way it became imperative to identify how mental disabilities had been passed through families, specifically of the poor, in order to confine children. For example, Thomas C., aged 13 was admitted to Colney Hatch in 1900, the cause of his insanity was listed as hereditary with the explanation that several members of his father's family were insane.³⁶ John M. was admitted to Northampton in 1891, aged 12, he had two brothers and two sisters that were also described as insane and because their 'father [was] a drunkard'.³⁷ Similarly, Percy C.

³⁶LMA, Friern Hospital, Male Patient Casebook 49,

³⁷NRO, St Crispin Collection, Out of County Patient Casebook 2, NCLA/6/2/3/2, John M., p. 378.

admitted to Northampton in 1894 had an intemperate father, and Caroline P.'s father was described as a 'habitual drunkard' when she was also admitted to Northampton in 1901.³⁸ In the eugenics influenced assessment of hereditary causes, vices such as alcoholism were considered a contributory factor that caused 'weak mindedness'. As mentioned above, there were also more obscure ties to hereditary insanity. Hannah J.'s diagnosis of idiocy was assigned a hereditary cause because her mother's uncle was insane.³⁹ Whilst in Northampton, Edmund K., was given a hereditary cause because his 'mother's cousin [was] idiotic'.⁴⁰ There are numerous other examples that emphasise vague connections to insanity, but there were also children admitted that had much closer ties to the insane.

A core element of Galton's eugenics argument was that the inferior should be prevented from reproducing.⁴¹ In this sample of children we see numerous conditions explained by reference to the mental capacity of parents. When Sarah M. was admitted to the asylum in 1896 she was said to be the product of 'weak minded' parents.⁴² The case-file of Charles B., aged 7, simply stated 'look at the father' as the cause of his idiocy.⁴³ And Jane J. was admitted to Three Counties with it noted that her mother was chronically insane.⁴⁴ The links to hereditary insanity were varied but it is evident that these assessments occurred more regularly as the period progressed and understanding of perceived explanations for insanity evolved.

Acquired causes constituted the second most common explanation for child insanity. The acquisition occurred both in ante-natal and post-natal phases of child development. Ante-natal causes were thought to have been brought about by a shock or injury to the mother while she was carrying the child and post-natal explanations ranged from injuries to the head, disease and even sunstroke. This causative explanation accounted for 41 per cent of all those recorded with the figure sub-divided between 35 per cent ante-natal causes and 65 per cent post-natal.

The introduction of acquired causes into the medical sphere usually resulted from domestic ideas and observations about the causes of insanity. Florry W. was admitted to the Winson Green Asylum in Birmingham, aged 10, on 26 January 1889. It was noted that she was 'the 3rd child in a family of 6 all of the others are perfectly normal'.⁴⁵ At the outset this statement eliminates any hereditary tie to insanity and suggests that something external caused the child's affliction. Such an explanative gap is filled by the girl's mother who told the medical officer that 'she was frightened while pregnant by a monkey at the zoo [London]'.⁴⁶ While such an explanation might appear farcical to a twenty-first-century observer, frights similar to that experienced by Florry W.'s mother

³⁸NRO, St Crispin, Male Patient Casebook 7, NCLA/6/2/2/7, Percy C., p. 24; NRO, St Crispin, Female Patient Casebook 10, NCLA/6/2/1/10, Caroline P., p. 71.

³⁹LRO, Prestwich Asylum, Female Patient Casebook 29, QAM6/5/29, Hannah J.

⁴⁰NRO, St Crispin, Male Patient Casebook 7, NCLA/6/2/2/7, Edward K., p. 17.

⁴¹F. Galton, *Essays in Eugenics* (London: The Eugenics Education Society, 1909), 42.

⁴²NRO, St Crispin, Female Patient Casebook 8, NCLA/6/2/1/8, Sarah M., p. 159, and Female Patient Casebook 9, NCLA/6/2/1/9, Sarah M., p. 235.

⁴³NRO, St Crispin, Male Patient Casebook 5, NCLA/6/2/2/5, Charles B., p. 173.

⁴⁴BLAS, Three Counties Asylum, Female Patient Casebook 8, LF29/8, p. 111.

⁴⁵Birmingham City Archive (BCA), Winson Green Asylum, Female Patient Casebook 8, MS344/12/46, Florry W., pp. 669–72.

