Pain, Childhood, and the Emotions: A Cultural History
c. 1870-1950

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A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the Degree of Doctor of Philosophy

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DECLARATION

I certify that the work contained in this thesis, or any part of it, has not been accepted in substance for any previous degree awarded to me, and is not concurrently being submitted for any degree other than that of Doctor of Philosophy being studied at the University of Greenwich. I also declare that this work is the result of my own investigations, except where otherwise identified by references and that the contents are not the outcome of any form of research misconduct.

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Date: 01/08/2017
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This thesis is a study of pain in childhood in British medical and scientific discourse between 1870 and 1950. It explores the physical, emotional, and performative dimensions of pain from a cultural perspective, analysing written documents and visual material and comparing the perspectives of disciplines including physiology, paediatrics, psychiatry, psychology, and psychoanalysis. Successive chapters focus on: Depictions of pain by medical authors before the period covered in depth by the thesis; how different types of medical professional interpreted children’s pain between 1870 and 1900, focusing on Great Ormond Street Hospital’s photographs of sick children; the development of “infant pain denial” from 1890 to 1950 in the Child Study movement, behavioural psychology, and paediatrics; concepts and treatment of child insanity and mental suffering in the second half of the nineteenth century; the rivalry between the competing theoretic frameworks of the clinical tradition (which claimed a somatic basis for mental illness) and psychotherapy; debates about evacuation of the children during the Second World War, exploring the contrasting figures of the victim of air raids and the victim of parental separation, showing the role played by psychoanalysis in understanding psychological trauma, with a focus on the work of psychoanalysts Anna Freud, Melanie Klein, and Donald Winnicott. The key findings of the thesis are: rivalry between different scientific disciplines meant that medical and scientific models of childhood pain and therapeutic treatments involved complex relationships between different professions and institutions; despite medicalisation, identifying and categorising children with pain often depended on non-medical factors, which usually reflected social norms; the figure of the child in pain accumulates power and value through its multiple figurations in distinct disciplines and contexts; a multidisciplinary approach is needed to be able to understand the cultural power of this figure.
CONTENTS

Figures 8

Introduction 11

Introduction 11

Literature Review 27

Sources and Methodology 40

Structure of the study 51

1. From Soft Wax to Scientific Objects: Medical Perceptions of Children’s Pain from Ancient Times to the Development of Anaesthesia 53

A controversial subject 56

A brief history of pain, from ancient times to the mid-nineteenth century 57

Nineteenth-century theories of pain 62

The history of pain in childhood 68

Surgery and Anaesthesia 76

Conclusion 82

2. The Language of Children’s Pain (1870-1900) 85

On Darwin, or emotional expressions as reflex actions 89

German contributions to child research: Experimental tests of infant pain sensitivity 97

The sick child in paediatrics 105

The diagnostic power of crying 109
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The visual limits of pain</td>
<td>113</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>131</td>
</tr>
<tr>
<td>3.</td>
<td>Infant Pain Denial (1890-1950)</td>
<td>134</td>
</tr>
<tr>
<td></td>
<td>Pleasure and pain in the Child Study movement</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>The influence of behaviourism</td>
<td>148</td>
</tr>
<tr>
<td></td>
<td>The ‘scientisation’ of paediatrics</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td>Infant pain denial and the use of anaesthesia</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>160</td>
</tr>
<tr>
<td>4.</td>
<td>Insane children: The articulation of mental diseases and pain (1860-1900)</td>
<td>163</td>
</tr>
<tr>
<td></td>
<td>The mind of the child</td>
<td>169</td>
</tr>
<tr>
<td></td>
<td>Night terrors, pain and hallucinations</td>
<td>174</td>
</tr>
<tr>
<td></td>
<td>Melancholia, mental pain and suicidal children</td>
<td>182</td>
</tr>
<tr>
<td></td>
<td>Pain, hysterical children, and their treatment</td>
<td>190</td>
</tr>
<tr>
<td></td>
<td>The harmful child, or moral disease as cause of external pain</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>Conclusion</td>
<td>205</td>
</tr>
<tr>
<td>5.</td>
<td>From nervous conditions to nervous disorders: Children and somatic pain in British medical discourse, (1900-1939)</td>
<td>208</td>
</tr>
<tr>
<td></td>
<td>Nervous pain</td>
<td>215</td>
</tr>
<tr>
<td></td>
<td>Paediatrics and functional neuroses of childhood</td>
<td>222</td>
</tr>
<tr>
<td></td>
<td>The signs of nervous pain</td>
<td>230</td>
</tr>
<tr>
<td></td>
<td>Unconscious pain</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>The nervous child</td>
<td>238</td>
</tr>
</tbody>
</table>
6. Traumatic pain: air raids and separation (1938-1945)

Pain as propaganda
Psychoanalytic discourse versus government propaganda
Evacuation and the moral economy of children's signs
‘A Cruel Psychological Experiment’: scientific literature on evacuation
Alternative views – “war strain” and “air-raid shock”
Evaluating symptoms
The scientific method during wartime: a “natural experiment”
Conclusion

Conclusion

Bibliography
FIGURES


2.3 Photographer unknown, *Outpatients* (c. 1870), B-INT 01989, Great Ormond Street Archives.

2.4 Photographer Unknown, *Dresden Ward* (c.1870), B-INT 00478D, Great Ormond Street Archives.

2.5 Langley & Sons, *Dresden Ward* (c.1879), B-INT 00237, Great Ormond Street Archives.

2.6 *Dresden Postcard* (c.1900), B-INT 00478D, Great Ormond Street Archives.

2.7 Robert Faulkner & Co, *Nellie Wallace* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.

2.8 Robert Faulkner & Co, *Nellie Wallace* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.

2.9 Robert Faulkner & Co, *Sidney Jones* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.

2.10 Robert Faulkner & Co, *Annie Eastland* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.


6.3 Cecil Beaton, *Children in hospital series* (c.1940), negative, GOS_01 jpg
Cecil Beaton 2, Great Ormond Street Archives.

6.4 Photographer unknown, *Evacuated children from London dance happily on the lawn at the country mansion of a well known peer. The house was given over entirely to the children* (c.1940), HU 69020, Ministry of Information Second World War Press Agency Print, Imperial War Museum.
NOTES ON REFERENCING


- In books and chapters and articles in books the first word in titles has been capitalised and then all nouns, strong or main verbs, adjectives, and adverbs, leaving as lower-case any conjunctions, prepositions, and articles not starting the title. In articles in periodicals, scientific and non-scientific, titles of articles have been printed with capital initials for proper nouns only.
- In scientific works, titles of articles are printed with quotation marks.
- In the bibliography, unattributed books and articles are listed under the title Anon.
- Thesis: the degree is always placed within the parenthesis under the dome unpublished PhD thesis.
“We all must die. But that I can save him from days of torture, that is what I feel as my great and ever new privilege. Pain is a more terrible lord of mankind than even death himself.”

In this vivid way, Albert Schweitzer – humanitarian, doctor and Nobel Peace Prize winner – described both the nature of pain and the need for physicians and other health professionals to relieve it. Today, as when Schweitzer wrote these words in 1931, appropriate pain treatment remains a fundamental issue for the scientific community and for society as a whole. Its importance stems from the fact that chronic pain affects 20 per cent of the global population, according to the World Health Organization, which says that one third of these are less able to maintain a self-sufficient lifestyle because of their pain and many not receiving adequate relief. Medical technology to treat pain has developed from anaesthetics to analgesics, the latter known colloquially as “painkillers”, suggesting that the contemporary attitude is that pain is something that must be killed (whereas previous generations, for whom such relief was not available, saw pain more as something to be endured). The central role that pain plays in our postmodern society is reflected in the recent proliferation of narratives about medical and physiological theories related to suffering and to the remedies used to combat it. Many of these contributions join increasing efforts to analyse the development of punitive practices and the use of pain within the fields of

1 Albert Schweitzer, On the Edge of the Primeval Forest (Macmillan, New York, 1931), 62.
education and certain branches of medicine, such as surgery and obstetrics. Attention has increasingly been paid to representations of violence, including those of military operations, religious war and modern terrorism. More and more, pain invades the bookshelves, the television documentaries, and the exhibition halls, as if it were a register of the endless consumption of cruelty or of our postmodern world’s burgeoning industry of recovered memory. Pain, therefore, does not just have a body – it also has a history.

**What is pain?**

But what is pain? That it is an experience cannot be disputed. In fact, pain can be described as being constitutive of one of the most universal cultural phenomena. Nonetheless, despite this universality, theories about pain and about the modes through which it is perceived have changed across the

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centuries. Today, the International Association for the Study of Pain (IASP) defines pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”\textsuperscript{10} The IASP definition allows a cultural re-evaluation of something that is supposed to be biologically universal. In this model, pain occurs through the interaction of the body, psyche and culture. In contrast with part of the history visited by this study, IASP has also validated patient histories of pain as factual evidence for clinical practice. Once the study of pain accepts the presence of cultural and evaluative elements, then this is followed by recognition of the subjective experience as a cultural act that can, in turn, be studied. Nonetheless, clarifying exactly where the “culturality” of pain resides is still a work in progress, and there is a need for research into the ways that the same experience is modified by cultural norms and patterns, and the ways that the experience and expression of pain are learnt. If pain is, in part, a cultural experience, then we need to explore its historical variations, examine how socially mediated tools allow experience to be expressed and modulated, and ask how it can best be studied.

By acknowledging that pain is at the same time both sensory and emotional, the IASP definition recognises two different dimensions: the biological and the psychological. If pain were only an automatic action it could be considered a merely mechanical reaction of the nervous system, the study of which would be the exclusive domain of biomedical science. But, as this thesis shows, the dimensions of pain are nonlinear. Back at the start of the twentieth century, the British neurologist Charles Scott Sherrington (1857-1952) had already understood that pain involved more than a reflex action and argued that physical suffering resulted from a psychological experience tied to the body’s automatic activity. Sherrington, who won the Nobel prize for medicine in 1932, highlighted that many patients who had severe morphological lesions but uttered no complaint existed side by side with many who complained of pain without any apparent lesion.\textsuperscript{11} This “puzzle of pain” was highlighted in the 1960s by the neuroscientist Patrick Wall (1925-2001) and the psychologist Ronald Melzack

\textsuperscript{9} See Rey, *History of Pain*, for a historical review of concepts of pain.
\textsuperscript{10} International Association for the Study of Pain, ‘Pain terms: a list with definitions and notes on usage recommended by the IASP Subcommittee on Taxonomy’, *Pain*, 6, 3 (1979) 249-252.
(1929-) who developed the “gate control theory” of pain, which holds that non-painful input closes the “gates” to painful input, which has the effect of preventing pain sensations from travelling to the central nervous system. Melzack later argued that pain is subjective and multidimensional because several parts of the brain contribute to it at the same time.\(^\text{12}\) The fact that people can suffer pain without any lesion leads to considering the role that other factors — psychological or cultural — might play in the perception and treatment of pain. Thus, the history of pain has two lines of investigation: as an aspect of the history of science, it explores theories and clinical practices that study and treat pain; but as a piece of the history of ideas, it also examines the cultural forms that have influenced the recognition and tackling of this form of human suffering.

The cultural history of pain needs to avoid two big pitfalls. First, the potentially destructive lens of cultural perspectivism, which may collapse manifestations of pain into historical peculiarities, instead of treating those manifestations as the results of cultural and institutional actions. If pain is culturally-bound, one may object, then why continue to believe that there is a single experience and why not recognise that there are as many experiences as there are cultures or, ultimately, subjects of experience? The second risk is writing a teleological account of pain in the context of the process of civilisation or linear scientific progress, so that the modern conceptualisation and management of chronic pain is somehow seen as the inevitable and only possible conclusion of human progress. Any serious history of pain should therefore examine very carefully all the different rhetorical devices that have defined and shaped the experience of pain, and thus seek to provide a critical illumination of contemporary constructions of pain and the undisputed assumptions about how to treat it. This thesis studies the forms of objectification of painful experience and the rhetorical modalities that have allowed the cultural understanding of childhood pain across the ages, with a focus on British medical discourse from the advent of Darwinism until the dawn of the welfare state. Hence, the study covers the period from the 1870s – when Darwin published his ‘A biographical sketch of an

infant’ in 1877 and opened the door to the scientific study of childhood,\(^\text{13}\) to the end of the Second World War, at which point there was an important shift in conceiving the environments of children’s pain: the institution, the home, the street.\(^\text{14}\)

**The recognition of pain as an emotion**

One of the justifications for the focus of this thesis on the perceptions and practices of physicians and scientists regarding pain is that there are few surviving narratives of children’s personal experiences of pain. The detailed examination of the ways in which leading British and North American physicians understood pain does not imply any wish to downplay (or even invalidate) the experiences of pain suffered by the patients themselves. Rather, it is that arriving at an understanding of how medical professionals viewed their little patients’ pain is a valid and worthy subject in its own right, all the more so because their understanding of pain played an important role in influencing their treatments and in making decisions about their patients, including whether any intervention was necessary. Pain is often seen as something that is both invisible and inarticulate, as a very personal sensation which is difficult to communicate. Elaine Scarry, for instance, has famously described the “unsharability” of pain in terms of its resistance to language.\(^\text{15}\) However, while the verbal arena may present many problems as a vehicle for communicating the experience of pain, perhaps the visual field might offer a better form of expression – particularly when one considers that pain has been a consistent motif in Western art and visual culture. This thesis argues that photographic history provides a particularly interesting framework through which to approach experiences of pain.\(^\text{16}\)


\(^{14}\) In regards to this shift see Mathew Thomson, *Lost Freedom: The Landscape of the Child and the British Post-War Settlement* (Oxford University Press, Oxford, 2013) particularly Chapter 3.


debates on this issue have discussed whether pain is socially and culturally shaped – and therefore a communicable experience – or whether, on the contrary, it is irretrievably “unsharable”. If the “act of translating pain into images converts isolated misery into tangible suffering”, the analysis of photographic practices provides access not only to circumscribed expressions of pain but also to the question of how this experience is constructed and felt in interpersonal interactions.

Independently of whether pain is framed as an emotion or as an experience, its understanding as a psychological phenomenon worthy of study beyond the realm of the life sciences is framed in the salience of the literature on emotions and their importance for understanding historical processes. Since the days when Lucien Febvre’s extensively referenced article on the emotional life of the past was written, it has become even more urgent to connect past and present on a dimension that includes the psychological nature of emotions. As Nietzsche wrote, the advantages and uses of history for current life are even more revealing in the history of emotional experience. In opposition to the “impersonal history”, the history of abstract ideas or cold institutions, Febvre defended a new form of historical narrative that would not transform our universe in a horrid heap of corpses. While some pages of his article examined sources and methodological difficulties, the most fascinating piece of the paper appeared just at the end of it: in a remarkable last paragraph, the French historian advocated a new approach to the subject of history that would derive from a psychological standpoint: history understood as a link between the old new, as “our own history, a perpetual sentimental history of resurgences and resurrections.” His defence of an investigation of sensitivity in history called into question not only factual idolatry, but also the notion of the past as being too far


17 Moscoso, Pain, 1-9.
18 Scarry, The Body in Pain, 3-27.
removed from the present. The new “sentimental history” would explain the resilience of primitive emotional forces threatening culture. When Febvre urged a massive programme of research into the fundamental feelings of humanity, there was a clear political inspiration behind his demand, arising from his belief that emotions themselves are political.  

Of course, Febvre, was not alone in his claim, which loosely followed the sense of Adorno and Horkheimer’s Dialectik der Aufklärung, Norbert Elias’ civilisation process or Weber’s Entzauberung: under the explicitly known history of Europe there was another, hidden, stream: the history of the human instincts and passions repressed and disfigured by civilisation.  

In his enlightening Theses on the Philosophy of History, Walter Benjamin had argued that the exercise of memory, or “rememoration”, consisted in saving what had failed, rescuing the memory of the nameless, listening to the voice of the defeated.  

This connection between the history of emotions and the political dimension of history has also been underlined, in a very different perspective, by many contemporary authors. The historian Ruth Leys, for example, argues that the “affective turn” took place because of a desire to challenge the way that the discourse of reason dominated fields such as politics, ethics, and aesthetics. Ley points to the philosopher Brian Massumi, who claimed that affects need to be seen as both independent of and prior to intentions and meanings.  

According to Massumi, affects are autonomic processes which take place below the threshold of our conscious awareness. Thus, the history of the emotions involves revealing the “inhuman” and “presubjective” unconscious forces that at are the very heart of our intentions and behaviour.  

New theoretical frameworks which set the history of emotions against political demands have recently emerged. The ethnohistorian Monique Sheer, for instance, considered that emotions are “a kind of practice”, while historian

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23 Theodor. W. Adorno and Max Horkheimer, Dialectic of Enlightenment (Verso Books, United Kingdom, 1997).


26 Leys, ‘The turn to affect’, 437.

27 Monique Sheer, ‘Are emotions a kind of practice (and is that what makes them to have a history)? A Bourdieuan approach to understanding emotion’, History and Theory, 51 (May 2012) 209-217.
Joanna Bourke has described pain as “a type of event”.\(^\text{28}\) Here, the performative vision of emotions impacts how we conceive subjectivity and history\(^\text{29}\) and suggests that to treat emotions as entirely natural and independent from the self would appear to imply to “depoliticize emotions by naturalizing them and endowing them with fundamental autonomy, thus denying their social and historical contingency.”\(^\text{30}\)

Just as pain is a concept that does not have a single universal meaning, childhood has been seen differently across cultures and times. The age at which “children” are deemed to become “adults” varies, and across the world today much variation can still be seen, both in legal terms and in practical ways (street children in Asia or Latin America may act with an independence that would be considered adult from a European perspective). In the period covered in this thesis, childhood was valued in terms of personal maturation, initially in a physical sense dominated by 'biological benchmarks', but increasingly with regards to psychological transformation into adulthood.\(^\text{31}\) For the purposes of this thesis, childhood covers the period from birth to puberty or adolescence. The guiding principle here is drawn from the medical treatises which make a distinction between childhood and puberty based on sexual development, which gives rise to a series of illnesses that are not suffered by children. However, this frontier is culturally bound and fuzzy, as the sexual element in puberty can be stimulated or deflected vis-à-vis the cultural conditions of a particular moment.\(^\text{32}\)

More generally, childhood is far from being a factual concept, as the extensive variations and partial overlaps between English words for non-adults show (“child”, “kid”, “infant”, “baby”, and so on).

Several recent historical studies of children have highlighted the fact that the adult population had a vested interested in the development of 'normal' healthy


\(^{29}\) Dolores Martín Moruno has recently published an excellent article on pain as a kind of practice: Dolores Martín Moruno, ‘Pain as practice in Paolo Mantegazza’s science of emotions’, *Osiris*, 31, 1 (2016) 137-168.

\(^{30}\) Sheer, ‘Are emotions a kind of practice?’, 208.


children for the continuation of national economic and political status, focusing on the significance of children as future citizens of the British Empire. Analysis of the motivating factors shaping approaches to pain in childhood supports this argument to a degree. It was often a reason publicly presented by different individuals and groups as their source of concern, particularly in the earlier decades of the twentieth century, when issues of eugenics and social hygiene were still prominent. Hendrick suggests that one defining characteristic of the category of child is that they have no political significance. Whilst it is true that individual children did not have the power to vote, this study aims to show that children were of immense political significance. In seeking to analyse historical variations in notions of childhood, Anna Davin has argued that the attainment of adult status and adult authority is confirmed through control and/or support of children. In addition, adults have had the power to set the terms of childhood according to their priorities in the present and for the future. The study confirms this view by showing that in many cases, the agents placing emphasis on the health of children in relation to the future of the nation were often working to altogether different agendas, with alternative motivations, using the issue of child health and welfare for political or professional advancement.


35 Hendrick, Children, Childhood and English Society, 3.

36 Davin, 'What is a child?', 19.
Of children as subjects

The fact that the exhibition *Pain: Passion, Compassion, Sensibility*, held at the Wellcome Trust in London in 2004, attracted 200,000 visitors suggests how important pain has become to our society. The ever-proliferating historical analyses of medical and physiological constructions related either to suffering or to the remedies that prevent and treat it, together with insights into the development of punitive practices, confirm that pain has become an important topic within the historiography of experience and the emotions. However, despite the abundant and still growing body of literature on the human relationship with pain, very little has been written about the historical experience of pain in children, possibly as a result of the methodological hardships that a history of a subjective phenomenon must tackle.\(^{37}\) When the subject is not only studied as a *locus* of pain but also as a *child in pain*, this negative consideration of subjectivity is doubled: very few scholars of science have attempted to approach children subjectivity with an authentic will to recognise its irreducible autonomy. A notable exception which must be mentioned is the work of Matthew Daniel Eddy, who has framed the voice of the child in archival studies of infant writing.\(^{38}\)

Under similar coordinates, the ostensible referent of pain might seem doomed to invisibility – children are deemed incapable of properly articulating the nature and characteristics of their suffering. By exploring the attribution of meaning to children’s pain from a historical perspective, this thesis contributes to historiographical debates about the experience of harm. Situated halfway between cultural history and the history of science, this thesis asserts that the persuasive forms used to relate to others experiences of harm are especially important in cases of individuals who either lack the ability to speak (such as animals) or who lack verbal dexterity (such as children). Although much effort

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has been devoted to the study of animal pain, very little has yet been written about the historical forms of suffering in childhood.\textsuperscript{39}

To cover this difficult topic, the study attempts to explore the physical, emotional, and performative dimensions of pain from a cultural perspective – that is, it seeks to explore the relationship between the experience of pain in childhood and the social perception of that experience. This approach enables the understanding of how and why the physical and emotional discomfort of a child became understood and accepted historically and also how it led to clinical treatment and, in some cases, financial support. Through an analysis of written narratives and visual culture, this thesis emphasises the “performative nature of pain” as it was performed in different contexts such as the hospital, the war nursery and the asylum. The drama of pain twists and turns behind and around the child in pain – usually a secondary subject of inquiry – and the sympathetic, impassive, or oblivious onlookers, as each of them inculcated pain with different meanings, values, and emotions, thereby reflecting pain as a by-product of a heterogeneous principal activity. For instance, in the children’s nurseries of the Second World War, the child in pain became a symbol of national resistance and courage in the face of the Blitz. If, as David Morris argues, pain is subjected to historical changes, this thesis addresses the nature of these shifts and how are they configured.\textsuperscript{40} In this context, this project addresses the following questions: How did ideas of pain in childhood change over the eight decades examined and how do these shifts represent the cultures, scientific disciplines, and emotional worlds of those times? What were the cultural elements that configured the expression of children’s pain? And what were the cultural conditions that made those experiences possible in the first place?

Seeking to supplement the most frequent methods adopted by the history of science to shed light on hidden subjectivities, the present study draws on theoretical resources from interdisciplinary work. The objective is to bring childhood into the heart of discussions concerning the construction of historically situated cultural assumptions about human nature, medicine, and the nature of


\textsuperscript{40} See David Morris, \textit{The Culture of Pain}, 1-9.
suffering. To address the question of the child accordingly, I juxtapose scientific figurations of the child against distinct figurations in other cultural domains. A key argument of this thesis is that the child accrues power and value across the multiple figurations created by different disciplines, and that only by addressing this multiplicity can its cultural complexity be adequately addressed. By adopting the structure of a comparative study between different disciplines – physiology, paediatrics, psychiatry, psychology and psychoanalysis – this thesis studies the various ways in which the child in pain came into being as a figure, and also the many forms (bodies and worlds) that this figure then generates. This selective juxtaposition emphasises the power of scientific discourses in the everyday understanding and treatment of children while insisting on the cultural specificity of those scientific claims.

This thesis examines the politics of diagnosis, by virtue of which the institution of medicine ascribed meaning or value to different states of pain and suffering, which in turn make it possible to unveil or reconstruct the sense-making experiences of patients. In other, more explicitly Foucauldian, terms: while the examination of authoritative medical discourses allows the framing of specific biopolitics affecting children in situations of harm, the disciplinary archaeology operated within the margins of an interdisciplinary, historical examination constitutes a taxonomy of bodies of knowledge that lends a critical stance towards those institutionalised practices and at the same time, opens a window that empowers the contemporary subject to deconstruct the often invisible discourses on the nature of pain, suffering, and healing. The central argument is that each discipline constructs its own figurations of childhood on the base of the same symptoms or expressive signs: the child without pain, the sick child, the insane child, the nervous child, and the uprooted child. This thesis asserts that these different figurations, in turn, played a unique and constitutive role in the (adult) construction of worlds, particularly the worlds of nature and culture.⁴¹ In a

⁴¹ See Claudia Castañeda, *Figurations: Child, Bodies, Worlds* (Duke University Press, Durham NC, 2002). My own conceptualisation and use of figuration draws heavily on the work of Claudia Castañeda. For Castañeda, *figuration* entails “simultaneously semiotic and material practices” […] “To use the figuration as a descriptive tool is to unpack the domains of practice and significance that are built into each figure. A figure, from this point of view, is the simultaneously material and semiotic effect of specific practices. Understood as figures, furthermore, particular categories of existence can also be considered in terms of their uses - what they “body forth” in turn. Figuration is thus understood here to incorporate a double force: constitutive effect and generative circulation.” Castañeda’s conceptualisation draws on Donna Haraway, for whom figuration entails “universes of knowledge, practice and power” and describes the effects of “all
simplified manner, the task in each chapter follows two lines: first, the
constellation of practices, materialities, and knowledge through which a specific
figuration occurs and is consolidated in the context of disciplines and epistemic
communities is described. Second, the significance of that figuration for the
making of wider cultural claims, both within and beyond the disciplinary realms,
is unveiled.

In a thesis that covers different disciplines over nearly a century it is not
possible to adopt a uniform approach to sources or their modulations. The
subject of this thesis – pain in childhood – is addressed by a loose community of
“scientists” that includes evolutionary theorists, physiologists, medical doctors,
public-health officials, political gurus, eugenicists, psychiatrists, and
psychoanalysts. What unites the disparate band is an interest in the scientific
study of childhood. This thesis argues that the diversification of knowledge about
the human body and its treatment that took place during the nineteenth century
and was consolidated in the twentieth century turned pain into an unstable object
that was invested with different properties and meanings in each discipline: as
the sign of illness, as a symptom of an organic lesion, as a necessary element in
the process of learning, as an aid to illustrate the myth of the subjective in
philosophy of mind and, even, as a condition of economic development. In all
cases, the study and understanding of pain follows a sequence: examining the
subject as a sign, taking it as evidence, and finally considering it as a fluctuating
object of a new science. A similar process can be observed in the intellectual
understanding of pain, whether in science, medicine, philosophy, the social
sciences, or religion. While to the general scientist pain might be a series of
complex neural circuits, a medical professional might see the patient’s
experience of pain as more than an electrical sensation, while the historian or
social scientist might focus, for example, on how humankind’s views of pain have
changed from something that might be good for us (whether to build character, to
encourage a change of behaviour, or build up our defences to cope with stronger
pain) and whether today the lack of a “meaning” in pain has reduced our ability to
cope with it. In this context, I suggest that the figure of the child in pain appears

material-semiotic practices”. For an extended discussion of figures and figuration in relation to the
material-semiotic, see Donna Haraway, ‘Modest witness’, British Journal for the History of Science, 10, 2
in medical, scientific, and popular discourses both in its own right and as a bodily theatre through which other stories are told. In so doing, I also suggest that the study of the child is important not only with respect to children and their experience of the world, but also in a more general way to the making of worlds. Asking how and why the figure of the child has been utilised and categorised for wider cultural endeavours makes the child the focus of analysis about how it has been used and valued in adult discourses.

Since the early 1990s, the historiography of childhood has burgeoned. Historians have studied – and continue to study – the gradual evolution of the concept of childhood, tracing the social, cultural, economic, and political context of the “birth of the modern child.”42 These efforts have highlighted the absence of adequate representations and understanding of children’s experience in the historic forms of medical and scientific disciplines. The effect these varied conceptualisations of childhood had on the actual life experiences of children has been the focus of attention of recent work in the history of childhood. An outstanding example of this approach is Childhood, Youth and Emotions in Modern History: National, Colonial and Global Perspectives, edited by Stephanie Olsen.43 Nonetheless, the question of the child has rarely been considered in wider theoretical debates and theorists have paid limited attention to the function and roles that the figurations of childhood have displayed in the making of adult worlds, including consequences which work against the best interests of those whom the category purportedly represents.44 As Claudia Castañeda has pointed

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out, this lack of attention to childhood is significant because it means that children are not placed at the centre of social, political, and cultural concerns.\textsuperscript{45} I align myself with this approach and attempt to reveal the processes grounded in scientific figurations and artistic representations that have shaped the cultural understanding of children’s experience of pain.

While the category “child” entails actual children and their experience of the world, this thesis is not about that relationship – at least not directly. I do not seek to offer an account of how these assumptions affect real children, although I am convinced that they do. This thesis is, rather, about the creation of different figures of the child in pain, and their prolific and multiple uses across disparate cultural sites. This thesis argues that the study of the different categories of children’s pain provides an important context for understanding the emergence of other discourses on childhood in the nineteenth and twentieth centuries. It also offers an opportunity to explore the boundaries of psychiatry, physiology, paediatrics, psychology, and psychoanalysis during this period. The scientific texts used in this thesis lead us to an important issue in the history of science, which is also a methodological problem close to the difficulty of practising interdisciplinary studies: the lack of scientific unity.\textsuperscript{46} A radical epistemology would see the object of study of each discipline as a disconnected entity: the infant brain of neurology, the infant body of paediatrics, and the infant mind of psychology would find no common ground and no common language.

Rather than insisting on the historical disagreements between the disciplines, this thesis seeks to advance the understanding of the contemporary construction of the relationship between the mind and the body by uncovering the different meanings of children’s pain in a collection of traditions of scientific discourse. It may be surprising to modern readers – who might assume a clear distinction between organic and psychological processes – that there was a considerable overlap between body and mind in much medical thinking in the nineteenth and early twentieth centuries. Indeed, it is difficult to make a clean separation between the late-nineteenth-century specialism of neurology, the earlier discipline of “physiological psychology”, practical and legal attention to

\textsuperscript{45} Castañeda, \textit{Figurations}, 4.

\textsuperscript{46} For a discussion on whether science science is unified or disunified see Mario Biagoli and Peter Galison, \textit{The Disunity of Science: Boundaries, Contexts, and Power} (Stanford University Press, Stanford, 1996).
behaviour, and the explicit interest in mental processes. Thus, this study seeks to illustrate how the variety and complexity of concepts about children’s pain clearly transcended the simple dualistic perspective that treats mind and body as separate entities.

My interest in the child emerges to a certain extent from my engagement with three separate academic fields: the history of childhood, the history of medicine, and the study of science. In these already interdisciplinary fields, scholars theorise about the relationship between power, materiality, and inequality as a key feature of the making of cultural worlds. Taken together, they provide indispensable tools for critical thought that can confront the factual cultural domination of existing hierarchies. Indeed, this thesis would not be possible without the already massive body of work of theorists who have articulated how the institutions, facts, technologies, and meanings that make up our bodies and worlds simultaneously exert power and exist in a situation of fluid contingency.

The approaches of several writers have proved particularly useful in informing my approach. In the first instance is Foucault’s work on power and knowledge, in particular *Discipline and Punish*, and his work on the birth of the clinic.⁴⁷ Although Foucault’s ideas have certainly proved valuable to the history of psychiatry and medicine, the rigid application of his approach by later writers has led to a historiography that is skewed towards power/knowledge relationships and away from practice.⁴⁸ More relevant has been the work of other authors who, though taking their lead from Foucault, have worked in this particular direction. Ian Hacking’s reflections on the philosophical uses of history, especially the insightful model offered in *Historical Ontology* (2002), has aided my efforts to understand the historicity of core epistemological referents such as “objectivity”, “demonstration”, and “explanation”.⁴⁹

By examining medical perceptions of children, this thesis draws attention to the more general notion of age. The patient’s constitution, vulnerability to disease, and treatment, were intimately linked to age. Historians of pain have

often overlooked age as a category, concentrating instead on gender as the organising principle of modern medicine. Martin Pernick has shown how, following the great “Chain of Feeling”, certain social groups – identified by race, class, gender, and religion – were considered to be relatively insensitive to pain. Many scholars have since engaged with this idea, debating the politics of gender in relation to pain. This thesis argues that gender, though evidently crucial in medical perceptions of adults, was far less significant in the understanding of the bodies and minds of children. This argument cuts against the current historical picture regarding children’s gendered identities, which suggests that gender was of considerable importance “across the life-cycle,” from the “moment of birth” and in particular after the age of about seven.

Literature Review

Over the last fifty years, our ways of relating to the past have undergone some important changes. In 1929 Marc Bloch and Lucien Febvre founded the French historical magazine *Annales*. With the intention of overthrowing a model of historical narration configured around political developments and the ideologies of the ruling classes, this French historiographic revolution proposed a new model, one that allowed the writing of a full “history” that considers the material transformations of the conditions of life and which considered history “from

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50 Many scholars have since engaged with this idea, debating the politics of gender in relation to pain. For instance Javier Moscoso discussion on the pain of childbirth, see Javier Moscoso, *Pain*, 96-104; See also Wood “‘When I Think of What is Before Me’”, 187-203; Martin Pernick, *A Calculus of Suffering: Pain, Professionalism, and Anesthesia in Nineteenth-Century America* (Columbia University Press, New York, 1985).


If it is true, as Reinhart Koselleck suggests, that historical revolutions always arise from the defeated, we should ask which subjects or experiences of the past were silenced by the historiography of the victors. In the wake of this particular revolution, no one can be surprised that we have started to be aware of the history of admiration and wonder, of collective representation, and of the structures of knowledge. Daily life, material civilisation, punitive practices, and forms of conduct find themselves among the new objects of history in general, as does the history of science. We not only write the history of thought or of theoretical representations of elusive objects, but we have also started to pay attention to the history of the behaviour of these very entities, and to the processes by which they came into being and are transformed.

One of these objects of new history has always been among us. It would be difficult for it to be otherwise when the capacity to react to damaging stimuli is found not only in the earliest stages of evolution, but also among the most primitive of cellular organisms. Pain is one of the most universal cultural phenomena. There is no society which does not include harm or grief as an important element within its system of social integration. Furthermore, this object has been tied to specific social groups, such as patients with untreatable chronic pain. Throughout history, pain has been interpreted variously as a means of salvation, as a sign of sickness, as a symptom of an organic wound, as a necessary element in the process of learning, as a helpful example to illustrate the myth of the subjective in the philosophy of mind, and even as a condition for economic development. In all cases, the study and understanding of pain followed a sequence which examined it first as a sign, then took it as evidence, and finally considered it to be the fluctuating object of a new science.

