Children, Insanity and Child Psychiatry c.1800 - 1935

Zbigniew Kotowicz
(CFCUL)
z.kotowicz@yahoo.fr

PART 1 – The 19th century

Psychiatry emerged, all historians agree on this, at the end of the 18th century and the beginning of 19th. First reports of mad children also go back to this time (Crichton 1798, Haslam 1809, Esquirol 1838). However, Leo Kanner's *Child Psychiatry*, incontestably the first child psychiatry textbook proper, appeared only in 1935. The question therefore arises: Why did it take so long (almost a hundred and fifty years)? What happened to mentally afflicted children during that period? Those who have taken a historical look at the 19th century are not in agreement. Kanner himself, who had a good grasp of history, goes so far as to state that there was nothing in that period that could be called child psychiatry (Kanner 1935), but historians paint a somewhat different picture (Neve & Turner 2002, Parry-Jones 1989, Wardle 1991, von Gontard 1988, Stone 1973) and one explicitly rejects Kanner's view (Harms 1962).

In this article, von Gontard's paper 'The Development of Child Psychiatry in 19th Century Britain' will stand out as it is one of the earlier studies, it is very thoroughly researched and, most of all, it was the first study on the subject that this author read; it set the tone for subsequent thought and research, first questions on the subject were formulated after reading von Gontard's article. Here are some of the statements that we find there:

a. 'Many authors have shown that, for most European countries, the origins of child psychiatry can be traced back to the 19th century' (Gontard 1988: 569);

b. 'The diagnosis of childhood insanity was greatly facilitated by the introduction of the term 'moral insanity' in 1835 by James Cowles Prichard (1786-1848). It was to become the most common diagnosis for children' (*ibid.*: 573);

c. 'most children were diagnosed as morally insane, with only exceptional cases of true intellectual insanities: Sir Alexander Morison (1779-1866), one of the acclaimed authorities during the first half of the 19th century, described a 14-yr-old boy with mania (Morison, 1828) and an even rarer case of mania in a 6-yr-old, whose "conduct was violent and mischievous, with incoherence of speech" (Morison 1848)' (*ibid.*: 574);

d. 'Despite its popularity, moral insanity was only one of seven distinct types of childhood insanity in Maudsley's original nosographical system (Maudsley, 1867). The other forms were (1) monomania, (2) choreic delirium, (3) cataleptoid insanity, (4) epileptic insanity, (5) mania and (6) melancholia' (*ibid.*: 580);

e. 'Finally, children began to be admitted to specialised asylums' but 'Despite this process [the massive increase of number of inmates in hospitals in the 19th century], only a few children were actually admitted to the hospitals […] many – especially younger children – must have been seen as outpatients. One can therefore safely conclude that, with the expansion of the institutions and the increase of population, a slowly increasing number of children were seen or hospitalised in asylums during the 19th century' (*ibid.*: 573);

f. '… by 1900, all elements which later merged into child psychiatry had evolved – with the exception only of psychoanalysis and child guidance' (*ibid.*: 570).

Von Gontard's paper is meticulously researched and, no doubt, he would have also included a study on children in Bethlem Hospital in the 19th century had it been carried out before his time. In 1987 Robert Wilkins published his findings based on research in the archives of the hospital. 1067 children and adolescents were admitted in the 19th century into Bethlem. This figure is impressive and it is often quoted in historical accounts. One historian wrote about Wilkins's study: 'Over one thousand children and adolescents were admitted to Bethlem Royal Hospital between 1815 and 1899, and Wilkins has shown that there is remarkable scope for research on such material' (Parry-Jones 86).

Since the insane children were a rarity in asylums, the Bethlem admission figures are strikingly large. It comes, therefore, as a surprise to see that, although this famous institution has been studied thoroughly by historians (O'Donoghue 1914, Masters 1997, Russell 1997, Allderidge 1997, Andrews *et al.* 1997), and although it was unusual in that it often admitted children, the questions that this might pose have slipped through the historians' net. First: what kind of behaviour led these children to be certified insane? What were their backgrounds? How did they fare in the hospital? Second: was Bethlem altogether unique? Or, does the high number of children that it admitted suggest that London had a higher incidence of child insanity than the rest of the country?

Bethlem in the 19th century

The 19th century is particularly interesting in the history of this institution. At the beginning of the century, its reputation was dreadful. In 1815 The House of Commons Select Committee on Madhouses savaged the hospital's practices (Andrews *et al*. 1997). In the same year, Bethlem moved from the dilapidated Moorgate site to Southwark. Conditions in the new location were much improved but the hospital's bad reputation continued. Full change came with the I852 appointment of the first Resident Chief Physician William Charles Hood, which saw the end of the over a century old Monro dynasty. The hospital adopted the 'moral treatment' regime. Various forms of occupational therapy were introduced; a library was set up as well as exercise yards. The hospital was no longer completely isolated from the outside world, either; some patients were allowed to go alone for walks, staff organised group outings, and there were the famous monthly balls to which members of the public were invited. In time the hospital shed its grim reputation and became a far more preferable place to stay in than a County Asylum, so much so, that in 1886 the hospital started admitting 'voluntary boarders', that is, people seeking treatment who had not been certified insane (Gale and Howard 2003: 6). One of the hospital's attractions was that it remained a relatively small institution. While throughout the 19th century hospitals tended to grow in size, Bethlem's population remained stable at around two hundred and fifty inmates (Colney Hatch in North London ended up housing some 2 500 patients). Another attraction was that unlike county asylums, which were isolated on the outskirts of the city, Bethlem was relatively close to the centre of London.

Because of its strict admissions policy, Bethlem had a somewhat unusual population. Those who had been insane for more than a year were not accepted (unless they had been already treated in Bethlem); those suffering from chronic conditions such as general paresis or epilepsy, or patients discharged uncured from other asylums were not accepted either (Thurnam 1845). The maximum stay in the hospital was twelve months. This was sometimes extended, if recovery seemed imminent, although there were some striking exceptions, for example, one seventeen year old boy admitted in 1850 remained in the hospital for four years and three months after which time he was discharged as uncured (CB/49) From the middle of the century, the hospital did not admit pauper lunatics. The consequence of this policy was a higher than average recovery rate. (This caused resentment on the part of county asylum psychiatrists who could not so freely refuse admission. Lockhart Robertson 1865.)

Bethlem's admissions policy was not unique, as the same policy was followed in St Luke's. But children were not accepted at St Luke's (Thurnam 1845), while Bethlem had no age limit. However, there seems to be no evidence that there was an explicitly stated rationale for this policy. No special provisions for children were made and when in the 1880s diagnosis was introduced on the admission forms, children were given the same type of diagnoses as adults. Also, the same admissions criteria applied irrespective of age, which meant that the children admitted to the hospital were very unlikely to have been congenital idiots or epileptic, as was often found in county asylums. This makes the Bethlem cohort a unique sample, both in terms of size and relative homogeneity.

How did children fit into the pattern of the hospital? In which wards were they kept?[1] What types of treatment did they receive? How did their recovery rates compare with the overall population of the hospital? Was there indeed no 'specialist' approach to children, of any kind?

[1] The hospital had eight wards (which were called in the nineteenth century galleries), four for women, four for men. From the early 1880s onwards the lowest galleries on the male and female side (M1 and F1) were divided into section A and B. A good idea of what kind of patients were kept in different galleries can be found in this witty poem written by a patient who obviously harboured a deep dislike for the physician in charge George Savage.