⁴⁶*Ibid.*

featured regularly in patient case-files. At Three Counties the mother of Ernest M. was also scared by a monkey when pregnant and William S.'s mother had been frightened by two horses.⁴⁷ The mother of Edward O. had been startled by a lunatic when she was pregnant, and the mothers of James O. and Ernest L. had suffered unspecified frights.⁴⁸ At the asylum in Northampton, Clara A.'s mother endured a fright from a dog whilst pregnant and Arthur H.'s mother had suffered a shock.⁴⁹ In Birmingham, the mother of James G. was frightened by a cat when pregnant and James H.'s mother had endured an unspecified shock.⁵⁰ The presence of experiences such as these in medical records suggest that medical officers and asylum doctors saw value in the observations and assessments of family, otherwise these stories would have been deemed irrelevant and dismissed. Not all ante-natal causes, however, were a result of the mother being shocked. Oliver B.'s mother suffered a fall while pregnant and John R.'s was said to have been injured but the nature of this incident is not recorded.⁵¹

Post-natal explanations usually had a more obvious causal link to the child's mental condition. The individual might have displayed normal cognitive function prior to a specific event that caused a shift in their intellectual abilities. Stephen W. was sent to the asylum in 1882 and was said to have been intelligent up until three years earlier when his head was injured by a plough.⁵² The circumstances surrounding this incident are not recorded but the experience is emblematic of other cases: William M. was sent to the asylum after he suffered a severe fall from a tree;⁵³ the mental condition of Thomas S. was caused when he fell out of a carriage.⁵⁴ At Three Counties Asylum John H. had been hurt on the head, Fulton C.'s condition was caused by a fall, Norman G. had fallen down the stairs, Bertram W. experienced a 'traumatic injury to the head', and Frank I. was injured in a fall.⁵⁵ At Northampton Grace S. suffered a fall and injured her head aged 10 months, and George A. admitted to Birmingham had fallen from a ladder.⁵⁶ Some children suffered injuries in the process of being born. It is unclear the extent to which these were the result of medical interventions. For example, Frederick L., aged 6, was admitted to Northampton after having his head injured at birth; Horace M.,

⁴⁷BLAS, Three Counties, Male Patient Casebook 3, LF31/3, Ernest M. p. 206; BLAS, Three Counties, Male Patient Casebook 12, LF31/12, William S., p. 113.

⁴⁸BLAS, Three Counties, Male Patient Casebook 14, LF31/14, Edward O. p. 121; BLAS, Three Counties, Male Patient Casebook 11, LF31/11, James O., p. 155; BLAS, Three Counties, Male Patient Casebook 7, LF31/7, Ernest L. p. 136.

⁴⁹NRO, St Crispin Collection, Female Patient Casebook 3, NCLA/6/2/1/3, Clara A., p. 77; NRO, St Crispin Collection, Male Patient Casebook 5, NCLA/6/2/2/5, Arthur H., p. 229.

⁵⁰BCA, Winson Green Asylum, Male Patient Casebook 13, MS344/12/13, James G., pp. 749–50; BCA, Winson Green Asylum, Patient Index 6, MS344/5/6, James H., p. 10.

⁵¹NRO, St Crispin Collection, Male Patient Casebook 9, NCLA/6/2/2/9, Oliver B., p. 188; LMA, Friern Hospital, Male Patient Casebook 53, H12/CH/B/13/053, John R., p. 119.

⁵²NRO, St Crispin Collection, Male Patient Casebook 3, NCLA/6/2/2/3, Stephen W., p. 205.

⁵³NRO, St Crispin Collection, Male Patient Casebook 9, NCLA/6/2/2/9, William M., p. 218.

⁵⁴NRO, St Crispin Collection, Out of County Casebook 2, NCLA/6/2/3/2, Thomas S., p. 846.

⁵⁵BLAS, Three Counties, Male Patient Casebook 2, LF31/2, John H., pp. 27 and 110; BLAS, Three Counties, Male Patient Casebook 3, LF31/3, Fulton C., p. 134; BLAS, Three Counties, Male Patient Casebook 5, LF31/5, Norman G., p. 90; BLAS, Three Counties, Male Patient Casebook 7, LF31/7, Bertram W., p. 80; BLAS, Three Counties, Male Patient Casebook 14, LF31/14, Frank I., p. 73.