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Another of the objects of the new history is childhood. Despite the existence of some isolated earlier attempts, one can say that it was only after the work of Darwin that this period of life started to become a scientific object of study in anthropology, sociology, and psychology.\textsuperscript{58} Finally, it also came to be of interest to the historian. It is not surprising therefore that it was precisely the revolution in approaches to history heralded by *Annales* that led to a recovery of the child as an object of historical research and to the production of the first significant work on the history of childhood, Philippe Ariès’ *Centuries of Childhood*, which was published in 1960.\textsuperscript{59} This “new” history, in approaching areas that had not previously been explored and in investigating the way in which different levels of society experienced the events of daily life, took into consideration social groups that until then had been little regarded and converted them into the preferred subjects of investigation. In the specific case of childhood, it can be said that Ariès’s study led to a surge in publications that have made the subject so fashionable today. As with the histories of sexuality, the emotions and the body, the study of childhood has also become a medium used to cast light on present-day situations, most notably about situations of violence and abuse committed against children.\textsuperscript{60}

The subject of the child in pain brings together the previously separate fields of the history of medicine and the history of childhood. As Peter Stearns argued in his “Challenges in the History of Childhood”, those interested in the existential significance of history—that which Nietzsche claimed as history for life\textsuperscript{61}—can’t ignore the importance of the historical study of childhood.\textsuperscript{62} Differently to many historical examinations that have an internal vision of periodization and accuracy, many practising historians of childhood have a retroactive interest: they are concerned with the world in which they live, and feel the urge to explain it through the yet untold “history of childhood”.\textsuperscript{63}

\textsuperscript{62} Peter Stearns, ‘Challenges in the history of childhood’ in *The Journal of the History of Childhood and Youth*, Volume 1, Number 1 (Winter 2008) 35-42.
As concerns about children have increased, stories about children of the past have proliferated. In the light of this – and the fact that few fields of study have grown with such enthusiasm as the history of childhood, which now comprises so many competing areas of expertise that it has been described as a “mass of tangled strands” – it comes as a surprise that child pain has received such scant attention from the historians of childhood.64 Until the 1980s, most studies of the history of childhood focused on the parent-child relationship, concepts of childhood, the disciplining of children, and child abuse.65 Ariës’s ground-breaking work and Lawrence Stone’s Family, Sex, and Marriage (1977) had a big impact on much of this scholarship. While Ariës argued that the “idea” of childhood did not exist until the late seventeenth century, Stone claimed that parents had been cold and aloof towards their children until the emergence of the “compassionate” family towards the end of the early modern period.66 These ideas were initially endorsed by other historians and then rejected, and by the mid-1980s a new consensus had emerged: that parents had always generally loved their children and that concepts of “childhood” had existed before the end of the seventeenth century.67

The history of childhood has expanded considerably since the early 1990s, tackling a wide range of subjects including: infant mortality rates; children as apprentices, child labour, and poverty; the legal aspects of childhood; leisure and toys; crimes against infants and children; children’s clothing; children’s involvement and representation in drama and theatre; education, reading, and books; child sexuality, gender, and identity; and children’s religious status. Significant recent contributions to the history of childhood, some of which have attempted to pull some of these different threads together, include those by Hugh Cunningham, Paula S. Fass, Jane Humphries, and Shirleene Robinson and Simon Sleight. Unlike earlier works on childhood, these studies have tended to highlight the importance of social and cultural constructions of childhood, claiming that the way that childhood and age are perceived is determined, at least in part, by societal attitudes. Perhaps the most notable example of this approach is the abovementioned Childhood, Youth and Emotions in Modern History (2015), edited by Stephanie Olsen, which explores the diverse ways that children’s identities were fashioned in different contexts. This book stands out because, as well as a series of excellent chapters on the subject, it includes a methodology for historians of childhood. Most studies of emotions lack this methodology and this volume seeks to explain how the history of the emotions can be used by historians of childhood as a way to approach the experience of the child. Nonetheless, despite the expansion over the last two decades in the topics covered by historians of childhood, little attention has been paid to the area of child pain and medicine.


Since the 1992 publication of *In The Name of the Child: Health and Welfare 1880-1940*, Roger Cooter’s landmark collection of essays, there have been some advances in the historiography of child health. Themes that have been addressed (sometimes including consideration of the topic of pain) include: children’s hospitals and health, disability and mental deficiency and mental health. An important publication, which has been recognised as the successor to Cooter for its influence, is *Cultures of Child Health in Britain and the Netherlands in the Twentieth Century*, edited by Marijke Gijswijt-Hofstra and

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69 Cooter, *In the Name of the Child*, 1-12.


Hilary Marland and published in 2003.\textsuperscript{73} Exploring advances in the area of the history of children's health that had taken place in the years after Cooter's book was published, this volume highlights the importance of seeing children's health in a wider social and cultural context. The book's final chapter was written by Cooter himself who said that it was a shame that children and still not yet become a major focus of historical research in their own right, rather than when related to general historical agenda or to specific areas such as the history of sports, masculinity or “mental defectives”.\textsuperscript{74}

The recent publication of Hannah Newton's \textit{The Sick Child in Early Modern England, 1580-1720} addressed and developed the issue of the sick child, raised by Cooter in his introduction to the 1992 essay collection, thereby filling one of the gaps that existed until recently in the historiography of child health. My own project also starts out from one of Cooter’s observations and reflects on how, where, and why the “concept of childhood became far more socially homogeneous by virtue of its reconstruction in predominantly psycho-medical terms.”\textsuperscript{75} I take a new perspective on the history of childhood health and welfare by focussing on an issue that has been a neglected but integral part of the life sciences since antiquity: children’s pain, its negotiation in medical and psychological practices, and the underlying philosophical and political debates about the status of children.

Both historians of medicine and historians of pain have largely overlooked the topic of the child in pain. In the last three decades, the topic of pain in Western societies has received increasing attention from historians. The best example of contemporary interest in the knowledge of pain – coming not only from laboratory research and medical practice but also from the humanities – is perhaps the publication of the interdisciplinary book \textit{Pain and its Transformations: The Interface of Biology and Culture}. The volume, comprising papers and editorial responses by a dozen distinguished scholars, focuses on pain (both physical and emotional) and its social transformation. Of all the book’s fifteen chapters, just

\textsuperscript{73} Marijke Gijswijt-Hofstra and Hilary Marland, \textit{Cultures of Child Health in Britain and the Netherlands in the Twentieth Century} (Rodopi, Amsterdam and New York, 2003).
\textsuperscript{75} Cooter, \textit{In the Name of the Child}, 2.
one addresses the problem of pain in childhood.76 This fact highlights how, despite all the recent efforts devoted to the historical study of pain, very little has been written about the historical experience of pain in children. Joanna Bourke argues that the reluctance of historians “to tackle the history of pain” results from its subjective character.77 Such subjectivity is doubled if the object of study is a child in pain.

As Hannah Newton has indicated, historians of childhood and medicine have often assumed that until more recent times doctors did not treat children, and if they did, they failed to administer medicines in appropriate dosages.78 An extensive and still-growing body of literature in the humanities has been produced devoted to the subject of the human relationship with pain, but there has been hardly any serious discussion in the history of science and medicine about the systematic reliance on the bodies of children who suffer illness and pain as a source of knowledge about the normal child. Elissa N. Rodkey and Rebecca Pillai Riddell, who devoted an article to the subject in 2013, concluded that despite the importance of the historical record for studying medical assumptions of children’s experiences of pain, few published works have reviewed this history. 79 The phenomenon of infant-pain denial – which characterised many medical approaches to children during much of the twentieth century – can be seen as, in part, a consequence of the invisibility of the subject and the consequent lack of investigative focus on children’s experience of pain.

The Austrian philosopher Ivan Illich has drawn attention to the central role that culture plays in providing ways to experience, express, and understand pain: “Precisely because culture provides a mode of organizing this experience, it provides an important condition for health care: it allows individuals to deal with their own pain.”80 It is through society’s norms and values that pain is culturally obtained and placed.81 It is not difficult to identify extreme cases where cultural

81 This has been given several expressions from within the world of pain science. See Robert J. Gatchel, Yuan Bo Peng, Madelon L. Peters, Perry N. Fuchs and Dennis C. Turk, ‘The biopsychosocial approach to
norms dictate what are unacceptable and acceptable pains. Certain pains, such as menstrual pain or some forms of psychological pain, are expected to remain silent while others, such as grief and mourning, are required to be displayed in public. As Joanna Bourke has pointed out, even when they are “suffering, people adhere to societal norms, rituals, and stories”. 82 One could thus say that there is no such thing as “pain”: there are only “people in pain”, who are joined to a specific society through their feelings and emotions. Thus, pain is not just a physical experience: it is an embodied experience to which meaning is attached through culturally validated and rhetorical artefacts, including societal classifications and norms, codified identities, and even moral taboos. 83 There is no single and universally accepted meaning of pain. People who suffer pain appeal to all kinds of different value systems in order to frame their suffering with meaning. 84 Similarly, susceptibility to pain has been taken as an indication of civilisation and sensitivity, while pain has also been dismissed as a mere product of neurology. In other words, pain has been read by people in many very different ways as they attempt to make sense of what they feel and to explain these feelings within a coherent worldview.

But tacit and explicit social norms on what is proper, just and decorous are not the only masters of pain and its sense-making. The ways we express pain are very much influenced by the medical theories, theological theories, and theories of the body that are in currency at the time in which we are living. 85 Therefore experiences of pain differ from individual to person and from one social group to another, and change according to geography and time. Contrary to the notion

82 Bourke, Pain and the Politics of Sympathy, 6.
83 Bourke, ‘History of Medicine’, 57.
that the experience of pain is timeless, the meaning of pain arises from cultural and social interactions.

Rather than infecting the phenomenon of painful experiences with the virus of relativism, sociocultural determination opens the door to the work of historians and cultural theorists, who can delve into the specifics of cultural manifestations at a given time. Hannah Newton has argued in *The Sick Child in Early Modern England, 1580-1720* that research on the experiences of illness and pain in childhood can be undertaken by studying their expressive metaphors. In *The Story of Pain*, Joanna Bourke also argues that sufferers from the past have used metaphors as a way of conveying their pain – “A hundred windmills turning round in my head”, a “blank whirlwind of emotion”, “a well of red, flowing anguish” – which gives students of pain some insight into the subjective experiences of historical individuals. In contrast, in *The Body in Pain* (1985) Elaine Scarry asserts that the experience of pain cannot be shared because of its essentially private nature. For Scarry, pain’s subjective nature borders on solipsism: it “does not simply resist language but actively destroys it.” Following a quite radical interpretation of modern theories of knowledge and perception, she argues that physical pain “has no referential content. It is not of or for anything, [and] resists objectification in language.” Despite opposition and criticism, this theory of an insubstantial, noumenal pain has encouraged a new line of scholarship in which the focus has moved away from pain as an entity towards exploring the narratives of “people in pain”. Theorists have had to wrestle with the problem that words often seem inadequate for expressing pain, with Virginia Woolf’s essay ‘On Being Ill’ often cited as evidence: “The merest schoolgirl, when she falls in love, has Shakespeare, Donne, Keats to speak her mind for her; but let a sufferer try to describe a pain in his head to a doctor and language at once runs dry.”

In *The Representation of Bodily Pain in Late Nineteenth-Century English Culture*, Lucy Bending challenges this point of view and argues that “physical pain does not entirely resist linguistic expression” – or at least not to any greater

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86 Newton, *The Sick Child*, 196-197.
90 Quoted in Bending, *Representation of Bodily Pain*, 84.
extent than any other sensation or emotion. In fact, Moscoso’s *Pain: A Cultural History* (2012) reveals that pain experiences and their cultural meaning are based and built upon science, art and legislation processes. Moscoso sees pain as what Victor Turner in *The Anthropology of Performance* calls a “social drama”, a form of human experience that follows the ritual structure of rites of passage. In his view, the cultural historian should analyse the objectified forms of this subjective experience, together with the rhetorical means employed to relate experiences and expressions. Joanna Bourke and the Birkbeck Pain Project shift the focus from “illness” to the “body-in-pain”. While Elaine Scarry argues that pain and language are refractory, the Birkbeck Pain Project is based on the assumption that, either directly or indirectly, embodied suffering becomes entangled in social behaviour, either in observance and adhesion or in reluctance and disagreement to social norms, but always around the complex language of socialization. According to this approach, certain kinds of pain – notably chronic pain – do not fracture language but rather generate a wide range of linguistic manifestations. The Birkbeck project, examining narratives of pain from a historical perspective, argues that it is possible to develop an historical understanding of pain and the different ways in which “people-in-pain” handle it and continue to live meaningful lives. Likewise, in *The Story of Pain*, Joanna Bourke explores how “pain-talk” and the experience of pain has changed over two centuries and among different social groups.

This thesis shares the view endorsed by Bending, Scarry, Moscoso, and Bourke that there are linguistic conventions in both fiction and nonfiction for discussing both subjective pain and the pain of others. One of the main goals of this thesis is to identify how these conventions function in specific historical moments in the discourses of doctors and in public discourses, thus contributing to the construction of the intersubjective level of discourse on pain, where intersubjective does not refer to the horizontal, dialogical negotiation of sense among subjects with exchangeable positions, but rather to the institutionalised and normalised patterns for determining states and subjects of pain, which are then inherited in exchanges among subjects. Since the methodologies offered by

91 Bending, *Representation of Bodily Pain*, 1-5.
93 The Birkbeck Pain Project, [http://www.bbk.ac.uk/history/our-research/birkbeckpainproject](http://www.bbk.ac.uk/history/our-research/birkbeckpainproject).
94 Bourke, *The Story*. 
Moscoso and Bourke have not proved helpful for the study of children’s pain – precisely because they are constituted around metaphors and language – this thesis addresses the more difficult question of what happens in the case of historical subjects, such as children, who either lack verbal dexterity or do not have a recognizable cultural voice. Focusing on how certain adults – the paediatrician, the psychiatrist, and the psychoanalyst – approached the experience of pain of their “little patients”, this study also explores the larger problem of how the historian can approach the past experiences of a person in pain.

Although the history of children’s pain has been hidden to scholars until recently, earlier manifestations of theoretical interest in the history of child medicine cannot be neglected, as they include some reflective insights on the nature of child pain from within specific disciplinary boundaries. From the start of the twentieth century, various paediatricians wrote histories of their specialism, of which the most famous are John Ruhrah’s *Pediatrics of the Past* (1925) and George Still’s *The History of Paediatrics: The Progress of the Study of Diseases of Children* (1931).95 The subtitle of Still’s book indicates the style of these works, which were written to celebrate the rise of modern paediatrics. They thus tend to be teleological in structure, attempting to uncover the past origins of current medical knowledge and to identify the “real condition” behind the diagnosis. In opposition to the condescending view on past practices, this thesis seeks to explore historical medical views on children’s pain in their own terms, examining the coherence and logic of the medical ideas, however irrational they might seem from a modern perspective.96


The child in pain is also mentioned in another context, that of current scientific and psychological articles of research into infant pain. Important articles of this sort include: David Chamberlain’s, who reviews twentieth-century infant-pain research from an anti-circumcision perspective; Patrick McGrath, who considers the history of infant pain research in the 1980s; Emilia Pabis, Anita Unruh, and others who review ancient and medieval views of infant pain; and the already cited Elissa N. Rodkey and Rebecca Pillai Riddell, who investigate the origins of infant pain denial.97 In a similar way, Joanna Bourke’s recent book The Story of Pain examines the history of child pain and calls attention to the way that the understanding of children’s pain has been revised. Bourke argues that for most of the twentieth century “many scientists and clinicians [claim] that infants were almost totally insensible to pain.”98 This thesis will argue, however, that this theoretical perspective describes only partially the medical, physiological, and psychological theories and practices related to children’s pain that existed at the end of the nineteenth century and early twentieth century in the Anglo-American worlds.

Finally, while writing this thesis, I have encountered some surprising reactions from those around me. From these reactions is evident that the topic of the child in pain invites much conjecture. Like David Morris in his book The Culture of Pain, I was repeatedly struck by the consistency with which I was asked, over

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98 Bourke, Story of Pain, 214.
and over: Are you writing about physical pain or mental pain? This uniform reaction convinced me that modern culture rests upon an underlying belief so strong that it grips us with the force of a founding myth, which Morris terms the “Myth of Two Pains.” We live in an era when many people have a fundamental and unexamined belief that physical and mental pain are separate entities and we imagine a huge gulf that separates these two types of pain. However, different sources of pain do not necessarily imply different pains. One of the purposes of this thesis is to support the collapsing of the artificial division of human pain into categories labelled “physical” and “mental”. Guided by the history of emotions and the consideration of a common substratum of affectivity in both forms of suffering, an important attempt in this direction can be found in Rob Boddice’s Pain and Emotion in Modern History.

**Sources and Methodology**

It is important to set out clearly from the start the approach, scope, and justification for the use this thesis makes of its sources, which are described in the corresponding section of this introduction. This thesis is a work of interdisciplinary history and its methodology is drawn largely from the fields of the history of medicine and cultural history. However, these methods have some significant limitations when used to analyse the history of pain because of the very nature of the subject in question. The concept of pain as an evolving, polyvalent interpretation and construction is represented differently throughout communities as social practices and rituals prove so. Consequently, pain as an object has been studied by writers and scholars in many varied ways and contexts, such as theology and religion, politics, social welfare, and rhetoric. Many historical studies of pain have displayed a tendency towards literary and cultural historiography, which is perhaps not surprising as pain so easily lends itself to figurative language. But where there is a real lack of study and scholarship about pain is within the field of historiographies of medicine and health. Why should this be so? Two main reasons can be suggested. First, the

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absence of sources in a range of historical periods drives pain discussions to
contexts of disease, medicine, and treatment; second, the frequent assumption
that pain is a symptom or a result of an unknown disease, pathology, or morbid
state, by which pain is left aside from an individual analysis.101 By examining
pain in childhood, this thesis contributes on the previous efforts that work to
cover these holes, the sources for which are located for the most part in settings
of illness, disease, medicine, and therapeutics. Thus, this study contributes to
the identification of the authoritative sources of pain in the studied disciplines.

The main challenge for compiling, accessing and analysing primary sources
that are relevant to the problem of infant pain in medical discourse between 1870
and 1950 is certainly relevant. In absence of a dedicated discipline of pain, there
is no easy method for identifying which sources touch upon the subject and
which do not. When possible, the examination of digitized sources was
conducted through queries of the word “pain”. This is the case with the online
repository of the UCL Institute of Child Health102, which contains 118 books
published between 1870 and 1950. However, the number of heterogeneous
sources does not allow for a unified consultation methodology and for the
exhaustive analysis of the word pain and its collocations in medical texts—a
method that has yielded impressive results in historical research in many areas
of the humanities103. When printed sources were not digitized, the examination
was based on the identification of chapters or sections about pain and suffering
in indexes, if possible. Otherwise I resorted to the sections on diagnosis, which
tend to cover the issue of the expression of children’s pain and its use as a
diagnostic tool.

101 For the exceptions, see, Julia L. Epstein, ‘Writing the unspeakable: Fanny Burney’s mastectomy and the
of physical absence and narrative presence in Frances Burney’s mastectomy letter (1811)’, Women, A
Cultural Review, 19 (2008) 188-207;
102 https://www.ucl.ac.uk/ich/support-services/library/library-historical-collection-history
103 An outstanding example is Marco Sgarbi’s analysis of the term “Urteil” throughout Kant’s entire work.
See Marco Sgarbi, “La logica dell’irrazionale. Studio sul significato e sui problemi della Kritik der
Primary Sources

Following the approach of cultural historians, this thesis asserts that the history of pain – or, at least, a dynamic history of pain purporting to cover changes over time, and not only the fixed image of a given age – is only possible through a multidisciplinary exercise that, in addition to the study of published sources, also draws evidence from visual and material culture. Sources should be seen as cultural constructs containing not the actual experiences themselves but expressions of experiences. To appreciate the cultural processes that might have been at work during their production, a critical approach to the use of archival material has been adopted. Studies on pain and the fact that a medical discipline regarding pain as an object of study does not exist, produce a series of tensions in relation to thematization. Even though, as mentioned previously, treatises studied in this thesis do not contain a section devoted to pain, these sources do present theories, ideas and representations of pain. Nevertheless, one of the difficulties of this study has been its aim to confront the treatment, in those sources, of a phenomenon that is of extensive nature, like color or shape, but subjective and of elusive nature too. The primary sources used in this thesis come from a variety of genres: patient casebooks, hospital general admissions registers, annual reports, minutes of meetings, medical textbooks, journal articles, postcards and published reports and surveys.

Printed Sources

Medical literature has been studied in order to discover medical perceptions and treatments of children. During the period being studied (roughly 1870 to 1950) there was an explosion in printed medical literature about children’s illnesses and ailments. These texts ranged from medical books of a more general nature to academic and theoretical treatises about specific diseases and treatments. The medical texts on children’s diseases studied in Chapter 2, Chapter 3, Chapter 4 and Chapter 5 include textbooks on children’s diseases, more general medical treatises, and other treatises that deal with specific diseases and

104 The Library Historical Collections at UCL on the History of Paediatrics mention 173 works as the most important historical material on paediatrics.
treatments, manuals for mothers, textbooks on children psychiatry and psychology among others. The accessible writing style and direct statements of purpose of most of the paediatric texts used in this investigation suggest that they were written to provide medical knowledge not only to the community of elite doctors that were contributing through this publications to the professionalization of paediatrics, but also to practising doctors. Charles West, for example, started his Lectures on the Diseases of Infancy and Childhood recommend his students that where “there is real love for children, the tact necessary for examining into their ailments will not be long in being acquired, still a few hints on this subject may not be out of place in an introductory lecture [sic]”. Of particular value in this case are the treatises on children’s diseases and manuals for mothers, which sometimes devote their initial sections to children’s pain as a form of diagnosis. David Forsyth’s 1909 treatise Children in Health and Disease: A Study of Child-Life is more than 360 pages in length and discusses children’s bodily expressions of pain. These publications suggest an interest to provide medical knowledge not only to practising doctors and surgeons but also to literate laypeople.

In comparison the published texts of British alienists, psychologist and psychoanalysts studied in Chapter 4, Chapter 5 and Chapter 6 were written in a highly specialized language that was probably aimed at the elite of physicians rather than to the general population. In regards to Chapter 4, while nearly all of these texts are dedicated to adult conditions, the sections on childhood reveal a great deal about medical perceptions and treatment of children. Less specialised medical texts discussed in Chapter Four concerning the study of nervous conditions (Thomas Dixon Savill’s Clinical Lectures on Neurasthenia, for instance), are useful in providing opportunities for comparison between the treatment of children and the treatment of adults. This study has not compared in a systematic way textbooks on children’s and adult’s ailments. A comparative analysis of these different sources would enrich the

105 Charles West, Diseases of Children, 19.
107 Mathew Thomson has written that the composition of the audience of medical texts in Britain was probably a mixture of elite practitioners, general practitioners, and a lay audience. See ‘Neurasthenia in Britain, An Overview’, in Marijke Gijswijt-Hofstra and Roy Porter (eds.), Cultures of Neurasthenia from Beard to the First World War (Rodopi, Amsterdam & New York, 2001), 78.
108 Alienist is an archaic term for a psychiatrist or psychologist.
A historiographical study of pain in childhood. Likewise, the sources analysed do not provide consistent laypeople perceptions on children’s pain. The study of vernacular medical texts on children’s pain will provide valuable information on the treatment of children by lay people and allow a comparison between the types of treatment prescribed by the medical elite and other types of professional and families.

In addition to these sources, I also draw upon articles from medical periodicals including *Mind, The Lancet*, the *British Medical Journal, The Archives of Disease in Childhood, British Journal of Sociology of Education, Journal of Mental Health, The Nervous Child*, and *The British Journal of Educational Psychology* written between 1877 and 1950.\(^\text{110}\) These sources have shed light on the changes in medical ideas about children’s pain and how these shifts affected both medical and popular understandings of the body. In general, the authors of these texts were established medical practitioners, physicians, and surgeons from the United Kingdom and the rest of Europe. During this period, medical knowledge was very much transnational, as English doctors tended to study medicine on the continent and there was a significant trade in medical books between different countries. Articles in medical journals were written in a more scholarly and exclusive style, indicating that they were intended mainly for professional physicians rather than the general public. For instance, Margaret Gray Blanton’s article ‘The behavior of the human infant in the first 30 days of life,’ comes into this second category: most of the text explains complex chemical concepts about children’s sensitivity to pain and very little space is dedicated to practical advice.\(^\text{111}\)

In addition to these records, various reports, surveys, and commentaries written by doctors, psychologists, educationalists, welfare workers, voluntary groups, and others have proved particularly informative. The final chapter incorporates texts such as the detailed *Evacuation Survey* by Padley and Cole (1940), *Our Towns: A Close-Up* (1943) compiled by the Women’s Group on Public Welfare and *The Cambridge Evacuation Survey* (1942). While these


\(^{111}\) Margaret Gray Blanton, ‘The behavior of the human infant in the first 30 days of life’, *Psychological Review*, 24 (1917) 472.
sources have been treated by authors like Michal Shapira\textsuperscript{112}, the aim of this part of the study has been to access perceptions from less elitist psychological fields than the higher reaches of psychoanalysis and also to include lay perceptions of children’s pain. At the same time, professional journals such as The Lancet, The British Medical Journal, British Journal of Sociology of Education, Journal of Mental Health, The Nervous Child, and The British Journal of Educational Psychology were also consulted. Additional sources included the magazines Life and the Illustrated London News. Newspapers indicated some of the ways in which children’s pain was represented in photographs and understood outside a medico-scientific context.

Two major obstacles ensue from the use of printed sources to extract valid theoretical inferences. One area of difficulty is that of gauging the extent to which these published medical texts are representative of the opinions held by most doctors of the time. Most practising physicians did not publish formal medical texts. Thus, it is quite possible that some – or even many – medical professionals did not share the opinions of the authors of these textbooks and journal articles. In other words, the risk is of focusing on the medical avant-garde instead of drawing the accepted, established boundaries after they have found acceptance and are operating as cultural frameworks. One could hypothesise a reasonable lag between the time of first publication of an idea and its time of acceptance. However, the numerous editions of many of these treatises indicate significant demand for medical information about children, and a favourable view of their audience. For instance, Frederic Still’s book Common Disorders and Diseases of Childhood went through five editions between 1910 and 1927. In circumscribed domains, the experimental investigations with children produced results that were incorporated into the general theoretical knowledge on adults. Although this is far from a general pattern, Chapter 4 has documented it in the community of alienists, and Chapter 5 in the context of neurasthenia.

Medical texts present yet another problem in that what they depict may not have been reflected in actual everyday clinical practice. According to Mathew Thomson, many doctors and laymen did not follow precise instructions on how to

\textsuperscript{112} These texts have been used in academic studies on the historical development of child psychoanalysis and its relation to the evacuation process. See Shapira, The War Inside.
treat patients. It is even possible that books were not used at all, and remained unopened as adornments to bookshelves. As said above, many of these books were reprinted, which suggests that their purchasers did use them.

Finally, there is an important gender bias in the chapters devoted to the late nineteenth century, in which almost all authors are men. The bias is not in the sampling, but in the makeup of the scientific community, which was dominated by men and tended to discredit women's perceptions of the child's pain as lay and deficient from a methodological perspective, particularly in the case of mothers and nurses. However, as the twentieth century moved forward, more women were involved in the specialized debates around children's pain, especially in the fields of psychology and psychoanalysis.

Manuscript Sources

Other primary sources may offer a way in which to accurately evaluate the lacuna that may be found between theory and practice, that otherwise could be difficult to assess, such as medical casebooks, which have a closer relationship to the reality of patients in hospitals and other places of clinical practice. One main archives have been used for this regard: The Hospital for Sick Children, Great Ormond Street Hospital. Three eminent doctors emerge from the case notes collected: the paediatricians Charles West, W.H. Dickinson and Frederic Still. As for the latter, the archives contain his casenotes between 1913 and 1926 but are subject to an important legal limitation: since part of an NHS institution and therefore considered public records, they are managed under the terms of the 1958 Public Records Act and its subsequent amendments. The Act’s 1991 amendment states that named patient records can only be released when over hundred years old. In spite of more recent Freedom of Information, the hundred year rule is still considered valid. For that reason, only the casenotes ranging from 1913-1916 were analysed, as further consultation would require an application to the Hospital/Institute of Child Health’s Research Ethics Committee that extended beyond the timely scope of this study.

113 Thomson, ‘Neurasthenia in Britain’, 79.
The pioneering paediatrician Charles West left nineteen volumes of case notes from 1838 to 1880, together with the books from his library, which have also been used. Dr. W.H. Dickinson, on the staff from 1869-82, was the first to keep separate volumes of casenotes for particular groups of conditions. His volume of ‘Nervous Diseases’ (so large that is re-bound in 3 parts) is very broad in its definition by today’s standards, ranging from what today would be Neurosurgery cases to what would now be Psychiatric. I have also accessed the Historic Hospital Admission Records Project based at Kingston University. According to their own website, the project currently “provides access to 140,213 admission records to four children’s hospitals”, including GOSH and ranging from 1852 to 1921.116

While these archives have been used by other scholars to frame the figure of the sick child, none of them have attempted to frame the problem of pain.117 In that sense, while the validation of what are the most important archives for studying British medical discourse regarding children in the period of this study can be inferred from their work, original analysis of these primary sources had to be conducted again in order to identify relevant authors, cases and passages. The Great Ormond Street Hospital archive contains many volumes of case notes, as well as surgical case notes, personal papers of doctors, nursing records, and unpublished memoirs. These sources cast much light on both medical and lay perceptions and treatments of children. This thesis utilises some of these medical casebooks, which are very detailed and offer full accounts of the medical histories and treatments of child patients. Contrary to the argument presented by Hannah Newton about what happened in Early Modern England, most case notes were never published.118 However, one must take care not to overestimate the reliability of unpublished material. Writers, even in documents

118 Hannah Newton, The Sick Child, 15.
of an essentially private nature, may have been “self-fashioning” (perhaps even unconsciously), recording their medical cases in a way that boosted their own morale and self-image. Some of the cases described in these casebooks were also mentioned in articles in medical journals to illustrate theoretical arguments. In such cases, it may well be that the authors were selective about their choice of cases, opting for the unusually successful ones to boost their reputations and further their careers. Such is the example of Frederic Still, who used his GOSH cases for the “Goulstonian Lectures on some abnormal psychical conditions in children”.119

**Visual Sources**

This thesis explores the ways in which non-written evidence – in particular that which comes under the heading “visual culture” – can be used to open up new possibilities for studying the history of childhood and the history of pain. One could claim that all histories written about children are related, in one way or another, to the book that is considered to represent the origin of the discipline: Philippe Ariès’ 1960 *Centuries of Childhood* [*L’Enfant et la Vie Familiale sous l’Ancien Régime*]. Ariès’s great success was to convince almost all his readers that childhood has a history and that, across time and in different cultures, both ideas about childhood and the experience of being a child have changed. While Ariès’ evidence was wide-ranging, he has been much criticised for failing to subject it to proper scrutiny. In particular, he has been accused of “reading” images too literally.120 As a result, historians became very cautious about the use of non-written evidence, which has only recently started to make a renewed and welcome impact within the discipline. It is clear that most approaches to the history of childhood depend heavily on textual sources, but this approach can lead to a distorted understanding because “many experiences of the past are not reflected in those texts”.121 A similar issue calls into question the credibility of the

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120 Ariès work has been subjected to severe criticism, these critics reject the view that childhood did not exist in medieval times. In relation to Ariès’s use of pictorial evidence see Adrian Wilson, ‘The infancy of the history of childhood: an appraisal of Philippe Ariès’, *History and Theory: Studies in the Philosophy of History*, 19 (1980), 132-152.
121 Some of these issues were discussed at a conference I organized in 2015 at the University of Greenwich, entitled Re-imagining Childhood: Images, Objects and the Voice of the Child (May 9 2015). A part of this
written sources on pain, which rarely comes into focus as the primary subject of investigation. Therefore, a historiographic approach based entirely on written sources is likely to fail in the attempt of framing the magnitude of the historical phenomenon of children’s pain. This thesis attempts to overcome this limitation by exploring the relationship between pain and visual culture, an under-explored field of inquiry. This new approach will open the door to a new understanding of how emotions shaped the experiences of our forebears. The stress on the relationship between experience and visual culture provides a new and interesting approach to the history of pain and childhood, leading to a scarcely explored area of study and to an additional form of interdisciplinarity: the plurality of disciplines does not belong just in the realm of the authors, practitioners and diseases that fall within the scope of this investigation, but is extended to the angle of the author: my background as an art historian has persuaded me of the importance of combining the insights provided by written sources with the immediate information that visual representations offer. However, far from taking the visual texts as truthful representations, this study takes them as further symptoms of the institutionalized politics of pain. In fact, this thesis argues that a fruitful way to penetrate the embodied emotional experiences of the past is photography. It does not put forward, however, a comprehensive study of visual sources of infant pain, but a very selective offer of pictures from institutional contexts. In particular, it includes three graphical sources: Darwin’s photographic illustrations of children’s emotions, pictures from the archives at the Great Ormond Street Hospital, and children involved in the evacuation process during the Second World War.

The study does not focus on clinical photography because this practice barely contributes to the visual culture of the sick child, which is generally to be found in art forms and mass media, including public health or advocacy campaigns. In other words, while clinical photography represented skin irritations, irregular symptoms and so on, child photographies tied to fundraising and other campaigns underscored the importance of the individual’s particularity and facial

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expression to make the institutional (the hospital) and the disciplinary case (paediatrics). The adherence of the child to that double dimension transforms the photographs into a particular illustration of the abstract notion of the sick child. This kind of portrait of children became very popular among the British population, and they were printed in several formats (cartes-de-visite, journals, and postcards) and bought by a varied audience.\textsuperscript{123}

This thesis has been informed by the works of others that have focused on photographic practices in medical and scientific contexts.\textsuperscript{124} Tanya Sheehan has shown how photographers in Philadelphia appropriated the language of medicine to construct the social value of their work during the second half of the nineteenth century.\textsuperscript{125} As a result of this appropriation, photographic sessions and the bodily discomfort and pain experienced by patrons were interpreted as showing the power of photography to modify and heal bodies. In a different way, Phillip Prodger has examined the art and photography collection owned by Charles Darwin in order to analyse the photographs and other images that illustrated his classical work on emotions.\textsuperscript{126} In this way, Prodger shows the dynamics between popular and scientific representations of emotional expressions, and how photography was able become an adequate tool for the scientific study of emotions.\textsuperscript{127}

Historiographical concerns have informed my choice of sources. I do not wish to impose a modern understanding about the image of a child in pain onto nineteenth- and twentieth-century photographs. Nor do I assume the photographs provide a record that is necessarily or entirely truthful. Nonetheless, while keeping in mind the fact that photographs are culturally mediated and socially constructed artefacts, they do allow us to glimpse the reality of bodies in

\textsuperscript{123} Andrea Tanner, ‘Choice and the children’s hospital’, 138.
pain through a lens that is other than that of the doctor or other medical specialist. I have presented photographic sources only where photography was an integral part of the scientific narrative constructed through textbooks, journal articles, and case notes. A critical analysis of photographs can offer insights into how the hospital (and the individual artists it employed) tried to use images of children as a way to generate funding from the state and the public. The broader social and political images of childhood can be explored by considering the use of images of children in movements initiated by the state in particular moments of crisis, such as the Second World War. However, they also help us to tap into children’s experiences of suffering, and consequently serve as an useful tool to unravel the complex meaning of pain.

Structure of the study

Chapter One presents how medical authors depicted pain generally, and infant pain more specifically, in the historical prelude to the period covered by the rest of the study, focusing on the competing theories that existed in early modern times but including references to the classical doctors that exerted their authority throughout the centuries. Specific attention is given to: the humoral tradition in contrast to the anatomo-clinical method; to Descartes’ mechanical notion of pain; to the Enlightenment’s “man of feeling”; and to the two main theories of pain in the nineteenth century – specificity and summative intensity. A separate section covers the practices of vivisection and anaesthesia as products of scientific progress that transformed the administration of pain.

Chapter Two examines the interpretations of children’s language of pain, particularly screams and cries, by different professional bodies between 1870 and 1900. The chapter connects Charles Darwin’s evolutionist perspective inaugurated in “A biographical sketch of an infant” with the theoretical curiosity that informed embryologists’ and psychologists’ instrumental approach to pain, contrasting this with the practical paediatric challenge of understanding children to diagnose and treat them. This chapter also considers the photographic representations of sick children used for fundraising by the Great Ormond Street Hospital.
Anchored in the theoretical perspectives explored in Chapter Two, Chapter Three surveys the historical development of infant pain denial from 1890 until 1950 in three scientific communities: the Child Study movement, behavioural psychology, and paediatrics. The analysis shows the extent to which figurations of children’s pain were products of a struggle for recognition between contending disciplines, and delves into the reasons for the scepticism towards pain, which had important consequences in paediatrics.

Chapter Four goes back in time to cover the second half of the nineteenth century with regards to the issue of children’s insanity and mental suffering. The notion of the child mind and the debates surrounding its understanding and relation with the body are explored through a series of representative diseases, including “night terrors”, melancholia, hysteria, and monomania. The limitations of the anatomo-clinical method are discussed in relation with the work of leading psychiatrists and neurologists, including Crichton Browne and Henry Maudsley.