Dear Doctor, when the trumpet sounds
And God proclaims the judgment day
You'll try I know to be at least
Some fifty miles or more away
'Twill be no use, no tree no bush
Will hide you from God's searching eye
With other Savages you'll have
To toddle up your luck to try
You'll go to heaven I believe
But not to galleries II or III
With fifth-rate angels you will be
In lower gallery in M.I.B.
You'll daily scrub the gallery floors
And cleanse your brother angels' sores
You'll smooth their wings and comb their tails
And empty too their slops in pails
In course of years some three or more
You may be raised to gallery IV.
(in Gale and Howard 2003: 23)

Wilkins's study

Wilkins's intention was to determine whether, as the century progressed, there was an increase in hallucinations in the child and teenage population of the hospital. This was carried out with the intention of testing Hare's hypothesis that the dramatic increase in the hospital population in the 19th century was due to a real increase in the incidence of insanity (with a possible viral aetiology) (Hare 1983), rather than a consequence of changes in the society and the widening of the psychiatrists' net, as one historian has argued in response to Hare's hypothesis (Scull 1989). To this effect, Wilkins looked to see whether there was any increase in hallucinations in the young population of the hospital. Hallucinations were chosen as they are one of the 'rank symptoms' of Kurt Schneider; that is, symptoms which suggest a likelihood of the onset of schizophrenia (Schneider 1959).

For the purposes of this research it was essential to return to the archives and to conceptualise the material differently. First of all, Wilkins separates the patients into two groups, the first, aged under 17 and the second, from 17 to 19, in order to make the younger group comparable to patients seen in Child Guidance Clinics (however, Wilkins does not carry out any such comparable study). The under 17 category numbered 235, the youngest being six years old. However, most of the results pertaining to the incidence of hallucinations are given with respect to the entire under 20 years old group. In this study the principal age bracket of the children will be under 15. There are two reasons for this. First, 14 or 15 is the age most frequently mentioned by psychiatrists as the age at which the onset of madness becomes more common; second, statistics of the Reports of the Commissioners in Lunacy divide the groups by five-yearly intervals (ten-yearly in the adult population); keeping the same division in this study will make possible comparisons with nationwide statistics.

Secondly, Wilkins's decision to seek the incidence of 'first rank' symptoms tells us little about the children from the younger group, as few of them exhibited these symptoms; most were found in the 17 to 19 age group. (The same applies to Wilkins's subsequent study, in which the same procedures were followed with respect to the incidence of delusions. Wilkins 1993.) Therefore, concentrating on reported symptoms will not be a suitable method. Because of the lowering of the age to under 15, the number of cases will be significantly lower than the 235 of Wilkins's group and this should allow for an in-depth descriptive analysis, based directly on the patients' notes.

Patients' notes

The red buckram bound ledgers with the patients' notes are held in the Bethlem Royal Hospital Archives in Beckenham. The records begin in 1815, the year the hospital relocated from Moorgate to Southwark; notes from 1824 to 1829 are missing. In the earlier years, separate volumes for doctors who were responsible for the cases (Monro, Morison) were kept. From 1835, male and female cases were kept in separate volumes. At first, there was no standard form, although the doctors followed similar procedures. The notes gave name, sex, age (but not date of birth), two doctors' certificates, date of admission, previous history, possible cause and/or hereditary factors were taken on admission; then followed notes, written at regular intervals (at least in principle) on the patient's progress in the hospital; the entry ended with the date of discharge plus an added note 'discharged cured', 'well', 'discharged uncured', 'taken by friends', or, in some cases, 'died', accompanied in later years by a death certificate. In 1848, a new standardised format of admission was introduced, which collected the same data (it became standard in other hospitals too). In 1875, the notes were expanded and on admission a description of the patient by some relative was taken. The new form also specifically sought to establish whether the patients suffered from hallucinations; in 1888, five types of hallucinations were distinguished (auditory, visual, taste, smell, touch) and were added to the form.

Terminology

The terminology used in this article reflects the one that was current in the 19th century. In those pre-Kraepelinian days, terms such as 'madness', 'insanity', 'mental alienation' were used interchangeably. Nevertheless, despite a certain semantic chaos and vagueness, clinical descriptions that we find in the psychiatric texts show a degree of consensus – those considered insane we would today describe as psychotic, that is, suffering from delusional and/or hallucinatory states, or as manic-depressive, or as severely depressed. However, there was also some confusion. For decades, much to the dissatisfaction of some (Monro 1856), almost every psychiatrist proposed a new classification of mental disturbances, some very elaborate. But the terminology that the psychiatrists used in their everyday day practice was loose. Bethlem's case notes bear this out. A diagnosis was specifically entered on the case notes only in the 1880s, (but it was entered in the admission form already in 1856); it was practically always mania or melancholia. Earlier, the form would state the time of the 'first

attack', and would only describe the patient as 'insane' (or not). The descriptions could be lax. Monro described one 1822 patient as 'slightly insane' who recovered 'perfectly well'. But, as the century progressed, the notes became increasingly more detailed not only in the contents of the form but also in the descriptions of the patients' behaviour in the hospital, and there is evidence of increased clinical sophistication.[2] The quality of these descriptions varied depending on the doctor in charge, however, in another respect, there was a degree of constancy – every request for admission to hospital was accompanied by letters from two physicians. Therefore, there is a description of the behaviour of every Bethlem child, prior to admission, which in the opinion of two physicians justified hospitalisation. These should be a source of valuable information.

Analysis of patients' notes

The archival research brought up a big surprise. Once the cut off point is made at the age of 15, which is when one can speak of children proper, the number whittles down to a mere 58. Over a half of those (32) were 14 year olds, 17 aged 13 years, two aged 12, the same number of 11 year olds, three aged 10, one nine year old and one aged six. How many of them could be judged insane? The youngest patient poses a problem. Alexander Morison wrote this about the girl:

> Eliza A - ; A little girl, aged six years, was admitted into Bethlem Hospital on the 30th August, 1842, labouring under the attack of Mania of ten weeks duration. The case is remarkable, as presenting well marked features of insanity at so early an age. The cause of the attack was stated to be inflammation of the brain, preceded by convulsions. When admitted into the hospital, her conduct was violent and mischievous, with incoherence of speech; occasionally, however, by strongly arresting her attention, a correct reply could be obtained. The first portrait was taken while in this state; a considerable improvement soon take place in her conduct and behaviour, and she began to pay attention to the directions of one of the patients who took charge of her; but still continued decidedly insane. She was ultimately discharged cured, in about two years time, at which time the second portrait was taken. (Morison 1848: 282-3)

(The text is accompanied by two portraits of the girl, one taken at the time of her admission, the second at the time of her discharge, but there is scarcely any difference between them.) In fact, the 'about two years time', was two years and eight months (from 2.9.1942 to 25.4.1845). It is a mystery why she spent so long in the hospital.

[2] A more detailed analysis of this one can find in Suzuki 1999.

Furthermore, the first date of discharge is 16.12.42, that is three and a half months after admission, but this is followed by a note dated 23.12.42, 'Continues in hospital.' The reasons why the girl remained in the hospital are not given. Not a great deal more is stated in the notes, only that prior to admission to Bethlem the girl was hospitalised in St. Georges Hospital in June of the same year after being 'attacked with convulsions' and that she suffered a similar attack when she was 18 months old (CB/28 p.43). What made her 'decidedly insane' is not clear.

The nine year old boy was epileptic and died a little over a month after admission (CB/56 p.27).