⁵⁶For Grace S., see NRO, St Crispin, Female Patient Casebook 6, NCLA/6/2/1/6, Grace S., p. 76; for George A. see BCA, Winson Green Asylum, Male Patient Casebook 11, MS344/12/11, George A., pp. 69–70.

who was 'a blind and nearly deaf idiot boy' was also admitted to the same asylum at the age of 12 after experiencing a head injury in the process of being born; and Ewart T. and Agnes S. also found their way to the asylum as a result of a head injury at birth.⁵⁷

The consequences of disease were also considered an acquired cause of childhood mental illness and disability. John O. was admitted to Three Counties and Samuel G. to Birmingham following recovery from measles.⁵⁸ Typhoid fever was given as the cause of Angelina C.'s mental disability and Melinda Q. was taken to the asylum following whooping cough.⁵⁹ These examples could be explained by the relationship between fever and mental illness and therefore are understandable, but Amelia G. was admitted to Three Counties after suffering from scabies.⁶⁰ And, perhaps a reflection of more recent debates about the acquisition of child mental health issues, Ann K. was admitted to the Prestwich Asylum in Manchester in 1891 with her idiocy said to have been caused by 'vaccination'.⁶¹

The final causative strand for childhood insanity was developmental. This featured less often than the previous two causes but nonetheless appeared in the patient case-files of all of the asylums examined. Developmental causes accounted for 3 per cent of all recorded explanations and occurred at specific points of a child's growth. These were divided between 14 cases of teething in infants and five cases of puberty in older children. The onset of puberty was only recorded as a cause for female patients and could symbolise broader contemporary fears, again influenced by the eugenics movement, about the reproductive capabilities of the mentally impaired.⁶² Insanity caused by teething was divided more equally between the genders.⁶³ A common thread in the cases of teething was the recording of 'fits' as a symptom of mental impairment. It was most likely that these were febrile seizures caused by the rapid onset of a fever associated with teething, but they have been mistaken for epilepsy as medical understanding of fits was relatively undeveloped throughout the period.

Exploring Constructions of Childhood Insanity

The role played by the family in the process of admission is fundamental to the analysis of this article. Three broad issues concerning familial involvement can be identified. Firstly, there is the role played by the family in observing and defining insanity in the domestic sphere and how medical practitioners handled and incorporated family testimonies into medical diagnoses. Secondly, are the circumstances that led families to seek asylum admission; and finally are the attitudes of families towards their insane children.

⁵⁷For Frederick L., see NRO, St Crispin Collection, Male Patient Casebook 10, NCLA/6/2/2/10, Frederick L., p. 124; for Horace M., see NRO, St Crispin Collection, Male Patient Casebook 8, NCLA/6/2/2/8, Horace M, p. 57; for Ewart T. and Agnes S., see NRO, St Crispin Collection, Male Patient Casebook 5, NCLA/6/2/2/2, Ewart T., p. 105 and NRO, St Crispin, Female Patient Casebook 7, NCLA/6/2/1/7, Agnes S., p. 236.

⁵⁸BLAS, Three Counties, Male Patient Casebook 1, LF31/1, John O., p. 300; BCA, Winson Green Asylum, Male Patient Casebook 29, MS344/12/29, Samuel G., pp. 621–2.

⁵⁹NRO, St Crispin, Female Patient Casebook 5, NCLA/6/2/1/5, Angelina C., p. 135; NRO, St Crispin, Female Patient Casebook 7, NCLA/6/2/1/7, Melinda Q., p. 137.

⁶⁰BLAS, Three Counties Asylum, Female Patient Casebook 1, LF29/1, p.336.

⁶¹GMRCO, Prestwich Asylum, Female Patient Casebook 2, ADMF/2/2, Ann K.

⁶²Jackson, *Borderland of Imbecility*.

⁶³The divide in cases of teething was 57% male and 43% female.

A total of 376 (49%) children were admitted to the institutions directly from their own homes. This is a surprisingly high number as asylum admission took place within the administrative framework of the Poor law and only the destitute were supposed to be admitted.⁶⁴ Therefore, the domestic situation was crucial in pushing children towards the asylum. The remaining 51 per cent found their way to the asylum via other institutions, such as workhouses, infirmaries, licensed houses and other asylums. Arthur Kleinman has argued that the diagnosis of illness was a result of a cultural negotiation between lay and expert opinion.⁶⁵ The narrative of illness was developed within the domestic sphere and presented to the medical establishment, in this instance the asylum, where it was shaped into disease by those with perceived expert knowledge. Certificates of Insanity contained a section that allowed 'others' to record any notable facts about the case. This was where family members had the opportunity to provide details about the causes and behaviours of insanity of a loved one. It has been argued that testimonies provided by families not only supported the diagnosis but heavily influenced the shaping of medical opinion.⁶⁶ The case-notes were, however, filtered by asylum physicians. Consequently, we are aware of the examples where familial contributions were most convincing and influential, and have limited access to situations where family comments were considered unhelpful, unimportant or irrelevant.