Chapter Five continues the theme of the preceding chapter in chronological order, and seeks to expose the contrast between two coexisting theoretical frameworks: the clinical tradition, which still argued for the somatic basis of mental illnesses, and the emerging field of psychotherapy. The second part of the chapter examines the figuration of the “nervous child”, which recognised the importance of the environment in mental health.

Finally, Chapter Six examines the complex debates around the evacuation policies conducted in the United Kingdom before and during the Second World War. The discourses and figurations of children’s pain that were used to legitimise public policies are compared with the social results of those policies and contrasted with the ways in which different medical communities analysed the figure of the evacuated child: as a victim of air raids or as a victim of parental separation. The momentum of psychoanalysis as the predominant framework to understand psychological trauma is examined in this context, looking closely at the work and research of prominent figures such as Anna Freud and Melanie Klein.
CHAPTER ONE

From Soft Wax to Scientific Objects: Medical Perceptions of Children's Pain from Ancient Times to the Development of Anaesthesia

Introduction

The first surgical treatise devoted to the diseases of children is generally held to be the *Children’s Book*, written by the sixteenth-century Swiss military surgeon Felix Würtz and published posthumously in 1656. In this work, Würtz discusses the factors involved in caring for sick children and problems relating to conducting surgery on child patients. He therefore raises the question of children’s pain and suffering and, in the section entitled “Of crooked and lame children, coming thus into the world, we read: “No splinter must be too close applied here, neither must they be bound too hard; if too hard, and the child cryeth out by reason of the pains it feels, then instantly tie it slacker, for such pains would cause great mischief: therefore bind such joints softly and gently, according to the place.”

Almost a century later, Walter Harris strongly attacked, in his 1742 book *A Full View of All the Diseases Incident to Children*, the use of opiates for treating children’s pain, “the feeble Strength of Children, now quite broken and enervated with the Disease, cannot bear the sudden and forcible Effect of Opiates, without imminent Danger of Death.”

Despite the different historical periods and contexts of these two physicians, both believed in the importance of creating a science of children’s diseases that was different from that relating to adults. Felix Würtz, contributed to the surgical care of children, owing his fame to his *Children’s Book*, published by his brother after his death, in 1612. The text was dedicated to “young Surgeons, wet and dry Nurses, Maid Servants, and other parties, to whose trust and overlooking

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128 Peter M. Dunn, ‘Felix Wurtz of Basel (1518-75) and club feet’, *Archives of Disease in Childhood*, 67 (1992) 1242.
129 Walter Harris, *A Full View of All the Diseases Incident to Children*, (A. Millar, London, 1742), 76.
little Children are committed."\textsuperscript{131} After studying medicine in France, Walter Harris returned to England and became a successful physician. In 1689, he published \textit{De morbis acutis infantum}, which deals with the diseases of children.\textsuperscript{132} The work of both Würtz and Harris serves to refute the assumptions of certain historians of medicine, childhood and paediatrics, according to which pain in children was largely ignored in previous centuries.\textsuperscript{133}

This chapter examines how medical authors and doctors depicted pain – and more specifically the bodies, minds, and pain of children – in the historical prelude to the period covered by the rest of the study. Methodologically distinct from the remaining five chapters, the pages that follow provide the historical context for the eighty years (1870-1950) that are the focus of this thesis in terms of the most relevant theories, practices, and medical traditions. Despite the tremendous progress experienced in the medical world throughout this period, many of the contributions and debates would be hard to understand in the absence of this necessary historical preface. For example, the ultimate nature of the shift brought about at the time of Darwin’s iconic “A biographical sketch of an infant” in 1870 would certainly be missed without some familiarity with the medical frameworks that had reigned before that time, while the difficult elaboration of the notion of mental pain owes a great deal to the Cartesian tradition of dualism. Similar to Foucault’s realisation that the formulation of the anatomo-clinical method was anchored in the conditions that preceded it – so that asking the question “How was the clinic born?” implies a survey of its antecedents – this first chapter seeks to understand approaches to pain in children up until the end of the nineteenth century, and to reveal both the internal logic of physicians’ beliefs and the historical specificity of the concept of “children’s physic”.\textsuperscript{134}

Given that a prospect of all relevant contributions since ancient times is beyond the scope of these pages, the focus will be on the contending theories that existed in early modern times. Of course, this includes references to the

\textsuperscript{131} Würzt, ‘An Experimental’, 199.

\textsuperscript{132} The first English book on children's diseases was \textit{The Booke of Children}, published in 1544 by the physician Thomas Phaer, see Hannah Newton, \textit{The Sick Child}, 14.


\textsuperscript{134} The term “children’s physic” refers to the notion that children were physiologically distinct from adults and therefore required special medical care. See Hannah Newton, \textit{The Sick Child}, 1-30.
Greek and Roman doctors that exerted their authority in post-Renaissance Europe through the force of classicism and the Arab transmission of knowledge. The invention of anaesthesia in 1845, which endurably transformed the meaning of pain and the medical practice of the time, signals the end of this timespan. Naturally, this historical preface and the body of the study share the same subject – that is, medical perceptions of children in pain; they differ only in the historical scope and the level of detail that is allowed to each part. Structurally, the chapter is divided in two. The first part is more general, presenting an overview of the conception and treatment of pain, including how pain became an instrument for cognitive investigation. After the general framework of theories and traditions on pain has been presented to the reader, the second part of the chapter focuses on the specifics of the history of childhood, and considers early medical approaches to pain in children up until the end of the nineteenth century. Although it is true that paediatrics itself did not develop as a separate medical specialism until the late nineteenth century, historical medical writings provide rich evidence of attention to and concern about pain and disease in children in earlier times.  

In line with the argument put forward by Hannah Newton, according to which early modern doctors treated children and adapted their medical treatments accordingly, this chapter claims that childhood pain was taken into account throughout this period, and that infants were believed to be particularly sensitive to noxious stimuli. It also seeks to demonstrate that the constitutions and sensibility to pain of infants and children were fundamentally distinguished in medical understanding from those of adults, and therefore a concept of "children's physic" existed. This argument taps into historiographical debates about concepts of "childhood" in earlier societies, and contributes to the revisionist work that challenges Philippe Ariès’ famous thesis that the idea of childhood did not exist until the seventeenth century. The concept of “proto-paediatrics” – which will be employed extensively in this chapter to refer to the identified practitioners of child medicine – fundamentally challenges the view commonly accepted by paediatric historians that until the nineteenth century

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137 See Philippe Ariès, Centuries, 125.
doctors did not recognise “the physiological differences in infants, young children, adolescents, and adults.” Also, the term is more appropriate than “paediatrics”, which consolidated in the nineteenth century as a body of theory and practice, and which would be anachronistic in this earlier historical context: medical ideas of children are culturally constructed and hence vary across time.

A controversial subject

Before embarking on the review of early modern precedents, it is important to set our gaze on the general system of medical practice that reigned in the nineteenth century. According to Foucault’s classic *The Birth of the Clinic*, a new approach to the sick body and the patient was born in the transition from the question “what is the matter? to the question “where does it hurt?” The so-called anatomo-clinical episteme signals a significant departure from the Hippocratic postulates: if previous medical cosmo logies, such as Hippocratic humourism, advocated for a holistic approach and predicated on humoral balance in favor of local pathologies, clinic efforts center themselves in the capability of localising separate and distinct agents of disease in relation to the body. In contrast, clinical practice was anchored in the medical expert’s gaze, which marked a shift from previous medical models. Roselyne Ray argues that “at the dawn of the nineteenth century, physicians were looking for a pure sign which would remove the ambiguities inherent in symptoms. They wished to find a sign, the meaning of which would be as certain as that provided by the lesion found at dissection.”

This quest for anatomical certainty places pain in a prominent position within medical epistemology and practice. As the driver of communication between doctor and patient, the primary symptom of an injury, and the initial input of

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139 The term “paediatrics” was not in use in the United Kingdom until the early twentieth century. The doctors who worked at Great Ormond Street and the other children’s hospitals in the late nineteenth century were general physicians who had an interest in children’s health and welfare. They would all also have run clinics for adults at general hospitals and had mainly adult private patients, from whom they earned their living. However, in the United States, The American Pediatric Society (APS) had already been created by 1888, founded by Dr Job Lewis Smith, the best-known American paediatrician of his time, other than Abraham Jacobi. Despite this, I shall henceforth use “paediatrics” to refer to those doctors and hospitals that were interested in the study of childhood.
140 See Michel Foucault, *The Birth of the Clinic* (Taylor & Francis, Abingdon, 2002), 18.
examinations, pain was instrumentalised until it became a *methodological artefact*. However, nineteenth-century scientists did not agree on the nature of pain. There were historical and disciplinary reasons for their lack of consensus. Historically, there were at least three contending theories of pain backed by authoritative sources: the theory of specificity, the theory of intensity, and the emotional theory of pain, connected to Aristotle. None of these had been sufficiently backed experimentally. Instead of converging, the consolidation of differentiated medical specialisations during the nineteenth century prevented any of these three theories from gaining primacy, with debates developing internally within each discipline without reference to the others. Thus, while physiologists and some psychologists adopted the theories of specificity and intensity, many philosophers and theorists of pleasure and pain still supported views connected to the Aristotelian tradition. Methodological instrumentalisation turned pain into an unstable object of study and differentiated it within each disciplinary realm. Additionally, as Chapter 2 will show, the development of paediatrics in the second half of the century was based on the important principle of taking pain as a primitive fact. In spite of fully belonging to the age of the clinic, paediatricians were not interested in explaining the nature of pain – unlike practitioners of disciplines such as neurology and physiology – but were concerned with adequately diagnosing children.

**A brief history of pain, from ancient times to the mid-nineteenth century**

_The Classics: Hippocrates, Aristotle, Galen, Augustine_

Few experiences are as universal and yet intensely personal as pain, so it is therefore not surprising that pain awakened the interest of medicine from the discipline’s very inception. Greek medicine created the oldest scientific interpretations of symptoms that would be incorporated to the Western cultural repertory.142 The Hippocratic Corpus, a collection of medical manuscripts from different anonymous authors dating from around 450-350 BCE and attributed to Hippocrates, established the canonical theory that the human body consists in an equilibrium of four humours: blood, phlegm, yellow bile, and black bile. Any

turmoil or loss of balance between the humours would result in illness and pain. In spite of the diversity of the collection – or perhaps because of it – Sarah Scullin appreciates pain as a major leitmotif: “Even a cursory perusal of the corpus reveals that the strongest thread holding these various texts together is the topic of pain. [...] it is one of the most common and reliable indications of disease; it is proof of the theory of humors [...] ; it is even present when it is not mentioned: surgical treatises do not mention the pain of the (more often than not) non-medicated patient ... but they do recommend that strong attendants hold the patients down and urge them to stop struggling during surgery. In short, pain is everywhere in the corpus.”143 However, different authors in the corpus offered varying accounts of the exact mechanisms of pain.

For many centuries, the main contenders in the dispute about the organ of pain were Aristotle (384-322 BCE) and Galen of Pergamum (130-200 CE). Galen tied together the theories of Aristotle, Plato, the Alexandrian anatomist-physicians, and Hippocratic medicine, thus creating an anatomical and medical vision of the body that remained standard throughout the medieval period and beyond, and was debunked only by the advent of physiological experimentation from the seventeenth century onwards.144 While Aristotle centred the genesis of pain in the heart, which was understood to be the centre of all feelings, Galen defended the theory – also backed by Plato and Democritus – that the brain was the centre of sensitivity.145 Besides the location of the organ responsible for pain, there was little agreement regarding the status of pain, and whether it was related to touch or a specific sense, as Galen claimed. Aristotle’s philosophy was dominant during the Middle Ages, but perhaps the most influential theory of pain in the Middle Ages was expressed by Augustine of Hippo (354-430 CE). Guilt and fear were concepts related directly with pain.146 Augustine wrote that it was the absence of guilt and fear that made possible for martyrs’ and Virgin Mary’s lack of pain. In the words of Esther Cohen, “all major late medieval discourses on

144 Fay Bound Alberti, This Mortal Coil: The Human Body in History and Culture (Oxford University Press, Oxford, 2016), 102
pain – in theology, medicine, and law – viewed ‘physical’ pain as a function of the soul.”¹⁴⁷ This theory of pain is of enormous importance for its popularity and its durability. Giving meaning to pain in the nineteenth century implied a critical stance towards the most common existential interpretation of suffering, which was by default of a religious character.¹⁴⁸ But perhaps the most important medical author bridging the classics with modern times is Avicenna (Ibn Sina, Arabic physician, 980-1036 CE). Avicenna synthesised the works of the masters that preceded him and made important contributions of his own, describing the origin of fifteen types of pain caused by humoral changes.¹⁴⁹

Renaissance and Modern: Descartes and the mechanical conception of pain

An important contribution from the Renaissance that found contemporary acceptance and possibly influenced other authors, including Descartes himself, is that of Leonardo Da Vinci (1452-1519), who described the nerves to be tubular structures and considered pain as a sensation related to tactile sensitivity.¹⁵⁰ The sensorium commune was said to be located in the third ventricle of the brain, and Leonardo stated that the spinal cord was the driver of the sensations to the brain. In the sixteenth century, other scientists, such as Vesalius and Varolio, accepted the concept proposed by Leonardo regarding the anatomy and physiology of sensations, considering the brain as the centre of sensations and nerves as tubular structures. In the seventeenth century, more evidence of the role of the brain in the experience of sensation was obtained, but many authorities on the subject still accepted the Aristotelian concept. So, William Harvey, who in 1628 discovered blood circulation, still thought that the heart was the place where pain was perceived.¹⁵¹ Meanwhile, Réné Descartes (1596-1650), a contemporary of Harvey, favoured Galenic physiology and considered

¹⁴⁸ Bending, ‘Pain and Religion’.
the brain to be the seat of sensation and motor activity.\footnote{For a detailed overview of Descartes’ life and the various strands of influence that shaped his philosophy, see Stephen Gaukroger, Descartes: An Intellectual Biography (Clarendon Press, Oxford, 1995).} It was Descartes who codified the most influential modern theory of physical pain in the West.\footnote{Bourke, ‘The sensible’, 2.} In his work \textit{L’Homme}, published in 1664, Descartes described the nerves as tubes that enclosed fine threads, which formed the “backbone of the nerves” and connected the brain parenchyma with the nerve endings in the skin and other tissues. Through such strands, sensory stimuli were conveyed to the brain. The mechanistic model of pain espoused by Descartes was a profoundly influential theory, and it came to be even more central after it was embraced by Herman Boerhaave, the founder of clinical teaching.\footnote{Bourke, ‘The sensible’, 3.} Descartes also added to this theory his well-known theory of dualism, which separates the body (the machine) from the mind (soul), a separation that had a profound influence on medicine for centuries.

In his vision of the workings of the body, Descartes maintained the ancient paradigm of spirits being extracted from the blood, and his notion of the heart heating the blood conjures up the Aristotelian notion of the heart as a furnace. Methodologically, his avowed programme of dissecting animals in order to see for himself betrays another familiar agenda that had been advocated not only by Vesalius but went back as far as Galen and Aristotle. Though he reworked this intellectual legacy to some extent, Descartes was nonetheless heir to a philosophical and anatomical tradition that had compared and contemplated the nature of human and animal bodies since antiquity. What Descartes developed to greater perfection were two ideas: firstly, that all aspects of the human body acted according to mechanical principles, while its owner’s true constituent – the immaterial rational soul or the mind – determined his humanity. The animal, thereby, acted as the perfect backdrop for establishing the concept of the body machine, as it exemplified all bodily functions and aspects of behaviour that did not require an intervention from the soul. Secondly, by counting sense perception among the faculties of the \textit{res cogitans}, he differentiated between human and animal sense experience to a degree that essentially deprived
animals not only of the traditional sensitive soul but also of a number of faculties
associated with it.

In the Treatise on Man, Descartes chose the example of pain, not because
pain perception could easily be explained, but because it seemed to illustrate
especially well the machine-like responses of the body to a stimulus from the
outside world, exemplified by the well-known image of the naked boy
withdrawing his foot from the flames. The transmission of a painful stimulus to
the brain is here depicted and described as a thread, reaching from the foot to
the brain, which—in a famous simile—is being pulled, like the rope that pulls a
church bell. The pathway is common to animals and humans; however, while the
former do show responses to painful stimuli, only humans are aware of them.

Forced by his mind-body dualism, Descartes envisaged two forms of bodily
responses to pain, but was unable to uphold the strict separation in his writings.
In the Sixth Meditation, for instance, he chose the example of pain yet again, but
this time it served to underline the unity of body and mind: “Nature also teaches
me, by these sensations of pain, hunger, thirst and so on, that I am not merely
present in my body as a sailor is present in a ship, but that I am very closely
joined, and as it were intermingled, with it, so that I and the body form a unit. […]
For these sensations of hunger, thirst, pain and so on are nothing but confused
modes of thinking which arise from the union and, as it were, intermingling, of the
mind with the body.”¹⁵⁵ For a contemporary reader, this passage could be read
as a tell-tale sign that pain became a critical point in Cartesian dualism, which
culminated in the aporia of confirming the general duplicity while admitting to the
unity of suffering stimuli. In any case, by situating the site of the interaction of
mind and body in a particular place in the brain, Descartes upheld or else
reinvigorated the brain-centred view of the body that determined subsequent
research on the localisation of cerebral functions.

The Enlightenment and the “man of feeling”

Although humoral medicine and the Galenic tradition had received a mortal blow
with Harvey’s discovery of the circulation of blood in the 1620s, it was in the

¹⁵⁵ René Descartes, Sixth Meditation in John Cottingham, Robert Stoothoff, Dugald Murdoch and John
Kennedy (eds. & trans.), The Philosophical Writings of Descartes, Vol. 2 (Cambridge University Press,
eighteenth century when the post-Cartesian and anti-metaphysical programme of mechanistic experimentation found great acceptance. According to the historian Fay Bound Alberti, “experimentation promoted new accounts of vitality and the relationship of body and soul, and discussions flourished in an attempt to re-examine the laws of health and sickness.”\textsuperscript{156} However, scientific dualism had its enlightenment counterweight. In the eighteenth century, the theories of sympathy and compassion towards the feelings of others configured the experience of harm and pain. Edmund Burke (1729-1797), defined sympathy as a “form of substitution by which we are put in the place of another man, and affected in many respects as he is affected.”\textsuperscript{157} In a similar way, David Hume (1711-1776) considered it an act that allowed the individual to share the pain or the pleasure of a different person.\textsuperscript{158} The inhomogeneous distribution of pain –like wealth or property– during the Enlightenment encouraged, as well as a logic of taste that allowed a new arrangement in relation to personal preference, an emotional contract between people of different affections and sensibilities. The basis of this covenant was not only moral, but also anchored in physiological and medical research: while Nicolas Malebranche (1638-1715) argued for the influence of maternal imagination on embryonic development, sensualist physiologists sought a correspondence for sympathy in human anatomical structures. The enlightened concept of the “man of feeling”, together with its associated rhetoric, were quickly adopted by Eighteenth Century medical thinkers, who situated the notion of sympathy within the broader concept of sensibility.

**Nineteenth-century theories of pain**

Scientific advances in the nineteenth century crystallised into two physiological concepts of pain, called specificity theory and intensity theory. In 1840, Johannes Müller proposed the law of specific energies of the nerves. This theory held that the brain received information by means of sensory nerves that corresponded to the five senses, carrying a particular form of energy that was specific to each

\textsuperscript{156}Alberti, *This Mortal Coil*, 102.
sense. However, Müller recognised only the five classic senses (sight, hearing, smell, taste, and touch), while the sense of touch incorporated all the characteristics of the stimulation of the body, including the feeling of itching, heat, cold, and pain. Müller’s contributions, together with some other authors, provoked considerable controversy and were the starting point for investigations about all aspects of feeling, including pain.

The notion that pain has a specific sensorial pathway independent of the other senses had been defended repeatedly by many authors across history, including Galen, Avicenna, and Descartes. However, a turning point was reached when Hermann Lotze’s 1853 formulation was supported experimentally by Moritz Schiff’s 1858 analgesic trials on animals. Observing the effects of various incisions in the spinal cord, it was observed that the cutting of the grey matter of the spinal cord eliminated pain but not touch, and the cutting of the white substance had the effect of removing the sense of touch but did not affect pain. Schiff’s experiments were strengthened by subsequent experiments by Funke in 1879 and by the classic experiments of Magnus Blix, Alfred Goldscheider, and Henry Donaldson, who between 1882 and 1885 discovered separate regions which corresponded to heat, cold, and touch on the skin, reducing pain to the nerves.

In opposition to the specific pathways for pain, the theory of intensity proclaimed that any sensory stimulus could cause pain over a certain threshold. Implicit in the Aristotelian concept that pain resulted from the excessive stimulation of the sense of touch, intensity found a contemporary advocate in Darwin, but it was Wilhelm Heinrich Erb (1840-1921) who explicitly formulated it in 1874. Indicating the immaturity of the field in spite of growing empirical evidence, the theory was supported by – among others – some of the leading former proponents of specificity, such as Blix and Goldscheider. In

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fact, the latter completed in 1894 the theory that the intensity of the stimuli and central summation were the decisive determinants of pain. According to this idea, pain was produced when the impulses out of the cells exceeded a critical level caused by the excessive stimulation of receptors that were normally activated by harmless thermal or tactile stimuli, or by pathological symptoms that intensify the summation of impulses produced by stimuli that are normally harmless.

**Anaesthesia, pain and the nineteenth century**

The meaning of pain and the methods for its management had undergone tremendous renovation in the time that spanned the shift from the humoral tradition to experimental medicine and the anatomo-clinical method analysed by Foucault. However, Koselleck’s “acceleration of history” could find its application also in the history of medicine in the industrial era.\(^{165}\) After the consolidation of the clinic, much was still to happen and, in fact, 1846 inaugurated the beginning of a new period in the history of pain, and one that directly connects with its present consideration, treatment and even economic significance. The introduction of anaesthesia at the beginning of the nineteenth century resulted in a totally new evaluation of harmful phenomena.\(^ {166}\) Besides the advent of anaesthesia, the systematic exercise of vivisection also counts as a major medical technology related to pain. Both practices inscribed themselves in the European and American conscience in the context of the success of science between the last quarter of the eighteenth century and the second half of the nineteenth century. The way in which pain was understood during the nineteenth century in Britain developed from Christian doctrine and belief to a medical discourse; dominance regarding pain understanding was held by these two mindsets.\(^{167}\)

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\(^{166}\) See Moscoso, *Pain*, 113.

With the advent of anaesthesia, society was confronted with a new image of pain, which was no longer seen as a necessary evil. The power to erase physical pain made it difficult to justify, and transformed it in an important physiological problem, as well as a medical, technical and experimental challenge.\textsuperscript{168} Medical practitioners began to address pain no longer as a mystery, but as an object of knowledge and of consumption. Suspending the philosophical question of sense-making and the Augustinian answer that still prevailed in the Christian mentality, attention was no longer focused on the meaning of pain, but on its functioning, its connection to the body, and its possible cure.\textsuperscript{169}

Until the middle of the nineteenth century, the impossibility of efficiently eliminating pain – above all in the fields of surgery and what we would today call obstetrics and dentistry – implied that suffering had to be fought with small medicinal remedies and large doses of resignation. The new possibilities for treating pain and the historical debate that ensued not only presented the problem of doctors' wariness about the introduction of ether or chloroform, but also patients' concerns towards the work of surgeons.\textsuperscript{170}

Attribution of the discovery of anaesthetic ether has been a polemical subject since the very beginning. Although the story of the emergence of anaesthesia has been told many times, there still is no agreement as to who deserves the fame for having “conquered pain”. The glorious discovery that would change the experience of pain as it had hitherto been known is disputed between three Americans: the scientist Charles Jackson and the dentists Horace Wells and William Thomas Green Morton. Public opinion soon welcomed the discovery. As Percival Leigh wrote in the May 10, 1851 issue of Charles Dickens’s magazine \textit{Household Words}, anaesthesia was among the greatest discoveries of modern science: “The amount of human comfort has been greatly augmented; the sum of human wretchedness has been diminished by a very large figure. Among the reductions of this kind that have been accomplished in modern times, the most signal, unquestionably, is the abolition of physical pain, in so far as it has been


\textsuperscript{169} See Donald Caton, \textit{What a Blessing She Had Chloroform: The Medical and Social Response to the Pain of Childbirth from 1800 to the Present} (Yale University Press, New Haven & London, 1999). A second, more general, book is Pernick, \textit{A Calculus}.

\textsuperscript{170} Moscoso, \textit{Pain}, 113-114.
effected by the discovery of the anaesthetic properties of chloroform.” The article, which clearly subscribed to utilitarian ethics and considered pain a quantifiable entity, ends on the optimistic prospects of scientific progress, as anaesthesia “has stilled the shriek of agony and pain, which is so direful a discord in ‘the still sad music of humanity’.”

Together with the initial enthusiasm, the emergence of anaesthesia was also met with resistance. Abolishing pain was seen as risky, counterproductive, or altogether wrong. Although the current understanding of pain as an alarm system was seldom if ever mentioned, the “natural” status of pain was an important argument: according to many, the presence of pain was necessary either as an instrument to strengthen body and soul or, more traditionally, as a form of expiation. Even physiological approaches often framed pain as beneficial. Since pain often occurred in the natural course of illness, it was seen to be useful not only in diagnosis but also in treatment. Although not great in number, some doctors induced pain in order to bring on the crisis of an illness, and because pain was associated with healing, whereas the loss of sensation often indicated nearness to death. In 1826, for example, American doctor Felix Pascalis wrote in his treatise on pain: “Painful sensations all require sound and healthy organs. It is therefore our axiom, that the greater the pain, the greater must be our confidence in the power and energy of life.” The surgeon agreed with François Bilon, an apologist for pain for whom the screams of the patients guided the scalpel. Quite apart from these proclamations, many surgeons understood that anaesthesia was potentially dangerous and that, although few in number, the deaths attributed to its use added serious practical problems to the ideological issues. In spite of some contrary opinions, the greater part of the profession showed itself in favour of the use of gas inhalation as one method, among others, to remove or relieve suffering.

171 Charles Dickens, ‘Some account of chloroform’, Household Words (10 May 1851) 151.
173 Moscoso, Pain, 112.
174 Rey, History of Pain, 43.
175 Hippolite Bilon, Dissertation sur la Doleur (Feugueray, Paris, 1803), 38, cited in Moscoso, Pain, 81.
176 See Pernick, A Calculus, 148.
**Vivisection**

Together with the deliberate production of unconsciousness, the history of the technologies related to pain at the start of the contemporary world includes the systematic exercise of animal vivisection. Since the seventeenth century, animal anatomy and physiology remained a steady source for the formation of knowledge about human bodily functioning. Far from operating as one more element among others, the use of vivisection started to reveal itself as the method *par excellence* of studying organic functions under a programme of investigation that abandoned the speculative hypothesis of the humoral tradition in favour of a search for constant relationships between phenomena. It must be emphasised, nonetheless, that at no time was pain the object of knowledge; rather, it was the instrument that would be of service to science in the study of life. The instrumentalisation of pain allowed a rapid adoption and expansion of sometimes risky experimental practices, but for some time there was no underlying scientific agreement to frame the understanding of pain or the nervous system.

While the animal-human analogy was the principal justification for vivisection, the animal-infant analogy gains particular importance in this study. The lack of language in the animal was one of the justifications to vivisect animals as they did not “behave as if they felt pain to such an extent as the human species.”

That words are unavailable to the suffering animal implies that the unarticulated or deficient language of children is a deficit in the communication of pain to

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adults with possible repercussions on medical theories and treatment, as will be seen in Chapters 2 and 3. Voices against vivisection insisted that animals did, in fact, feel; but Cartesian negationism endured well towards the end of the nineteenth century. Social reformer Edward Deacon Girdlestone wrote in 1884: “Movement, Gesture and Outcry do not necessarily connote pain [...] like children [...] brutes are in the habit of crying out before they are hurt.”

**The history of pain in childhood**

Before the nineteenth century, medical writings offer limited details on the topic of childhood pain. However, a closer examination of their discussions and theories can yield evidence of their writers’ notions of suffering children. Often, these authors exemplify an understanding that children’s constitutions and bodies were to be treated differently from those of adults, together with the belief that children felt more pain than adults did. This section is designed to stand in stark contrast with Chapter 2, which presents the arguments provided by several physicians between around 1870 and 1950, according to which children were unable to feel pain, and their cries and laments were an innate demand for attention with no objective correlate. In view of the historical account presented in this chapter, the fact that these theories were once popular has to shock, not only from the point of view of present sensibilities but also given the longstanding traditions that credited the simple observations of children’s extreme sensitivity to painful stimuli.

**Children’s sentience and diagnosis**

Ancient writers believed that children experienced more pain than adults for three reasons. Firstly, the belief in increased paediatric sensitivity to pain may have been formed on a general philosophical position concerning the nature of life experiences in general, and pain in particular; secondly, developmental immaturity was considered the cause of more vulnerability to harm; thirdly, the physiological immaturity of the infant. Generally, medical authors throughout

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history have agreed that children experience more pain than adults, whereas the perspective in the twentieth century has been the contrary.

In his *Laws*, the Greek philosopher Plato wrote: “Pleasure and pain I maintain to be the first perceptions of children, and I say that they are the forms under which virtue and vice are originally present to them.”\(^{181}\) He also believed that children’s bodies and constitutions were more prone to pain than those of adults. Analogously to Hippocrates’ theory of the humours, Plato conceptualised pleasure and suffering as the result of interactions of the four elements (earth, fire, air, and water) with the soul.\(^{182}\) Given that at the beginning of life these interactions were said to be especially violent, for an infant all sensations were essentially painful. The aphorisms of the Hippocratic Corpus also illustrate the idea that children were more prone to pain than adults. Aphorism 49 reads: “Those who are used to bearing an accustomed pain, even if they be weak and old, bear it more easily than the young and strong who are unaccustomed.”\(^{183}\) Given that the strength to withstand pain was determined by previous experiences of pain, children’s inexperience made them more vulnerable to it.

The Hippocratic and Galenic medical traditions that lasted well until the eighteenth century generally assumed that children were more sensitive to pain because of their apparent physiological immaturity. For humoral physicians, each individual had a particular make-up (which varied according to age) and health was defined as the proper balance of humours in each person.\(^{184}\) According to this tradition, the blood humour was particularly abundant in children, who were therefore characterised by warmth and moisture, with consequences on the child’s constitution, which is therefore softer, weaker (“tender”) and more prone to pain.

The Roman physician Celsus advised children’s surgeons to “have a strong, stable and intrepid hand and a mind resolute and merciless; so that to heal him that he taketh in hand, he be not moved to make more haste than the thing requireth, or to cut less than is needful, but which doth all things as if he were

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\(^{184}\) Newton, *The Sick Child*, 32.
nothing affected with their cries." Celsus’ recommendation illustrates that medical authors and doctors in Ancient Rome were already concerned with the pain and suffering of children. His words also reveal the importance of a child’s crying when diagnosing disease and pain, and how surgeons were affected when they operated on children. In the Christian era, some writers still maintained that infants were particularly vulnerable to pain. Augustine of Hippo (also known as St Augustine) thought that diseases of Christians were “to be ascribed to demons,” and that they specially “torment the fresh baptized, yea even the guiltless newborn infant.” In the seventeenth century, Felix Würzt also considered that immaturity was a significant factor regarding infants particular sense of pain, which gave explanation to the fact that older children were less sensitive to pain than younger ones. He added that the pain suffered by children was “twice worse” than that of an adult, because of the sensitivity of the “new grown flesh.”

The debate around the sensitivity of infants to painful stimuli was instrumental in the professionalization of paediatrics during the eighteenth century. Birth itself was seen as extremely painful for the emerging infant. The poet-physician Hugh Downman (1740-1809), reminded readers in the 1770s of the agonies of children and mothers at birth and argued passionately that children gave both behavioural and physiological evidence of pain easily understandable by any decent practitioner whose practice was not based on ancient prognostication or folklore.

The physician Michael Underwood also justified the extreme sensitivity of children’s constitutions to pain. He pointed out in the 1780s that very young children were especially sensitive due to “vast […] secretion” from their glands, which was “much larger in proportion than those of adults”. These glands were “continually pouring out their contents into the first passages […] This abundance of slimy matter often overloads the stomach and bowels, the constant seat of the

188 Hugh Downman, Infancy; or the Management of Children: A Didactic Poem, in Six Parts (n.p., Exeter, 1803), 96.
first complaints in the infant state." These physiological reasons for the sensitivity of infants to pain were exacerbated by "some accidental causes arising from mismanagement," said Underwood. In 1840 Charles-Michel Billard went further, arguing that pain was the only sensation that very young infants experienced. The physician claimed in *A Treatise on the Diseases of Infants* (1840) that:

Pain, at least during the first month, is the only sensation an infant can experience, and the enjoyment resulting from the exercise of all its functions is rather the absence of pain than the existence of pleasure, such as we experience.

Despite the recognition of children’s sensitivity, the diagnosis of diseases in children was historically regarded as extremely difficult. The difficulties faced by practitioners were such that many writers believed that children were unable to provide a reliable account of their own experiences. “I know very well in how unbeaten and almost unknown a path I am to walk, for sick Children, and especially Infants, give no other Light into the Knowledge of their Diseases, than what we are able to discover from their uneasy Cries, and the uncertain Tokens of their Crossness,” complained the physician Walter Harris in 1693. The difficulty of child diagnosis was related to the fact of immaturity, that is to say, a cognitive, linguistic and behavioural lack of development, which made complicated to infants to express their pain. In 1664, Daniel Sennert explained, "pain and inflammation are hard to be known” in children because “they cannot

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In 1849, Hess described paediatrics as the most arduous of the medical specialities “arising from the inability or the unwillingness of children to give a proper description of their feelings, or owing to their fretfulness, shyness, and resistance to the proceedings of the physician.” However, at the end of the eighteenth century some experts indicated their reliance on the direct accounts of child patients. In 1768, Jean-Emmanuel Gilbert emphasised the importance of obtaining a good history of the patient, declaring: “whenever a child is brought for a consultation, I question him with the utmost attention, putting down on paper all his answers or those of his mother. I write down what I observe, the symptoms and incidents of his disease, his temperament, his age, his affinities, his habits, his previous diseases.” He added how he “wrote down day after day the history of the disease, and decide upon the treatment only after meditating at length on the enemy that I have to fight and the weapons that are to be used.” Once the child was healthy, he wrote down “the exact history of the symptoms. Of other occurrences, of the positive or negative effects of the drugs, and particularly of the achievements of nature.”

Some doctors escaped the conflict by focusing the analysis of pain not on children’s accounts of their experiences, but on the symptoms shown on their bodies, and on behavioural changes. Crying appears to be the behaviour most often thought to be associated with pain. Felix Würzt maintained that crying was always a signal of pain and a call to receive attention to prevent ill health. “Little children will not cry, unless they ail somewhat,” declared Würzt. “They are not able to make their complaints anyway but by crying. Hence [...] good notice must be taken what these crying children aileth, wherein they are grieved or pained,” he suggested. But there was a difference of opinion about whether crying always indicated pain or disease in the child. Some authors, such as Samuel Smiles in 1848 in relation to new-born children, maintained that crying was necessary as exercise for the infant. “Instead of being feared, the practice of
crying in children in want of muscular exercise is most beneficial in its effects." Restlessness and sleeplessness were also considered symptoms of a child’s distress and pain.

**Children’s conditions and treatments**

It was not until paediatrics became a separate speciality in medicine that broader research in relation to the source of pain in infants could take place in order to be capable of associating infant pain with paediatric disease or injury as well as assessment and treatment procedures. The most common childhood pain discussed by ancient writers is that caused by teething. Comments taken from several authors of different centuries exemplify the concerns of physicians toward teething pain and possible death associated with teething.