All of the three ten year old patients were girls. The first was admitted in 1836 with her 'attack of insanity' coming after a bout of hooping cough and was discharged 'well' after five and a half months. The second showed signs of insanity (mania) after an attack of pneumonia; she was discharged 'well' after a month and a half (CB/32 p.34). The third was admitted after reports of three 'attacks of rigidity', of which the first lasted half an hour the two subsequent ones ten minutes and which were preceded by a 'flighty and restless state'. There was no appearance of these attacks after she was admitted to hospital and although at times she had a 'slight disposition to hysterical laughing', she was described as 'quite rational' and 'very orderly'. She was discharged, 01.2.1850, 'well' after two and a half months in the hospital (CB/45 p.91).

Of the two eleven year olds, the first, a girl, was admitted on 18.10.1850 and discharged a month and a half later as the physician in charge (Morison) did not see any reason for prolonging her stay in the hospital as 'there has been no evidence of insanity since her admission' (CB/49, p. 79). The other patient was a boy admitted on 23.4.1885, after he suffered a 'shock at a funeral'. His one noticeably odd behaviour was that he walked on the sides of his feet. But after a while in the hospital he did this only 'when noticed', otherwise, 'will play in the racket court and then generally runs about with his feet in almost a normal position'. He was discharged after two and a half months as 'recovered' (CB/126, p.43).

Both twelve year old patients were boys. The first, admitted on 24.4.1846 was described as 'decidedly insane', but was discharged after a year as not fit as he was eventually found to be epileptic (CB/32, p.159). The second, admitted 26.10.49 was diagnosed as suffering from mania and was described as 'wild, violent and incoherent. He was discharged 'well' after eight months in the hospital after no symptoms were observed for some 'two or three months' (CB/46, p. 56)

The number of children aged 13 rises to seventeen. Of those, 14 were discharged as 'recovered', one died after two months in the hospital (CB/42, p.45); one diagnosed as suffering from mania was discharged after 12 months (21.1.1958 – 20.1.1959) as 'not

improved', the last one described as weak-minded and kleptomaniac left the hospital after two months as 'not improved' but nevertheless 'relieved' (CB/127, p.116).

This leaves the 32 patients who were 14 years old. Of those five were released as 'uncured', one was found as suffering from 'imbecility'. All the others left the hospital pronounced well.

Before attempting some final assessment of this material, some general comments have to be made. There is no evidence from the notes of any special provision for children; nothing is said about which wards they were kept on, and, in all, they were treated much the same as adult patients. Another point has to be made. Although, as the century progressed, one finds an increased sophistication of the descriptions of patients' conditions with notes at times running to several pages, descriptions of children remained fragmentary and scant; there is nothing that we could call a proper clinical description and, for example, the statement saying that the patient was 'decidedly insane' is hardly illuminating. In all, because of the lack of clear clinical material it is difficult to say with any certainty how many children suffered from proper psychiatric problems. However, one feature stands out, the frequent relatively short stay in the hospital – 37 of the 58 admissions remained in hospital for less than six months – suggests that these children often suffered transitory troubles and that these troubles were often consequence of a physical injury.[3]

However, the real surprise is not just the small number of children that found their way into the hospital, but it is the realisation that these are numbers out of some twenty thousand admissions in that period. This, Wilkins does not say.

Bethlem and County Asylums

How do the numbers of children in Bethlem compare with the situation in county asylums?

The picture is somewhat complicated by the fact that in the 19th century psychiatrists also had to deal with a great number of idiot children. The distinction between idiocy and insanity was already spelt out by John Locke in the 17th century (Locke 1690); it was often reiterated, and some psychiatrists concentrated on working with idiot children in special asylums (Seguin, Voisin, Ireland). The different challenges that the idiot and insane children posed were clear to most psychiatrists

[3] Of the 60 cases of adult patients presented in *Presumed Curable. An illustrated casebook of Victorian patients in Bethlem hospital* (Gale and Howard 2003), which could be taken as a random sample, only four were discharged within less than 6 months.

(but not all, writing in 1898, Beach mixes these two categories). However, few idiot children were housed in special asylums, the majority were found in workhouses, and what was clear to psychiatrists was not always clear to workhouse masters or Poor Law officials who spoke of 'idiots', 'lunatics' or persons of 'unsound mind' almost interchangeably (Digby 1996). Consequently, some idiot children found their way into county asylums. Research carried out in a few of these institutions confirms this.

In his study of Bethlem, Wilkins also looked at admission registers in Brookwood Hospital in Surrey. He found that of the 28 patients under the age of 20 admitted in 1893, 18 were congenital idiots. Findings from another county asylum (Worcester) show that from a total of 6573 admissions in the years 1854-1900, 195 were under the age of s16; some two thirds of those were suffering from epilepsy and/or idiocy (Gingell 2001). A study of a Devon County Asylum reveals that of the total of 101 children under the age of 15 admitted between 1845 and 1914, again, two thirds were diagnosed idiots or imbeciles (Melling, Adair, Forsythe 1997). This study also gives a detailed picture of the dealings between workhouses, Poor Law officials and asylums. Since Bethlem did not accept pauper lunatics, it was not part of this circuit. Of the cases that came directly from their family homes that Melling *et al*. discuss, an epileptic girl who tumbled into the fire would not be admitted, nor would exceptionally violent children, but a 12 year old melancholic boy who attempted suicide probably would.

Nationwide statistics suggest that the numbers in these hospitals are typical. The 54th Report of the Lunacy Commission shows that in the last five years of the century, out of the total annual average of 18437 hospital admissions only 217 were under the age of 15.

Therefore, national statistics and findings coming from research in County Asylums show that there was nothing exceptional about numbers of young patients in Bethlem hospital. And so the view, expressed earlier, that historians who studied Bethlem 'missed' the problem of children in this institution is not correct.

A final word about Wilkins's study is necessary. Wilkins did not have children as such as subject of his research; his aim was to see whether there was an increase in first rank symptoms in the young population of the hospital. Had he specified that the number of children that he studied came from some 20000 admissions, it would be enough to compare these figures with nationwide statistics to realise that it was nothing exceptional. One has to say there was no obvious need for Wilkins to do so and, as it is, the figure of 1069 children and adolescents admitted to Bethlem in the 19th century has entered historiographical folklore.

Von Gontard

We can now return to some of von Gontard's statements quoted earlier (p.1).

The first thing that strikes about one these statements is that they give the impression of an abundance of mad children treated by psychiatrists ('most common diagnosis for children', 'most children'); this is deeply misleading. It is sufficient to consult 19th century statistics, which the Lunacy Commission regularly published, to see how small was the number of children in hospitals, nothing that gives the impression of abundance. Furthermore, there is no sign of an increase of children in hospitals towards the end of the century as von Gontart states in quote e.; in fact, the national statistics indicate a slight decrease of number children in the last decade of the century (or, to be more precise, the number of children admitted nationally stabilised at around 200 per year, while the overall numbers kept growing); in the same decade, in Bethlem, five children under 15 were admitted (out of the total of 2387 admissions).

Further still, the idea that Alexander Morison was one of the 'acclaimed authorities' (on children, von Gontard's text suggests) during the first half of the 19th century gives the impression that there was already a budding speciality. In fact, the two cases that von Gontard refers to are the only cases of supposed child insanity that Morison mentions.