There are numerous examples in the patient sample that include testimony from lay observers. George C. was admitted to Three Counties Asylum in 1876. He was said to be 'very restless, spiteful to his brother and sisters not safe to be left alone for one minute'.⁶⁷ Similarly, Sydney V. was a resident of Colney Hatch from 1898, he received comments on his Certificate of Insanity from a medical man and his mother. His mother stated 'he is very violent at times, uses dreadful language, molests and spits in peoples [sic] faces in the streets'.⁶⁸ These comments were validated by the medical statements that noted he is 'deficient in manner, restless, excitable and dangerous to himself... requires constant watching'.⁶⁹ Such examples demonstrate the importance of family in constructing child insanity. This is reinforced further when considering the causative framework developed above. Whether the cause of insanity was perceived to be hereditary, acquired or developmental, the facts that were used to make this judgement initially emerged from the domestic sphere. In essence, it was lay opinion that presented the case for child insanity and the medical establishment that validated it.⁷⁰ Bearing this fact in mind, it is important to examine how, and when, families sought out the asylum for their children.

Scholars such as Scull have argued that families used the asylum to deposit their unwanted, unproductive or awkward members.⁷¹ It is also argued that these chronic cases silted up the asylum system through extended periods of confinement. Of the

⁶⁴Bartlett, *The Poor Law of Lunacy*.

⁶⁵A. Kleinman, *The Illness Narratives: Suffering, Healing and the Human Condition* (New York: Basic Books, 1988), 3–5.

⁶⁶Wright 'Childlike'; Melling *et al.*, 'Proper Lunatic', 377.

⁶⁷BLA, Three Counties, Male Casebook 4, LF31/4, George C., p. 92.

⁶⁸LMA, Friern Hospital Colney Hatch, Male Casebook 46, H12/CH/B/13/046, Sydney V., p. 25.

⁶⁹*Ibid.*

⁷⁰Wright, 'Childlike'.

⁷¹Scull, *Museums of Madness*; Scull, *Most Solitary of Afflictions*.

patient sample considered here, there were 418 (54%) children who had suffered with their condition all of their lives and had no record of being treated elsewhere before asylum admission. Such a high figure might suggest that asylums were resorted to at the first instance by families, but we can see that this was not the case. For those described as suffering from their conditions since birth, and with a causative explanation, the length of time before admission was at least four years, but the child could have been managed in the domestic sphere for up to 13 years. For those with non-congenital acquired causative explanations, the time before admission was on average just below four years and for developmental cases it was slightly over four years. Interestingly, those with hereditary explanations, but not displaying symptoms since birth, were admitted to the asylum on average ten months after their mental defects became apparent. It seems that this patient group were considered a particular danger by those responsible for certifying the insane. It is clear though that the average length of time before admission could be substantial, and thus a better explanation is required than that offered by Scull.

It has been argued by Smith, Walton and Wright that when families turned to the asylum they did so 'strategically'.⁷² These scholars have suggested that the greatest strain on household economies came after child-bearing had ceased, but before children contributed more to the household than they took from it.⁷³ Due to the nature of pauper records, identifying any strategic use of the asylum is complex and the extant medical documentation offers little insight into the domestic dynamic. The duration of stay for child patients inside institutions could be considered a crucial element in determining how the asylum was utilised by families. The core issue will be whether children were long-term patients, as Scull would suggest, or were there short-term, strategic, solutions sought by families, similar to Cathy Smith's findings?⁷⁴ The only other institutional study that has extensively looked at children as patients is David Wright's study of the Earlswood Idiot Asylum.⁷⁵ At Earlswood, confinement was limited to a period of five years in order to deter long-stay patients, and thus the issue was irrelevant.⁷⁶ The sample of children used here, therefore, provides the first instance where we can assess how the asylum was accessed for younger patients.

The average duration of confinement for the sample of children across the five asylums was four years and five months. One standard deviation from the norm was seven years, so it is evident that plenty of children were confined for much longer than the average. Exploring further, we see those who fit within the causative framework on average remained in the institution for just under two years and eleven months. One standard deviation from the norm here was just over six years and shows that whilst those with causative explanations were confined for less time than the whole sample, the length of duration of stay could still be considerable. The average duration in both instances was

⁷²Wright, *Earlswood*; Wright, 'Getting out the Asylum'; C. Smith, 'Living with Insanity', 119.

⁷³Wright, *Earlswood*, 82; R. Smith, 'Some Issues Concerning Families and their Property in Rural England, 1250–1800', in Smith, ed., *Land, Kinship and Life-Cycle* (Cambridge: Cambridge University Press, 1985), 1–86, at 68–9; J. Parr, *Labouring Children: British Immigrant Apprentices to Canada, 1869–1924* (London: Croom Helm, 1980), ch.1.