The Hippocratic writings mentioned for the first time the painful gums of children who were teething. There was considerable worry that children could die during the time of teething because associated fever could lead to convulsions. Concerns about teething pain were mentioned in virtually all subsequent paediatric texts. Writing in the mid-sixteenth century, the physician Thomas Phaer – who in 1544 wrote *The Book of Children*, the first English book on children’s diseases – referred to the pain caused by teething, commenting how “about the seventh month, sometimes more, sometimes less, after the birth, it is natural for a child for to breed teeth, in which time many one is sore vexed with sundry diseases and pains.” In 1767, the English physician George Armstrong went a step further by stating that “almost all children that die whilst they are about teeth, are said to die of teething.” *Perry’s Treatise on the Prevention and Cure of the Tooth-Ache* (1827) described how when infants cut their teeth the “general system of the child is deranged, and considerable pain endured.” Michael Underwood was particularly concerned about teething,
which was “amongst the most dangerous” to an infant and “subjects it to manifest complains.”

Another common paediatric distress noted by modern medical writers involved colic and abdominal pain. In a section entitled “Of colike and rumbling in the guttes”, Thomas Phaer described colic as “a common disease of children, it commeth either of worms, or of taking cold, or of evyl mylke, ye signes thereof are to well knowen, for the chylds cannot rest, but cryeth and fretteth it selfe.”

Some writers related abdominal pain to colic, while others claimed it was caused by flatulence, constipation, or worms. The Italian physician Veterrio of Bologna thought that “pain on the stomach occurs in infants sometimes from flatulence existing in the intestines, sometimes from the coolness of the atmosphere or some other cause chilling the stomach; sometimes it also results from worms biting the intestines.”

Often treatments were offered specifically to cure or palliate the suffering of young patients. One approach employed across the ages involved the use of amulets that could be hung around an infant’s neck to prevent or relieve pain. Such amulets were made from different materials: the tooth of colocynth, a viper tooth, or green jasper to soothe teething pain (Aelius, sixth century); red coral to aid digestion (Oestereicher, sixteenth century); and a dead man’s tooth. Another approach to treating pain was to direct attention to the wet nurse or the breast-feeding mother on the assumption that beneficial agents administered to her would be passed to the infant through breast milk. When treating colic, Thomas Phaer advised nurses to have in mind that: “the nourse muste avoyde all sake and sower meates that engender cholere, as mustarde, vynegre and such, and all maner frutes.”

A third method of pain relief consisted in the direct administration of remedies to children. The use of remedies commenced in ancient times and involved a vast array of ingredients and forms. In the first century CE, Soranus proposed giving teething infants a piece of fat to suck, and rubbing the gums with

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205 Ruhrah, *Paediatrics*, 120.

chicken fat or hare’s brain. After teeth had emerged, he recommended the use of woollen wraps around the infant’s neck with various poultices applied to the gums. Poultices for the treatment of infant pain were common, and the instructions for their preparation were often very complex. For example, the following is a Thomas Phaer prescription for “an other good playster for the same entente” for colic: “Take good stale ale and fresh butter, seeth them with an handful of comyne poudred, and after put it all togyther into a swynes bladder, and bynde the mouthe faste that the lycoure yssue not out; then wynde it in a cloth and turne it up and downe upon the belly as hote as the pacient maye suffer. This is good for the colyke after a sodayne colde in all ages, but in chyldren ye must beware ye applye it not too hote.” Soranus refers to a suppository made of boiled honey, and Bagellardus recommended infusing mouse excrement in common edible oil that would then be gently inserted into the child’s anus to relieve constipation. Whether these treatments were effective was left unsaid, but some of the remedies were used for many centuries.

Arguably the most controversial treatment, and the precedent of anaesthesia, was the use of opium, which first appeared in prescriptions in the Ebers Papyrus, an Egyptian manuscript written between 1553 and 1550 BCE, where it was advised as a treatment for crying children: “Capsules of the poppy-plant; excrement of wasps on the wall; rub together; strain and administer for four days running; it will stop immediately.” Opium was also advocated by Rhazes (854-925 CE) and by Avicena to relieve crying and sleeplessness in children. By the fifteenth century, concerns were being raised about the use of opium. Bagellardus emphasized that treatment of crying, sleepless children should begin with milder remedies because of the sedative nature of opium.

The Gloucestershire physician Walter Harris (1647-1732) was adamantly...

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208 Phaer, The Booke of Children, 58.
209 Ruhrah, Paediatrics, 165.
211 Cameron Gruner, A Treatise on the Canon of Medicine of Avicenna Incorporating a Translation of the First Book (Luzac, London, 1930), 47.
212 Ruhrah, Paediatrics, 57.
opposed to the use of opiates for infants, maintaining that other remedies would provide adequate relief if applied in sufficient quantities.\textsuperscript{213}

\textbf{Surgery and Anaesthesia}

\textit{Child surgery before anaesthesia}

Although paediatrics as a specialism did not develop until the mid-nineteenth century, more than a few cases of surgery before this date describe operations for wry neck, curvature of the spine, birthmarks, cleft palate, hare lip, and club foot – all conditions that were considered exclusive to (or at least most common in) childhood. Celsus was notable for discussing a variety of surgical procedures for children, such as those for inguinal hernia, repair of harelip and nasal defect, tonsillectomy, and treatment of sore eyes by expiration or cauterisation of the scalp.\textsuperscript{214} Classical authors discussed diverse operations on children often intended to treat birth defects, such as: imperforate anus, urethra, vagina, glans, and ears; removal of fingers in polydactyly; severance of the frenulum and the tongue; and more invasive or culturally located interventions, such as circumcision and castration by excision.\textsuperscript{215}

Two main surgical procedures were most commonly practice on children in Western Europe before the development of anaesthesia: trepanation (boring a hole in the skull to treat headaches, mental illness, and convulsions) and circumcision.\textsuperscript{216} Surgical procedures were exceedingly painful and difficult for both the child patient and the physician. Pain relief during surgery was sometimes provided with opium, hyoscyamus, mandragora, and wine, but physical restraint remained the more common approach to control the patient. Before the introduction of ether, surgery could not get beyond two main approaches: subjection and weakening.\textsuperscript{217}

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{213} Garrison, \textit{A System of Pediatrics}, 87.
\item\textsuperscript{214} See C.C. Mettler and F.A. Mettler, \textit{History of Medicine} (The Blakiston Co, Philadelphia PA, 1947) 691-788.
\item\textsuperscript{215} Mettler and Mettler, \textit{History of Medicine}, 691-788.
\item\textsuperscript{217} Moscoso, \textit{Pain}, 117.
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For a long time, the main provision against the horrors of prolonged surgical interventions was the skill of the surgeon, which could result in a speedy operation or intervention. Scottish Surgeon William Ferguson (1773-1846) boasted of his ability in conducting operations to correct harelip in babies and children. According to the surgeon himself, he could insert the pins twenty seconds after making the initial incision and so quickly that “scarcely any blood is lost.” Despite the possibility of alleviating these conditions, the decision to submit a child to the scalpel came after no little tribulation. The parents of such children often found themselves confronted with a fearful decision: the dilemma of deciding between the torture of the illness and the pain to which the children would be subjected during the operation. In some cases, parents denied submitting their child to a surgical intervention that could just as easily end the life of the patient as relieve an unbearable suffering. Doctor John Crichton complained in 1828 of how some parents “could never bring their minds to consent to an operation until his life was despaired of” – by which time it was often too late.

The arrival of anaesthesia

Surgical anaesthesia profoundly changed both the experience of patients and that of their doctors. For patients, advantages were immediate: anaesthesia reduced the alarm and anxieties of anticipation, but above all it cancelled or rendered bearable the excruciating, often traumatizing pain during surgery. Surgeons welcomed the possibility of preventing surgical pain. Those practising before ether and chloroform were agents of great suffering that was thought of as a necessary evil for the alleviation of other symptoms. It is reported how Astley Cooper (1768-1841), one of the leading surgeons of his time, lost control over his emotions only on one occasion. A friend took his son to Cooper to see if he could remove a birthmark, and the child looked at the doctor with such sweetness that he could not resist bursting into tears. The description of the eminent surgeon as a sympathetic man is not isolated or merely anecdotal. Rather, it is framed by the reconceptualisation in the eighteenth and early

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219 ‘Mr Crichton on lithotomy’, Edinburgh Medical & Surgical Journal, 9 (1828) 232.
nineteenth centuries of the physician as a “man of feeling” and the cultivation of sympathetic identification. The Scottish doctor James Miller (1812-1864) considered that there was “nothing so painful to the operating surgeon – more especially if he happen to be himself a father – as the being compelled, in the exercise of his profession, to inflict tortures on young children, and to have his ears stunned with their piercing cries.” Along the same lines, Frederic Skey (1798-1872) recommended to his colleagues that a surgeon should perform only those operations to which he “would unhesitatingly subject his own child.” The reference to the delicate constitutions of children in these cases, and the medical idea that their constitutions were more susceptible to pain, owed much to the very concept of “sensibility” discussed above.

While it is true that the works of Miller and Skey show how nineteenth-century doctors claimed to be inspired by instincts of compassion, at the same time they also assigned different sensibilities to different human groups. In fact, the same scientists and philosophers who highlighted the centrality of sympathy in the evolutionary process also were responsible for the formulation of a hierarchy of sensitivity, insisting that susceptibility to pain seemed to depend on variables such as sex, age, social background, or geographical provenance. The drawn corollary was that the perception of men, women, children and the elderly was not alike, thereby destroying the intersubjective foundations of suffering. Following a cultural narrative that very much contradicts the more familiar prejudices about the masculinity of pain endurance, there was an abundance of stories of heroic impassivity or stoicism towards suffering from women and children as well as men. As a result, there appeared to be no necessary causal link between the source of pain and its effect.

In 1842, William Ferguson removed a tumour the size of an orange from the face of a 12-year-old girl. The half-hour operation was carried out in front of 200 spectators in the operating theatre of King’s College Hospital and reported in detail in *The Times*. The intervention in which Ferguson “never once lost his presence of mind” brought him immense prestige. The unnamed patient “cried

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221 James Miller, *Surgical Experience of Chloroform* (Sutherland & Knox, Edinburgh, 1848), 24.
piteously” at the beginning but then “exhibited great moral courage.” Although it may be true that Ferguson seemed to have behaved heroically by this account, the values related to the way in which pain should appear where it was expressed by his patient. Extraordinary though it may seem, children were apparently able to bear serious operations with the same fortitude as adults, and many surgeons testified that children – though “more susceptible of pain than men” – could, as a member of the Royal College of Surgeons of Edinburgh, William Griffin noted, “surpass them in fortitude.”

Far from ending the debate, the arrival of anaesthetics served to galvanize it. The administration of anaesthesia became dependent on the variables described above and a selective pattern in the application of anaesthesia ensued. Many, if not most, mid-nineteenth-century practitioners anaesthetised some of their patients and not others, and the issue for them was not whether to use anaesthetics, but when to use them and on whom. For children, who were considered more sensitive, anaesthesia was deemed to be appropriate from the very start. Thus, the English physician John Snow (1813-1858) asserted: “I have given chloroform in a few cases as early as the ages of eight and ten days, and in a considerable number before the age of two months; and I have at this time, June 30th, 1857, memoranda of the cases of 186 infants under a year old to whom I have administered this agent.” Unlike American authors who perceived children as having more problems associated with anaesthesia – such as nausea, vomiting, and cardiac arrest – Snow in England explored the use of both ether and chloroform, and considered that both substances were more suitable for operating on infants and children than on adults.

**The debate on child anaesthetics**

Snow’s belief that the use of chloroform in children was safe was longstanding in Britain and his distinction between children and adults is found in almost all surgical treatises of the time. In the fourth edition (1900) of *The Diseases of Children: Medical and Surgical*, Henry Ashby, the physician to the general

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224 *The Times*, 3 February 1842.
hospital for Sick Children in Manchester, addressed the two questions that needed to be considered in the production of anaesthesia in children as compared with adults, “that is, their capacity for the inhalation and absorption of the anesthetic vapour and its reaction on their more unstable nervous and usually healthy vascular systems.” Like Snow, Wilson regarded children as “better subjects than adults merely in so far as they are more free from those degenerative changes which in older subjects complicate the administration.” He thought that children “also have an advantage in not being habituated to the excessive use of alcohol.”

Not all authors agreed with Snow and Wilson on this point. In his lengthy report on ether to the Boston Society for Medical Improvement, the American surgeon Henry Bigelow (1818-1890) stated that “very young subjects are affected with nausea and vomiting, and for this reason Dr Morton has refused to give it (ether) to children.” It is worth noting that just two years after this statement, Bigelow argued in Ether and Chloroform: Their Discovery and Physiological Effects, that anaesthesia was not necessary in infants because their limited memory capacity rendered them incapable of suffering. This is one of the earliest cases of infant pain denial based on scientific arguments and will be echoed by many of the authors covered in Chapter 2 of this thesis. However, it is possible that Bigelow added this scientific argument as a reason to avoid the dangers implied in the use of anaesthesia. Four years later, Dr Abel Peirson of Salem reported on six successful harelip surgeries that led him to recommend surgery as close to birth as possible. Peirson reports: “The sensibility to pain is less distinctly marked at first, than after a few days. In the last-mentioned case of harelip operation, the child actually slept while the lip was being dissected from the maxillary bone.” John Snow was also performing harelip surgeries in England but, unlike Bigelow and Peirson, he used chloroform in these cases and criticised those who did not.

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228 Henry Ashby, The Diseases of Children: Medical and Surgical (Longsman Green, New York, 1900), 818.
229 Ashby, Diseases, 819.
231 Henry J. Bigelow, Ether and Chloroform: A Compendium of their History, Surgical Use, Dangers and Discovery (David Clapp, Boston MA, 1848).
232 For further discussion on anaesthesia and infant pain see Chapter 3.
I have seen a few operations in the hospital for hare-lip, without chloroform, whilst the children were on their backs. In these cases they cried violently from the pain, set the blood in the mouth into violent commotion, and then drawing a deep inspiration, drew a little of the blood into the larynx, which caused a violent cough; so that there was usually much more appearance of choking than in the cases where chloroform was given.²³⁴

Although the primary advantage of anaesthesia was the relief of pain, it was also used as an attempt to immobilise difficult patients, as shown by a report of an infant who was “rolled firmly in a sheet as a substitute for ether” during hare-lip surgery.²³⁵ Children were viewed as more sensitive to pain and more difficult to control if they were anxious and fearful about the procedure. Snow considered that the significance of ether went beyond “preventing the pain” and helped the surgeon at the time of the operation by keeping quiet those patients “who otherwise would not be.”²³⁶ Henry Ashby’s The Diseases of Children (1896) underlines how there was not yet a single criterion for the use of anaesthesia on children. Ashby emphasised in reference to surgery on children that “no child should be allowed to lie in pain after an operation.” He advised that the surgeon who operated on children should follow some rules. First of all, “do not let a child know that he is going to be operated upon, until the time actually comes for the operation,” then he remarked on the importance of avoiding “with the utmost care unnecessary loss of blood.” During the whole procedure, it was vital to “keep the child warmly wrapped up,” but above all “never let a child suffer pain if it can be avoided; thus, an anaesthetic should be given for any painful dressing or manipulation, and opium as soon as recovery from the anaesthetic has taken place.”²³⁷ When Ashby wrote this treatise, anaesthesia was a medical practice with a history of less than 50 years. Despite the attempts of doctors such as

²³⁴ Snow, On Chloroform, 293.
²³⁵ Pernick, A Calculus, 229.
²³⁶ Snow, On Chloroform, 293.
²³⁷ Ashby, Diseases of Children, 337
John Snow to understand the way in which anaesthesia worked in children’s bodies, at the end of the nineteenth century it was still an experimental practice based more on trial and error than a unified knowledge.

Conclusion

Before the invention of anaesthesia, the development of experimental physiology, and the establishment of the anatomo-clinical method, pain was a stable object, very much linked and contained by religious explanations and the Galenic focus on speculative postulates and metaphysics. However, in the nineteenth century pain was instrumentalised, linked to anatomical knowledge and removed from the patient: the patients’ discourse lost ground against the medical gaze that could locate the reason for the injury. With the specialisation of medicine into a diversity of disciplines, pain lost its ontological unity and assumed a variety of representations within the plurality of disciplinary boundaries. Towards the second half of the nineteenth century, two main theories of pain entered a debate that would not reach a quick resolution: the theory of specificity, advocated by classic authors including Democritus and Descartes, claimed a specific pathway for harmful sensations independent of the other senses, including touch; on the contrary, the theory of additive intensity saw pain as the result of breaching tolerance thresholds in any of the sensory channels.

Thanks to anaesthesia, the shifts in the medical concept of pain were joined by radical alterations in the experience and the sense-making of pain. The earlier foundation of pain on religious and theological grounds was gradually replaced with a new concept of pain as an unnecessary byproduct that could be alleviated and treated.238 Before the end of the nineteenth century, pain-related issues concerning children had already been addressed by many authors and practitioners of proto-paediatrics. Contrary to general assumptions that pain in children and the voices of children were largely ignored in previous centuries, the works of Avicenna, Thomas Phaer, Henry Ashby, and many others clearly demonstrate concern about the needs of infants and children. From this, it can be deduced that concern for children’s health, and interest in the prevention and

treatment of their pain and diseases, were widespread and popular. According to the few authoritative writers sampled in this chapters, it was firmly believed that children felt more pain than adults did, and that their pain and discomfort was sufficiently communicated through both verbal and nonverbal means. It also appears that many medical authors believed children to be distinct from adults in their constitutions, bodies, minds, and behaviours. The disciplinarily diverse experimental enquiries to which children’s pain was subjected from around 1870 changed this trend, with many scientists and clinicians claiming infants’ insensitivity.

Before this time, the debate around the sensitivity to pain among newborns and children was not only based on philosophical and physiological arguments, but also on direct observations, which often implied a consideration of the problem of how to assess and measure pain. The cry of infants and children was usually relied on as an indicator of pain and diseases, although until the nineteenth century we do not have any record of classifications of different types of cries related to specific causes – an initiative that was not attempted by any of the classical and ancient authors passed on to us, but also perhaps the type of work that – because it deals precisely with the doubly opaque subject of pain and childhood – might not have been considered worthy of copying and translating by Arab, medieval and Renaissance authors.

In terms of the maladies and conditions classically associated with childhood – especially early childhood – teething pain was long considered a serious problem, having been discussed in virtually all proto-paediatric texts, along with abdominal pain and colic. Although there is evidence that children were also cared for, and that efforts were made to manage their pain, not until the advent of anaesthesia was there any prospect of significant pain relief. The introduction and use of pain-relieving substances or stupefying gases at the beginning of the nineteenth century transformed the experience of pain from a divine punishment to a physiological problem and a medical challenge, transferring theological interpretations of pain from the domain of medicine to the lay domains of private conscience and popular beliefs. Although it has been stated that children were not the demographic most likely to receive anaesthesia, this chapter has argued that children were in fact the subjects of many of anaesthesia’s early applications, and that children’s bodies in pain were an important part of public
debates around the use of anaesthesia before it consolidated in an established body of practice.\textsuperscript{239}

\textsuperscript{239} Rodkey and Pillai Riddell, ‘The infancy of infant pain’, 338-350.
CHAPTER TWO

The Language of Children’s Pain (1870-1900)

Introduction

For some people, the mere mention of the words “children” and “pain” will bring to mind Oscar Rejlander’s photographs of children crying that Charles Darwin (1809-1882) used in his work *The Expression of the Emotions in Man and Animals*. One of these illustrations, which bears the title “Mental Distress” in the book but became known to the public as “Ginx’s Baby”, met with such success that Rejlander ended up selling 250,000 *cartes de visite* based on it.240 The photograph shows what Darwin claimed was the characteristic physiognomy of a baby “weeping or crying”: The eyes closed, “so that the skin round them is wrinkled, and the forehead contracted into a frown;” the mouth open with the lips “retracted in a peculiar manner,” and the teeth “being more or less exposed.” For Darwin, the “violent and prolonged screams” of children were emotional expressions associated with “pain, moderate hunger, or discomfort.”241 But how, in fact, can we then know why this particular child is crying? Is “Ginx’s Baby” a representation of pain, hunger, frustration or – as it appears in Darwin’s book – “mental distress”? Does “Ginx’s Baby” have anything to tell us from a medical point of view? For many medical professionals in the late nineteenth century, the answer would undoubtedly have been in the affirmative.

This chapter develops Joanna Bourke’s argument in *The Story of Pain*, according to which children’s pain was subject to a reevaluation that concluded in the first half of the twentieth century, when “many scientists and clinicians [claim] that infants were almost totally insensible to pain”.242 By developing this line of argument and extending it to the field of the history of paediatrics, this chapter explores how the emotional expression of children’s suffering, chiefly represented by cries and screams, was subject to different interpretations.

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depending on the different professional bodies invested with the performative authority required to shape its meaning. As this chapter will argue, Bourke’s perspective describes just partially the medical, physiological and psychological theories and practices related to children’s pain that existed at the end of the nineteenth century and early twentieth century in the Anglo-American worlds.

An exploration of the interpretation of children’s screams and cries in this period leads us to two debates of the time that constitute the subject of this chapter. While centred around the communication of children’s pain – and therefore with a common ground in the construction of the possibility of the child in pain as a research subject – the two research questions aim in opposite directions. The first question is oriented externally, towards understanding children as human voices, and was addressed significantly in the then nascent fields of anthropology and paediatrics (which arrived at different conclusions). The question is: Are children’s expressions of pain and suffering capable of communicating certain states, conditions and emotions? More importantly, if the answer to this question is affirmative: Is there a univocal correspondence between expressions and their internal referents that justifies a scientific programme of description, classification, and analysis? While anthropologists (or proto-anthropologists) tended to frame childhood within an evolutionary view of humankind and interpreted infant emotions as stages of development in a linear notion of progress that ultimately begged for the cancellation of the past, paediatricians sought to decode the language of children in order to treat them and heal them. The second question is a more radical one, and emerges from the consolidated belief that infants are mechanically programmed to cry. Beyond the communicational use of screams and cries to relate to adults nonverbally, the question is whether children are capable of feeling pain? While the question may seem morally repugnant judged with a contemporary eye, the conspicuous gaps in the understanding of neurology at the time justified a research programme that included experimenting with children to test the development of sentience and its relationship with nonverbal expression.

Thus, this chapter explores how the nonverbal expression of children’s suffering – chiefly represented by cries and screams – was framed by different research programmes and, as a result, understood from different theoretical angles and given different interpretations depending on the different professional
bodies invested with the performative authority required to shape its meaning. A comparison between the discourses on childhood of the emerging sciences of human life in the late nineteenth century – including embryology and psychology – and those of paediatricians or physicians who were at the same time developing a new science of children’s illnesses shows a marked difference of perspective. Many of the former, approaching matters with a theoretical curiosity for which infants were instrumental yet temporary research subjects, claimed children were essentially insensitive to pain and had in general a lower vulnerability to pain than adults. Meanwhile, paediatricians – confronted with the practical challenge of diagnosing and treating children – took expressions of pain as valid evidence of it, and used such expressions to diagnose children’s sickness. Darwin tried to connect children’s expressions to their emotions, physiologists linked pain with the nervous system, and doctors interested in childhood tried to connect signs of pain with organic injuries. Indeed, the work of paediatricians such as Charles West and Richard Tonson Evanson can serve to refute claims that paediatricians were “likewise naive about the suffering of infants.”

A major contribution of this chapter to the current state of the history of pain is that, in spite of the much-supported scientific claim of infant insensitivity in the discourses and practices of late-nineteenth-century life sciences, some leading paediatricians (proto-paediatricians) were nonetheless using pain as a tool to diagnose childhood pathologies both in theory (manuals) and in practice (clinical cases). This chapter also seeks to cast doubt on the idea that emotions correspond in any mechanical and invariable way to specific bodily gestures, showing how the scream and the cry created significantly different emotional bodies in paediatric and experimental contexts. To shed light on this issue, it is important to investigate what physiologists, psychologists, doctors, and paediatricians considered to be the causes of pain in children and, where appropriate, to explore their reasons for believing that such pain did not exist.

Chronologically, this chapter focuses on the second half of the nineteenth century and, in particular, on the field of paediatrics, while the following chapter takes up the subject from the 1890s until the Second World War, focusing on the development of the Child Study Movement and new scientific forms of observing pain.

David Chamberlain, ‘Babies don’t feel pain’, 155.
childhood. While previous publications by scholars of the history of medicine offer useful reviews of the literature on the history of research and experiments about infant pain, they do not evaluate paediatric pain in any depth. In contrast, this chapter pays careful attention to the assumptions and ideas generated not only in the laboratory but also in the hospital and in the field of paediatrics. In addition to scientific sources previously analysed in published works that review infant-pain experiments, this chapter involved an extensive literature search for medical and paediatric publications about infant pain, which began with the Institute of Child Health (UCL) Library Historical Collections on the History of Paediatrics. To uncover medical perceptions of children’s pain, vernacular medical texts have been analysed. The study of paediatrics textbooks and journal articles can shed light on the changes in medical ideas about children’s pain and how these shifts affected popular, as well as medical, understandings of the body. With this aim in mind, this chapter examines Great Ormond Street Hospital’s Cartes de Visite that were used in fundraising, and juxtaposes some of them with the clinical stories found at the Hospital’s archives. Although this childhood photography had financial motivations, the use of photography to study emotions and childhood had been inaugurated by some pioneering works: Darwin’s The Expression of the Emotions in Man and Animals is the second work to use photography as a tool for the scientific study of emotions, after the publication in 1862 of Mécanisme de la Physionomie Humaine ou Analyse Électro-physiologique de L’expression des Passions by the French physician Guillaume Benjamin Duchenne (de Boulogne). The invention of photography allowed scientists to examine rapid movement without relying on the expertise of visual artists. For the first time, a technology existed that could depict physiological movement without the direct intervention of a painter or draftsman, and the camera had emerged as an authoritative source of information.

David Chamberlain, who reviews twentieth-century infant-pain research from an anti-circumcision perspective; Patrick McGrath, who considers the history of infant pain research in the 1980s; Emilia Pabis, Anita Unruh, and others who review ancient and medieval views of infant pain; and the already cited Elissa N. Rodkey and Rebecca Pillai Riddell, who investigate the origins of infant pain denial. See, Chamberlain, ‘Babies don’t feel pain’, 145-168; McGrath, ‘Science is not enough’, 2457-2459; E. Pabis, M. Kowalczyk, T.B. Kulik, Anestejol Intens Ter 42 (2010) 2010; Anita Unruh, ‘Voices from the past’, 247-254; Rodkey and Riddell, ‘The infancy of infant pain’, 338-350.
On Darwin, or emotional expressions as reflex actions

The subject of Darwin’s 1877 ‘biographical sketch’ was his own son “Willy”. The article began in the following way:

During the first seven days various reflex actions, namely sneezing, hickuping, yawning, stretching, and of course sucking and screaming, were well performed by my infant. On the seventh day, I touched the naked sole of his foot with a bit of paper, and he jerked it away, curling at the same time his toes, like a much older child when tickled.245

With the aim of evaluating the distinct behaviours and reactions of the child, Darwin centred himself in the kingdom of the instincts, differentiating the innate from the acquired and, at the same time, adopting an approach according to which development implied a process of hierarchy, with a gradual increase in the complexity of behaviour. Thus, throughout the text, two polarities are woven together: that of the child as an adult-in-training – which, in the Darwinian perspective was linked to the evolution from animals to humans – and that of the adult as a person of will. Four paragraphs below, the writer describes Willy’s first visit to the zoo, at the age of two. While the contemplation of known animals, such as the antelope and the deer, produced great enthusiasm in the child, the vision of the “beasts in houses” provoked much concern and alarm in the little one. Not being able to explain the child’s fear on the basis of previous experiences, Darwin asked if his son’s vague but real fear might not be “the inherited effects of real dangers and abject superstitions during ancient savage times?”246

The importance of this question and the repercussions of Darwin’s publication lies both in its content and in the identity of the author. Inspired by the publication

of L’Acquisition du langage chez l’enfant et dans l'espèce humaine by French philosopher Hippolyte Taine, the father of the theory of evolution decided to make use of the notes in his notebooks “M” and “N” about the development of his son William.\(^{247}\) Darwin’s publication took place at a time, during the middle of the nineteenth century, when the first systematic studies of human development – the so-called “biographies of babies” – started to appear. In Darwin’s narration, as in other biographies of the same subject, the child appears as an object of knowledge through which the history of human development, or of humanity to come, is told. As Claudia Castañeda has indicated, the underlying theme of the biography of the baby is not only that of the individual self but also that of human nature itself.\(^{248}\)

Other popular treatments of child development were more focused on the individual and the appearance of personality. For instance, in 1835 – the year in which the English version of Madame Necker de Saussure’s *L’Éducation progressif* (1828-32) was published – Elizabeth Gaskell, a well-known English novelist of the time, wrote a brief biography of her daughter Marianne, then aged six months. Like Darwin, Gaskell used her diary to make precise observations about her oldest daughter’s physical, emotional, moral, and educational development. Even though this and other experimental studies about child behaviour were published while Darwin was recording the development of his son William, it is ‘A biographical sketch of an infant’ which is often cited as the beginning of scientific interest in Britain in the area of child development. A major reason for this starting point might seem sexist from a contemporary perspective, but was nonetheless a powerful agent in the public reception at the time: female diarists were often thought to partake in a more romantic approach to their recordings, possibly because of the introduction of their own feelings and emotions. Ultimately, their observations might have been lucid, inspiring, or sensible, but partly because they were intrinsically feminine – and, in these cases, maternal – they were not considered scientific.\(^{249}\) Gaskell’s diary is both a record of child development and a touching account of motherly worries as she


\(^{249}\) For a clear account of the ‘advice to parents’ industry see Christina Hardyment, *Dream Babies: Child Care from Locke to Spock* (Oxford Paperbacks, Oxford, 2007).
struggles to bring up her child: “I feel myself so unknowing, so doubtful about many things in her intellectual and moral treatment already, and what shall I be when she grows older, and asks those puzzling questions that children do?” She felt “extreme anxiety in the formation of [her] little daughter’s character” and prayed, when little Marianne was 13 months old in 1835, “Oh! may this indeed be the beginning of self-government.” She struggles with conflicting advice – “Crying has been a great difficulty with me. Books do so differ” – and worries about her passions and whether tears might betoken “a morbid feeling … that for her happiness had better be checked.”

Darwin, who was distantly related to Gaskell, produced a document of a very different style. The diary is not a record of parental anxiety but rather a precise observational study of the physiological processes of development, noting sensitivity to touch, tickling, or the function of hiccoughing. While Gaskell’s diary gives us a view of the infant-mother relationship and emphasises the importance of the individual infant, in Darwin’s narration the child appears as an object of knowledge through which the history of human development, or of humanity to come, is told: a universal figure seen through the angle of a specimen. As will be shown in Chapter 3, taking the child as a symbol whereby research could mount a diachronic investigation of the human species would become a cornerstone for Darwinist anthropologists and representatives of the Child Study movement.

The observations on the physical and mental development of “Willy” – articulated around expression and including rage, fear, affection, and moral sense – set in motion the investigation that culminated in the publication of The Expression of the Emotions in Man and Animals (1872). Darwin considered childhood to be the only natural, rather than cultural, stage of life, a blank page which hid two potentialities: the possibility of moulding the future adult and

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250 J.A.V. Chapple and Anita Wilson, Private Voices: The Diaries of Elizabeth Gaskell and Sophia Holland (Keele University Press, Keele, 1996), 52, 54, 56.
(which Darwin considered more important) the possibility of finding the ancestors of the human being in the behaviour and expressions of the child. In not granting the child the human attributes of freedom and free will, Darwin classified it alongside animals and automata. In spite of the fact that the body of the child was constituted by the same muscles that permitted adults to express their emotions, the absence of both conscious control and conditioning proper to experience allowed one to see in the child the instinctive expressions of human beings and the traits shared with animals.\textsuperscript{252} This child in pain, seen as a bodily theatre through which expressions of human history can be observed, is reinforced through the distribution of the chapters and the illustrations of \textit{The Expression}. Darwin used these images not only as research material but also as a visual strategy that established a hierarchy of man and animal. While representations of animals appear only in the first half of the book (and only in the form of traditional woodcuts), pictures of humans are found in the second half of the book, from infants to older children and adults, and predominantly in the form of photographs.\textsuperscript{253}

Darwin was among the first scientists to adopt photography in order to record evidence that previously escaped the human eye. As he recognised, “the study of expression is difficult, owing to the movements being often extremely slight, and of a fleeting nature.”\textsuperscript{254} Then, again, the question was to find an adequate technology that could synchronise with these slight, fleeting movements. According to Darwin, “it is easy to observe infants whilst screaming; but I have found photographs made by the instantaneous process the best means for observation, as allowing more deliberation.”\textsuperscript{255} The development of photography in the nineteenth century was crucial for the history of both medicine and photography. The rapid proliferation of photographic technology took place while medicine was establishing itself as both a science and a profession. Photography and medicine developed in parallel and reinforced each other. Photography could help medical professionals by revealing phenomena the naked eye could not see and could do so with relatively little intervention from


\textsuperscript{253} Progder, \textit{Darwin’s Camera}, 155.

\textsuperscript{254} Progder, \textit{Darwin’s Camera}, 155.

\textsuperscript{255} Progder, \textit{Expression of Emotions}, 13.

human hand (unlike painting or drawing). As Lorraine Daston and Peter Galison have argued, this aspect presented unique opportunities and enhanced photography’s claim to be able to provide evidence: the camera lens was indiscriminate and therefore unbiased. Made without human selection or intervention the photograph had the power to display simply what was there.\footnote{256}{See Daston and Galison, \textit{Objectivity}, 115-190.}

Although technical limitations compromised the utility of these photographs, Darwin used many of them to illustrate \textit{The Expression of the Emotions}. The British naturalist had started to pay attention to emotional expressions early in the 1830s when his first son was born, but it was not until the 1870s that these observations made part of his published research. What was supposed to be a chapter of \textit{The Descent of Man} (1871) became a book of its own as a result of the extensive material that he had collected: besides the multitude of annotations on his notebooks, Darwin had gathered a significant amount of visual evidence and had sent questionnaires to collaborators and other researchers around the world.\footnote{257}{Prodger, \textit{Darwin’s Camera}, 3.} The origin of his photographic collection was varied.\footnote{258}{For a discussion on Darwin’s art collection see Prodger, \textit{Darwin’s Camera}, 3-20.} Besides the famous collaboration with the Victorian artistic photographer Oscar Rejlander, Darwin also owned photographs sent by the psychiatrist James Crichton-Browne and the photographer Giacomo Brogi (collaborator of the Italian physiologist Paolo Mantegazza), as well as portraits from different English photographic studios. He also drew on multiple sources, from woodcuts to paintings and commercial photographs. Just as he collected specimens of plants, Darwin also compiled photographs, as long as they contained valuable observations of natural human expressions.

Photography became a valuable tool not only for the images it provided but also because it fitted the time that was needed to capture the expression. Exposure times had been reduced from a few seconds to under a second, approaching the concept of a snapshot. Darwin explained in the text how the muscles contracted, but the photographs depicted only the instant that defined and identified the expressions, leaving out of representation the movements that led up to that instant. Therefore, Darwin consolidated the idea that the “expression” was what had been captured by photography, and introduced the
concept of “natural” expressions. The problem now was not only to capture “fleeting states” but also to photograph real expressions.

This quest for naturalness led Darwin and Rejlander to ask whether the very act of taking a portrait could affect the sitter’s expression. These difficulties were not particular to Darwin’s enterprise. In the 1870s, it became common that the photographic press published articles discussing the best methods to capture real expressions in portraiture. The main problem addressed by these texts was that the act of taking a picture was usually annoying and made people feel nervous. Most of these commentators advised photographers to interact with the sitters, so they could forget that they were at the photographic studio, while others introduced changes in the camera. These strategies – which were also adopted in hospitals, as will be shown in the next section of this chapter – were intended to guarantee the mirror effect of photography by minimising the intervention of the camera. Along the same lines, Rejlander tried to connect with the sitters, even using his wife, and explicitly recognised in a letter to Darwin, for example, that “It is very difficult to get, at will – those expressions you wish – Few have the command of imagination to appear real – In time, I might catch some – So I have tried in propria persona.”