However, von Gontard based his account principally on the writings of the 19th century practitioners. For example, when he states that 'many – especially younger children – must have been seen as outpatients', he repeats the claim already made in that century. In Bucknill and Tuke's *Manual of Psychological Medicine* we find the following statement:

> [I]t may be observed that no age is exempt from attacks of Insanity. Such attacks, it is true, are comparatively infrequent under fourteen or fifteen years of age. Scattered throughout this work, however, will be found a considerable number of references to cases of Insanity under puberty, and they might have been considerably increased. They are met with in private practice much more frequently than in asylums, the statistics of which, therefore, give too favourable an impression as to the frequency of attacks of Insanity in the young. (Bucknill and Tuke 1879: 74)

However, although towards the end of the 19th century some well-off patients would seek help in Harley Street, there is no evidence of regular outpatient activities. In those times psychiatrists mostly operated from inside the asylums and were dealing with those who were delivered to them by the community (with certificates of insanity from two General Practitioners). The idea of the psychiatrist's involvement in the community, as we understand it today, did not yet exist. And then, when one peruses this voluminous

text in search of the 'considerable number of cases of Insanity under puberty', which the authors refer to, one finds that children are specifically mentioned in only two mental afflictions, kleptomania and pyromania. (And anyone who knows children well could have guessed this. In fact, bearing in mind how often children exhibit fascination with fire, the number of them becoming pyromaniac is, if anything, very small.)

There were also other writings. One could begin with a case first reported in German (by John Ernest Greding) that Crichton translated and included in his 1797 *An Inquiry into the Nature and Origin of Mental Derangement*. This extraordinary case speaks of a child born 'raving mad', who, when he was four days (yes, days!) old possessed so much strength in his legs and arms that four women could, at times, with difficulty restrain him. These paroxysms either ended with an indescribable laughter, for which no evident reason could be observed, or else he tore in anger every thing near him, cloathes [*sic*], linen, bed furniture, and even thread when he could get hold of it. We did not allow him to be alone, otherwise he would get on the benches and tables, and even attempt to climb up the walls. Afterwards, however, when he began to have teeth, he fell into a general wasting, and died. (Crichton 1797: 355-6)

This 'case' is quoted a few times by the 19th century psychiatrists without any sign of incredulity (Crichton Browne, Maudsley). On seeing this, it seems prudent to be a little sceptical about what these psychiatrists had to say.

Crichton Browne's 1863 paper is often quoted. One historian discusses it at length and wonders why it failed to receive any attention and suggests that: 'Generally, the acceptance and implementation of ideas depends on the status of the protagonist, a sympathetic climate of opinion, and the readiness of others to take the idea up with enthusiasm: all these must have been lacking' (Wardle 1991: 284). One would like to think that the intrinsic quality and coherence of the ideas should also play some role because when one reads the article, one cannot be but sceptical about what Crichton Browne has to say. The principal problem of Crichton Browne's exposition is that he is arguing the inherent insanity of children judging them from the point of view of adult psychology. And, really, what is one to make of his insistence that insanity can already occur 'in utero',

> Almost all writers on the subject of psychology are agreed as to the extreme rarity of mental diseases before that period of life [puberty], and I am not aware that any one has ever suggested its occurrence in utero. Unfortunately, however, I shall be enabled to demonstrate that insanity does occur in utero, in infancy, and childhood, and that it is by no means so uncommon as supposed. (Crichton Browne 1860: 286)[4]

[4] It should be specified that Crichton Browne speaks of madness 'in utero' in two distinct ways. First, he says that reasons for madness can already be planted in utero if during the pregnancy

Crichton Browne gave the paper when he was a 19 years old medical student and, in fact, he impresses with the thoroughness of his research, his confidence is prodigious; but this is a piece of juvenilia, which might be of interest to those who want to know the details of Crichton Browne's very long professional career, but it is difficult to see how this could be considered an event in the history of child psychiatry.

As for Maudsley's list of types of childhood insanity that von Gontard mentions, it would be interesting to see how he constructs this list. His approach, one could say, is somewhat idiosyncratic. The chapter in which he presents his views on childhood insanity begins with a speculative exposition of the development of the child's nervous system. Then, Maudsley states 'Suppose now that an infant becomes insane immediately after birth, what sort of insanity must it exhibit?' (Maudsley 1867: 260). This is a strange suggestion. Has anyone seen such a child? Has Maudsley seen one? He does not refer in his text to any observations of such children. But, he goes on to quote the case of the child 'born raving mad' from Crichton, and he finds this case altogether credible, as he found there symptoms that confirmed his views on the development of the child's nervous system. Then, in a colourful description, Maudsley compares such a child to insane animals, which includes an image of an insane elephant!

> There is far more power in an insane elephant than in an insane infant, and it is able to do a great deal more mischief; but there is really no difference in the fundamental nature of the madness; the maddened acts are the reactions of morbid motor centres to impressions made on morbid sensory centres; and the whole mind, whether of the infant or of the animal, is absorbed in the convulsive reaction. (*ibid.*: 263)

Later in the text Maudsley describes the seven types of childhood insanity and, one can only marvel how he managed to describe so many of them, based on personal observations of just two children (and the second was added in the appendix, after the text was written) and just over a dozen of cases that he found in other psychiatric texts. What does, however, come through is Maudsley's manifest dislike of children, who 'like brutes, live in the present' (*ibid.*: 269).

Another interesting example, this time from French literature, is a chapter on child insanity, which we find in Benedict Morel's *Traité des maladies mentales*, published in 1860. Morel does mention, but briefly, two cases that he had dealt with personally, and instead, furnished as proof of existence of childhood insanity the fact

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the mother falls ill or suffers a physical trauma (only that examples that he gives are cases of children with forms of idiocy); second, Crichton Browne insists that insanity can already exist in this state. While the first formulation can be accepted, the second leaves one with raised eyebrows.

that there are known instances of children falling prey to a psychic epidemic, of which he gave three examples. The first, the infamous so-called children's crusade of 1212, would not be today accepted, as historians do not think that the events of that year involved children (Raedts 1977), the other two, one an *epidémie démonolâtrique* in 1609 in Basses-Pyrénées (then pays de Labourd), the other a collective outburst of delirium in a hospice for found children in Amsterdam in 1556, would have to be looked at. The argument is in itself interesting, but what is striking in Morel's, as well as other psychiatrists' accounts, is that although he was based in an asylum he could not furnish sufficient clinical material to substantiate his discourse.

Then, there is the question of Prichard's concept of moral insanity, which, according to von Gontard, was the most common diagnosis given to children. The argument goes that in the early period psychiatrists were not keen on the idea of childhood insanity as it was thought that madness is a breakdown of reason and children being pre-reasoning beings should not go mad.[5] This was meant to change with the publication, in 1835, of Prichard's *A Treatise on Insanity* in which the concept of moral insanity is introduced, as it removed any theoretical objections to the idea of childhood madness, and von Gontard claims that this diagnosis became frequently used. It seems that this view has no substance. The diagnosis 'moral insanity' is not used once in relation to children in the Bethlem archives (as stated earlier, it was either mania, or melancholia or dementia). As far as literature is concerned, two things have to be said about the matter. First, it should be pointed out that Prichard did not have children in mind when he introduced the notion of moral insanity; second, when it appeared in relation to children, it was a few decades after Prichard's treatise was published and the term 'moral' had by then morphed into something altogether different to what Prichard meant by it. In the time of Prichard, 'moral' meant what we today would call 'psychological', and so, for example, the famous 'moral treatment' introduced by Pinel at the Salpétrière and the Tukes at the York Retreat, would be today designated as 'psychological treatment'.[6] However, in the second half of the 19th century the term began to acquire ethical connotations and when it was put into use to speak of children, it usually meant 'spiteful' or 'vicious' children (Maudsley 1867, Savage 1881), or as Crichton Browne put it, he who suffers from moral insanity 'suffers from entire perversion of the moral principle, from the want of every good and honest sentiment. He is actuated

[5] This author has not seen this argument put explicitly forward by the psychiatrists of the time, which suggests that this might be the historians' construction rather than a genuinely held view. And, at any rate, the tiny number of reports of insane children was not due to some conceptual difficulty, but simply because such children were a real rarity.