⁷⁴Scull, *Museums of Madness*; C. Smith, 'Family, Community and the Victorian Asylum'.

⁷⁵Wright, *Earlswood*; also Melling et al., 'Proper Lunatic', have examined the admission of children to the Devon County Asylum but their analysis is restricted to one county and is limited in scope.

⁷⁶Wright, *Earlswood*.

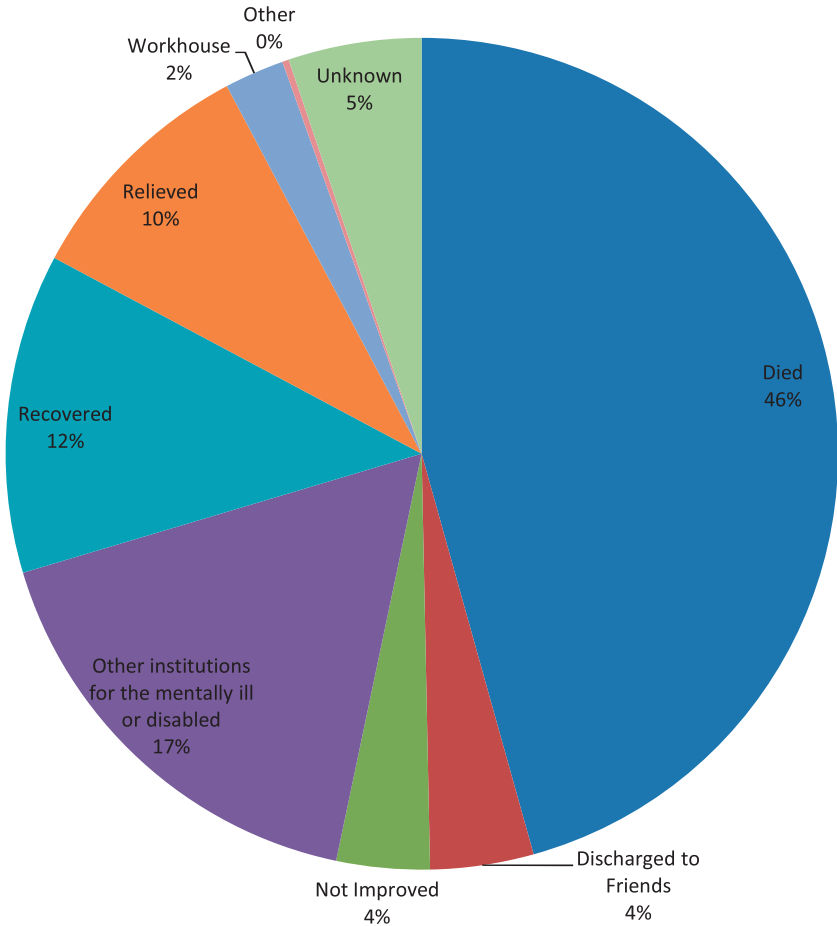


Fig. 2. Destinations for children on departure from the asylum.
Source: BCA, Male Patient Casebooks, MS344/12/2 & 2a, MS344/12/5, MS344/12/7–9, MS344/12/11–14, MS344/12/20–22, MS344/12/27; BCA, Female Patient Casebooks, MS344/12/41–47, MS344/12/49–51, MS344/12/53 & 54, MS344/12/56 & 57, MS344/12/60–63; BCA, Patient Index, MS344/11/1 & 2; LMA, Colney Hatch Male Patient Casebooks, H12/CH/B/13/001–61; LMA, Colney Hatch Female Patient Casebooks, H12/CH/B/11/001–085; NRO, Male Patient Casebooks, NCLA/6/2/2/1–12; NRO Female Patient Casebooks, NCLA/6/2/1/1–13; GMCRO, Male Patient Casebooks, ADMM/2/1–16; GMCRO, ADMF/2/1–21; LRO, Male Patient Casebooks, QAM/6/6/1–34; LRO, Female Patient Casebooks, QAM/6/6/1–34; BLAS, Male Patient Casebooks, LF31/1–12; BLAS, Female Patient Casebooks, LF29/1–12.

shorter than the five-year limit at Earlswood. Children were not always long-stay patients in the asylum, but that does not mean that they eventually returned to their homes and previous lives when they departed the institution.

Maintaining a focus on the strategic use of asylums by families, [Figure 2](#) highlights the various destinations for children on their departure from the asylum. A large number died. When considering tactical accessing of asylum provision, those most likely to have

returned directly to the domestic environment would have been discharged at the request of 'friends' and those that had recovered from their conditions. Removal to 'friends', usually meaning family, was a rare occurrence in the sample and only accounts for 31 cases. It therefore seems that, if asylums were used strategically at the point of admission, then families were incapable of, or less active in, seeking the discharge of their children.