Ultimately, Darwin’s practice and collaboration with Rejlander contributed to the consolidation of two ideas: that the face is the locus of the emotions, and that the particular instant captured by photography defined and identified what the expressions looked like. For Darwin, the child’s emotional expressions illustrated human history. He considered a child’s crying to be central to his investigations of expression, as it was one of the first and most common expressions. While other habits, such as laughing and weeping, were acquired gradually, “the art of screaming […] from being of service to infants, has become finely developed from the earliest days.” Considered an innate expression, screaming proved ideal for studying the similarities between human and animal behaviour. Unsurprisingly, then, the first photographs of the chapter ‘Special Expressions of Man: Suffering and Weeping’ – which marks the narrative’s transition from

animals to humans – are of babies screaming and crying (Figure 1). Foremost among these was the one entitled “Mental Distress” – taken by Rejlander and which became famous as “Ginx’s Baby” (Figure 2) – which Darwin claimed illustrated the characteristic physiognomy of a baby “weeping or crying”. According to the naturalist, the “violent and prolonged screams” of children were emotional expressions associated with “pain, moderate hunger, or discomfort.” Nevertheless, within the context of the evolutionary process they became reflex actions strengthened by custom and, as a result, they were not reliable as indicators of pain.

‘A biographical sketch of an infant’ launched a new field of observation and experimentation – the child in his early months – and would ultimately allow a naturalisation of the experimentation of childhood pain in the so-called “century of the child”.

Following the publication of Darwin’s On The Origins of Species (1859), and more specifically through the emergence of evolutionary psychology and psychiatry, there were pronounced displacements in the construction of childhood. The enduring popular notion of the child as an animal or savage received an apparent scientific validation in the recapitulation theories, which saw in the child a mirror of the ancestral forms of the species, both human and animal. Further, Darwin’s interest in infant senses and the sorting of responses into reflexes and instinct was an important influence on later experimental investigations that superimposed a preconceived interpretation of gestural language as a symbol of the biological past.

In fact, the publication of Darwin’s ‘A biographical sketch of an infant’ proclaimed the emergence in Europe of a new field of observation and experimentation that had as its core subject the child in his first months of life.

262 Darwin, Expression of Emotions, 147.
265 See Chapter 3.
German contributions to child research: Experimental tests of infant pain sensitivity

Darwin was one of various authors who converged in the configuration of research programmes in which children’s pain, or children expressions of pain,
were fixed as a representation of something else – whether the primitive past of the species or some kind of “common sense” superstition. Many of the contributions to what would consolidate in the theories of infant pain denial in the twentieth century came from Germany. The growth of science programmes at German universities coincided with this psychophysical interest and supported the growth of experimental physiology. This new physiology set out to understand the nature of the nervous system with an approach imbued in methodological scepticism and experimental caution. The experimental practices of prominent continental scientists, including Genzmer, Kroner, and Canestrini, are framed within the development of the new physiology, which emerged in Germany around the figure of Johannes Müller (1801-1858). This new body of knowledge proposed an empirical programme for the study of vital functions and was greatly dependent on the development of new theoretical lines of investigating pain.  

Ernst Weber (1795-1878) investigated tactile thresholds and localisation but did not venture into the mechanisms of pain. However, his pioneering research on physical senses and the establishment of perceptual thresholds for each of the individual senses influenced the direction of nineteenth-century psychophysical research. Müller and other professionals – including Richard Bright, Maximilian Von Frey, and Arthur Goldscheider – emphasized the nerves in their descriptions of the physiology of pain. This led to a more and more sophisticated understanding of the human nervous system. However, the incomplete nature of knowledge about the nervous system prevented the attainment of a consensus about important points. Thus, scientists debated if pain depended on the central or peripheral nervous systems and whether the receptors and pathways of pain served only to perceive pain or whether, on the contrary, they had more general functions. Finally, they tried to settle the question of which theory described the physiology of pain with greater certainty: the theory of specificity (according to which the body perceives pain via a

267 Javier Moscoso, Pain, 122.
268 See Finger, Origins of Neuroscience, 134
269 Rey, History of Pain, 138.
differentiated sensory system) or the pattern theory (pain receptors are shared with other senses).  

The development of experimental embryology strengthened the theoretic framework and enabled researchers to apply it to the understanding of the nervous system and the experience of pain. In 1872, Paul Emil Flechsig (1847-1929), Special Professor of Psychiatry at Leipzig University, started an investigation with sections of the brains of infants and children. His analysis of the brain sections led to the discovery that nerve fibre myelination took place at different rhythms during different states of development. While the newly born had both myelinated and unmyelinated fibres, only the myelinated ones were completely functional. The conclusion was that the demyelination of the newly born ensured that sensory stimuli, such as pain, were not completely functional and that a child at birth might have only simple sensations.  

The noted German internist Adolf Kussmaul (1822-1902) published his experimental studies of child behaviour nearly two decades before Darwin's book. He conducted these experiments and published them in 1859 under the title Untersuchungen Über Das Seelenleben des Neugeborenen Menschen (Investigations of the Mental Life of the Newborn Child). In the same year that Darwin paved the way for the anthropological interpretations of children with “A biographical sketch of an infant”, Kussmaul was analysing the “normal” development of childhood to understand the adult mind’s constitution. Inscribed in the tradition of New German Physiology, his report about the behaviour and sensory repertoire of the newly born can be considered as a work of experimental psychiatry, in which children became a privileged subject for conducting laboratory research. Discussions about normal development during early childhood were an essential part of Kussmaul’s psychiatric classes at the University of Heidelberg, and it was precisely his dissatisfaction with existing books that pushed him to carry out his own experiments. His investigation

272 The Paul Flechsig conference, summarised by Frederick W. Mott, can be found in ‘Cerebral development and function’, British Medical Journal, 1.3145, (9 April 1921) 529, cited in Bourke, The Story of Pain, 216.
centred on the function of the senses, including touch, sensitivity to temperature, experiments about smell, sight, audition, pain, muscular sensitivity, and “air hunger”. Unlike the rest of the book, however, the section on sensitivity to pain was merely anecdotal and did not include experimental results. Kussmaul’s reticence here stemmed from the fact that his attempts to carry out experiments on pain appeared to cause discomfort to the baby: trial experiments with tartaric acid were met with cries and discomfort that led him to cancel this line of investigation.

The first to combine Darwin’s and Kussmaul’s lines of research to conduct an experimental test of infants’ pain sensitivity was Alfred Genzmer (1851-1912) who, as a doctoral candidate in medicine and surgery at Halle-Wittenberg University, published *Investigations on the Psychic Function of the Newborn* in 1873. The dissertation is a critical study of Kussmaul’s work. But if Kussmaul’s discussion, like that of Darwin, is based on observations that were more incidental than experimental, Genzmer deliberately produced pain in children, prickling them with pins in the nose, the upper lip, and the hands. Even though the intensity of the stimulus was such that “small drops of blood oozed from these openings,” he claimed that the children “gave no evidence of discomfort – not even a slight quivering.” However, he recognised that the stimulus was preceded by an expression: “the wetness of their eyes” increased when the pins were placed in the children’s faces. From all of this, he concluded that pain was “exceptionally poorly developed in the neonate.” In Genzmer’s work, pain is presented as a tool of the experimental method, and children are objects of experimentation linked to the investigation of the development of organic functions.

Genzmer’s work was continued by disciples including Traugott Kroner (1854-1899), who in 1882 delivered an inaugural lecture at the University of Breslau.

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which tackled the same subject, and Silvio Calnestrini, who in 1913 experimented with a group of seventy children and concluded that infantile touch showed a surprisingly light reaction to painful stimuli and a limited electrical excitability of the nervous system. However, Genzmer’s work remained obscure to the point that it would probably have been forgotten had it not been cited by William Thierry Preyer in an 1889 work that was published in Germany, which explicitly merged Genzmer’s research programme with Darwin’s theories.

In 1889, the English physiologist William Thierry Preyer (1841-1897) published in Germany Die Seele des Kindes [The Mind of the Child], which summarised his observation of the development of his son Axel during his first three years, as well as the discoveries of many other investigators, making reference to recent empirical work in physiology and child psychology, including that carried out by Genzmer and Darwin. Strongly influenced by the theory of evolution, Preyer understood development as a trajectory in which language and assertive action gradually took the place of instinct and reflex. The biography of Preyer’s son opened a new period of studying the child through the rigour and meticulousness of his work, which was the most complete observational record of child development up until that time.

Even though Preyer had full confidence in Genzmer as an authority on the study of new-born infants, in the section dedicated to “Unpleasant Feelings in General,” the psychologist wrote: “It is an error to maintain that the very young child is not yet capable of having the genuine feeling of pain or even a high degree of unpleasant feeling,” arguing that “he who can enjoy must also be able to suffer, otherwise he could not enjoy.” Although Preyer admitted that the new-born child is less sensitive to painful impressions than adults, he added that “it would be a mistake to infer from this a condition of anaesthesia or

281 Preyer's initial findings were published in the German journal Deutsche Rundschau as ‘The mental development of man during the first few years of life’ in May 1880. This preceded the publication of his more widely read The Mind of the Child, which was published in German as Die Seele des Kinder in 1881.
analgesia.” Noting that his son Axel “reacted by movements upon the slightest touches of his face,” Preyer thought that babies showed indications of experiencing pain and declared that it was something “unmistakable for every diligent observer. Above all, crying is characteristic: it is piercing and persistent in pain.”

Rather than dismissing Genzmer’s work, Preyer used recent knowledge of nerve development to interpret Genzmer’s results, arguing that lack of response need not necessarily mean that infants were insensible to pain, merely that in experiments using a fine needle the painful stimuli reaches only a few nerves. Preyer’s conclusion is thus somewhat contradictory: he denies that babies experience pain at the level of adults, but maintains that this does not mean that they do not experience any pain because “screaming and movements can be elicited from children and animals just born […] by pinching the skin.” However, he also articulates a concern with infant reflexes that was common in his time: “It would be of great interest to draw up a list, as complete as possible, of the reflex movements of the newly-born.” Such a list would have made it possible to distinguish between merely mechanical movement and “personal action”.

Preyer supported his analysis with accounts of laboratory experiments involving animals such as guinea pigs and chickens. He explains how babies could experience both pleasure and pain during the process of birth itself, writing: “When I put into the mouth of the screaming child, whose head alone was as yet for, an ivory pencil or a finger, the child began to suck, opened its eyes, and seemed, to judge from its countenance, to be “most agreeably affected.” Scientists’ use of the “baby diary” went hand in hand with experiments, some of which started before the moment of birth. Preyer repeated many of Kussmaul’s experiments and also drew upon the evolutionary approach of Darwin’s Expression of the Emotions. In discussing reflex movements, Preyer notes that a comparison of the reflexes of chimpanzees, orangutans, and “Negro children” might well show no differences, and he also cites the parallels shown

284 Preyer, The Mind, 147.
286 Preyer, The Mind, 147.
287 Preyer, The Mind, 97.
by Darwin between a cross child and a chimpanzee, and between the act of laughing in children and monkeys. He supports Darwin's contention that laughing develops at a later stage than crying because crying is more useful to the needs of the infant.\footnote{Shuttleworth, \textit{Mind}, 227-228.}

As has been shown in Chapter 1, the belief that a child's external features reveal its inner qualities – moral character and intellectual capacity, in particular – was something that emerged during the eighteenth-century Enlightenment. Thus, it became possible to consider the child as more than “an object of aesthetic contemplation” and to see it also from the point of view of scientific curiosity.\footnote{James Sully, \textit{Studies of Childhood} (Longmans, Green & Co, London, 1896), 10. Stephanie Olsen has written about James Sully in the context of emotional education and masculinity. See: Olsen, \textit{Juvenile Nation}, 159.}

During the nineteenth century, evolutionary theories which showed the link between humans and animals provoked a change in concepts of human development, presenting it as a Dynamic process rather than a series of static events.\footnote{Michael Wertheimer, \textit{The Evolution of the Concept of Development in the History of Psychology}, in G. Eckardt, W. G. Bringmann, & L. Sprung (eds.), \textit{Contributions to a History of Developmental Psychology: International William T. Preyer Symposium} (Mouton Publishers, New York, 1982), 13-26.}

From this perspective, children were seen as an embodiment of a primitive past and a link to the natural world which could be studied to reveal the processes behind the formation of adult capacities.

This approach was notably advocated by George Romanes (1848-1894), a prominent Darwinist and pioneer of comparative psychology. In his book \textit{Mental Evolution in Man} (1888), Romanes wrote: “The emotional life of animals is so strikingly similar to the emotional life of man – and especially young children – that I think the similarity ought to be taken as direct evidence of a genetic continuity between them.”\footnote{George Romanes, \textit{Mental Evolution in Man: Origin of Human Faculty} (Kegan Paul, London, 1888), 7.}

He argued that by studying the “psycho-genesis of a child” it was possible to ascertain if there were a difference in kind between human self-consciousness and the emotions displayed by animals. The child was considered to be the ideal embodiment of the concept that “ontology repeats phylogeny” – that each living organism goes through the evolutionary stages of its genus.\footnote{Steedman, \textit{Strange Dislocations}, 83.}

In the manner of the baby biographies, he took an incident where his own child knocked his head against a table.\footnote{For Romanes’ experiments with his child and the chimpanzee see Rob Boddice, ‘Vivisecting major: a Victorian gentleman scientist defends animal experimentation, 1876-1885’, \textit{Isis} 102, no. 2 (2011) 215-37.} On asking where he was hurt,
the child “immediately touched the part of his head in question – i.e. indicated the painful spot.” Now, Romanes asks, “will it be said that in doing this the child was predicating the seat of injury?” If so, he continues, “all the distinctive meaning which belongs to the term predicating […] is discharged.” The “gesture-signs” that are “abundantly employed” by animals would have to be regarded in a similar way because “they differ in no respect from those of the still speechless infant.”

The clinical and academic interest in the functioning of reflex actions and the nervous system, the development of the scientific method, and the Darwinist vision of the infant as an inferior primitive being and the child as an adult in training, contributed to the generation of a mechanistic vision of childhood: a perspective which allowed a naturalisation of the experimentation of childhood pain in the so-called “century of the child”. Nonetheless, it is surprising how, just as science started to take a significant interest in childhood, both childhood itself and childhood pain seemed to disappear as autonomous subjects. All these detailed scientific annotations about the first movements and expressions of children and their reactions to sensation and pain did not stem from an interest in the child itself, but in its function as an index of evolutionary development. In all these narratives, the child is key to understanding the mind of the adult and the appearance of self-consciousness. By seeing the child’s body as embodying the animal and the savage, Preyer and Darwin contributed to the naturalisation of experiments on childhood pain and to the consequent denial of its dignity as a locus of recognition and empathy. While these two approaches converged, there is a marked contrast between Darwin’s account of the child as the embodiment of the long-lost savage and the scientific practices of Genzmer and Canestrini. By deliberately producing pain, practices in the laboratory generated a very different body: that of the child in pain.

295 Romanes, Mental Evolution in Man, 324
296 Romanes, Mental Evolution in Man, 324
297 Romanes, Mental Evolution in Man, 324
298 Key, Century of the Child.
The sick child in paediatrics

With the emergence of dedicated children’s hospitals in Great Britain in the mid-nineteenth century, these institutions soon became the primary location of observation and clinical practice on ill children and the primary source of specialised research published in respected journals throughout Europe. However, where the experimental caution and methodological scepticism of physiologists and evolutionists had doubted the authenticity of children’s language for communicating pain, the construction of the sick child as an object of study ran parallel with the programme of decoding the meaning of gestural language of pain in infants.

In 1833, in a review of a pioneering French text about childhood illness, a contributor to *The Lancet* recognised that, in spite of medicine’s general progress, children’s illnesses had been ignored or attributed to teething, to the presence of worms, or to a vague notion of “growth.” Even though earlier doctors had recognised a series of illnesses that were either very common during childhood or that were considered exclusive to children, the study of pathologies proper to this period of life developed as a medical speciality only in the second half of the century. A series of concomitant factors explain this development. The search for professional recognition by anaesthetists at the end of the nineteenth century and the interest of physiology and evolutionary psychology in the development of the child coincided with the aspirations for legitimacy of another professional group: children’s doctors. Thus, this medical speciality, based on the scientific construction of the child/adult dichotomy, started to organise the care of childhood in more scientific ways.

Given these conditions, the first hospitals dedicated exclusively to the care of sick children were created in different European cities during the nineteenth century. In 1802, the world’s first independent children’s hospital was opened in Paris: the *Maison Royale de l’Enfant-Jésus*, which later became the *Hôpital des*

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The arrival of paediatric hospitals and specialist institutions in the United States and the United Kingdom came much later, encountering considerable resistance on the part of the medical guild and public opinion which insisted that children did not need to be subjects of hospital care. In London, Great Ormond Street Hospital (GOSH) opened in February 1852 as the first specialist hospital for children in England. The hospital has been described many times as the realisation of the vision and dream of one man, doctor Charles West. Trained as a “Physician Accoucheur” – in modern terms somewhere between a male midwife and a gynaecologist – West had gained interest in child health via women’s health and through direct experience of children’s hospitals in France and Germany and maternity hospitals in Dublin, where he trained. West had the fortune of counting among his friends the British novelist Charles Dickens, who wrote an article in the widely read magazine *Household Words* to draw attention to the hospital when it opened. So, although the hospital was at first treated with suspicion, little by little its fame began to spread across the whole city.

Five years before Great Ormond Street opened its doors to the public, West delivered a series of lectures to students at the Middlesex Hospital about the illnesses of infants and children, which already contained the seeds of what would be his future paediatric practice. The text, like many others of the period, opens with the debate about whether children can communicate their emotions and their pain in a credible way. The difficulties faced by practitioners when diagnosing children’s diseases and pains were such that many writers believed that children were unable to provide a reliable account of their own experiences. Already in 1849, Hess had described paediatrics as the most

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302 Andrea Tanner, ‘Too Many Mothers?’, 136.
303 For an account of Charles Dickens’s support of the hospital see Jules Kosky, *Mutual Friends: Charles Dickens and Great Ormond Street Hospital* (Weidenfeld & Nicolson, London, 1989). Dickens wrote a strong appeal on behalf of the hospital, ‘Drooping Buds’, which was published in *Household Words*, 3 April 1852, shortly after the hospital opened. Unfortunately, there are no surviving records of any discussions between Charles West and Dickens about childhood illnesses
arduous of medical specialities “...arising from the inability or the unwillingness of children to give a proper description of their feelings, or owing to their fretfulness, shyness, and resistance to the proceedings of the physician.”

West passionately believed that, in spite of the significant barriers that young doctors faced when they came to examine children, the latter demonstrated their pain both through their behaviour and physiologically, providing sufficient proof to be correctly recognised by any decent doctor whose praxis was not based on folklore or on ancient forms of diagnosis. “You cannot question your patient,” explained West. Their lack of response, he said, could be explained by the absence of verbal abilities at early ages and by the paralysis provoked by fear. Doctors needed to obtain information from the child’s expression and behaviour, which was also not an easy matter. “The child is fretful and will not be looked at, you endeavour to feel his pulse, he struggles in alarm: you try to auscultate his chest, and he breaks out in a violent fit of crying.”

Some young men, not familiar with treating children and accustomed to more robust constitutions, showed themselves incapable of learning how to examine and diagnose their youngest patients. West urged them to persevere: although the child could not talk “yet it has a language of its own, and that language must be your object to learn.” With these words West not only showed the difficulties that faced those who were interested in treating childhood illness, he also emphasised the importance and necessity of the figure of the paediatrician.

West compared the children’s doctor with an explorer who expects the inhabitants of a country to speak an already known language but finds that they speak a completely foreign tongue. While some professionals never overcame this difficulty – and for them children’s illnesses became a closed book – the “good” doctor dedicated himself patiently to study “a new semiotics, a new pathology and a new therapy,” gaining access through this new language to an understanding of the child and his illness. West, who used the metaphor of the explorer as a way to express the lack of a first-person account from the patient, argued that those who did not cultivate their powers of observation would never

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307 West, Lectures, 1-3.
308 West, Lectures, 1-3.
309 See J. Gillis. ‘Not just small adults: the metaphors of paediatrics’, Archives of Disease in Childhood (22 March 2007), 946-947.
310 West, Lectures, 1-3.
be able to learn the language of childhood. He went further still, telling his students that those doctors who did not appreciate young children would not be able to learn this language, “for they soon make up their minds as to who loves them, and when ill they will express their real feelings, whether by words or signs, to no one else.” Those who were interested in the “practical” or “theoretical" study of children’s illnesses not only had to be disposed to listen to and understand their patients; they also had to love them. The metaphor of the explorer (with all its implications of empire) persisted throughout the second half of the nineteenth century. Thus, in his 1891 presidential address to the American Pediatric Society, Thomas Rotch, the first chair in paediatrics at Harvard, spoke in words similar to West, telling his colleagues: “We have entered upon the especial investigation of and research in this branch of anthropology with the keen interests of explorers in an almost unknown country.”

The dominant view, until well into the nineteenth century, was that sick children were better off being looked after within their families than in institutions dedicated to their care. So, it is not so strange that the accounts of these doctors, like those found in many other treatises of the period, serve not only as a guide for those interested in the conditions proper to childhood but also as an exaltation of the qualities of paediatrics and the vindication of its existence. The discourse of Charles West and Thomas Rotch took place during the process of the consolidation of the paediatric speciality, which happened within the wider battle for legitimisation of the new professional bodies and the institutions that could strengthen this legitimisation. With the persistence of high levels of infant mortality in the cities, the role of hospitals as a suitable place for sick children was gradually accepted. Their defenders believed that children’s hospitals had beneficial effects – both physical and moral – for patients and the hospital wards were seen as middle-class homes beyond the strictly domestic sphere, promoting good behaviour and making working-class children more respectable. With the recognition of the children’s hospital as the ideal scenario for social change came the validation of the figure of the paediatrician,

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311 Thomas Rotch, ‘Iconoclasm and original thought in the study of pediatrics’, Archives of Pediatrics, 7 (1891) 811.
312 Lomax, Small and Special, 12.
whose importance lay not only in his being a healer of the body but also in being the trainer of the spirit.

**The diagnostic power of crying**

As the narratives of West and Rotch show, the correct diagnosis of children’s illness was a challenge faced by many doctors, which meant that pain was a subject treated with great seriousness by doctors who were interested in the field of children’s health. At the end of the nineteenth century, pain – which the scientific community had come to see as representing not much more than a symptom of disease or of injury – was reclaimed for its diagnostic value. In the middle of the century, the Irish doctor Richard Tonson Evanson demonstrated the instrumental use of pain in the “Diagnosis” section of his manual about children’s diseases. For this doctor, it was essential to determine the existence of pain and its seat in the child or the cause that might make an infant cry, given that pain and the expressive gestures which accompanied it were the most direct manner of accessing childhood illness. As West had already indicated, the importance of children’s physical signs and their translation into clinical signs could confer on them the status of a code that could be deciphered, allowing doctors to approach childhood pain. Doctors such as West and Evanson encouraged the screams and cries of the children not because they could not remedy them, but because they believed that in promoting the abundance of such signs they could arrive at a more accurate diagnosis of the illness.

This semiotic effort was a specific epistemological tool that the incipient discipline of paediatrics chose to adopt, and it marked a differentiated approach to the inclusion of pain in a body of scientific knowledge. Towards the end of the nineteenth century, paediatricians embraced the anatomo-clinical tradition and tried to connect signs of pain with organic injuries. Hence, a search for the most systematic tests for pain in children began expanding observations about childhood crying and examining the changes in children’s facial expressions or sleeping habits under the effects of illness. The semantics of pain encountered many of the same problems that any scientific analysis of natural language.

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315 See Hide, Bourke, and Mangion, ‘Perspectives on pain’, 5; Bending, ‘Pain and religion’, 1-5.
needs to tackle, mainly homonymy (the same sounds having different meanings) and polysemy (the inability to connect each term to only one meaning, and only one meaning to each term), beginning with the polysemy of tears. The American doctor Louis Starr, who believed that healthy children rarely cried, noted that crying was a single means to communicate various meanings: “Crying is the chief, if not the only means that the young infant possesses of indicating his displeasure, discomfort or suffering.” 317 Although crying seems to be the behaviour most often associated with pain, there were controversies over whether crying always indicated discomfort, pain, or illness in a child. For this reason, doctors put their efforts into developing a scheme for evaluating children’s pain based on different kinds of crying in an attempt to distinguish the crying of pain from that caused by boredom, frustration, or exercising the lungs. Evanson thought that crying that came from acute suffering “is clear, loud, sounding and continuous,” belonging more to exhalation than inspiration. 318 The paediatrician added to crying a series of complementary gestures, such as the position of the eyebrows and the hands, trying to construct an invariable connection between the sign and the anatomic injury. For Starr, the first professor of paediatrics at the University of Pennsylvania Medical School, a direct relationship could be established between different kinds of crying and specific illnesses and degrees of pain. While hydrocephalic crying consisted of a sudden, paroxysmal, and loud cry which implied headache, “loud brazen crying” was a precursor of spasmodic croup, and a child who cried during a coughing fit or soon afterwards – when the crying was accompanied by a distortion of the feature – was suffering from pneumonia. 319

The American paediatrician Luther Holt, who was particularly concerned that the pain of infants under two months of age, should not be ignored. In 1899 he argued that the absence of tears before this time should not be taken as an indication that the young baby did not feel pain. Holt divided children’s cries into several functional groups according to whether the cause was hunger, indigestion, temper, weakness or exhaustion, discomfort, pain, or habit. Holt suggested that children suffering extreme pain cried in a sharp and penetrating

318 Evanson, Practical Treatise, 108.
way, contracting their facial features, raising their legs and, sometimes, ending up falling into an exhausted sleep.\textsuperscript{320} In his opinion, crying that resulted from less severe pain was more like moaning and less sharp in tone. Ralph Vincent, who founded The Infants’ Hospital in Westminster in 1907, also affirmed that crying produced by an intense pain was characteristic: “it is sharp and penetrating and is united with the contraction of the extremities and the features.” Some lines later he adds: “one of the cries which is often misinterpreted is that which results from the pain of indigestion. The cry itself is not as sharp as in the case of those that result from more intense pains and is closer to that of the cry of hunger.”\textsuperscript{321} Just as for Darwin there was a direction relationship between emotions and their expression, for Starr pain was also expressed always through the same gestures and expressions. He described the facial expression of childhood pain and indicated how to infer the origin of the pain from these expressions – for instance, “the contraction of the frown denotes headache”, the stretching of the nasal cavities indicated “chest pain, and the raising of the upper lip pointed to abdominal pain.”\textsuperscript{322}

But not all authors agreed with Starr on this. Although the manuals about childhood conditions published in the second half of the nineteenth century never questioned the diagnostic value of pain, authors such as the American John Forsyth Meigs, one of the pioneers of the study of childhood illness, criticised the belief that the origin of pain could be localised through the response of the patient.\textsuperscript{323} Those doctors who repudiated the concept that associated specific pathologies with their expressive signs underlined the importance of obtaining a good history. Thus, James Carmichael, physician at the Royal Hospital for Sick Children, advised the doctor to “talk to the mother or nurse and learn the history of the present and previous illnesses, the number of children, and where the patient comes in the family; the number and health of those living; the causes of death of any which are dead; the mother’s health during pregnancy; the nature of the confinement, and of any difficulties or abnormalities at birth; the number of

\footnotesize{\textsuperscript{320} Luther Emmett Holt, \textit{The Diseases of Infancy and Childhood: For the Use of Students and Practitioners of Medicine} (Appleton, New York, 1899), 1-45.  
\textsuperscript{322} Starr, ‘Clinical investigation’, 3-4.  
\textsuperscript{323} John Forsyth Meigs, \textit{A Practical Treatise on the Diseases of Children} (Lindsay and Blackiston, Philadelphia, 1853), 23.}
miscarriages, and the mode of feeding.”

Carmichael recommended practising these investigations before exploring any concrete illness, given that parents could suppose that they could seek to ascribe the cause of the said illness to a life circumstance or the previous history of the family. Although, like many of his colleagues, this doctor believed that heredity played a major role in certain illnesses, he did not consider it advisable to mention this to the family and thought that it could even be considered “unkind” to do so, given that “ready as a parent may be to transmit disease to the child, there is a natural objection to taking the blame thereof.”

And in this, Carmichael was not alone.

The diagnostic method used by Charles West follows the same line, as explained in his book Lectures on the Diseases of Infancy and Childhood, and was applied in an almost literal form by all the paediatricians at GOSH. On this occasion, as on the others, the case notes register the doctor’s first impressions of the child and its family, and cover the territory relating to the pregnancy of the mother, the method of weaning, the sobriety and health of the mother. Children’s hospitals had a contradictory vision of the mothers of the patients. On the one hand, the institutions needed parental consent, without which no patient could be admitted; for this reason, it was important to sell the hospital services to the families. On the other hand, there was the conviction that maternal incapacity was partly responsible for childhood illnesses.

Despite this lack of confidence, the information that the doctor obtained about the state of the child before its entry into the hospital came almost always from the mother, so the maternal account was another of the methods used to diagnose childhood illness.

Regarding these notes, it is striking that, despite the disputes about the credibility of children’s accounts of their own suffering, children’s voices are indeed reported in relation to pain through their mother’s accounts. Henry Ashby refers to the case of a child of “of nine years of age was suddenly seized (22 April 1881) with pain in the abdomen whilst at school, followed by the passage of blood and mucus by the bowel.” Some pages later he describes the case of John

325 Carmichael, Disease in Children, 3
326 Charles West left nineteen volumes of case notes from 1838 to 1880, which are stored in the archives at The Hospital for Sick Children, Great Ormond Street, together with the books from his library.
327 Tanner, ‘Too Many Mothers’, 55.
328 Tanner, ‘Too Many Mothers’, 55.
C., nine years old, who “one day complained of pain in the belly, and vomited the same evening. He continued to vomit five or six times a day till his admission to hospital (under Dr. Hutton), on the fifth day of illness […] He complained of paroxysms of pain in the abdomen.” 329 The clinical cases reproduced in paediatric books were taken from the personal case notes of different doctors. In all of these we find the same situation. Every time a reference is made to the child’s experience it is in relation to its pain. Thus, we find the case of Ada Smith who, during the afternoon of 10 January, “came to Nurse complaining of pain in the front of the chest (over sternum) and of feeling sick.” 330 Another case was Sarah Bennett, a four-year-old child from Camden Town who, having contracted pneumonia, returned one June day complaining of “being cold & having a pain in the right side.” 331

Paediatricians working at The Great Ormond Street Hospital clearly had considerable empathy with their child patients and they sought to encourage a similar attitude in society at large, believing that the public could ally itself to the cause of caring for sick children if the work of the hospital was communicated effectively.

The visual limits of pain

Although Darwin had used photography to support his claim of the universality of most expressions, subsequent paediatric treatises contained few photographs. Photography was nonetheless used in the field of children’s health – extensively in fundraising and as a support for medical practice. This section does not look at clinical photography but rather at what can be considered a visual culture of the sick child, usually identified in art, media coverage, public health campaigns, and activist icons. 332 While clinical photographs served well to demonstrate unusualness, irritating appearances, and irregular symptoms, fund-raising photographs and the “Little patients” campaign focused on the face and

329 Henry Ashby, *The Diseases of Children: Medical and Surgical*, 120.
332 The photographic representation of the sick child has been studied in the context of Canadian Hospitals, see Anne Marie Adams, David Theodore, and Patricia McKeever, *Pictures of Health: Sick Kids Exposed*, in Loren Lerner (ed.) *Depicting Canada’s Children* (Wilfrid Laurier, Waterloo Ontario, 2009).
individuality of the sick children, to proclaim the importance of the new hospital and of the emerging field of paediatrics.

Like all Victorian philanthropic creations, Great Ormond Street had to compete for attention and funds in a market that was saturated with good causes. As would be the case with later children’s hospitals, GOSH came into being thanks to the work of a strong and determined medic – West – who was supported by a group of private patrons. Its dependence on patronage meant that there was a constant struggle to raise funds and to maintain a high profile in the eyes of the public. Unlike certain specialist institutions – such as St Mark’s Hospital for Fistula, also in London and supported by Dickens – the children’s hospitals generalist approach granted them a potentially instantaneous entrée into the Victorian heart through the tales of their small patients, which filled many columns in the general and religious press. Engravings of the wards and of visitors to the hospital were used to illustrate these pieces, showing idealised images of the quasi-domestic atmosphere of the institution, with bouncing, happy children, and the respectable adults who cared for them. Almost from the very beginning, the Great Ormond Street Hospital was taken up by the press and social reformers as a symbol for campaigns to improve sanitation and rescue children from the effects of poverty and deprivation. They described the hospital and West’s principles of paediatric care in terms of an approach to childhood that was largely characterised by middle-class values and sentimentalism. West and his hospital, indeed, encouraged such attitudes, not least in the materials used for fundraising purposes.

In the late 1860s and early 1870s, the hospital needed to raise funds for two projects: the acquisition of a convalescent home in the country and the building of a completely new hospital on the Great Ormond Street site. The latter required a massive fundraising programme and the hospital turned to the relatively new medium of photography – which it already used to provide its supporters with images of its work – as one of its main tools. Two well-respected photographic companies – the Stereoscopic Company and Faulkner – were hired to take these images, which presented the hospital as a welcoming place for children, while

333 Boehm, Charles Dickens, 81.
334 Boehm, Charles Dickens, 82.
335 Steedman, Strange Dislocations, 66.
The photographs can be seen as falling into two categories: on the one hand, ward images depict the hospital as the place where heroic physicians used the latest medical knowledge to heal child patients who are portrayed as the frail and helpless beneficiaries of healthcare expertise; on the other hand, images of playfulness promote the institution as a place of social interaction and fun. These more positive images of hospital life portray sick children actively defying, through friendship and recreation, the seriousness of their circumstances and the fear and anxiety associated with illness.

Photographs of the hospital wards were produced and distributed in the form of postcards as a way to raise funds. These images did not focus on the sick child but, rather, showed the conditions in which these children lived at the hospital as well as documenting the medical techniques, the healthcare environment and hospital life. Most of the extant images of the hospital were produced specifically for fundraising purposes. Some of the photographs show the “bad” aspects of the hospital – crowded waiting rooms and stark corridors, for instance (Figure 3) – as a way of illustrating why it needs more money in order to become a better hospital. It was a difficult balancing act, as the images needed to show both that the institution was powerful and worthy of funding, but also that it lacked the funds needed for the optimal performance of its role. So, there were also photographs that showed the “good” aspects of the hospital, thereby demonstrating that money had been well invested. These images show an environment which is calm and orderly, where children walk around and play with toys while those who are confined to beds lie in ordered rows between neatly tucked blankets and bright white sheets. The ward is light and airy, with high windows that are open, and a sense of home is created through the deployment of plants and toys. In these photographs, the only adults are usually women – the nurses (as surrogate mothers). These ward photographs show the hospital as clean, orderly, efficient, and comforting for those inside while projecting also an image of the institution as welcoming and urbane.

336 Great Ormond Street Hospital GOS/1/2/12, Hospital Minutes, 22 February 1872.
337 Great Ormond Street Hospital GOS/1/2/12, Hospital Minutes, 22 February 1872.
A remarkable series of photographs, produced by the Commercial & General Photographic Co., (c.1870) shows the efficiency and antiseptic cleanliness of the hospital departments, featuring the white-clad nurses as almost angel-like healers of sick children (Figure 4). The children themselves are in their beds and appear to be still and vulnerable. Such images were designed to inspire hope in those who saw them, particularly those who might be willing to provide financial support to an institution that – long before the advent of state funding and national healthcare coverage – depended totally on patronage. Similarly, a photograph produced by the studio of Langley & Sons Ltd, shows children in the ward, with a couple of children in the foreground, one reading a book to the other (Figure 5). Here, the hospital environment is turned into a school setting: health and education occupy the same space. The image also presents the architecture
of the institution in a way that evokes associations with comforting places, such as a family home, a well-appointed hotel, or a church. The elegant wood panelling and carving convey to the view that the child patients will be treated with dignity and respect in this hospital. Looking at these images in chronological order can serve to show the changes that were carried out at the hospital through the success of its fundraising efforts, such as the opening of new spaces and the deployment of new equipment.