[6] For a succinct but clear exposition of the confusion around Prichard's notion of 'moral insanity' see Berrios 1999.

by impulse, or by the most selfish, depraved, and cruel motives' (Crichton Browne 1860: 314). At any rate, whether used in the sense that Prichard meant it or not, the term 'moral insanity' was liberally used by those who speculated on mad children, but if Bethlem archives are anything to go by, it was not used as a diagnosis given to children, as von Gontard claims.

In all, archival research in Bethlem archives, consultation of national statistics and reading of psychiatrists' texts lead one to conclude that, in the 19th century, cases of children that could be described as mentally ill, to use a modern term, were extremely rare, to the point were one can say that they were practically non-existent.

The absent mad child

For a number of reasons this absence of mad children comes as a surprise.

First, this lack of increase in incidents of childhood insanity must be seen against the massive growth in numbers of the mentally ill in the adult population in the same period (in Britain from around 5000 at the beginning of the century to well over a 100000 at the end). Second, in the same period, children became full medical subjects; first children's hospitals were set up (Great Ormond Street opened in 1852). Third, there was a great supply, so to speak, of marginal children in various institutions such as foundling hospitals, hospitals for idiot children, work-houses. Studies in county asylums indicate that there was some decanting from those institutions into the psychiatric domain, but nevertheless, as far as psychiatrists were concerned, the distinction between idiot and insane children that had been worked out in the first half of the century, remained clear.

In all, psychiatry established itself on the social and medical landscape, a fully-fledged paediatrics emerged, there were great numbers of marginal children in other institutions, we find an increased rhetoric about childhood insanity, but, despite all this, mad children are absent. The upshot of these observations is that it is not in the developments of the 19th century that we should look for the beginnings of child psychiatry. And von Gontard' claim that 'by 1900, all elements which later merged into child psychiatry had evolved – with the exception only of psychoanalysis and child guidance' cannot be accepted.

Katherine Gingell, who carried out the study in the Worcester County Asylum, referred to earlier, makes these two succinct comments:

> Children were treated exactly like adult patients, and therefore asylums did not contribute significantly to the development of the discipline of child psychiatry. (Gingell 2001: 432)

> Social historians […] have stated that changing society, increased industrialisation and declining community tolerance for the mad forced the insane into the asylum, allowing the psychiatrists of the day to assume an expertise and carve out a speciality for themselves. A sub-speciality of child psychiatry did not evolve within this context. […] Modern child psychiatric services have evolved from different roots to these. (*ibid.*: 435)

These are conclusions that this author fully agrees with.

The virtual absence of the mad child in the 19th century is remarkable and it goes against intuition, but this realisation is a singularly important one for our understanding of today's child psychiatry. It goes against intuition until one takes some time to reflect rather than get carried away by the rhetoric of some of the 19th century practitioners. Those who discoursed on child insanity were small in numbers and, throughout the century, we find it frequently stated that insanity under puberty is extremely rare; this was also the view of Leo Kanner, 'Fully-fledged mental illness […] is exceedingly rare before the 15th year of life' (Kanner 1935 :509). (And Kanner also quotes a study which found that among six thousand patients admitted to the Boston Psychopathic Hospital in the years 1923, 1924 and 1924 there were only four cases of manic-depression under the age of 16, and in all four the disorder developed after the 14th year of life. *ibid.*: 506). In other words, although in the 19th century, children often found themselves in conditions that can only be described as horrendous, they did not break down, in the manner that adults would. To put it simply, children do not go mad. It would take someone with knowledge of child psychology to explain why this is so, but the idea of a nine year old paranoiac sounds like an aberration, and this is why a child suicide always strikes as something absolutely shocking. But if the mad child is absent, than how did today's child psychiatry emerge?

PART 2 – 1902-1935

The turn of the century saw a change in psychiatry's conceptual outlook. In 1883, Emil Kraepelin published *Compendium der Psychiatrie* (English translation *Lectures on Clinical Psychiatry*). In this work Kraepelin began to outline a new classification of mental illness. He divided mental illnesses into two groups, in the first he grouped various forms of 'dementia praecox' (later renamed by Bleuler

'schizophrenia'), in the second manic-depressive psychoses. The book went through numerous editions, the last one appearing in 1927, and throughout the century it remained a blueprint for psychiatry's taxonomical efforts. The beginning of the 20th century also saw the wane of the influence of Morel's theory of degeneration. The influence of psychoanalysis and phenomenology brought in a new sophistication in thinking about mental illness. However, as far as practice went no noticeable change took place; hospitals continued to grow in size and what is important in the context of this article, children remained outside psychiatry's sphere of activities. Nevertheless, reports on difficult children started appearing, penned by those who had a great deal to do with them – paediatricians.

The nervous child

The first significant development of the 20th century that draws one's attention is a 1902 report of twenty children with a cluster of symptoms that was called 'defect of moral control'. Although this communication did not exert immediate discernable influence, it is nevertheless very significant as it points to the new developments concerning childhood and mental well being.

1. This report, which was published in the *Lancet*, came from a King's College and Great Ormond Street hospitals paediatrician George F. Still and it was presented in a series of three lectures to the Royal College of Physicians in London.

2. This was the first diagnosis to specifically describe a condition found in children, in other words, it was not an extension of already existing terminology developed in adult psychiatry onto children, like in 'childhood mania', for example.

3. Although Still named this new disorder 'defect of moral control', couched his rhetoric in the language of degeneration, and like a criminal anthropologist sought 'stigmata', the concept was new as he argued that the reason for a defect of moral control lie in a disturbed 'cognitive relation to environment' (Still 1902: 1008), which in time will transmute into 'attention deficit' and a disorder known as AD/HD (Attention Deficit/Hyperactivity Disorder).[7] This had nothing to do with earlier

[7] Still's report is mentioned in a number of historical accounts (Stone 1973, Wardle 1991, Neve and Turner 2002). But that his description of children with 'defect of moral control' was in fact the first clinical description of the 'attention deficit disorder' seems to have been first noted in a recent article (2007) by Mayes and Rafalovich. One should, however, point out that Still's long presentation includes such children amongst a number of other afflictions that he describes under the term 'defect of moral control'. Children suffering from psychological disturbances after various bouts of illness are mentioned, as well as a child that seemed to suffer from a severe form of

theories about masturbatory activities, childhood sexuality (which was already on the agenda for at least two decades by the time Freud announced his theory), or 'instinctual insanity'; it is an entirely new clinical finding.

4. Still considered this condition to be distinct from idiocy or child insanity (which, like his predecessors, he considered extremely rare). It is not necessarily a chronic condition; it can come and go, '[there are] cases in which periods of defective moral control alternate with periods in which no such defect is present' (ibid,: 1163), and this makes it also distinct from another childhood condition that was receiving much attention, feeble-mindedness.

5. The fact that 'attention' or, in Still's language, poor 'cognitive relation to environment' has become the focus for a diagnosis, points towards a new social context in which the child's comportment will be judged – the classroom, as by this time the education system had become compulsory and universal. Still evokes the importance of this context as some of these children have an 'abnormal incapacity for sustained attention' (*ibid.*: 1166) and he suggests that there might be a need to separate children suffering from 'defect of moral control' from others in a classroom (*ibid.*: 1167).