A picture emerges of children who were unlikely to return home after being admitted to the asylum. An examination of the domestic circumstances that led to certification and admission of children is therefore important. In roughly 10 per cent of cases children were admitted to the institution due to the illness of a parent or carer. The recorded conditions were those that affected the poorer elements of society, such as phthisis, tuberculosis and consumption. This coincided with an emerging medical opinion in the mid-nineteenth century that linked insanity and tuberculosis.⁷⁷ As well as hereditary links to insanity, family ties, or the lack of them, and such complaints as degenerative lung conditions regularly featured in the certification comments at admission. Thus John S. was admitted to the asylum in Northampton from his grandfather's home because both of his parents were consumptive.⁷⁸ In Birmingham, Tom S. was admitted to the asylum following the death of his grandparents with whom he lived. His mother was stated to also be dead and his father absconded. He eventually died from phthisis in the institution.⁷⁹

Developing the impact of these illnesses further on our patient sample, lung diseases were the most prolific killers of children in the asylum, accounting for 103 of the 353 (29%) deaths that occurred in the sample.⁸⁰ We can thus see that the asylum became a destination for insane children when families were faced with shifts in their domestic circumstances that affected their ability to provide care.⁸¹ In these situations familial attitudes towards insane children can be considered as positive and the asylum was used as a last resort to provide safety and care, rather than the punitive institution of the workhouse.

Nineteenth-century medical records, unlike their modern counterparts, were much more fluid in what they documented, and while they often gave the impression of distant and uncaring families they also provide glimpses of parental emotions towards children. If we look at the children who died inside the asylum, a staggeringly high number, it is possible to make some broader observations about childhood and death. Recently, within the field of the history of emotions, Hannah Newton has argued that childhood death in early modern England was part of a Christian ideology that had salvation at its core.⁸² An element of this religious paradigm was the desire of parents to be with

⁷⁷This view was first put forward by the influential asylum doctor Thomas Clouston and is examined in depth by G. E Berrios, 'Phthisical Insanity', *History of Psychiatry*, 2005, 16, 473–95.

⁷⁸NRO, St Crispin Collection, Male Casebook 8, NCLAV 6/2/2/8, John Scott, p. 39.

⁷⁹BCA, All Saints, Male Casebook 13, MS344/12/13, Tom Skirrow, pp. 429–30.

⁸⁰Again this figure is most likely more than the 103 stated. There are 104 cases that have unknown

causes of death. These are mainly due to data protection embargos and case-notes being recorded in continuation books that have been lost or are not fit for public viewing. The second largest cause of death was epilepsy which accounted for 63 deaths within the sample.

⁸¹C. Smith, 'Living with Insanity'.

⁸²H. Newton, "'Rapt up with Joy": Children's Emotional Responses to Death in Early Modern England', in K. Barclay, C. Rawnsley and K. Reynolds,

their offspring in their final days and hours. The Victorian process of institutionalisation suggests a departure from this pattern of behaviour that could be interpreted as a lack of emotion or care towards an impaired child. Examination of the patient case-files, however, reveals evidence that parents did love and care for their children although it was not emblematic of the religious approaches of previous centuries. For example, in the Northampton Asylum a newspaper obituary was attached to Walter Q.'s case-file. The insertion reports the death of 'Walter, beloved son of Daniel and Edith Q., after a long and painful illness, aged 7'.⁸³ While the wording might appear typical of this kind of public notification, the fact that the family went to the cost and effort of making it is a clear sign of compassion for, and sadness at, the passing of a family member who had suffered from a mental disability and been treated in an asylum. The presence of the obituary on the correct page for the patient, who had been discharged from the asylum two years previously, also shows a certain degree of compassion on the part of the institution. We are, however, unaware who was responsible for its placement. The family may have sent it to the asylum to inform them of the passing of their son or it may have been found in the newspaper by a member of staff who had treated the child. Unfortunately we cannot say for certain how it came to be placed on Walter's page.

Similarly, and again in Northampton, Sidney C.'s family described their feelings on the passing of their son in a heartfelt letter to the asylum. The family stated that they 'would like to thank you for your kindness to our dear Sidney and for your kind sympathy in our great loss for we did love him so much'.⁸⁴ Again, these are hardly sentiments of families who saw their insane children as unwanted or a burden. At Colney Hatch, Henrietta L.'s parents wrote to the asylum asking when they could visit, displaying a clear desire to see their child even though they lived in Bedfordshire, quite a distance from the institution.⁸⁵ We can thus observe a continuity in concern and care for children, although it is no longer framed within the religious paradigm of earlier centuries. The main difficulty here with attempting to identify family emotions towards children living with a mental illness or disability is that these issues rarely permeated the medical documents. It has, therefore, been too easy to deduce a lack of care or compassion from the records and assume that children were deposited in the asylum because they were a burden and unloved.