**Figure 2.4**

Photographer Unknown, *Dresden Ward* (c.1870), B-INT 00478D, Great Ormond Street Archives.
But these photographs also had a use beyond fundraising. They were an important means of communication between the hospital (represented by the ward sister) and the patients’ parents. Visiting for family and friends was restricted to one afternoon a week, with the occasional Sunday afternoon known as ‘Father’s Day’, and was suspended completely during infectious outbreaks. These images became a precious means for families to keep track of their children’s health. For parents living far from London, they might be the only news they had of their child until reception of the final letter, which would request their visit to take the child home. Cards were sent out each week, with a pencilled note, usually in large, cursive female writing, reporting the patient’s health during the previous seven days. The language is rather domestic: “Baby is not so well
this week” and “baby is teething and sends you all a kiss”, are two frequently sent messages (Figure 6). 338

Figure 2.6

_Dresden Postcard (c.1900), B-INT 00478D, Great Ormond Street Archives._

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338 Great Ormond Street Hospital B-INT 0478, Wards postcards.
The photographs of children’s hospitals are populated by happy and active children who smile for the photographer, despite their illnesses, injuries, and physical limitations. Most of the patients at Great Ormond Street were from poor families, who did not have the means to contribute to a health insurance scheme let alone pay a general practitioner when they were ill. As Andrea Tanner has shown, parents retained some power to allow or prevent hospital treatments given to their children.\(^{339}\) These children lived in overcrowded and insanitary conditions and their bodies displayed the marks of infectious disease, malnourishment and, very often, tuberculosis. They were a long way from the rosy-cheeked little cherubs so beloved of the engravers, which presented something of a challenge to the photographers. The hospital required that the photographs used in fundraising were sufficiently full of pathos to open the hearts and the wallets of the spectator, but they also had to present the children in a way that was sufficiently middle class to engender feelings of empathy in those at whom they were directed.\(^{340}\)

In 1870 the hospital decided to move beyond the photographs of the wards and to create a campaign based on images of individual child patients, which were sold as *cartes de visite*.\(^{341}\) Children pose for the photographer in a happy mood despite their illnesses and physical limitations. The main objective of these images was to present the hospital’s mission in such a way that it could generate a sympathetic response from people and encourage them to donate money.

One of the photographs portrays Nellie Wallace (Figure 7) (Figure 8), admitted to the hospital on 29 June 1872 with problems with her knee (probably a tubercular condition). Despite recovering, Nellie was readmitted on 10 March 1873 and doctors removed part of the knee.\(^{342}\) Another photograph shows Sydney Jones (Figure 9), admitted on 13 June 1873, whose diseased right knee led doctors to amputate his leg up to the thigh.\(^{343}\) A third image shows Annie Kezia Eastland (Figure 10), who was admitted on 21 November 1870 suffering

\(^{339}\) Tanner, ‘Too Many Mothers?’, 136.
\(^{341}\) Great Ormond Street Hospital GOS/1/2/12, Hospital Minutes, 22 February 1872.
\(^{342}\) GOS/9/1/2,1865-72; GOS/9/1/3, 1872-78, Hospital’s General Admissions Registers, Great Ormond Street Archives.
\(^{343}\) GOS/9/1/2,1865-72; GOS/9/1/3, 1872-78, Hospital’s General Admissions Registers, Great Ormond Street Archives.
from necrosis. Although all three children suffered from painful conditions and two of them underwent surgery, there is little visible sign of the pain of their illnesses and procedures they went through.

In attempting to reconstruct the historic experiences of children in pain, these photographs are important precisely because of the interplay between what is visible and invisible in them, as can be sometimes inferred from the patient histories reported below. Because of their intended use, their main objective was to present the hospital’s mission in such a way that it could generate a sympathetic response from people and encourage them to donate money. However, photographers had to find new ways to display pain, disability, and poverty while staying within the limits of certain moral conventions.

**Figure 2.7**

Robert Faulkner & Co, *Nellie Wallace* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.
Figure 2.8

Robert Faulkner & Co, *Nellie Wallace* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.
Nellie (otherwise Nelly or Ellen) Wallace, was admitted from her home in Hoxton (in London’s East End) aged four and a half in 1872, suffering from a diseased knee. After three months, she was sent to the hospital’s convalescent home in Highgate, where she contracted scarlet fever. She was readmitted in March 1873 when part of her knee joint was excised. In July, she was sent to Cromwell House, and then on to Brighton, to convalesce, although she returned for more surgery in November of that year and was finally discharged on 11 March 1874, once again pronounced fully recovered. Nellie’s repeated stays at the hospital between the ages of four and seven seem to have made her a favourite of the hospital, and she was the subject of a short series of photographs, sitting in a rather grand chariot–style, padded child’s wheelchair, and playing with Smut, the hospital cat. His short hair is brushed back, to show her fine bone structure, and she is wearing what would appear to be a party dress, complete with ribbons and extensive ruching. It is possible that the photograph dates from after her brush with scarlet fever, as cutting off long hair “to preserve strength” was a common strategy in cases of infectious fevers. There are toys strewn around the wheelchair, but no exotic backdrop, which would suggest that the images were taken in the hospital itself.345

345 GOS/9/1/2,1865-72; GOS/9/1/3, 1872-78, Hospital’s General Admissions Registers, Great Ormond Street Archives.
Figure 2.9

Robert Faulkner & Co, *Sidney Jones* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.
Sydney Jones, who had the boys’ Aunt Judy’s Cot in 1873, had been admitted suffering from “disease of the knee” – probably tubercular – which was so severe that his leg required amputation.\textsuperscript{346} The tenting of his blankets indicates it was probably his left leg which had been affected. Nevertheless, there he sits, looking cheerful and holding tightly onto his toy horse, with a wooden train tucked away to one side. His face is long, somewhat pinched and narrow, and his eyes may have a squint – it is possible that the reassuring toys and the checked smock serve as distractions from a face that is arguably older than its years and far removed from the chubbiness of the well-nourished eight-year-old. The photograph was taken by Robert Faulkner, a fashionable society photographer whose reputation largely rested in his child portraits.\textsuperscript{347} His studio was in Baker Street, but this portrait was clearly taken at the hospital, and was probably commissioned either by Aunt Judy’s Magazine or the Anglican magazine Day of Rest which featured an article about the hospital and some of its inhabitants.\textsuperscript{348} Faulkner did a lot of photography for the hospital cartes des visites but – curiously – retained the copyright of the images throughout. This image of an occupant of the Aunt Judy’s Magazine Cot is professional and distinctive, with the patient looking towards the photographer, clutching a pull-along horse, with a toy steam engine on the bed.

\textsuperscript{346} GOS/9/1/2, 1865-72; GOS/9/1/3, 1872-78, Hospital’s General Admissions Registers, Great Ormond Street Archives.
\textsuperscript{347} Several of his studies of children were published both as transparencies and as prints, which appeared in Photographic News (22 October 1880, 506-507) and which was said to have sold over 10,000 copies. Michael Pritchard, A Directory of London Photographers 1841-1908 (PhotoResearch, Watford, 1994), 59.
\textsuperscript{348} GOS/1/2/12, Hospital’s Committee of Management minute books, 1871-1872.
Robert Faulkner & Co, *Annie Eastland* (c.1875), Hospital For Sick Children Fundraising Album, Great Ormond Street Archives.
Annie Kezia Eastland was nine years old when she was admitted to the Hospital for Sick Children on 21 November 1870, “with a node on her tibia and a secondary diagnosis of necrosis”. She was discharged more than six months later (on 15 June 1871) and it was said that her condition had been relieved. However, she was admitted to the hospital again on 25 August of that same year and “with the same diagnosis”. The picture was probably taken for the sponsors of the Amy Louise Cot, and shows Annie gazing wistfully into the distance, her long dark hair held back by a ribbon and wearing the hospital garibaldi jacket.

The images of Great Ormond Street suggest that the limits of the visually bearable were not – or, at least, not only – a matter of the external manifestations of pain. In a context where medical and scientific debates were concerned with the definition of its physical signs, pain could be represented in a variety of forms, and pictures like these could refer to experiences of pain without showing any apparent signs of it. This part of the chapter will try to uncover precisely the visual and material strategies that photographers such as Robert Faulkner followed in order to represent children in pain.349

Photographs are never disembodied images in a vacuum, but material objects taken in particular circumstances. Shifting away from the visual content to the circumstances of their making, these staged photographs can easily be read as performative acts intended to provoke two actions in the viewing public: to feel compassion or pity for the suffering children and to donate money for their recovery. With these aims, the photographs were circulated as cartes de visite available for sale at the hospital for the price of sixpence and were published in journals such as Aunt Judy. The example of the children’s magazine Aunt Judy sheds light on the ways in which pain was indirectly represented through objects rather than directly through expressions. This magazine, like foundations such as “Kensington” or “Mary H West”, sponsored a bed at the hospital, the “Aunt Judy’s Cot”. This served a double purpose: on the one hand, each month the magazine told the story of the patients that occupied its cot, describing their condition and evolution, as well as the facilities provided by the hospital. On the other hand, the

349 The adaption of methods from art history to visual history and their transformation toward an understanding of photography in its scientific application in the production of knowledge has been critically developed in recent historical scholarship. See Jennifer Tucker, Nature Exposed; Lorraine Daston and Peter Galison, Objectivity; Kelley E. Wilder, Photography and Science; Daniela Bleichmar, Visible Empire.
cot served to channel donations. This is why it was so important that patients such as Sydney Jones were portrayed with the Aunt Judy’s sign behind them. This sign not only identified the patient as someone whose story could be followed by the readers, but it also helped to interpret his body as a suffering body. The description of the patients’ conditions and the life at the hospital allowed readers to decode some objects in the pictures as part of the experience of pain. For example, many stories related that the patients had to spend several months in bed, usually because they had suffered the amputation of limbs.350

These images had to transmit a positive image of recovery. This is why another column related the story of a child, also suffering great pain after surgery, who had supposedly said “Oh, I would be better if I only had Aunt Judy’s label,” as if being in Aunt Judy’s cot would be a relief in itself.351 Moreover, all these stories also stressed the presence of toys donated to the hospital by readers and the beneficial impact they had on children, especially at Christmas.352 Sydney’s portrait presents all these features: the bed suggests a painful condition, but the Aunt Judy’s sign and the toys imply recovery. Precisely because these objects alluded to his pain, there was no need to express it by any physical signs.

Certain codes had to be followed to represent the body in pain. As fundraising tools, these images sought to convey a sense of hope to the people who viewed them, especially those who were potential donors. At a time before the expansion of state sponsorship and national healthcare coverage, hospitals and other medical institutions depended on patronage.353 These images also needed to provide a positive image of recovery, hence the emphasis on the presence of donated toys and their beneficial effect on child patients.354 In Sydney’s portrait, the boy’s smile also transforms the hospital ward from a terrifying place of disease and death into an everyday environment typical of a happy childhood. In a photograph clearly designed to appeal to a middle-class audience, the boy wears a check smock and adopts a pose that echoes Victorian studio portraits of

353 See Tanner, ‘Too Many Mothers?’, 135.
gentlemen. These children came from poor families, and their physical recovery was presented as also involving moral betterment. The photograph – which presents Sydney as the living embodiment of the civilising influence of the hospital – seems to suggest how children should behave when in pain. Another example is the depiction of children using crutches. As one of the columns of Aunt Judy related, handling crutches was not an easy task for any child, who had to train for months before really being able to walk with them. In this sense, the body of the child in this photograph showed how he had overcome difficulties and was able to stand up with the support of the crutches.

But these photographs worked not only because they displayed objects and bodies. A key factor in the success of these images was the action of the photographer, Robert Faulkner, renowned as a specialist in two fields: children’s photography and backgrounds. The mastery of background became an essential element because the popular press stressed “the cheerful and bright atmosphere of the ward” to a point that it seemed more like a nursery than a hospital. Faulkner’s technique was so good that he even patented it, and it was praised and explained in leading journals such as the British Journal of Photography. According to these articles, his method produced graduated backgrounds that did not “absorb the figure” but brought forwards “in a prominent manner the principal proportions of the figure,” giving “breadth, massiveness and harmony of effect.” By means of these backgrounds, the portraits of sick children resembled those he had previously done for the bourgeoisie, facilitating the identification between the potential donors – who were middle-class women – and the children. In the pictures of cots, the backgrounds emphasised the idea that the sponsored cots were places of relief.

But even more important was Faulkner’s relationship with children. He was compared to the “pied piper of Hamelin” by a contemporary commentator because he could do “as he pleased with his little people [...] in his hands, they are not only plastic as clay, but smiles and tears, humour and pathos are called

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357 Boehm, Charles Dickens and the Sciences, 103.
up in the little faces at his bidding.” This was a highly-praised skill because getting the desired expression on children’s faces was one of the most difficult tasks of photographers, as can be seen from debates in the photographic press. Children were compared to dogs as the most difficult subjects in photography because they could not remain still. Therefore Faulkner had developed a technique that allowed hiding the shutter, so its movement would not distract the children.

In addition to the impact of these two techniques in the achievement of the images, there is another important element that is missing in the abovementioned narratives of Faulkner’s work: the performance by the children themselves. As other accounts published in the photographic press relate, the best way to photograph children involved playing with them, and allowing them to adopt the most comfortable poses. In this context, the toys become not only signs to the viewers of the commodities at the hospital but also traces of the prior play between the photographer and the children. Play adds another layer of meaning to these photographs. It suggests that these pictures were important not only because of their effect on the public but also because of the very act of photography. These photographic sessions were spaces in which children who had not moved from their beds in months could receive attention by engaging with toys and play. In this way, the moment of taking the picture could be something that children enjoyed. Therefore, being in one of the sponsored cots could provide a momentary relief thanks to the privileges it involved, such as being portrayed photographically. This interpretation of the photographic act is consistent with Faulkner’s method. As many articles in the photographic press pointed out, having a portrait taken caused anxiety to many sitters. Hiding the shutter not only avoided distractions but also allowed a more comfortable experience and an easier relationship between the photographer and the photographed person. These photographs thus allow us to reconstruct how photography engaged with medical and scientific debates on the nature of expressions of pain in children. Photographs served to communicate the

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hospital’s aims and to construct social meanings of pain by means of their publication in journals. But besides the photographs, the very act of taking pictures also shaped the child patients’ experiences of pain by introducing moments of relief.

**Conclusion**

The debate about childhood pain drives into an important issue at the crossroads between the history of science and the history of childhood: the lack of scientific unity and scientists’ reflections on the definition, conceptualisation, and treatment of pain. The scientific and paediatric texts used in this article demonstrate the lack of scientific unity at the end of the nineteenth century and the varied renderings of the child body. By understanding development as a trajectory in which language and assertive action gradually took the place of instinct and reflex, the scientific texts by Darwin and Romanes show the story of human development. In biographical portraits, the child is presented as a developing body, an example of the “human” that activates the exemplary observation of the history of humanity. In other words: the application of Darwinism to the interpretation of human development throughout each individual’s lifespan contributed to the construction of a scientific fact: the notion that children and natural emotions represented past stages of human civilisation. In addition, scientific practices do not only construct notions – they also constitute pragmatic devices for the generation of knowledge and experimental realities that include bodies. While the textual rendering of the child body produced the instinctual and emotional body, the practices of Gezmer and his followers generated the body of the child in pain.

The operationalisation of the scientific method in the late nineteenth century among natural scientists manifested in the transformation of the child into a mechanistic object, an instrument for the discovery of medical and scientific truths that simplified the work of scientists. In relation to adults, the mechanistic, natural and instinctive nature of children often seemed to give permission to suspend the complex philosophical and moral questions related to

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experimentation with human subjects. The most obvious manifestation of this reduction “ad infantiam” was none other than the recurrent denial of infant pain. While Darwin and Preyer did not subscribe to this belief, their attention to children as a sign of human evolution – rather than as self-sufficient objects of knowledge – and the understanding of crying as a natural expression paved the way for later treatment of children as incapable of authentic suffering. Together with the extreme experimental caution that treated infant expressions of suffering through the sceptical interpretation of reflex actions, the chapter presents two major conditions for the consolidation of infant pain denial in scientific practice during the twentieth century, further sustained by the arrival of behaviourism and the increasing emphasis on brain and nervous-system development, both covered in Chapter 3.

While the scientific method transformed the child into a scientific and mechanistic object, paediatricians saw children from the perspective of disease and treated pain communication as the main access to the roots of the medical problem. In contrast to scientists and psychologists – who saw the child as a fledgling adult – children’s doctors recognised the existence of a language of pain specific of childhood, and thus stressed the great distance between children and their being understood as mere men and women in miniature. While the main debates about gestural languages in adults focused on their transparency and the extent to which they were indicative of inner sensations and moral character, doubts about a “natural language” that anyone could read were not enough to deter the effort to find such a language in the field of paediatrics. Thus, one could argue that the rights of children in the paediatric world are not based on the right to be treated as future adults, but are a form of insulation: the child hospital institutionalised and constructed physically the right to be a child and to exist in a space separated from the adult world. Additionally, we cannot forget that healthy children were considered to be a national asset and their health, the health of the country.365 In the Great Ormond Street Hospital

photographs, the sick child became a discursive category, an object of institutional efforts to return children both to health and to the values of innocence and goodness belonging to the Romantic conception of childhood. But photography did more than record the sick body: the very act of taking pictures, and the performances of courage and play that were enacted during the photographic sessions, also shaped the children’s experiences of pain and relief.

The debate about childhood pain provides more information about the cultural dominance of certain ideals of childhood than about the lack of unity in the sciences. Debates within paediatrics, physiology, and evolutionary and behavioural psychology drew upon and reinforced two of the approaches to childhood that had formed the Western view of childhood. On the one hand, childhood was considered as a road towards adulthood, a fundamental phase in the development of a complete human being. On the other hand, childhood is respected for its autonomy, often seen in idealised or Romantic terms. The ambivalence between childhood as a refuge of personal identity and as a testimony of past civilisations marked by the scars of heredity experienced strong tensions in the nineteenth century. Filtered through the problem of childhood pain, this ambivalence makes itself felt in our present frames of reference.
CHAPTER THREE

Infant Pain Denial (1890-1950)

Introduction

At the start of the twentieth century, new disciplines interested in the study of children started to emerge. This did not, however, represent the start of what Ellen Key\textsuperscript{366} has described as the “century of the child”, in which humanity realised its spiritual essence through the care of its children. It was, rather, a period in which children were progressively objectivised and turned into subjects of study and rational organisation. As child development as a field of inquiry started to take off, scientific observation categorised children’s development in progressive stages within the context of a universal ideal. As was suggested in the previous chapter, a new view of the dynamic nature of human development had emerged in the nineteenth century as a result of evolutionary theories.\textsuperscript{367}

This chapter continues to explore the debates covered in the previous chapter about the emotional expression of children’s suffering and how this was seen differently by scientists and psychologists on the one hand and paediatricians on the other. In so doing, the sources and methodologies are shared to a great extent. Indeed, the inspiration drawn from Bourke’s work in \textit{The Story of Pain} regarding the interdisciplinary analysis of children’s pain revisionism continues, although the conclusions reached here are significantly different: in fact, infant pain denial appears as only one form among many figurations of children’s pain, although privileged by the interaction of a number of disciplinary constructs. In comparison to Bourke, the scope is additionally expanded with the inclusion of child guidance in addition to paediatrics, already considered in Chapter 2. Other authors that have devoted time to this topic, also in the framework of the Child Study movement, include Sally Shuttleworth, although her study does not enter into the twentieth century.

A key topic that emerged from the debate around infant pain was precisely the gradually consolidating notion of its denial. As the nineteenth century gave way

\textsuperscript{366} Key, \textit{Century of the Child}.
to the twentieth, scientific disciplines became clearly separated from each other both in theory and in practice. The nineteenth-century discourse on the figuration of the child derived from “global” evidence collected by “gentleman scientists” who traversed the boundaries of biology, anthropology, and other emerging disciplines. In contrast, twentieth-century scientific discourses drew a very different map of knowledge-making and practice, and scientific knowledge divided into increasingly specialist sub-disciplines, which often provided rival interpretations and perspectives.

In this chapter, I focus on figurations of the child in pain from the 1890s until the Second World War in three specific scientific disciplines: the Child Study movement, behavioural psychology, and paediatrics. Each approached the question of the child in pain – and the concept of infant pain denial – in a different way. But there was also some overlap between the disciplines and a certain amount of cross-fertilisation. The Child Study movement, which drew on Darwinism and anthropological theory (in particular “recapitulation theory”, which held that individual development proceeds through the evolutionary phases of the species), argued that children embodied the primitive past of the species and could thereby reveal the processes that formed adult capacities.368 Child Study presented pain as a reflex action in infants and as a sensation that children learned through experience, which was tied to the evolutionary process and to the emergence of self-consciousness. In contrast, the advocates of behavioural psychology adopted a mechanistic approach and were sceptical about the value of children’s expressions of pain. In particular, expressions of pain by new-born children were seen as mechanical reflex responses to stimuli – a perspective which led to the scientific hypothesis of infant pain denial.369 Meanwhile, the discipline of paediatrics became increasingly scientific and influenced by mechanistic and developmental theories. In the early days of paediatrics, figures such as Charles West had compared the figure of the paediatrician to that of the explorer, investigating uncharted terrain.370 But children’s medicine now became


370 See Chapter 2.
likened to veterinary science, and children’s development was seen in relation to that of animals. In this “scientised” context, there was no longer room for subjective signs of pain or for the testimony of mothers about their children’s suffering. There were also significant debates within paediatrics about the use of anaesthesia when operations were performed on infants.\footnote{For a discussion on the sentience of embryos, see Bourke, \textit{Story of Pain}, 218.}

Both the child-study movement and behavioural psychology were based largely in the USA and linked to Britain and the wider transnational English-language scientific culture. This chapter analyses the discourse of Child Study and behavioural psychology – together with their techniques, methods, and materials – to illustrate the role played by these disciplines in the scientific colonisation of childhood. It argues that, in terms of discourse, child development became structured according to concepts of rational achievement which gained dominance over other views of the child and childhood. The chapter also examines the role pain played in understanding human development and how Eurocentric ideas about “white” development meant that developmental differences were seen as pathologies.\footnote{For a discussion on the scientific comparison of non-white adults with the period of white childhood, see: Bill Ashcroft, \textit{On Post-colonial Futures: Transformations of Colonial Culture} (Continuum, London, 2001); Claudia Castañeda, \textit{Figurations}, Chapter 1.}

By moving away from strictly scientific discourses and analysing the child in pain in the field of paediatrics – including debates about surgery and anaesthesia that were strictly related to situations encountered in the context of medical practice – this chapter argues that competing and often contradictory figurations of the child in pain may have existed simultaneously in different locations, even within the same discipline. In fact, the archival work for this study shows that there were somewhat contradictory factors at the heart of the disciplinary trends that were reconstructed in the form of a unifying history. Thus, while the distance between medical theory and medical practice seems to have had important consequences in terms of differing epistemic considerations of pain – which was an \textit{abstract} instrument of knowledge for the former and a \textit{factual} symptom for the latter – it is also true that, during the first half of the twentieth century, the mechanistic view of childhood and scepticism about infant pain had an impact on
paediatric and clinical practice, as surgery on infants was routinely carried out with minimal or no anaesthesia even as late as the 1980s.  

This chapter seeks to give a historical explanation of how infant-pain scepticism became more common among paediatricians by reviewing and analysing the experimental research on infant pain that was carried out in the early twentieth century and which played a significant role in the development of infant pain denial. Three interrelated causes have been found to encourage the denial of infant pain, each corresponding to a different disciplinary perspective: the Darwinian view that the child was a lower being (child-study movement), a perspective grounded in mechanistic behaviourism (behavioural psychology), and experimental caution (paediatrics and anaesthesia).

Pleasure and pain in the the Child Study movement

The beginning of anthropologist Alexander Chamberlain’s book *The Child: A Study in the Evolution of Man* (1900), published at the dawn of the twentieth century features an image of a four year old white child (Figure 11). The photograph shows the child, wearing a smock, from above the waist and the only visible parts of his body are his face and his hands, which are folded in his lap. With a wide-open gaze, he looks slightly upwards towards the left. For Chamberlain, this boy embodied everything that was normal. The photograph was an image of a boy who “might stand for the child-type in its most genial form and expression.” At the start of the twentieth century, child-study scientists such as Chamberlain sought to interpret the essence of childhood development, establishing what was “normal” and what was “deviant”. In this *fin-de-siècle* projection, the child was both atavistic and prophetic, and it became the bearer of all future hope. Chamberlain’s text expresses the intense interest in the figure of the child during the 1890s. In this particular photograph, one can see the child

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as playing three roles: the key to unlock understanding of the self, the door to a long-last past, and as a guarantee of a better future.\textsuperscript{377}

\textbf{Figure 3.1}


\hspace{1cm}

From the 1890s onwards, the science of Child Study, based rather loosely on evolutionary assumptions, developed rapidly in both Europe and the USA. In Britain, the movement's pioneer was the psychologist James Sully (1843-1923), whose work contributed significantly to the initial conceptualisation of the "maladjusted child." Sully's interest in the psychology of children emerged both from his own experience of mental breakdown as a young man and from a philosophical background, rather than from formal medical training. Originally trained as a non-conformist minister, Sully studied at the German universities of Gottingen and Humboldt, where he encountered the work of psychologist Wilhelm Wundt (1832-1920). In 1871, Sully returned to England and sought a career in writing journal articles on philosophy. His first published piece about children, 'Mental Development in Children' in Mind in 1880, drew heavily on the diary observations of Darwin and Preyer. Following his own nervous breakdown, Sully believed that the early recognition of the signs of mental fatigue could prevent susceptible individuals from becoming "psychic invalids" in later life. His work was thus framed within the context of a preventive approach and he was also one of the first to shift the focus of attention for the welfare of children's physical and mental health onto parents, arguing that scientific observation was the duty of responsible parents.

Sully, who reviewed Preyer's Die Seele des Kindes for Mind in 1882, published Studies of Childhood in 1895, a text which established Child Study as a disciplinary field. Sully's interest in babyhood is primarily evolutionary:

The first years of a child, with their imperfect verbal expression, their crude fanciful ideas, their seizures by rage and terror, their absorption in the present moment, acquire a new and

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378 The scientific study of child behaviour in Britain originated from the work of Sir Francis Galton (1822-1911) who, in 1883, introduced the term 'eugenic', defined as 'the science of improving stock'. Francis Galton, Inquiries into the Human Faculty and its Development (Macmillan, London, 1883), 25. For details on Galton’s life and work, see Dorothy Middleton, Sir Francis Galton, 1822-1911 (Eugenics Society, London, 1982).

379 Considered by historians to be the ‘Founder of Modern Psychology’, Wundt opened his laboratory in Leipzig in 1879. It subsequently became the model for psychological methodology throughout the world. Witmer studied under Wundt in 1888. For more details on the work of Wilhelm Wundt, see Thomas Leahey, A History of Psychology (Routledge, London, 2015), 249-260.

antiquarian interest. They mirror for us, in a diminished distorted reflection no doubt, the probable condition of primitive man, the intellectual and moral resemblances between the lowest existing races of mankind and children are numerous and close.\textsuperscript{381}

Based on the Lamarckian premise of inheritable abilities, the quotation states the theory of recapitulation, in virtue of which individual development proceeds through the evolutionary phases of one's own species until reaching its current developmental level. Children were thus observed in order to discover “the beginning of things, the way in which human life begins to take its characteristic forms.”\textsuperscript{382} The observation of children's behaviour can be seen as an extension of interest in natural history. Following Herbert Spencer and G.H. Lewes, Sully did not envisage the infant as beginning at the level of a mollusc, as George Romanes had claimed. He saw the infant as the equivalent of primitive man, who enters life with additional “ancestral dowering” so that he begins at a higher level than the “race's starting point.”\textsuperscript{383} Sully's is a firmly progressive vision of human progress, to which the infant holds the key.

Like other contemporary scientists who studied childhood, Sully was fascinated by the relationship between language, thought, and self-consciousness. Romanes had argued that human life was distinct from animal life not because of language, but because only the human being emerges into self-consciousness. Sully, though, argued that thought and self-consciousness could precede language. The child could be observed thinking, he noted, before “the age of speech.”\textsuperscript{384} Considering “pre-linguistic babblings”, Sully states: “As everybody knows, long before the child begins to speak in the conventional sense he produces sounds. These are at first cries and wanting in the definiteness of true articulate sounds. Such cries are expressive, that is, utterances of changing conditions of feeling, pain and pleasure, and are also instinctive, springing out of certain congenital nervous arrangements by which

\textsuperscript{381} Sully, \textit{Studies of Childhood}, 8-9.
\textsuperscript{382} Sully, \textit{Studies of Childhood}, 4.
\textsuperscript{383} Sully, \textit{Studies of Childhood}, 9.
\textsuperscript{384} Sully, \textit{Studies of Childhood}, 4.
feeling acts upon the muscular organs.” For Sully, this crying “gradually differentiates itself into a rich variety of expressions for hunger, cold, pain, joy and so forth, of which it is safe to say that the majority of nurses and mothers have at best but a very imperfect knowledge.” Following Preyer, Sully interpreted pleasure and pain as basic instincts in the child and as the primary motivations for action, writing: “The earliest idea of self seems to be obtained by the child through an examination by the senses of touch and sight of his own body.” It is through “self-graspings, self-strikings, self-bitings, aided by the very varied, and often extremely disagreeable operations of the nurse and others on the surface of their bodies, they probably reach during the first year the idea that their body is different from all other things, is ‘me’ in the sense that it is the living seat of pain and pleasure.” Pain was presented as a sensation which the child learned through experience and which was tied to the evolutionary process and the emergence of self-consciousness.

Sully’s interpretation of pleasure and pain as basic instincts in the child, as well as the comparison of the infant with the animal, was common at the end of the nineteenth century and the beginning of the twentieth century, and had its origin in Darwinism as part of a wider project for explaining behaviour in adaptive terms. The persuasiveness of the core assumption that gaining pleasure and avoiding pain were primary motivations for action expanded, perhaps unconsciously, among diarists such as the American psychologist Millicent Washburn Shinn, whose book The Biography of a Baby was published in 1900. While journal entries did offer descriptions of changes in behaviours, the diarists’ preferences were individual and idiosyncratic, allowing for very little comparative analysis. Unlike Preyer, whose son’s skin sensitivity was “surprisingly great”, Shinn maintained that her baby “had no experience of skin pain in her early days, and being kept at an equable temperature, probably received no definite sensations either of heat or of cold.” Shinn went on to argue that pain was a sensation learned through experience and tied to the evolutionary process of self-consciousness.

385 Sully, Studies of Childhood, 4.
386 Sully, Studies of Childhood, 4.
387 Sully, Studies of Childhood, 4.
388 On Shinn see von Oertzen, ‘Science in the cradle’, 175-195.
389 Milicent Shinn, The Biography of a Baby (Houghton Mifflin, Boston & New York, 1900), 47.
The question of the relationship between the child and the animal also concerned participants in the Child Study movement, such as Robinson, one of the first British practitioners to follow Kussmaul’s example and perform experiments on babies in order to demonstrate the relationship between simian and infant human life. Robinson’s ‘Darwinism in the Nursery’ (1891) argued that there was a huge gap to be filled between embryology and anthropology, which could be achieved by opening the nursery to science. According to Robinson: “the average mother, in spite of many unquestioned merits, is about as competent to take an unprejudiced view of the facts bearing on the natural history of her infant as a West African negro would do to carry out an investigation of the anatomy and physiology of a fetish.”

The extraordinary condescension of this passage draws on the standard ethnological grouping of women, children, and savages as figures outside the charmed circle of (while masculine) scientific reasoning. Robinson sought to prove humans’ arboreal ancestry by testing babies’ power of grip to see if they could hang from a bar.

In his article ‘Reflex Action’ in D. H. Tuke’s *Dictionary of Psychological Medicine* (1892), Robinson included images of babies hanging onto a branch of a tree, to enable readers to imagine them as young monkeys swinging through their arboreal habitat. The posture of the hanging babies, Robinson observed, “and the disproportionately large development of the arms compared with the legs, give the photographs a striking resemblance to a well-known picture of the celebrated chimpanzee ‘Sally’ at the Zoological Gardens.”

Sully was not the only advocate of Child Study at this time. In the USA, psychologist G. Stanley Hall (1844-1924) played a major role in establishing psychological approaches to child development. The biological theories about recapitulation were initially posited in terms of the development of foetal anatomy. But Hall extended the concept and applied recapitulation theory to the study of consciousness and human behaviour from infancy until early adulthood. A student of psychologists William James and Wilhelm Wundt, Hall published a seminal work in 1893 introducing the concept of childhood as a specific and emotionally complex stage of life, when individuals were particularly vulnerable
and malleable.\textsuperscript{394} He created a science of “pedagogy”, aimed at making large-scale empirical studies of children and their development.\textsuperscript{395} In later work, he categorised specific stages of childhood, introducing the term “adolescence” in 1904 as a stage of development with particular problems that could not be considered neither adult nor strictly childlike.\textsuperscript{396}

Hall spent a year in Germany studying physiological psychology. Strongly influenced by Ernst Haeckel’s recapitulation theory, he had a deep interest in evolutionary psychology and child development. As in the work of Shinn, the study of the child and the adolescent was always conducted within the structural framework of biological and cultural evolution. Although there was strong opposition to recapitulation theory within psychology – because it was not able to explain development – Hall popularised the concept among teachers and parents.\textsuperscript{397} Applying Haeckel’s theory, Hall made the bold claim that children’s play was an “expression of earlier activities of the race” – something that was a necessary in order that civilized behaviour could later emerge. He also argued – somewhat more fancifully and showing the rather haphazard way in which observations were used to support theory – that early childhood play with sand and water was a replication of humankind’s emergence from its aquatic origins.\textsuperscript{398} Hall yoked recapitulation theory to Romantic conceptions of the child of nature. His faith in recapitulation as the key to human development seems hard to reconcile with twentieth-century demands for scientific procedures based on systematic observation, behavioural records, and quantitative analysis.

Back in the USA, Hall sought to apply what he had learnt in Europe to study children’s thought processes, interests and capacities, in the belief that this would lead him to discover a genetic – or “racial” – basis for development. In 1894, he had set up a child-study department within the US National Education Association. Often seen as the “father” of Child Study, he published the first systematic study of the infantile mind carried out in North America, \textit{Aspects of}

\textsuperscript{394} G. Stanley Hall, \textit{The Contents of Children’s Minds on Entering Education}, (E.L. Kellogg, New York, 1893).
\textsuperscript{395} In 1891, Hall founded the journal \textit{Pedagogical Seminary}, which he used as a tool both for publicising his theories and for collecting data, with issues containing surveys that could be filled in by parents and teachers and returned to his laboratory.
\textsuperscript{397} Varga, ‘Look – normal’, 143.
\textsuperscript{398} Varga, ‘Look – normal’, 143.
Child Life and Education in 1907. Hall’s sources included: white adults, who provided memories of their childhood; white teachers, who described the white children in their schools; and white children. Although at the time data sources were described as surveys and questionnaires, information was actually provided in the form of written reports based on anecdotes. Parents and teachers were told how to collect data and instructed to consider their own childhood and the childhoods of others in relation to a list of characteristics, to which they were invited to add their own variations. For instance, a study of “peculiarities” lists as “physical” characteristics:

Exceptional beauty or ugliness; largeness or smallness; any bodily deformity; conspicuous scars or traumatic lesions; defects of sense or limbs, dimness of vision or slightly under normal hearing, weakness of spine, legs or arms, and so forth; exceptional strength, agility, clumsiness or deafness, or gifts of sense; any other marked physical peculiarity.