Although the Attention Deficit Disorder has acquired immense currency (and has been since used in adult psychiatry), this only came later. What is important is that we see emerge a new type of a difficult child, one that is neither an idiot nor insane, it will be called the 'nervous child'. Mention of such a child appeared earlier, notably, in the text of Charles West, the eminent paediatrician based in the Great Ormond Street hospital. He first mentions such a child in his *Lectures on the Diseases of Infancy and Childhood* (1848), but in subsequent editions, he did not develop the theme. In time, the most famous became the 1919 text 'A Nervous Child' by Hector Charles Cameron, which went into a few editions. What were the types of afflictions typical of a nervous child? We find problems with appetite, disturbed sleep, bed wetting, bad habits, phobias, night terrors, nervous vomiting, and other signs of nervousness (twitching of facial muscles, air swallowing, over excitability, constipation, etc.). Cameron concluded the book with a chapter 'A nervous child and school'; in 1933, he extended the chapter into a full-length study, of the same title (Cameron 1933).

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dyslexia, for example. Nevertheless, it seems to this author that Mayes and Rafalovich are right, as the first description of AD/HD, if still only embryonic, can be teased out of Still's account particularly that at one point he does indeed concentrate on the problem of these children's disturbed capacity for any sustained attention (Still 1902: 1166).

Psychometric scales

In view of the fact that education became compulsory it is not surprising that this began to pose a problem in schools, as all children, whatever their aptitude, were compelled to sit in the classroom; the problems they posed soon became of paramount importance. In 1905, following a request of the French government, two psychologists Alfred Binet and his student Theodore Simon introduced a method of diagnosing different degrees of mental retardation (Binet and Simon 1905). This was a method consisting of a series of tasks that children were asked to perform that allowed a precise assessment of the child's development. Within the next few years this was extended to measure 'normal' children and this gave educators indicators of what could be expected of children at a specific age. Binet and Simon's work was swiftly translated into English (in the US), it was modified to become the Stamford – Binet scale; it became widely used and has been ever since developed and improved. The idea of being able to test and determine aptitude psychometrically goes back to Francis Galton's eugenics, but these scales were a new development that could only be achieved in the context of the new educational system. The introduction of the first psychometric scales was the beginning of a new science of children. Now they could be classified, segregated, it was known what could be expected of children at different stages of their development; and failure to achieve this, either because of mental retardation or some other problems, could be objectively measured.

Child Guidance

A nervous child was recognised and in detail described, new methods of measuring the child's development made the diagnoses more precise; and, before long, a need to help those children arose. As a consequence of this need, one can see the emergence of the Child Guidance Clinics. Historians' accounts (Thom 2000, Wardle 2000) suggest that this was a complex affair. Nevertheless, some basic themes can be discerned.

The beginnings take us to the US, where the Child Guidance movement grew out of the Mental Hygiene movement. The driving force behind the Mental Hygiene movement was Clifford W. Beers, who in his 1908 autobiographical work *A Mind That Found Itself* describes the kind of treatment he received in the mental hospital after suffering a breakdown (Beers 1913). In the following years he devoted his energy to establishing outpatient facilities for dealing with people with mental

problems. The Clifford Beers Clinic in New Haven was set up in 1913. Beers had the cooperation of the doyen of American psychiatry at the time, Adolf Meyer, who by then began to espouse a psychosocial model of mental illness and believed there was need for interventions in the community. These structures were used when, in the early twenties, first child guidance clinics were set up (Deutsch 1947).

Britain did not have the equivalent of the Mental Hygiene Movement (although, in time, the movement acquired a truly international dimension) but the inspiration, and most importantly funding, for the first Child Guidance Clinics came from the US. There were, however, two significant differences. The American initiative was closely linked, at least at the beginning, with juvenile courts, which was not the case in England (Thom 1992: 209) and, secondly, the involvement of psychiatrists was less prominent, there was no equivalent of Adolf Meyer in England, the driving force behind the Child Guidance Movement was the psychologist Cyril Burt. The first Clinic opened in 1927. One important development that took place, both in the US and Britain, was the emergence of social work, which was to play an integral part in these new settings. In the US, social work training began at the beginning of the century, in England the first course in social work was set up at the London School of Economics in 1929 (Wardle 1991: 56). But what seems most important is that, all historians' accounts underline the multidisciplinary character of the Child Guidance Clinics as it was an effort that involved paediatricians, health workers, educationalists, social workers, psychoanalysts, psychologists as well as psychiatrists.

Leo Kanner

What is notable is that none of the developments discussed above (the emergence of a 'nervous child', psychometric scales, Child Guidance Clinics) had any connection with psychiatric thought of the previous century. Furthermore, it is not clear whether these developments can be described as psychiatry, at any rate, in the first third of the century, the concept of a 'child psychiatrist' did not even exist. So a question remains. How did all the activities of paediatricians, health workers, educationalists, social workers, psychoanalysts, psychologists that were involved in the Child Guidance Clinics, and which took place outside the psychiatric context, become 'child psychiatry'? To all intents and purposes, the term was introduced by

Leo Kanner in his 1935 text, which carries that very title 'child psychiatry'. (According to Kanner, the term was used earlier only once.)[8]

Now, unlike the texts of Crichton Browne, Maudsley and others of the preceding century, which did not bear on the developments described above, Kanner's *Child Psychiatry* is a veritable event, the consequences of which are difficult to overestimate.

It is clear that Kanner had great knowledge of children, probably the first psychiatrist with such deep clinical experience of youngsters. And this is evident in his remarkable monograph. It runs to something like 250 thousand words and consists of 44 chapters. It is also preceded by two prefaces; the first, coming from Adolf Meyer, the second, coming from Edward A. Park, head of the psychiatry department at Johns Hopkins University. Kanner belonged to the cream of psychiatrists of his generation and in his work he displays extraordinary erudition. This publication could have not gone unnoticed; it became the standard text on the subject for the next three decades, its dominance only waning with the publication of Michael Rutter and Eric Taylor's *Child and Adolescent Psychiatry* in 1976.

There are a number of features that make this work stand out. First of all, the various problems concerning children that were reported first by paediatricians and which led to the emergence of the concept of a 'nervous child' are repeated. We find in Kanner's text everything – temper tantrums, nail-biting, problems with appetite, stuttering, antisocial behaviour, sleep disturbances, enuresis, migraine and they are all recast in psychiatric terms. One can see how different it is when we compare it with Cameron's *The Nervous Child*. Cameron was a paediatrician from Guy's Hospital, and his writings are devoid of any psychiatric thought (and he was a little apprehensive as far as the then emerging psychoanalytical theories were concerned); they come across as observations and advice of a good, sensible and sensitive doctor. Kanner's work is a *tour de force*, he almost overwhelms with his psychiatric erudition, (not all of it necessarily relevant to the subject). One way of putting it is that Kanner's 'child psychiatry' is no more than an annexation of the territory identified by the Child Guidance movement.

But since it is the territory of Child Guidance that is recast in psychiatric terms it is a psychiatry that shows a pronounced difference from adult psychiatry. This is not just the question of the age of patients. Although, as it has been demonstrated, psychiatry evolved at the beginning of the 19th century out of the confinement of the insane, that is, its origins lie in social control concerns rather than medical thought,

[8] Subsequently it has been shown that the term 'child psychiatry' has been used more than once (Harms 1962) but this does not change the picture significantly as it did not have any currency before Kanner's time.

and despite the frequent arguments (often crude) that mental illness is a social construct, it still remains incontestable that insanity exists (not even the likes of Foucault, Laing or Basaglia contested this). This, one could say, legitimises the psychiatric enterprise. And, since madness exists, we owe to psychiatrists sophisticated and often sensitive clinical descriptions of various mental conditions. Child psychiatry deals with restlessness, nervousness, bed wetting, disruptive behaviour, and the like, but its relation with insanity is tenuous, if there is any at all. Kanner does have a chapter on mental conditions that would be in earlier days referred to as insanity – under the title 'Major Psychoses' – but it is just one, penultimate chapter, out of the 44 that make up the book. The discussion is very thorough indeed, only that it is based exclusively on writings about madness in adults (Kraepelin, Bleurer, Schneider, etc.) and he confirms the observations of his predecessors that insanity in children under the age of 15 is 'exceedingly rare'. (Interestingly, he deleted this sentence in subsequent editions without, however, presenting a sufficient number of cases to invalidate this observation.)