Throughout the process of certifying child insanity, it is clear that family input and negotiation with medical practitioners was essential to diagnosis. It is, however, difficult to quantify the extent to which these family testimonies were ploys aimed at ensuring their children were admitted to the more comfortable environment of the asylum in times of need, rather than the workhouse. Such family agency has led David Wright to observe that the 'history of confinement' can be considered separately to the 'history of psychiatry'.⁸⁶ In turn, Cathy Smith has suggested that asylums became institutions that adapted to local needs and at times were used as an alternative to the less-eligibility

eds, *Death, Emotion and Childhood in Premodern Europe* (Basingstoke: Palgrave Macmillan, forthcoming).

⁸³NRO, St Crispin Collection, Male Casebook 9, NCLA/6/2/2/9, Walter Q., p. 108.

⁸⁴NRO, St Crispin Collection, Male Casebook 8, NCLA/6/2/2/8, Sidney C., p. 188.

⁸⁵LMA, Friern Hospital (Colney Hatch), Female Casebook 33, H12/CH/B/11/033, Henrietta L., p. 192.

⁸⁶D. Wright, 'Getting out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth Century', *Social History of Medicine*, 1997, 10, 137–55.

environment of the workhouse.⁸⁷ Child admissions therefore need to be understood in the wider context of family circumstance rather than being simply a reflection of the medical conditions of the children. For example, it might be assumed that families had developed coping mechanisms for children such as William W., aged 4, and James H., aged 13, who both acquired their mental impairments through injuries three and ten years before admission.⁸⁸ Thus what prompted their admission to the asylum is of importance. It may have been in the case of James H., that as he got older and stronger he began to be more difficult to manage in the domestic setting. The records demonstrate that having an event or point in time that can be referenced as directly causing the mental impairment was important, but it is unclear whether this was information volunteered by families or came about through questioning from doctors. Consequently, we might consider the confinement of children a testament to shifting family dynamics as much as the mental illnesses of individuals. As we might expect in these situations, some of the stories at the point of entry to the asylum are quite elaborate and designed to influence and convince external medical opinion. The reference to monkeys and lunatics reinforces this point. Therefore, how children were observed following admission to the asylum is an important element of constructing the insane child.

It could be argued that families found willing allies in Poor Law Medical Officers when diagnosing insane children.⁸⁹ Often they could be burdensome and time-consuming for medical officers who had to pay for expenses initially out of their own pockets.⁹⁰ We thus see a tension develop between the medical discourse of the Poor Law and asylum emerge over child patients. It has been demonstrated elsewhere that asylum observations did not always evidence the descriptions made on medical certificates prior to confinement.⁹¹ The process of certifying insanity spanned two separate but official medical discourses, each with differing motives for identifying and monitoring the insane.⁹² The experiences inside asylums, however, have not been developed for children and their specific mental illnesses and disabilities.⁹³ For example, William G. was admitted to the asylum in Northampton in 1889; a key feature of his medical certificate was that his mother said he was incapable of education.⁹⁴ The details reinforce arguments made earlier above about family testimony. In this case, however, the statement was challenged by the Medical Superintendent, Richard Greene, at the point of admission to the asylum. It was stated 'contrary to his mother's statement he knows the letters perfectly and can count upon his fingers up to 8 or 10'. The asylum was sceptical of the inexperienced Poor Law medical diagnoses influenced by family testimony and it can be seen that they were keen to stamp their perceived professional expertise on patients. Similarly, James R. was admitted to the Three Counties Asylum in 1876.⁹⁵ James

⁸⁷C. Smith, 'Family, Community and the Victorian Asylum: A Case Study of the Northampton General Lunatic Asylum and its Pauper Lunatics', *Family and Community History*, 2006, 9, 109–24.

⁸⁸BLAS, Three Counties, Male Patient Casebook 8, LF31/8, William W. p. 196; BLAS, Three Counties, Male Patient Casebook 6, LF31/6, James H., p. 127.

⁸⁹Bartlett, *Poor Law of Lunacy*; Scull, *Museums of Madness*.

⁹⁰K. Price, *Medical Negligence in Victorian Britain: The Crisis of Care under the English Poor Law, c.1834–1900* (London: Bloomsbury, 2015).