Hall’s emphasis was less on describing individual traits and more on providing detailed descriptions of children who had more than one trait “so marked as to color the entire character of the child, to be known to all who see much of it, to therefore bear on the child’s future career.”

There was an enthusiastic participation in Hall’s extensive research and between 1894 and 1896, he sent out 31 separate surveys, each one involving 800 correspondents. The more than 120 themes studied in Aspects of Child Life and Education were divided into various general groups, such as “Relations to Nature”, which included such topics as children’s experience of light and dark, and the development of the sense of self. Closely connected with this, Hall discussed studies of the “fundamental affectivities of the child” such as pleasure.

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401 Bohannon, ‘A study of peculiar’, 4
and pain, including crying and laughing. Hall understood pleasure and pain as the child’s fundamental and primary affectivities. He believed that physical self-consciousness started with the child’s recognition of its own hand and then the foot, but that “psychic self-consciousness is commonly only of pain, either internal, as of stomach ache, or peripheral, as of cuts, bruises.” Hall also discussed pain in the section devoted to children’s curiosity and interest, where he claimed that there were many cases of “children deliberately exposing themselves to pain to satisfy a desire for knowledge.” While Hall acknowledges children’s capacity to feel both pain and pleasure, some lines later he adds, “though probably with the same lack of actual realization of pain as in the case of experiments on animals.” Thus, one child who “had previously experienced an attack of colic” deliberately ate “green grapes” in order to see if it were true that they would make her sick, but the “mere memory of pain was not sufficiently vivid to check her desire for experiment.”

In a similar way, narrates Hall, “another child on being told that iron on a very cold day would burn her tongue deliberately tried it; and a boy of nine exposed himself to whooping cough to see how it felt.” A five-year-old girl, seeing her mother cry while she was peeling onions, said, “Mamma, the onions must hurt you. Give me an onion and let me find out where the hurt is.” Hall’s conclusion is clear: many cases which at first seem to suggest callousness in children in relation to the sufferings of others in fact concern children’s inability to appreciate the situation because they lacked experience of “physical or mental suffering”. While “most children have, of course, temporary experiences of pain,” children have short memories “and pain, unless exceptionally sharp or prolonged, is quickly forgotten”. Therefore “the average healthy child has very slight appreciation of illness or suffering, and exhibitions of sympathy are largely imitative.” Hall argues that a habitually cruel child is an abnormality and will almost certainly have other signs of cruelty. However, in all the cases cited above, the child’s underlying motive is curiosity, a desire for knowledge, rather than cruelty.

404 Hall, *Aspects of Child Life and Education*, 94
405 Hall, *Aspects of Child Life and Education*, 94
Similar sentiments are found in the writings of the anthropologist Alexander Francis Chamberlain, Hall’s pupil, who argued that there was an instinctive sense of self-preservation in children “as if they felt the fragility of their existence and clung to it with all their strength this is true physiologically and psychologically.” According to Chamberlain, the lack of sensitivity to pains, blows and wounds during the early years of life was often surprising: “not localising pain very readily until two or three years of age, they seem to resemble the savages in their resistance to their physical pain and their desperate clinging to life.” Chamberlain’s text also expresses the belief that less-evolved cultures had a greater resistance to pain. His 1900 text *The Child: A Study in the Evolution of Man* ends with an impassioned vision:

The child, in all the helpless infancy of his early years, in his later activity of play, in his naiveté and genius, in his repetitions and recapitulations of the race’s history, in his wonderful variety and manifoldness, in his atavisms and his prophecies, in his brutish and in his divine characteristics, is the evolutionary being of our species, he in whom the useless past tends to be suppressed and the beneficial future to be foretold. In a sense, he is all.

Atavistic and prophetic at the same time, the child here becomes the bearer of all hope for the future of mankind. Chamberlain’s text may be extreme in its optimism, but it nonetheless expresses the 1890s’ fascination with the figure of the child and shows the intensity of this interest. The child was now both an embodiment of the past and the expression of possibilities for the future. In this romanticised perspective, the role of play and imagination is emphasised, while the child’s “brutish” elements are seen in the teleological context of evolutionary progress towards perfection. The child here is the key to self-understanding and

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407 Chamberlain, *The Child*, 337
both the representative of a lost past and the guarantor of a better future. In the scientific context of Child Study, the mapping of children was necessary so that the rational adult mind could come to understand childhood. It was assumed that such mapping would be done by members of the white bourgeoisie, which would thereby enable the understanding of that which Sully termed “the race-mind” – in other words, the history of the mental processes of the white “race”. The work of Sully, Hall, and Chamberlain illustrates the centrality at the end of the nineteenth century of attempts to understand the child mind. The surge in literature for children in the century’s final two decades was accompanied by a similar growth of interest in finding scientific ways to study children’s development, which involved a range of disciplines and forms of practice.

Stanley Hall had a profound effect on American psychology, particularly child psychology and adolescent development, and many of his students went on to lead the new discipline of child psychology. Among the most notable was Arnold Gesell (1880-1961), who fully adopted Hall’s view of recapitulation theory and invented the term “maturation” to describe the integration of physical and social growth that Hall had defended. Gesell, director of the Clinic of Child Development and professor of child hygiene at the University of Yale, focused on children with developmental problems. He believed that to understand abnormality it was first necessary to understand normal child development. His normative studies started with infants and pre-school children and later extended to children aged from five to ten, and then to those aged up to sixteen. Gesell and his coinvestigators largely invented the observation techniques and methodologies that soon became the standard means for identifying the normal child’s innate (or natural) characteristics and for distinguishing between the normal and the deviant. As these technologies and methodologies were implemented, they had the effect of standardizing and objectifying the child’s subjective life (nurture) in order to create a supervisory manipulation that would prevent deviant development.

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In 1925, Gesell published his initial observations, a six-year “systematic survey of the ordinary and normal behavior of infancy and normal childhood,” which provided what Hall had been unable to come up with: the construction of normative developmental schedules that set down children’s physical, mental, emotional, and social abilities, and which be used as a means to measure and classify childhood. In 1928, in *Infant Behavior, Its Genesis And Growth*, Gesell studied the normal development of the infant. In the section devoted to perceptual and adaptive behaviour he discussed infants’ sentience. After stating that “the sensory life of the prenate is no longer a completely closed book,” he said that extensive observations of prematurely born infants had demonstrated a wide range of forms and degrees of receptivity. So, although sensitivity to light and changes of temperature “is probably present during the latter half of the gestation period”, sensitivity to pain “is more in doubt”. Gesell’s work helped to crystallise the idea of child pain as a reflex action, “prompt but immature”, even though he affirmed that sensitivity to painful stimuli definitely increases in the first week after birth.\(^{413}\)

**The influence of behaviourism**

At the end of the nineteenth century, an accumulation of factors contributed to a mechanistic vision of childhood, which in turn explains how the experimentation with childhood pain in the so-called “century of the child” was naturalised: the clinical and academic interest in the functioning of reflex actions and the nervous system, the development of the scientific method, together with the Darwinist vision of the infant as an inferior primitive being and the child as an adult in training. Since evolutionary psychology was coming to be the dominant paradigm, behaviourism applied to clinical practice both Darwinian theories and anatomical and histological data from the fields of embryology and physiology, thereby reinforcing the idea that babies and children were relatively insensitive to pain.\(^{414}\) Behaviourism was one of the scientific schools that focused most intently

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\(^{414}\) Rodkey & Pillai Riddell, ‘The infancy of infant pain’, 344.
on children, paying specific attention to the importance of pain. Although it soon lost traction to developmental psychology as the leading theory for framing pain, the influence of behaviourism is eye-catching: its methodological assumptions led to the widespread belief that infant’s expression of pain cannot be connected to the experience of pain, thereby giving rise to the most established scientific hypothesis of infant pain denial.

The experiments on sensitivity and childhood pain made their appearance in the history of behavioural psychology at the command of Margaret Gray Blanton (1887-1973), a specialist in the field of speech pathology. Blanton performed a series of experiments at Johns Hopkins University in Baltimore under the supervision of the psychologist John Broadus Watson. Watson, who was especially interested in studying the classical behaviourist model of stimulus-response and its applicability to the prediction and control of human behaviour, focused on what he considered to be the three fundamental human emotions – love, hate, and fear. His disciple’s experiments, however, focused on the study of pain. The investigation of pain fitted particularly well with the values of behaviourist psychology, given that expressions of pain could be interpreted as a mere mechanical response to stimulus. Margaret Gray Blanton analysed the reactions of a group of babies to harmful stimuli, such as the extraction of blood and pricks on the wrist while sleeping. The babies reacted with defensive attitudes to the experiments: extracting blood produced exaggerated crying, while pricking the babies with pins while they slept caused half of the sample to move their hands and forearms, and the rough rubbing of the back of their heads to remove vernix provoked the children to move their hands vigorously, to attempt to crawl away, and to cry angrily. Nonetheless, Blanton resists concluding that the medical procedure was the cause of the crying, arguing that, as expressions proper to infantile behaviour, no actual feeling could be firmly inferred from such reactions.415 Finally she concluded, “the reflex and instinctive equipment of the child at birth is more complex and advanced than has hitherto been thought.”416

The increasing sophistication of behaviourist experiments led to a more exact control of the experimental situation. This resulted in the replacement of the

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earlier harmful stimuli with electrical discharges, which removed the variability in the pressure of a pin. This approach was continued in experiments at the Lying-In Hospital and Northwestern University in Chicago under Mandel and Irene Sherman.\textsuperscript{417} Nearly all new-born babies reacted on the first day after their birth and the researchers concluded that they tended to react more to lesser stimulation between the first and the twelfth day. Their conclusion was that this finding suggests that children were not more sensitive in the moments immediately after birth but rather their sensitivity increased gradually.\textsuperscript{418} Like Blanton, the Shermans noted that the babies attempted to escape and moved in a defensive way, including hitting against the object to get away from it, but they doubted what conclusions could be drawn about pain in babies from their own experiment: “Perhaps the responses of infants to pain stimuli cannot be called ‘pain’ responses, as their psychological nature is unknown.”\textsuperscript{419}

The fact that the Shermans’ experiments were published in \textit{The Journal of Comparative Psychology} and in \textit{Comparative Psychology Monographs} in the context of similar experiments that used discharges in animals and registered the resulting “reflexes” suggests the dominant mechanistic vision of babies, together with the dominance of the analogy between children and animals.\textsuperscript{420} Together with beasts, babies constituted perfect passive objects for experiments that were carried out from a reductionist behaviourist perspective, given that the investigators were looking for reflexes and not consciousness. In this context, the Shermans’ interpretation of their results as a proof of the decorticate infant remained undisputed, paving the way for routine experiments on the pain threshold of babies without any need for a special ethical justification.\textsuperscript{421}

The Shermans’ presentation of the decorticate infant somehow anticipated the fate of behaviourism, which lost its dominance in psychological thinking to a new focus on research about pain in babies: brain development. The research by Myrtle McGraw (1899-1988) at the beginning of the 1940s at the University of Columbia and in the Babies Hospital in New York was particularly influential.

\textsuperscript{418} Sherman & Sherman, ‘Infant behavior’, 8.
\textsuperscript{419} Sherman & Sherman, ‘Infant behavior’, 38.
\textsuperscript{420} Rodkey & Pillai Riddell, ‘The infancy of infant pain’, 345.
\textsuperscript{421} Rodkey & Pillai Riddell, ‘The infancy of infant pain’, 345.
According to Bergenn, during the previous decade, the opinions of Gesell and
the behaviourist John Watson (1878-1958) were dominant in the field of the
psychology of infant development. Watson insisted that training could influence
development only when the nervous system of an infant had reached the
appropriate stage of growth. Both points of view stressed developmental norms
and applied standardised scales and texts. It was in this context that McGraw
became involved in the direction of the Normal Child Development Study at
Babies Hospital in New York City. She worked with neurologist Frederick Tilney
and neuro-embryologist George Coghill and drew on a variety of approaches as
she sought to understand the process of growth itself, rather than the specific
norms associated with growth.

Although McGraw’s research with the Woods twins was what made her work
popular, she also performed an ambitious study which sought to reveal the
process by which nerves mature through the use of pin pricks. The researcher
evaluated the reactions of children to pain provoked by cutting the ankle during
the taking of blood samples.422 She carried out a total of 2,008 observations,
evaluating 75 children aged between a few minutes of life and four years. Her
discoveries were that the youngest patients (those up to several days old) either
did not react to pain or demonstrated a dispersed reaction, while there was a
more localised reaction in older children. McGraw believed that in the new-born
child there was a high pain threshold in relation to external stimuli, as they were
not capable of identifying or localising the external source of pain. She also
reported that some neonates did not show any response to being pricked by
pins, and indicated that the typical response “consists of diffuse bodily
movements accompanied by crying, and possibly a local reflex.”423 Reacting to
the pin pricks, the babies cried and tried to remove their arms and legs. Despite
this, McGraw confidently concluded that they possessed a very limited sensitivity
to pain. In her view, a child’s first week or 10 days was a period of
“hypaesthesia” (a diminished capacity for physical sensation, especially of the
skin).424 The “local reflex” referred to by McGraw refers to the widely accepted

422 Myrtle B. McGraw, ‘Neural Maturation as Exemplified in the Changing Reaction of the Infant to Pin
Prick’, in Myrtle B. McGraw, The Neuromuscular Maturation of the Human Infant (Hafner, New York,
1969), 42-47.
medical view at the time that reactions were of a merely mechanical nature and therefore had no mental or emotional significance. “Even when there is sensitivity is it reasonable to assume that neural mediation does not extend above the level of the thalamus,” she wrote in the article’s discussion section.425

The ‘scientisation’ of paediatrics

Following the trend inaugurated by Charles West, doctors at the beginning of the twentieth century continued battling with the problem of how to determine the symptoms of children’s illness, and figures such as David Forsyth, doctor at the Evelina Hospital for Sick Children, still described pain as one of the many symptoms of disease, stressing that “none can rival it in diagnostic value.”426 Like many other authors who have commented on the diagnoses of children’s illnesses, Forsyth was very much concerned with the difficulty that children had in communicating an object as elusive as pain. He reminded his readers that:

at the age when children have no power of verbal expression, it is not always easy to recognise its presence, character, or intensity, still less to localise it or trace its distribution. This comes not only from the infant’s inability to speak, but also from his own ignorance of the site of his pain.427

These problems were far from being exclusive to babies, and doctors also lacked confidence in the testimony of older children: although a child might be able to speak, he “is quite incompetent to describe symptoms or to locate pain with trustworthy accuracy,” affirmed Forsyth.428 Another doctor who specialised in paediatrics and who was a pioneer in the study of children in institutions, the American Henry Dwight Chapin, argued in 1911 that the different parts of the child’s face betrayed the localisation of pain in certain parts of the body. The upper part of the face would point to pains or illnesses of the head; the alteration

426 Forsyth, Children in Health, 18.
427 Forsyth, Children in Health, 20.
428 Forsyth, Children in Health, 20.
of the countenance of the middle part of the face would be related to chest pains; and the lower part of the face would be an expression of pain in the abdominal organs. That same year, the obstetrician Pierre Budin warned mothers how to “detect disease at its first appearance, and thus insure for her child timely medical assistance.” Like Holt, Budin argued that, through the expression, the mother could carry out a diagnosis of the child. If the eyebrows were contracted, it indicated that the child had a headache. This gesture was often considered to be the first exterior sign that something was wrong and, Budin affirmed, always occurred “at the very onset of disease.” If this sign were not identified by the mother and the illness followed its course, “the eyes will become fixed and staring.” Later would come the grinding of teeth, movements of feet and hands, and – of course – crying. If the lips were separated in a way that the doctor could see the child’s teeth or gums, the pain was localised in the belly, while the expansion of the nasal cavities implied chest pain.

In 1913 the English doctor Archibald Garrod put forward once more the idea that love and empathy were indispensable conditions for the satisfactory conduct of medical practice. In this narrative, Garrod hailed the qualities that the doctor who was dedicated to this period of life should have, commenting: “The young child cannot tell us what he feels, and the seat of pain in an infant has often to be inferred from its actions … the youth of the patient calls for the exercise of special qualities in the medical attendant, and no man can be a good children’s doctor who has not a real love of children.” As written, Garrod’s narrative can be understood as a continuation of the discourse that Charles West and other paediatricians generated fifty years earlier. However, in the 1920s, medical discourse started to change.

At about that time, the mechanistic vision of the child started to permeate paediatric practice, which had by now achieved recognition by the medical

431 Budin, The Nursling, 13.
432 Budin, The Nursling, 13.
433 F. Batten, A. Garrod, and H. Thursfiel (eds.), Diseases of Children; By Various Authors (Edward Arnold London, 1913), 1.
profession.\textsuperscript{434} While in West’s time the absence of a direct account of the patient and the consequent insistence on the fundamental importance of the doctor’s physical examination led to the identification of the paediatrician with the figure of the explorer, now the practice of children’s medicine started to be compared with veterinary practice.\textsuperscript{435} The Scottish paediatrician Robert Hutchison used the analogy to rule out any attempt at constructing patient histories:

With what are called ‘subjective symptoms’ in children you are not in any way troubled, because there are none. Paediatrics is like veterinary work in this, that the patient is unable to give you an account of his sufferings, and you are thrown back entirely on your own observation, which, of course, makes the necessity for careful examination all the greater.\textsuperscript{436}

Some years later, the doctor Edmund Cautley recommended not looking at children directly in the eyes when carrying out a diagnosis, because “like animals, [they] intensely dislike being stared at.”\textsuperscript{437} Like Hutchison, Cautley compared practising on children with practising on animals, “for in each case we are dependent on the observation of onlookers, and on physical examination, and are neither assisted nor deceived by subjective symptoms.”\textsuperscript{438} If, as happened with the metaphor of the explorer, the analogy with the veterinarian strengthened the need for the doctor to develop a specialist capacity for carrying out a direct clinical evaluation of the child patient, at the same time it connected with observations at the end of the nineteenth century about the animal

\textsuperscript{434} Institutionalisation was crystallised in 1927 with the formal constitution of a professional body of child-health specialists, the British Paediatric Association, followed two years later by the foundation of the American Academy of Pediatrics.
\textsuperscript{436} Robert Hutchison, \textit{Lectures on Diseases of Children} (Edward Arnold, London, 1904), 4-5.
\textsuperscript{437} Edmund Cautley, \textit{The Diseases of Infants and Children} (Paul B. Hoeber, New York, 1912), 3.
\textsuperscript{438} Cautley, \textit{Diseases of Infants}, 4.
characteristics of younger children, which were considered to be a “recapitulation” of the evolution of the species.\textsuperscript{439}

In treatises written at this time, the paediatric perception of the child had changed. There is an increasing accordance with the scientific method and ideas coming from the experimental sciences, including behaviourism. In his \textit{Introduction to Child Study}, William Blackley Drummond itemised some of the varying ways in which science focused its attention on the child: “The philologist, for instance, turns to baby linguistics in the expectation of gaining a better understanding of the origin of human speech. The anthropologist, unable to discover a living specimen of primitive man, turns to the child as his nearest representative. The archaeologist finds valuable material in the child’s attempts to draw.”\textsuperscript{440} Some lines later, the Scottish doctor comments how, unlike anthropologists, philologists and physiologists, the main interest of the majority of students of children was in the impact of Child Study on the welfare of children themselves.

Drummond’s text reflects the change that was now being forged in the field of paediatrics. The doctor argues that the first stage of an individual’s development is characterised by a “sensation” stage, “in which the various sense organs are acted on by the outside world, and responsive movements are noticed more or less definitely of pleasure or pain”. From his point of view, the expressive movements of the “babies” indicated initially only pleasure or pain; thus “smiles, laughs and gurgles”, accompanied by movements of the extremities, were early signals of pleasure, while the downwards contraction of the corners of the mouth and the frowning of the brows indicated the appearance of tears.\textsuperscript{441} Even though Drummond recognised the child’s capacity to experience pain, he referred to Preyer’s investigation, introducing these sensations in the section dedicated to “reflex movements”. His reference to Preyer is particularly relevant when talking of the “child’s first cry on entering the world,” and he agreed with the physiologist that the child’s first cry had a reflex origin, “a much more reasonable vision than that of Kant when he spoke of it as the cry of indignation or anger, or of the

\textsuperscript{441}Drummond, \textit{The Child}, 76.
common notion, according to which it is the result of pain.” Within the framework of paediatrics as an institutionalised practice, paediatricians started to apply the theory of childhood development to their work, equating the infant and infantile development with animal development, at the same time as they introduced and established the standards of biological normality for life stages. Thus, in spite of the fact that many of the treatises of the period still started with a section dedicated to the examination of children, there was no longer room for the subjective signs of pain or the mother’s account.

Even though Cautley started his treatise by referring to the words of the Romantic poet William Wordsworth, commenting “The child is the father of the man, but is by no means a miniature adult,” he emphasised the importance of understanding childhood illness with the aim of developing an appreciation of the problems of life and pathology necessary for those whose work is mainly among adults. A child is not an adult in miniature but he has its own identity, which will be given to him, above all, through growth. This orientation appears explicitly in other paediatric texts of the period, such as those of doctor Frederic Still (1868-1941), the first full-time child-health specialist in Britain, and the first Professor of Child Health at King’s College London. Still did not start his treatise with a section dedicated to the diagnosis of childhood illnesses, but entitled his first chapter “Medical aspects of growth and development.” These treatises incorporated new understandings generated from the field of child physiology that allowed knowledge of the normal functions for each sub-stage of children’s lives, and studies of the medical data corresponding to the evolution of the child in the different stages of life, through anthropometric measures covering the period from neonatal until puberty. Thus, the sections dedicated to diagnosis are no longer centred on pain and its signs, but on weight – considered by many to be the more sensitive index of the health of an infant – the size of the head, dentition, and mental development.

442 Drummond, The Child, 73.
Infant pain denial and the use of anaesthesia

In 1920, treatises such as that of the Austrian doctor August Ritter von Reuss, director of the neonatal department at the University Women’s Clinic of Vienna, started to present the theory that babies had a lesser sensibility to pain because of the immaturity of their nervous systems, commenting:

Children under three weeks old remained comparatively quiet when stimulated by currents so strong as to be almost unendurable by adults; it is difficult to decide how far this is due to incomplete development of the peripheral nerve tracts or to backwardness of the central pain receptors.445

Surprisingly, this specialist did not deny that babies showed obvious signs of suffering when subjected to “stimulation of the skin, such as smack.” Moreover, the infant responded to these stimuli “with loud screams, thus showing that it is sensitive to pain.” Nevertheless, Ritter von Reuss continued, “it is generally accepted that while the reflex excitability for local tactile stimulation in the newborn is even greater than at a later period, the perception of pain is considerably less; that the time of reaction is longer than the pain, such as in operations, has on the whole not nearly so great an intensity and duration as in the older child.”446

The dominant view in psychology and physiology that infants and children had a reduced sensitivity to pain was reinforced within paediatrics by a fear about the use of opiates on young children, which justified the minimal use of anaesthesia in children’s surgery. In 1938, when describing a surgical procedure in a child, Max Thorek, founder of the International College of Surgeons, wrote: “anaesthesia is often not required. In many cases, a sponge soaked in the

446 Ritter von Reuss, _Diseases of the Newborn_, 77.
mixture of water and sugar is sufficient to calm a child.” Some year later, in his paper on paediatric anaesthesia, the English doctor Gordon Jackson Rees discussed in some detail the complications of paediatric anaesthesia, such as the tendency for infants under six months to become hypothermic in response to anaesthesia whereas older infants became hyperthermic. Hypothermia was more readily managed but hyperthermia sometimes led to convulsions and death. Ether anaesthesia and atropine premedication contributed to this risk. In summarising his views, Rees wrote, “the respiratory deficiencies of the infant during early life and the hazards of hyperthermia in older children suggest that controlled ventilation during the maintenance of anaesthesia has special advantages. It should be regarded as an essential part of the technique for prolonged operations, and is highly desirable for shorter procedures. Anaesthesia can be maintained at very light levels with nitrous oxide-oxygen and a relaxant drug, with the result that recovery is rapid. There are, therefore, cogent practical and theoretical reasons for maintaining anaesthesia with controlled ventilation, a relaxant drug, nitrous oxide and oxygen.” But there continued to be opposing points of view. Charles Robson, anaesthetist at the Hospital for Sick Children in Toronto, who was perhaps the first paediatric anaesthesiologist, vehemently rejected outright assumptions about infant insensitivity to pain: “First, it has been stated that infants under seven days of age do not require anaesthetics for operations – that their association tracts for pain are not fully established and that minor operations may be carried out without any damaging effects on the infant. Personally, I do not believe this and it is simply vivisection to operate on a conscious screaming wriggling infant without using a general or local anesthetic.” He used open-drop ether and cyclopropane along with tracheal intubation for infant anaesthesia.

Views such as Robson’s were probably in the minority. There is little discussion about pain in early textbooks about paediatric anaesthesia, not even with respect to neonates. Clement Smith’s The Physiology of the Newborn Infant (1945) did not mention pain at all. Nor did the English physician Margaret Pickles

in her book, *Haemolytic Disease of the New-born* (1949). Just one substantive comment can be found in Digby Leigh’s and Robert Smith’s book on paediatric anaesthesia, which became a reference source around the world: “Newborn infants are not as sensitive to pain and some degree of analgesia is present without anesthetic. Most infants, however, do have some pain sensation even at birth and one cannot rely on the old adage that there is no pain sensation for the first three weeks of life. It is nearer the truth to say that sensitivity to pain is decreased. Since there is some basic analgesia, very low concentrations of anaesthetic agent will produce complete analgesia.” In 1950, readers of *The Relief of Pain in Childhood* were told that it was as difficult to diagnose pain in infants as it was in “the veterinary sphere”, but children nonetheless seemed to “tolerate pain better than adults.” They “complain less, are more patient, and much less often adopt an attitude of self pity.” Readers were reminded that, “much needless pity is felt for ill children, who are usually infinitely happier than adults similarly placed.” Ten years later, David M. Levy argued that, at the very least, neonates did not have memories and so their pain could not be compared with that experienced by adults.

In 1952, French neurologist André Thomas issued a warning about the function of the myelin sheath, based on studies in animals that had shown how non-myelinated fibres could be excited. In 1957, Jones encapsulated the theory that in order for pain to be felt the capacity to remember it needed to be in place and that in order to feel pain sensations there first needed to be a mature nervous system. He argued that while an individual subject might recognise pain mentally he could not reconstruct it and that repeated pain sensations did not provide resistance. Harold Merskey suggested that children had an immature perception of pain and acquired this ability as they grew older. He argued that even if small children were able to feel pain, their reaction to it involved a weaker expression than that of adults. Merskey was a member of the panel that proposed the first definition of pain adopted by International Association

454 See Chapter 2.
for the Study of Pain (IASP) as “an unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage. Noteworthy, pain is always subjective. Everybody learns it through experiences related to injuries in early life.”

Conclusion

This chapter has shown how scientific disciplines – and paediatrics in particular – changed between the latter part of the nineteenth century and the first half of the twentieth century. Scientific investigation and understanding of pain and childhood became the domain of increasingly specialist – and often competing – disciplines, each of which had its own perspective on pain in childhood. Thus, the child-study movement, heavily influenced by Darwinism and the recapitulation theory, envisioned the child as an entity that embodied the primitive past of the species and held that pain was a mere reflex action in infants and a sensation which children learned as they grew up. The mechanistic vision of behaviourism was dismissive of children’s expressions of pain, particularly those of infants which were seen as reflex responses to stimuli. While paediatrics in the nineteenth century was often not considered as a branch of science, this changed in the twentieth century. However, far from consolidating the factual consideration of pain, the “scientisation” of paediatrics led to the influence of mechanistic and developmental theories, and eventually to the rejection of “subjective” testimony as a methodological approach to children. On the one hand, paediatrics started to conceive pain in a more theoretical perspective; on the other hand, practice was based on the underlying analogy between animals and children, and between veterinarians and paediatricians. The increasingly mechanistic vision and the dismissal of “subjectivity” and the role of the mothers’ accounts of children’s pain led to the growing importance of observation (by professionals rather than parents, and by doctors rather than nurses). But some of the observational practices – notably those of Hall and Gesell – were far from being as scientifically rigorous as they were presented at the time. They owed much to Romantic conceptions of the child and to the theory of recapitulation, and used the child as a symbol of the development of the

457 Harold Merskey, ‘Pain in terms: a list with definitions and notes on usage’, Pain, 6 (1979) 249.
human species. They were also informed by racist and class prejudices and emerged at a time of increasing industrial institutionalisation. Although they had different theoretical perspectives, all three disciplines – Child Study, behavioural psychology, and paediatrics – came to embrace the idea that infants did not feel pain or had considerable less sensitivity to pain than older children and adults.

The debate about infant pain denial encapsulates two important issues in both the history of pain and the history of childhood. Firstly, that of the politics of pain, an idea defended by several important writers. Lucy Bending's argument that the appropriation of physical pain by different interpretations opens the door to potential abuse by the authorities means that pain is not only subject to cultural conditioning but is also susceptible to being represented or distorted by those power groups. The infant pain research which this chapter has explored can be seen as a paradigm for the ways in which pain can be manipulated and defined by those in power. Whenever the communicative power of language is weakened or linguistic communication disappears, Elaine Scarry's thesis – that the inexpressibility of personal pain makes someone more vulnerable to being exploited, oppressed, or tortured by those who have power – resonates.

Connected to the politics of pain is the power of representation. Here, the normal example takes the place of the species, and the species the place of the specific individual, who disappears. This leads to metaphorical representations where the child takes the place of the savage and vice versa, where the normal replaces the abnormal, and so on. This kind of representation allows the creation of taxonomies and theories about development.

The second issue is the problem of the child's status as a developing body and the significance of pain in the scientific construction of the process of development. In the twentieth century, the child was figured as the embodiment of a potentially normative developmental process. The child was figured as a

458 Elaine Scarry insists that power can ignore the pain of those that do not have the capacity to express themselves, leading to a greater vulnerability to all kinds of physical abuse (Scarry, Body in Pain). Martin Pernick presents an account of the selection of human typology that needed or even deserved anaesthesia when it was making its entrance into habitual medical practice in the United States at the end of the 1840s and the beginning of the 1850s (Pernick, A Calculus of Suffering). See also Mary Poovey, Uneven Developments: the ideological work of gender in mid-Victorian England (Chicago University Press, Chicago, 1988), chapter 2. Joanna Bourke has added recent publications on the history of pain, 'Prothero Lecture: What is pain?’ A History’, Transactions of the Royal Historical Society, 23, 3 (2013), 155-173 and The Story of Pain, which considers the importance of the study of the polities of pain.
459 Bending, Representation of Bodily Pain, 1-11.
460 Scarry, Body in Pain, 27.
potentiality in need of control in order for that potential to be realised, because the outcome of development is never simply guaranteed. The experience of pain was an important aspect in measuring the distinct phases of development, both in the child-study movement and in behaviourism. Nineteenth-century scientific figurations of the child had taken the child’s body as a spatiotemporal form to generate global hierarchies according to race, gender, sexuality, and class. But twentieth-century scientific versions of the child materialise the child’s body as a site of human potential and transformation, thereby also assigning the child a potent cultural value as a quintessentially “flexible body”. Always primed for change because already in process, this child is figured in distinct semiotic-material terms that are fundamentally different from those of the nineteenth century. The nineteenth-century child-figure had a modular, flexible form of embodiment that generated a specific version of the human, and established a discontinuous difference between the child and the adult that did not exist before, even as the child “becomes” the adult through the developmental process. Despite these differences, the nineteenth-century and twentieth-century child figures that Chapters Two and Three have described were put to similar use: the child’s value in these scientific discourses is a body which is, in an ontological sense, the human in the making. As such, the child is both that which must be figured in order to make a claim on the human and the body from which the “facts” of human nature’s makings must be ascertained. The difference between the two figurations of the child can be associated with broader historical shifts in the relationship between nature and culture. Nature can now be constituted by the culture of science and scientifically directed parental and institutional pedagogy. The child “matters” as a flexible body and subject in the making. In this light, the sad history of infant pain research reads as an indictment of the modern scientific perspective. The transformation of the infant into the object of a mechanistic science resulted in medical insensitivity and experimental bias. Although certain aspects of this history are perversions of scientific method or products of a particular period (such as the desire to appear objective and scientific when science’s credentials were less well established), others (such as the exclusively mechanistic view of the infant) appear equally relevant in any era.
CHAPTER FOUR

Insane children: the articulation of mental diseases and pain (1860-1900)

Introduction

In October 1875, the young British doctor William H. Spurgin described the case of one of his patients, a ten-year-old girl whom he named “S.T.”. The girl’s parents called the physician in September 1874 after the child complained of “severe pain at the epigastrium.” According to her parents, who provided Spurgin with details of their child’s story, S.T. had always been healthy until three months before the doctor was sent for, when she started suffering “of the same pain once or twice a week”, a pain which progressively worsened. Spurgin reported that, on his first visit, S.T. was “a rosy healthy-looking child”, but the increasing pain meant that she “soon became sallow, developed an “abdominal aspect”, and “became quite unable to walk.” The girl later developed convulsions and had screaming fits. Spurgin deployed several known treatments: “I gave her tincture of opium, belladonna, hyoscyamus [sic], bromide of potassium, chloral hydrate, mustard and linseed poultries, blisters, and, in fact, tried every means to relieve the pain without the least (apparent) effect.” Eventually the child “appeared in the greatest agony and misery in spite of all treatment.” The girl’s symptoms, combined with her lack of response to treatment, led Spurgin to settle on a diagnosis of hysteria. Even though there was confusion about the symptoms of hysteria, nineteenth-century alienists agreed that the most unusual manifestations of hysteria always involved the continuous experience of chronic pain. S.T. was one of many children and young people in the second half of the nineteenth century who suffered from mental-health disorders and ended up being cared for by doctors or confined in state institutions. Her case provides insights into the overlapping ways in which the mental disorders of childhood were understood in relation to pain, which is the subject of this chapter.

461 William H. Spurgin, ‘Case of hysteria in a child aged ten years’, British Medical Journal 2, no. 770 (October 1875) 555.
462 Spurgin, ‘Case of hysteria’, 555.
In *The Body in Pain*, Elaine Scarry makes an important distinction between physical and psychological pain, arguing that psychological pain is present in almost all forms of literature, but physical pain has received scant attention. This chapter will argue, however, that during certain historical periods this kind of clear distinction between bodily and mental pain is not supported by the evidence. To make this argument, the analysis returns to the second half of the nineteenth century, when boundaries between psychiatry, psychology, neurology, and neighbouring medical and scientific discourses were still blurred. The analysis thus focuses on the overlapping ways in which the mental disorders of childhood were understood in relation to pain and, in some cases, the absence of pain. By arguing that mental illness and insanity often became known precisely through the physical manifestation of a pained body, this chapter supports the view voiced by, among others, the cultural historians Javier Moscoso and Louise Hide whose work explores the complex cultural connections between the body in pain and the disordered mind.

If those connections remain largely unexplored, so too is the very topic of childhood insanity. In her 2010 book *The Mind of the Child*, Sally Shuttleworth argues that “although there has been considerable work recently on Victorian medical constructions of the female mind and body,” comparatively little attention has been paid to medical discourses about insane children and adolescents. While I follow the impulse provided by Shuttleworth’s diagnosis to fill the gap in such discourses, the angle of this study (and its chronology) is different to hers: while Shuttleworth seeks to complement that lack of attention with an impressive case for complex reflective feedback between the medical discourse and the more accessible and popular literary representations of

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465 Some substantial studies have focused on the connections between literature and science. Thus, Katharina Boehm (*Charles Dickens and the Sciences of Childhood*) has produced a lengthy chapter on Charles Dickens’ engagement with medical and psychological debates about the mind of the child. In ‘Lewis Carroll’s dream-child and Victorian child psychopathology’, *Journal of the History of Ideas*, 76, 1 (2015) 93-114, literary scholar Stephanie L. Schatz reads *Alice’s Adventures in Wonderland* (1865) in the light of influential Victorian studies in psychology and describes the medical and historical links between childhood and dream states, explaining why medicine pathologised the latter. Neither of these studies addresses the question of pain nor discusses the subjective experience of children in asylums.
children in naturalist writers, her angle remains fundamentally external to theories on children’s pain. On the contrary, the examinations that compose this study are, at the same time, intra-disciplinary and inter-disciplinary. Intra-disciplinary, because they reconstruct the research questions and scientific principles at the base of each of the main contending figurations of child pain; inter-disciplinary, because no consensual scientific figuration results as the outcome of this reconstruction, representing instead a quite messy struggle of scientific debates, many of them centred around a core issue other than children’s pain.