So why did Kanner write the chapter? (In Cameron's *The Nervous Child* we do not find any mention of children suffering from what could be considered insanity.) Had Kanner not included the chapter, we would have a strange text that pertains to psychiatry but that has no relation to insanity. And while psychiatry as a whole can live without mad children, child psychiatry cannot. There might have been some sightings of a mad child, like that of a very rare animal, but it remains an imaginary child, a *possible* one, not one that is seen in the clinic.

For psychiatry to take over the clientele of the Child Guidance Movement one further profound change was necessary. Up to the time of Kanner, the practice of the psychiatrists was to treat those deemed by the community insane and, once this was confirmed by the GPs (in England), they were delivered by this community to the mental hospital. The psychiatrists' activities were practically entirely confined to the asylum, where they often resided. While they remained in the asylum *child* psychiatry could not have developed as the community was not inclined to deliver children to the asylums' gates, even more so with the emergence of the Child Guidance movement, which developed necessary services. Psychiatrists had to change their old habits; their sphere of activities had to be re-defined. Rather than being asylum based, this new psychiatry will be based in the school (and in the US also the juvenile court); it will also enter the family. In this sense, Kanner's text is quite revolutionary as it must be the first that carries the word 'psychiatry' in its title and which has nothing to do with the mental hospital.

Did the fact that psychiatry took over the problem of difficult children make a difference? Yes, it seems clear it did. It led to a medicalisation of children's troubles; the enthusiasm to try drugs on children would perhaps be less pronounced; first trials on amphetamines on children were carried out in 1937, and it comes as no surprise to learn that this happened within the context of a hospital clinic, the Boston 'neuropathological unit for children', to be precise, and the current trend to prescribe medication to children (mostly Ritalin) has grown to quite alarming proportions. Furthermore, only after children were brought into the psychiatric domain, will we start seeing separate wards for children set up in hospitals, something unthinkable in the 19th century, which is when, it is thought, psychiatry was at its most excessive.

Concluding remarks

If this account is just, than what strikes about it is the almost complete discontinuity between what we find regarding children and psychiatry in the 19th century and developments in the 20th. We can summarise by pointing out the elements that did not exist in the previous century. First, there is a new setting – the school, and it is in this setting that children became a concern. Second, we find a clinical description of a new type of troubled child – the 'nervous child'. And third, a new system of measurement and evaluation of the child's development, the psychometric tests, is put into place. These led to the emergence of the Child Guidance movement and the setting up of first clinics, which specifically dealt with children. The other set of changes pertains to psychiatry. First, in order to bring children into its orbit psychiatry had to forgo its link with insanity; second, in order to become involved with children, psychiatrists had to leave the walls of the asylum.

Perhaps the matter becomes clearer if we try to look at the problem by studying it backwards, beginning with the present day. We would begin by noticing that there are two parallel services for children, one designated as 'child psychiatry' the other as 'child guidance' (the emergence of child psychiatry did not lead to the disappearance of Child Guidance Clinics). We would then look, for example, at the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV-TR, to see what kinds of ailments are discussed in this psychiatry textbook. We would arrive at a conclusion that there is a considerable overlap between the services provided by Child Guidance Clinics and child psychiatrists. Moving back in time we would find the publication of Rutter and Taylor's *Child and Adolescent Psychiatry* in 1976 and then Leo Kanner's 1935 *Child Psychiatry*. At this point the 'child

psychiatry' thread would break. However, one could continue with the Child Guidance Movement story for another two decades (if the American developments are taken into account as well as the earlier Mental Hygiene movement). This would bring to an end the Child Guidance Movement story. The last element that would remain would be the clinical descriptions of 'nervous children' that paediatricians began to report at the beginning of the century. At this point, all the threads that make it possible to retrace these developments are broken; there does not seem to be any passage from these developments to the writings of the nineteenth century psychiatrists. The two main reasons why one cannot link the twentieth century developments with the earlier period have been spelt out earlier. First, the type of child that came to the attention of health workers was not yet identified; second, at the time, the psychiatrists' activities were confined to the asylums, as the notion of community work was not yet formulated.

However, a clarification as to why the school has such prominence in this account is necessary as one could raise objections to this. It could be pointed out that the Child Guidance Movement in the US was at first linked with juvenile courts, not with schools; and furthermore one notes that the Child Guidance Clinics saw a great number of children that presented symptoms such as delinquency or the frequent cases of bed wetting, which would not seem to be related to the school, at least not directly. First of all, one should note that the question of the problem of difficult children in the classroom is posed from the beginning by paediatricians who first reported cases of 'nervous children' (at least in English literature). Furthermore, although the American developments began in juvenile courts, soon we see the question of schoolchildren coming to the foreground in America as well. However, it is not just the frequency with which the problem of difficult children in schools crops up in various contexts, the prominence given to the school follows a precept worked out by French philosophers of science, beginning with Gaston Bachelard, which states that for knowledge to be constructed (for knowledge, in this line of reasoning, is a construct not a find) earlier knowledge is necessary, for example, without the tensor calculus the General Theory of Relativity could not have been formulated. However, as we have seen, prior psychiatric knowledge was not the condition for the development of child psychiatry (even if its emergence could not have happened without the earlier appearance on the social landscape of psychiatry as such). Therefore, a further argument of Bachelard has to be considered. It states that for knowledge to be constructed a suitable setting is also necessary.[9] To make advances

[9] What Bachelard meant by the 'setting' needs perhaps calls for some explaining. Bachelard's analyses are confined to 'hard sciences', mathematics, physics and chemistry. In this context he coined the term 'phénoménotechnique', by which he meant the complicated apparatus needed

in nuclear physics, for example, it was necessary to begin building particle accelerators; chemistry was always linked with the laboratory, and likewise in social sciences a setting is needed in order to arrive at knowledge of social phenomena. In this context one can say that psychiatric knowledge could have not been developed without the asylum, within which it was constructed, similarly, psychoanalytical knowledge could not have been arrived at without the couch; and, since we have seen that it was not the asylum that provided the setting for the development of child psychiatry, the context in which the 'nervous child' became apparent – and a problem – had to be identified. While the classroom was not the only place where we find such children, there were also juvenile courts, children's hospitals; nevertheless, a new science of children, which plays an integral part in child psychiatry, could not have emerged without the classroom. In the 19th century some children received no schooling, either because they were in some ways retarded, or because they already began to work and what they earned was crucial for their families survival, or simply because they were tearaway kids. Once education became compulsory, the classroom became a context that no child could escape, and it is in this context that the extent of the problem of the 'nervous child' became apparent, and in this context it could be compared to a 'normal' child. It is interesting to see, and it seems no coincidence, that the time George Still was making his first clinical observations of children with disturbed attention, which he presented in his 1902 lectures, was the time 100% education was finally achieved. (Although the first Education Act goes back to 1870, it took a few more Acts and a great deal of government effort and money to make universal education reality, this only happened at the turn of the century.)