⁹¹See the case of John Wenborn, Taylor 'All his ways'; Taylor, *Child Insanity in England, 1845–1907* (Basingstoke: Palgrave Macmillan, 2016), ch. 2.

⁹²Bartlett, *Poor Law of Lunacy*.

⁹³Melling, 'Proper Lunatic'; Wright, *Earlswood*.

⁹⁴NRO, St Crispin Collection, Male Casebook 5, NCLAV 6/2/2/5, William Gunn, p. 146.

Wright, the Poor Law Medical Officer, stated that the boy had told him there was 'a spider spinning webs in his head' and consequently sent him to the asylum. At admission the boy directly contradicted this statement and told the Superintendent he was sent because he refused to attend school. The Superintendent agreed with the patient and he was discharged showing 'no evidence of insanity'. This case is a unique one where we have direct access to the voice of the child. In the vast majority of cases voices of children are filtered out through an admission process that values expert opinion and lay observation over that of the subject. Only when a youngster provides a direct contradiction to the medical narrative do we see their thoughts and opinions emerge. Once confined inside an asylum the voice of the insane child becomes even more distant. The overcrowded nature of institutions and the incurable nature of their conditions mean that observational notes of patients were restricted to descriptions of somatic illness or simple comments such as 'no comment'.⁹⁶ Therefore the insane child has to be constructed from official accounts and documents.

Not all diagnostic embellishments were visible at the time of admission. Alfred S. was admitted to Colney Hatch in 1897, according to the medical certificate he was 'of inferior mental development and deficient in moral sense'.⁹⁷ He was alleged to have been frequently violent and had even attempted to poison his mother. One week after admission he was described as being 'well behaved' and 'fairly cheerful'.⁹⁸ The observations continued in this vein until the patient was discharged one month after being admitted. The cases of James R. and Alfred S. are testament to the fact that admission to the asylum was, sometimes, achieved by constructing a narrative that was thought to fit the expectation of insane behaviour. These narratives were constructed outside of the asylum and on occasion were exposed by the institution.

Conclusions

It is evident that families played a central role in constructing, diagnosing and committing the insane child in the second half of the nineteenth century in England. The causative framework developed here demonstrates such a fact. Eugenic ideas and a greater familiarity with child mental disabilities as the period progressed caused this process to evolve, but family testimony was always vital, even if it did become twisted and shaped by the medical profession in order to see heredity taints of the poor as being the main cause of child insanity. This article has also developed a more thorough and wide-ranging understanding of issues of child mental ill health in the nineteenth century. Mental disabilities were the dominant diagnoses and further analysis is required to incorporate this asylum patient sample more fully into the historiography. On a superficial level, it might be suggested that children fit well with Scull's narrative of asylums accommodating the unproductive and burdensome.⁹⁹ However, children were not deposited in asylums at the first instance. This suggests that families of mentally impaired children had important

⁹⁵BLA, Three Counties, Male Casebook 4, LF31/4, James Richardson, p. 71.

⁹⁶See the case of John Wenborn in Taylor, 'All his ways' and Taylor, 'Deprived, Depraved, Dangerous, and Deviant: Depicting the Insane Child in England's

County Asylums, 1845–1907', *History*, 2016, 101/347, 513–535.

⁹⁷LMA, Friern Hospital (Colney Hatch), Male Casebook 44, H12/CH/B/13/044, Alfred S., p. 95.

⁹⁸*Ibid.*, 20 February 1897, p. 95.

⁹⁹Scull, *Museums of Madness*.

emotional bonds with their offspring and were eager to preserve these whenever possible. Also, where we are able to access responses to child death, we see families that are saddened at their loss but also grateful for the medical interventions of asylums in attempting to ameliorate some of their children's symptoms. We can thus deduce that mentally 'imperfect' children were thought of within the romantic and innocent discourse that was emerging during the period. Furthermore, confinements were not always lengthy and children on occasion moved to other institutions of welfare, thus nullifying the idea that they were left to rot away alone in institutions.

This article has allowed a glimpse at how life in the asylum was experienced by children. It is evident that the situation was more complex than dealing with the behaviour of adolescent males and that those confined are worthy of historical investigation, even if they have been overlooked for so long. Both the nature and causes of their mental impairments significantly differed from those experienced by adult patients and asylums had to adapt to their needs. Through the discussion of diagnoses, observation and departure, we have learnt more about how youngsters came to and moved through these institutions. Such an approach has also revealed the approaches to the mentally imperfect child that existed and how they diverged in the medical spheres of the Poor Law and asylum. Contradictory attitudes were reflections of wider concerns about the cost and time of dealing with this class of patient.

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