However, this has to be qualified. This is not an argument that the educational system 'fabricated' nervous children, there could well have been children in the previous century that would have fitted that description; rather, the argument is that there did not exist the context in which this problem could have become apparent and also that there was no social necessity for identifying nervous children.

Finally, some remarks of a historiographical nature are necessary. When dealing with the history of child psychiatry we find two types of accounts. On the one hand, some historians speak of child psychiatry in the 19th century, as does von Gontard, which has been chosen as an exemplar of this view; on the other hand, we

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to perform scientific experiments (the particle accelerators are a good example of these). But this idea has been taken up by others, Georges Canguilhem and Michel Foucault, amongst others, to apply it to a wider range of scientific investigations, medicine and social sciences. In time, the term 'dispositif' has become the most widely used, but the discussion of the term and the philosophical specificity that it has acquired cannot be discussed within the scope of this article.

find accounts that do not make any reference to the 19th century, Kanner belongs to the latter. (Another example would be a recently published article about the development of Child Psychiatry in Norway, which makes no reference to the nineteenth century, Ludvigsen and Seip 2009.) This author read Kanner's account when already familiar with von Gontard's text and the first reaction was that Kanner wilfully ignored developments that preceded his time, and that he was making false claims about the novelty of child psychiatry; after all, attempts by historians to reconstruct some form of child psychiatry in the 19th century could not have been based on nothing.

Much depends on what status one accords to the findings in the 19th century. 'Many authors have shown that, for most European countries, the origins of child psychiatry can be traced back to the 19th century' stated von Gontard. In this context, 'origins' presumably means 'beginnings' (as it is difficult to see how it could mean 'cause'). However, locating the first reports of insane children does not necessarily mean that activities that could be called 'child psychiatry' began with these reports. This is because psychiatry is not constituted by an odd case description; psychiatry is a social phenomenon, which reflects the society's perception that a collective effort to deal with those who are deemed insane is necessary, psychiatry deals in large numbers. This was so from the very beginning; when Philippe Pinel was appointed at the Salpêtrière, which is considered one of the founding moments of psychiatry as we know it, he had some three thousand patients in his charge; England at the beginning of the 19th century already had around five thousand inmates in various establishments. While clinical descriptions of various conditions are indispensable for the development of the science of psychiatry, statistics are also an integral part of it (and one notes that the full title of the DSM-IV-TR, mentioned earlier, includes the word 'statistical'). The difference between Maudsley's classification of child insanities, in which he proposed seven types, and Kraepelin's division of mental illnesses into two great categories, is that Maudsley based his classification on less than two dozen reported cases, while Kraepelin had at his disposal notes on hundreds and hundreds of patients that passed through his clinic.

However, if one assumes that child psychiatry already existed in the 19th century, albeit without being formalised, there will be a temptation to produce an exhaustive account of *everything* that touches on children and psychiatry; *every* utterance coming from psychiatrists will be referred to and every reported case mentioned as adding to the body of knowledge on the subject. In such a narrative remarks about general conceptions of childhood also seem to be *de rigeur*. (Philippe Ariès's *Centuries of Childhood* is most often quoted. This is indeed a remarkable text, only that it is not clear what relevance it has to psychiatric practices in relation to

children.) In all, one sometimes gets the impression that we are confronting what one could call the method of 'hopeful accumulation', that is, if one can accumulate enough material on the subject than, somehow, an imaginary social phenomenon (in this case child psychiatry in the 19th century) will become reality. After all, the title of von Gontard's article, 'The Development of Child Psychiatry in 19th Century Britain', already announces the existence of this phenomenon. One is tempted to refer to Marc Bloch, as he expressed dislike of exhaustive research typical of some historical productions, he wrote, 'polymathy can well assume the form either of recreation or of mania, but it cannot pass for one of the proper tasks of the intellect […] history will rightfully claim its place among those sciences truly worthy of endeavour only in proportion as it promises us, not simply a disjointed and, you might say, a nearly infinite enumeration, but a rational classification and progressive intelligibility' (Bloch 1992: 9).

A disjointed and almost infinite enumeration is what characterises von Gontard's account. But there is more, one needs to understand why there were so many misrepresentations. For example, the term 'moral insanity' was not the most commonly used diagnosis as he states, research suggests that it was used by those who wrote about childhood insanity, but as a diagnosis, not at all; there is no evidence of any increase in child admissions towards the end of the nineteenth century; and, in general, the frequent usage of terms like 'most common', 'often' creates the impression of abundance of children in psychiatric care is deeply misleading and can lead a researcher astray.[10]

The eagerness to demonstrate the existence of child psychiatry in the nineteenth century would seem to mirror the conviction that there were insane children in the nineteenth century that we can see in the writings of some of the psychiatrists of the period. '[N]o age is exempt from attacks of Insanity' assure the readers Bucknill and Tuke. We also see this in Crichton Browne's essay and in Maudsley's writings. It is interesting to note that this conviction emerges only in the second half of the century. This could well have had something to do with the theory of degeneration, which was introduced in 1857 by Morel. This swept like quick fire throughout Europe. The theory stated that all afflictions such as alcoholism, prostitution, all sorts of deviancy as well as mental illness run through degenerate

[10] Such a presentation can be very misleading indeed. Some time ago, at Goldsmiths, a mature student prepared a proposal for a PhD thesis entitled 'Children and Insanity in the Nineteenth Century'. The proposal was based on secondary material and the application for funding was successful. Sadly, soon after, the student went down with cancer and passed away. This author was involved in helping put the project together and afterwards decided to pick up the research. It took well over a year to realise that funding was given for a proposal that was effectively a wild goose chase.

families. Soon, some psychiatrists held that children were just as prone to madness as adults; and, although the mad child remained an elusive being, entire chapters and the first monographs on child insanity began to appear. Psychiatrists have often been guilty of writing fiction, which is reason why historians should sift through the material with a critical eye.

But one does not want to end on a too negative note. There are a number of accounts that comprehensively enumerate nineteenth century developments that are of great help to any researcher on the subject and, which, unlike von Gontard's article, do not make statements that turn out to be inaccurate and misleading. If this account has taken a different approach, it is because as the research evolved, its focus changed. At the outset, the intention was to deepen our understanding of the developments in the 19th century. Since first reports on child insanity go so far back, finding a way of fleshing out the *de facto* existing child psychiatry in that period seemed to be desirable; even more so when one notes that in general histories of psychiatry or paediatrics the question of children and mental illness is never aired; a wider study of marginal children and their relation to psychiatry seemed necessary. But in time, it became clear that the existing historians' accounts give a rich and detailed enough picture and that any further research would only make the absence of mad children more striking and make it clearer that 20th century child psychiatry did not evolve out of the earlier practices. Consequently, focus of this work changed and ended up being governed by the question that is posed at the beginning of this article: Why is it that despite the fact that first reports of mad children go back to the beginning of the 19th century, child psychiatry only emerged about a century and a half later? It seemed that an approach that alerts to the differences between the two centuries, to the shifts in perceptions and changes in attitude towards children as well as changes in psychiatric practice that took place might go some way towards explaining the almost 150 year 'delay'. Whether this explanation is satisfactory it remains for the reader to decide.

Acknowledgements

Work for this article was carried out with the aid of a Research Grant from the Wellcome Trust.

I would like to thank Colin Gale, Archivist at Bethlem Royal Hospital Archives and Museum, in Beckenham, Kent. Apart from practical help in locating the patients' records, he was usually present during my research and we discussed my findings as I went along; this was very helpful. He also read the first draft of this paper and made some valuable comments.

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