The historiography of children’s insanity has grown considerably since Shuttleworth made this statement, but historians have paid little attention to the broader topic of children’s pain in post-Darwinian psychiatry. The gap extends to the institutions that hosted and treated insane infants and adolescents. The function and role of Victorian lunatic asylums has been a subject of much debate among historians but, as Steven Taylor has argued, “the significance of the institution for the treatment of children has been a topic relatively overlooked by academics.” An exception is psychiatrist Kate Gingell, who shows that there were very few asylum admissions of children under the age of 16 and argues that asylums did not make any significant contribution to the development of child psychiatry. Research by Richard Adair, Joseph Melling, and Bill Forsythe suggests that sending children to the asylum was only ever a last resort (“out relief” or the workhouse were more common approaches). These views challenge Andrew Scull’s idea of the “total” institution, where “the asylum was an efficient method of ridding the community of an ‘offensive burden’.” Steve Taylor’s recent book, *Child Insanity in England, 1845-1907*, has shown how families regularly sought care outside the asylum system, which resulted in the

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467 Steven Taylor, “‘All his ways are those of an idiot’: the admission, treatment and social reaction to two idiot children of Northampton Pauper Lunatic Asylum, 1877-1883”, *Family & Community History* 15 (2012) 35.


creation of numerous welfare systems that operated across England both within and beyond centralised legislation.\textsuperscript{471}

The main methodological difficulty of this chapter was the identification of references and ideas connected to pain in the context of children’s insanity. While the former two chapters explored infant pain denial and the expression of children’s pain, notions directly explored and mentioned by both theorists and practitioners, the interest for pain in the context of the authors and topics covered in this chapter is by far tangential. For that reason, the following pages will explore different mental conditions in search of ties with childhood and suffering, instead of pointing directly at statements, principles and practices circumscribed to that central topic.

To explore the intersection of children’s mental illness and pain at the end of the nineteenth century from the perspective of the practising psychiatrists of the time, this chapter will present different mental diseases that represent distinct ways of framing the complex interactions between the child mind, body, and pain. The different representations of pain that emerge straddle a range of scientific judgments and underlying theories. The first section marks the central year of 1860 as the date when the concept of the “child mind” was introduced by psychiatrist Sir James Crichton-Browne, who strongly advocated the extension of the notion of insanity to children. It then goes on to cover “night terrors”, a new category of disease strongly linked to hallucinations and painful attacks which rapidly gained popularity among theorists of mental illness despite the lack of documented cases. The cause of night terrors was often attributed to pain – typically intestinal disorders. First presented in Charles West’s \textit{Lectures on the Diseases of Infancy and Childhood}, the night-terrors category was further elaborated by Crichton-Browne, among others.\textsuperscript{472} The importance of night terrors is that it is the first example of a form of mental illness considered to be suffered exclusively by children. Crichton-Browne believed night terrors to be a passing form of “pantophobia” that was common in infancy and childhood, and both night terrors and daydreams came to be seen as part of a continuum that led directly

\textsuperscript{472} West, \textit{Lectures}, 188.
to mental illness, a view which shaped the late-nineteenth-century development of child psychiatry.  

The second section covers melancholia – also defined as “mental pain" and as a form of “affective insanity” – and explores the Darwinist, physiological research programme that considered this form of mental illness to result from an irritated brain. This new concept of melancholia and the separation between emotional and intellectual maladies was linked to the emergence of ideas about non-intellectual insanity that had emerged in the early nineteenth century, such as “moral insanity” – introduced by James Cowles Prichard in his 1835 book Treatise on Insanity and Other Disorders Affecting the Mind – where the moral faculties and emotions were considered to be disordered. The next section analyses hysteria, an umbrella or catch-all notion that included a multitude of bodily manifestations with the only common trait being that of manifest pain, often of an emotional nature. It shows how hysteria was used to explain all kinds of conditions – including religious ecstasy and sexual deviance – and how although it was initially applied in particular to adult women it was later extended to children. The final section explores children who enjoy inflicting pain on others or who engage in what today would be called self-harm. For the leading British alienist Henry Maudsley, such behaviour indicated “homicidal monomania”. As stated above, the present chapter is primarily concerned with the British context, from the 1860s until the end of the nineteenth century. During this period, conditions that had been seen as fluid diagnostic categories became well-established and clearly defined diseases with what was, for its time, a remarkably standardised symptomology.

These various conditions each involved different figurations of pain. So, while physical pain was considered to be the cause of hallucinations and irrational fears in the case of night terrors, with both melancholia and hysteria pain was seen in affective and emotional terms. In the case of hysteria, pain became the unifying symptom and articulating notion that allowed the construction of a range of bodies in emotional pain.

The Victorian system for classifying mental disorders placed a plethora of conditions within two main categories: idiocy and insanity. Children and young people who would today be categorised as developmentally disabled as the result of learning disabilities were often labelled “idiots”, “imbeciles”, or “feebleminded”.

Insanity was used to describe disorders and mental illnesses in which the mind deviated from normal activities and patterns, resulting in socially unacceptable behaviours. This chapter focuses on insanity, showing how neurologists and psychiatrists understood pain of non-organic origin.

Researching this chapter involved an extensive literature search for historical publications on children’s insanity and pain, which began with two historical reviews of the development of child psychiatry: Alexander von Gontard’s article ‘The development of child psychiatry in 19th century Britain’ (1988) and M. Neve’s and T. Turner’s History of Child and Adolescent Psychiatry (2002). Von Gontard’s article stands out for its thorough research, based mainly on the writings of nineteenth-century medical practitioners, as well as its description and analysis of the early development of child psychiatry in Britain. This chapter focuses on texts published by British alienists and paediatricians, as well as the European and American texts that they cite, from 1860 to 1900, the period in which the first studies of child psychiatry appeared. These texts, written in a discursive and scholastic style, seem likely to have been aimed at elite physicians rather than the public. Although nearly all of these texts are dedicated to adult conditions, the sections on childhood reveal a great deal about medical perceptions and treatment of children. I also explore the asylum practices of

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476 For a discussion on disability see: Martin, Disabled Children, 136-154; Borsay and Dale, Disabled Children; Humphries and Gordon, Out of Sight. For a discussion on these three categories see Mathew Thomson, The Problem of Mental Deficiency; Eugenics, Democracy and Social Policy in Britain, c 1870-1959 (Oxford University Press, Oxford, 1998).

various authors – including George Savage, Henry Maudsley, and Sir Thomas Smith Clouston – whose asylum practice certainly shaped their ideas and whose attempts to define and explain childhood insanity can provide much insight into the approaches adopted by asylums during this period.

The mind of the child

Although there was relative agreement on the definitions of idiocy and imbecility, many medical professionals found insanity more elusive. In fact, one of the most fundamental questions for British practitioners in the last quarter of the nineteenth century was whether children could be insane at all. Rather than indicating indifference toward the mental health of children, the scarcity of research dedicated to the issue reflects the rarity with which most medical practitioners found such cases under their care. Even among those who – like Beach, Langdon Down, and Ireland – began to specialise in the care of children and youth during the Victorian period, there were few who encountered cases that could clearly be identified as insanity. M.B. Ray, an assistant medical officer at the West Riding Asylum, writing in 1896, considered insane children and youths to be a rarity. “Acute insanity arising before the age of puberty,” he maintained, “is rarely met with in asylum practice; and there are, so far as I am aware, very few such cases recorded.”

During the first half of the nineteenth century there had been considerable reluctance to accept the idea that children could be afflicted by the same mental illnesses that affected adults. Reported cases tended to suggest causes such as faulty parenting or teaching rather than anything to do with the child mind itself. Despite the concerns about “degeneration” and the possibility that a young child might display the evidence of inherited insanity, in the 1850s the general belief was that children – although they could be imbeciles or “idiots” – could not be insane. Jean Etienne Dominique Esquirol, for example, argued in Mental Maladies that “it is only at puberty, during the earliest menstrual efforts, or

during, and after a too rapid growth, that we begin to notice certain cases of mental alienation… Mental alienation might, therefore, be divided, relative to ages, into imbecility for childhood, mania and monomania for youth, lypemania or melancholy for consistent age, and into dementia for advanced life.”

This kind of protected status for childhood rapidly disappears in post-1860 psychiatry, when children were regarded as not only capable of experiencing forms of insanity previously reserved for adulthood but, in fact, of being more vulnerable to them. In a communication published in 1860, Crichton-Browne warned his colleagues of the importance of paying attention to the language of children because “in them those incoherent speeches, or odd remarks, which are attributed to childish unmeaning babbling and folly, may sometimes be in reality the result of delusions, illusions and hallucination.”

Crichton-Browne’s essay ‘Psychical Diseases of Early Life’, published in the Asylum Journal of Mental Science in 1860, was a major influence on the new discipline of child psychiatry. It argued that “monomania or delusional insanity, we believe to be more common during infancy and childhood than at any other period of life.” Using recent research on heredity and idiocy, Crichton-Browne tried to change the understanding of the child mind. Where once children were assumed to be free from any form of insanity, now “almost every form of mental disease which may attack the adult, may also attack the infant and the child.” Indeed, there were certain forms of mental illness that Crichton-Browne considered to be more prevalent in childhood than in later years. Drawing heavily on Esquirol’s theories of monomania, Crichton-Browne outlined a wide range of childhood mental disorders, including homicidal mania, kleptomania, and...
pyromania, theomania and demonomania, pantophobia, moral insanity, mania, melancholia, and night terrors (which he regarded as a type of pantophobia).487

Unlike colleagues whose publications were based on years of medical practice, Crichton-Browne was still a 20-year-old student and a year away from qualifying as a doctor when he published this influential text. His daring claims are based on a mix of old medical paradigms, but at the same time they anticipate the concerns of late-nineteenth- and early-twentieth-century alienists, and include many areas of concern that would be developed in later decades, including sexuality and suicide. In Crichton-Browne’s approach, the very imaginative projections associated with childhood are used to define insanity. Thus imaginative “castle building” is denounced as a “pernicious practice” and “much mental derangement in mature life, we believe, is attributable to these reveries indulged in during childhood.”488

The lack of research on insane children was grounded in a widespread medical deficit. Soon after the publication of Crichton-Browne’s essay, the eminent psychiatrist John Conolly called for greater understanding of the child mind, writing in 1862: “In innumerable respects society and manners and modes of thinking have undergone great changes since the beginning of this century, but in no respect more strikingly than in the greater attention paid to the minds of children of every class.”489 Crichton-Browne and Conolly were not alone. As Sally Shuttleworth has argued in *The Mind of the Child*, although it was not until the end of the nineteenth century that the two fields of child psychology and child psychiatry started to consolidate, as early as the middle of the century, “the inner workings of the child mind [were] opened up to medical interrogation and intervention.”490 There was no specialist science in childhood mental conditions and studies were carried out by specialists in adult illnesses.

The turning points marked by Crichton-Browne’s 1860 essay lies in its dramatic claim that insanity could occur “in utero”.491 Thus, discussions of the mental disturbances of children started to focus increasingly on hereditary transmission, a tendency that was aided by the development of evolutionary

490 Shuttleworth, *Mind of the Child*, 42.
psychology and psychiatry in the wake of Darwin’s *On the Origin of Species* in 1859. The child, previously seen as immune from the majority of mental disorders, was now viewed as being vulnerable to all possible adult conditions: “From the end of the first dentition, up to puberty, we may state, as a general principle, that there is a liability to every psychical disease from which the adult may suffer, together with certain conditions peculiar to that stage of life.” These medical explorations of children’s nervous disorders overlapped with a wider cultural concern about the child mind, increasingly measured according to an autonomous notion of normality not derived from adult medicine. Research into children’s mental capacity was contemporary and instrumental to the introduction of compulsory education in the United Kingdom: it is no surprise that, by the end of the century, special care was provided for children who were considered abnormal or mentally deficient.

From 1860 onwards medical professionals debated not only whether children could be insane, but also at what stage could insanity be present. Many tried to distinguish between the sane and the insane mind. Scottish physician William Ireland observed: “Sanity is generally regarded as a natural and healthy growth of a man’s character, and insanity as something diseased or abnormal.” A mind afflicted by insanity was seen as deviating from the characteristics of a normal childhood, corrupting children’s natural innocence and manipulating their natural tendencies. There was also much debate about the developmental stage after which children could become insane. Considering the question “How soon can a child go mad?”, Henry Maudsley argued “obviously not before it has got some mind to go wrong, and then only in proportion to the quantity and quality of mind which it has.”

Crichton-Browne was not alone in his claims, although his tone may have been fiercer and provocative. As shown in Chapter 2, Charles West had called for more attention to be paid to the unique nature of the physical constitution of children and their pathologies. In his textbook on children’s diseases and a subsequent publication entitled *On the Peculiarities and Mental Disorders of*

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493 See Chapter 3.
494 Ireland, *The Mental Affections of Children*, 272
Childhood (1860), he suggested that similar consideration should be given to children’s minds, and in a letter published on February 11, 1860 in the medical magazine *The Medical Times and Gazette*, West claimed that the advances in the study of adult illnesses, which had enabled the move from studying symptoms – “diseases” – to studying the individuality of the patient – the “diseased” – had no equivalent in studies of children’s ailments. 496 According to West, medical practitioners who did not take into account the “mental and moral peculiarities of childhood” in the development of childhood illness would never be able to make a secure diagnosis. Just as happened “in the grown person,” factors such as anxiety and grief were actual factors “in conducting the patient to death, or in bringing his recovery.” It was thus fundamental to study the child “from its mental as well as from its physical side”, in order to understand “how in its immaturity the mind reacts on the body as well as the body on the mind.” 497

In the third, expanded, edition of his *Lectures on the Diseases of Infancy and Childhood* (1854), West enlarged the chapter on mental health, including new material about children’s imagination, dreams and nightmares, and various mental pathologies. 498 In the following edition (1860), West addressed the question of child insanity more directly, seeking to prevent his students “from going into practice with the impression that perversion of the intellect may not occur in the child as well as the adult.” In childhood, West noted, “the intellectual powers are imperfectly developed, the feelings and the impulses are stronger, or, at least, less under control, than they become with advancing years…Mental disorders, then, show themselves in the exaggeration of those feelings, the uncontrollable character of those impulses; in the ability or the indisposition to follow that advice or be swayed by those motives which govern other children.” West sought to persuade his readers that “perversion of the intellect or of the moral faculties, as distinguished from mere feebleness of mind, is met with in childhood as well as in adult age, and deserves to be regarded and to be treated as insanity no less in the one case than in the other.” 499

By pointing out the role of anxiety and mental unrest in sick children, and introducing the topic of mental disorders into a text on the physical ailments of children, West became a key figure in the development of child psychiatry. Noting the role of anxiety and mental unrest in sick children, he challenged the assumption that children, not having yet attained a state of reason, were incapable of losing it and therefore of becoming insane. It was now possible to view the child’s freedom from adult mental constraint as providing the foundations for insanity. Mental disorder – the loss of intellectual or emotional control – is thus defined as a kind of heightened state of childhood. This shift in perceptions of the child mind marks a crucial turning point, for it is now possible to see the origins of insanity in the child’s very freedom from adult mental constraint. As a characteristic example of this new disciplinary categorisation of incipient child psychiatry, the following section analyses the disease defined by West as “night terrors”, and its relation to pain.

Night terrors, pain and hallucinations

In his attempt to demonstrate that children were more susceptible than adults to monomania or delusional insanity, Crichton Browne used both images of children afflicted by visions of phantasms and Charles West’s recent diagnostic category of “night terrors”. Despite the Romantic interest in dreams, nightmares, and apparitions, West’s text was the first nineteenth-century medical textbook to consider children’s night terrors as a specific category. In the 1848 edition of the Lectures, West had presented the idea of an apparently psychological disorder whose origins he traced to a somatic source in digestive dysfunction. West’s lecture about night terrors begins with a graphic description of a child afflicted by this phenomenon. While sleeping one night, a little boy of 11 months awoke “with a sudden start, and a scream so violent that all the people in the

500 As Janet Oppenheim has argued in her discussion on nervous children, the growth of child psychology was only one aspect of the gradual development of paediatrics as a reputable branch of medicine during the nineteenth century. See Janet Oppenheim, ‘Shattered Nerves’: Doctors, Patients, and Depression in Victorian England (Oxford University Press, Oxford, 1991), 234.
501 From this point on, night terrors became a standard entry in medical manuals, usually citing West. See, for example, T. H. Tanner, A Practical Treatise on the Diseases of Infancy and Childhood (Henry Renshaw, London, 1858), 276-9.
house heard it." After he was removed from his bed he continued to cry loudly for a while and then, little by little, he calmed down and fell asleep again, sweating profusely. After an interval – sometimes half an hour, sometimes as much as two hours – he would wake up again in the same sudden way and with the same violent scream. And then, after a few minutes, he could again "sink into slumber". Six days later, the attacks returned more vehemently and increased in frequency, with “as many as seven or eight having occurred in the course of a single night.” The child also suffered similar attacks when he was sleeping during the daytime. His parents recalled that before the first attack the child had suffered for ten days with mild diarrhoea, “with dark and slimy evacuations.” Despite the apparent gravity of the illness the child was cheerful, sucked well, did not vomit and did not present fever. The only physical symptomology present was a swollen and tender abdomen, swollen gums and a furry tongue. The boy’s doctor, West, diagnosed the condition as a case of night terrors dependent upon intestinal disorder.

This account is one of various cases used to illustrate the new disease. Both in the second edition of the Lectures and in his essay ‘The Peculiarities and Mental Disorders of Childhood’, West expanded his understanding of the aetiology of night terrors, highlighting the connection with organic injuries, and adding experiences of intense physiological pain – especially following surgery – to other factors such as intestinal worms and digestive problems. Like Louise Hide in her study of clinical cases of asylum patients suffering from tertiary syphilis, West too saw a relationship between bodily pain and the persecutory delusions and hallucinations experienced by children.

Although West admitted the paucity of relevant works to cite, his comments on the connection between pain and hallucinations follow the emerging tradition in psychiatry that attempted to find a somatic location for conditions – such as melancholia, neuralgia, and hallucinations – with no obvious organic origin. Historians have generally agreed that, from the middle of the nineteenth century, a new generation of medically-trained “alienists” placed a greater emphasis on

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503 West, Lectures, 188.
504 West, Lectures, 188.
505 West, Lectures, 188.
507 Although Crichton-Browne was to draw on the Journal of Psychological Medicine in his own pronouncements, there is no direct reference to the journal in West’s work in this context.
somatic explanations of insanity. 508 These accounts involved both biological heredity and the rather vaguely defined concept of “nervous impulses”, principles which were used in the classification of children’s insanity. Such late-nineteenth-century definitions of insanity can be seen as part of a wider mind-set – manifested both in scientific and popular literature – that placed a twin emphasis on volition and self-control on the one hand, and the biology of the brain on the other. Roger Smith argues that many physiologists used cases of insanity to support these theories because the “simplest and most vivid evidence” for the existence of inhibition was in fact provided precisely by what happened when it was absent.509

This new generation of medical experts was convinced that insanity had a physical cause – whether a brain injury or some other kind of organic lesion – that could be brought to light by sophisticated medical practices. Thus, G. Fielding Blandford wrote in *Insanity and Its treatment* (1871): “Disorder of the mind means disorder of the brain, and […] the latter is an organ liable to disease and disturbance, like other organs of the body, to be investigated by the same method and subject to the same laws.”510 The alienist Henry Maudsley dismissed psychological enquiries into insanity as metaphysical and unscientific musings. 511 British and continental psychiatrists generally agreed that considerably more research was needed in order to establish the physical location of insanity. Maudsley, though, suggested that, until hard evidence became available, diagnoses should be made on the basis of the compendium of nervous symptoms. More than any other figure, he shifted the focus of British psychiatry from the metaphysical to the physical, arguing that the psychological symptoms of insanity were not especially significant and amounted to epiphenomena. Maudsley was convinced that organic causes would one day be


found that corresponded with the various symptoms that were the basis of classification. Within this medical cosmology, insanity in children could be viewed as “evidence” of anatomical lesions (in the brain), of pathological instinct, or of a functional disorder.

Within the wider literature about insanity, there has been much debate about the extent to which the insane were treated in institutions or at home.\textsuperscript{512} However, historians agree about the marginality of discussion about child insanity – which, when it took place, was generally within the context of adult insanity – even though children’s hallucinations and other mental disturbances were recognised. In the Victorian period, children and adults were sent to the same county asylums and had similar experiences of confinement.\textsuperscript{513} However, the emergence of the concept of night terrors challenged both the theory and the practice of approaching children and adults in similar terms regarding diagnosis and treatment. Night terrors were widely discussed in publications by alienists that dealt with insanity, but the concept had emerged from the study of diseases in children, which suggests that medical professionals had begun to see childhood insanity as a legitimate area of concern. Another factor to consider is that children were being diagnosed and treated for mental illnesses not only within British asylums – they were also being attended to in the new hospitals that specialised in children’s ailments. Child patients who showed signs of insanity were treated in hospitals such as Great Ormond Street Hospital, Evelina Hospital, and Glasgow Children’s Hospital, and their conditions were usually categorised as disorders of the nervous system.\textsuperscript{514} It would be wrong to conclude that the absence of published material about children’s medical conditions in the years following West’s text implies that children were not treated in hospital


\textsuperscript{514} Dr. W.H. Dickinson, on the staff from 1869-82, was the first to keep separate volumes of casenotes for particular groups of conditions. His volume for ‘Nervous Diseases’ (so large that is re-bound in 3 parts) is very broad in its definition by today’s standards, ranging from what today would be Neurosurgery cases to what would now be Psychiatric. GOS/10/26: Dr. W.H. Dickinson’s casenotes (1869-82).
wards. Hospital case notes make repeated references to conditions such as night terrors, hysteria, melancholia, and monomania. Practical interest in children’s insanity may, in fact, have been stronger and more widespread than might be suggested by the lack of consideration within contemporary theoretical discussions.

The diagnoses of “night terrors” applied specifically to children became very popular, although the amount of disagreement is striking: Just as for West the nocturnal terrors had their origin in a digestive condition or a cerebral condition, for Crichton-Browne they were “usually associated with, perhaps dependent upon, cardiac disease,” while authors such as Maudsley attempted more complex physiological explanations in the mechanism of the nervous system (see below). In any case, it seems that West’s lectures gave medical and scientific respectability to the popular perception of the mentally disturbed child. The fact that West’s account is repeated in nearly all the publications about night terrors implies that few Victorian medical professionals - not even those who, like Maudsley and Crichton-Browne, started to specialise in the care of children and young people – were involved in cases that could be identified clearly as insanity. Often, the clinical cases used to support the existence of insanity in childhood did not come from the medical practice of these alienists, but rather from earlier publications or cases of colleagues that had been recorded in articles or medical treatises.

An interesting example is offered by Daniel Tuke, an English physician and writer who made a detailed entry about the terrors in his Dictionary of Psychological Medicine (1892). Tuke uses a narrative structure like that of West, showing how information was exchanged between the various medical disciplines and their different knowledge bases. As a sign of recent developments, Tuke’s publication was the first medical compendium to offer detailed entries on a range of child psychiatric issues, including lengthy contributions from Thomas Clouston on “Developmental Insanities and

516 Shuttleworth, Mind of the Child, 51; Boehm, Charles Dickens and the Sciences, 123-124.
517 ‘An hour or two after onset of sleep, the child affected suddenly screams out and wakes in a great fright, not at first recognising its surroundings or nurse. The child often has difficulty in getting to sleep again, the fright passing off gradually. As a rule, there is no recurrence the same night, but there usually is on succeeding nights.” Tuke, Dictionary, 137. Tuke and Bucknill’s Manual of Psychological Medicine was the major standard British textbook at the time.
Psychoses”, and Donkin and Charcot on hysteria.\textsuperscript{518} In his section on “Developmental Insanities”, Clouston also included a systematic study of “night terrors.”\textsuperscript{519} The Scottish psychiatrist, who was the superintendent of several asylums and a celebrated lecturer on mental diseases, framed this phenomenon within his theory about the occurrence and form of insanity related to developmental stages. The view that insane children and young people were subject to the same theoretical and practical considerations regarding diagnosis, treatment, and confinement as insane adults had to contend with the rival opinion of the specificity of child insanity, and the concept of night terrors was essential for this point of view. In particular, authors such as Clouston identified differentiated developmental phases. Typically, between the ages of eleven and fourteen the individual would transition from the insanity of a younger child to that of an adolescent.

Thus, it was during the process of teething when children of a neurotic heredity and an unstable quality of brain were especially subject to convulsions, “that being the prevailing neurosis under four years of age.”\textsuperscript{520} The main two ways in which brain instability manifested itself in early childhood, argued Clouston, were “convulsions and delirium”, both transitory in character and very seldom leaving nervous effects when the immediate attack had passed. The condition known as “pavor nocturnus” or “night-terrors” fell into the second category, being “a form of transitory child delirium that rarely occurs except during sleep.”\textsuperscript{521} Clouston found two causes for this phenomenon. First, the night terrors that belonged to early childhood were already symptoms of an excess of imagination: “anything that rouses into premature activity the imagination of nervous children in whom the fancy is already very active may be followed at night by night-terrors”, especially “if there is undigested food in the stomach.”\textsuperscript{522} Second, the appearance of night terrors was common “after surgical injuries or during severe and painful inflammations.”\textsuperscript{523} As often happens with hallucinations and delusions, regardless of their cause, the night terrors supposedly induced by pain were often frightening and involved persecution and condemnation.

\textsuperscript{519} Tuke, Dictionary, 358.
\textsuperscript{520} Tuke, Dictionary, 358.
\textsuperscript{521} Tuke, Dictionary, 359.
\textsuperscript{522} Tuke, Dictionary, 360.
\textsuperscript{523} Tuke, Dictionary, 358.
The doctor James Taylor also supported the theory that “bodily pain” was an “excitant” of the hallucinations proper to night terrors, and that it could determine their character. Taylor referred to a case of night terrors described by Dr. Colman in which a child woke up screaming that someone was in the room hurting his finger. Although recognising his parents, he continued to see this phantom and, in a second similar attack, he said that his finger was not only hurt but also bleeding and pointed to imaginary spots of blood on the sheets. “Intestinal disturbance is the most commonly alleged cause of night terror,” concluded the doctor.\textsuperscript{524} Likewise, for Henry Maudsley the appearance of night terrors went hand in hand with a morphological condition. Adopting the reflex-action model and an evolutionary approach, Maudsley attempted a classification of child development in a series of neural centres: from the tertiary, which transmits reflex actions from the moment of birth with no associated sensations, to the primary or ideational, which allow the appearance of adult forms of insanity. Maudsley hoped that this approach to classification would lead to the revelation of associated lesions in the brain or nerves and thereby advance the medical-scientific side of psychology because diagnosis would be grounded in physiological research. In this model, the night terrors and other seemingly natural hallucinations suffered by infants and small children were often the result of a brain injury or the presence of a “morbid deposit” in the brain.\textsuperscript{525}

Hallucinations thus arose as the major factor of insanity in night terrors, which might otherwise have been classified as a merely physiological disease. In his 1860 essay, Crichton-Browne endorses the connection between night terrors, hallucinations, and bodily pain, and cites West’s work as he argues that delusions in childhood can lead to mental derangement in adult life. To West’s account of night terrors, Crichton-Browne adds details from previous texts and claims that “many cases of infantile insanity owe their origin to fear.”\textsuperscript{526} Thus night terrors and daydreams are viewed as belonging to a continuum that leads directly to mental illness, a view that would become very influential in the early years of child psychiatry. Crichton-Browne relates the case of “a boy, who, during infancy, was subject to night terrors, and who, at the age of twelve, and

\textsuperscript{525} Maudsley, \textit{Physiology and Pathology}, 370.
\textsuperscript{526} Crichton-Browne, ‘Psychical diseases’, 313.
for many succeeding years, was frequently attacked by pantophobia. The attacks were always introduced by palpitation, and characterized by the most intense, yet unaccountable, dread, by loss of identity, and by trembling over the whole body."527 Described as “an exalted or diseased state of the instinct of self-preservation”, often accompanied by delusions, this condition could cause such misery that self-injury and sometimes suicide was “resorted to as a means of relief.”528 The alienist concluded by urging parents to be unceasingly alert to signs of similar states in their children – such as day-dreaming and those conditions related to an excess of imagination – for Crichton-Browne felt confident that, if detected at an early stage, they could still be remedied by rest and a nourishing diet.529

Although the hallucinations characteristic of night terrors were often attributed to either pain or brain injury, they also had their impact on the patient’s emotional state. Writing in 1895, Maudsley was very critical of the adult ignorance of children’s suffering and observed: “It is difficult for grown-up persons, unless perchance helped by a hateful memory of their own terrors in childhood, to realise the terrible agonies of fright and anguish which seize some nervous children when they are alone in the dark.”530 Guthrie is much more explicit about the connection between night terrors and children’s suffering. In chapters on “The Fears of Neurotic Children” and “Disorders of Sleep”, he makes extensive reference to “a peculiarly horrible dream” which he himself experienced repeatedly since childhood.531 Guthrie substantially expands the category of night terrors so that it also includes dream hallucinations, day terrors, and “educational night terrors” where children “dream of lessons during the process of ‘being brought on’ by teachers of Dr. Blimber’s type”532. Like West, Guthrie attributes these disorders to impressions that act upon a morbidly excitable brain. Attempting to explain the seemingly inexplicable, writers very often

530 Maudsley, Pathology of Mind, 370. The book is a reworking of The Physiology and Pathology of the Mind (1867), which did not contain this passage.
532 A reference to the headmaster in Charles Dickens’ novel Dombey and Son, who runs a particularly Spartan boarding school. For a discussion of Dombey and Son in regards to the mind of the child see Shuttleworth, The Mind of the Child, chapter 6.
focused on the idea of an external cause, such as the corrupting influence of the working-class nurse and her terrifying stories on children in bourgeois nurseries, or adopted an evolutionary perspective which emphasised the influence of inherited memories and thereby located the origin of a child’s night terrors in the distant reaches of prehistory. Here, the somatisation of an internal injury is replaced by an environmental, acquired factor. Despite their obvious difference, both forms of explanation preserved the boundaries of childhood purity, thereby keeping the child separate from its own experiences.

**Melancholia, mental pain and suicidal children**

In an 1883 lecture, Thomas Clouston defined melancholia as “mental pain, emotional depression, and sense of ill-being, usually more intense than in melancholy, with loss of self-control, or insane delusions, or uncontrollable impulses towards suicide, with no proper capacity left to follow ordinary avocations, with some of the ordinary interests of life destroyed, and generally with marked bodily symptoms.” At this time, melancholia was the second most common form of mental illness, after mania, in British asylums. It had also become one of the most standardised diagnoses, with a coherent symptomology and an explanatory biological model. Although the term melancholia had been used since antiquity to denote a form of illness or madness, the biomedical model of melancholia that emerged in the mid-nineteenth century was completely new and conceptually different. Melancholy was now seen as an “affective insanity” – a mental disease that could manifest without intellectual delusion and whose main symptom was disordered mood – or as “an emotional disorder with neurophysiological basis.” Writing in the 1860s, Maudsley suggested that “sympathetic” or “reflexive” morbid activity in the body that caused repeated “irritation” of the brain would gradually affect the overall “tone” of this organ and eventually result in “disordered emotion”.

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534 For an account of the re-conceptualisation of melancholia as a biomedical mental disease in Victorian medicine, see Åsa Jansson, ‘The Creation of “Disordered Emotion”.
537 Maudsley, *Physiology and Pathology*, 139.
In line with the Darwinist interpretation of the mind, emotion was considered a process (or an event) within the human nervous system.\textsuperscript{538} Wilhelm Griesinger in Germany and Thomas Laycock in Britain developed the idea of reflex beyond mere motor activity to include the operations of the mind.\textsuperscript{539} Laycock argued that a morbid emotional reaction producing involuntary muscular movement could be triggered \textit{by an idea alone} (claiming that, for example, hydrophobia could be induced by the mere mention of water). Griesinger also argued that ideas could excite motor action and emotional reactions, claiming that the brain could react to internal and external stimuli and produce entirely new impressions and ideas, which were kept mental storage (\textit{geistiges Vorrraths}) and could spontaneously and internally react with another. This could cause “irritation” to the brain, provoking the loss of mental balance and morbid reactions.\textsuperscript{540}

This physiological model was widely appropriated by late-nineteenth-century psychiatrists, including Maudsley, for whom the “equilibrium between the individual and his surroundings” could “be disturbed by a subjective modification, or an internal commotion, as well as by an unwonted impression from without.”\textsuperscript{541} This would then affect the brain, resulting in cerebral morbidity. Once this state had been reached, virtually any impression would cause painful emotions. Maudsley suggested, quite radically, that pathological emotionality could be present without any disturbance of the intellect, and rejected “the present artificial classification [of insanity], which is not really in conformity with nature.”\textsuperscript{542} Instead, he proposed the umbrella categories of \textit{affective} and \textit{ideational} insanity, thereby establishing the concept of pathological mood without intellectual derangement.

As with hysteria, some medical professionals were reluctant to apply the diagnosis of melancholia to children. Others – including Crichton-Browne and Maudsley – were convinced that the “insanities of early life” could include

\textsuperscript{541} Maudsley, \textit{Physiology and Pathology}, 129, 134-135.
\textsuperscript{542} Maudsley, \textit{Physiology and Pathology}, 137, 322.
He recognised a range of melancholic disorders, principally "pure, abstract indefinite depression" and religious melancholy. Other forms, including hypochondriasis, were less common before puberty, "as their existence implies subjectivity of thought". Finally, "simple melancholia, a mere exaggeration of that feeling of depression to which we are all at times liable, may, in youth, as in mature life, exist without at all involving the intellectual faculties."

This new concept of melancholia and the separation between emotional and intellectual maladies is also related to ideas about non-intellectual insanity that emerged in the early nineteenth century, such as "moral insanity", introduced by James Cowles Prichard in his 1835 book Treatise on Insanity and Other Disorders Affecting the Mind, whereby the moral faculties and emotions were considered to be disordered. According to Prichard, “this form of mental disease has been said above to consist of a morbid perversion of the feelings, affections, habits, without any hallucination or erroneous conviction impressed upon the understanding; it sometimes co-exists with an apparently unimpaired state of the intellectual faculties.” He considered children as natural sufferers of moral insanity: since it was assumed that the emotions developed in childhood before the capacity for reasoning, it was a rapid corollary to recognise that forms of insanity affecting only the emotions could exist in childhood. Maudsley, who also used the term “affective insanity”, described this condition as “a form of disease which undoubtedly occurs in early life, and which, indeed, is more readily acknowledged when it is met with in such young children than when it is met with in the adult.” In his view, depressive symptoms marked “a constitutional defect of nervous element whereby an emotional or sensational reaction of a painful kind follows all impressions; the nervous or cyclical tone is radically infected with some vice of constitution so that every impression is painful.” For Maudsley, all impressions (whether positive or negative) received by a morbidly sensitive brain would produce feelings of displeasure.

543 Crichton-Browne, ‘Psychical diseases’, 312-313
544 Crichton-Browne, ‘Psychical diseases’, 312-313
545 J. C. Prichard, A Treatise on Insanity and Other Disorders Affecting the Mind (Sherwood, Gilbert and Piper, London, 1835), 14.
546 J. C. Prichard, A Treatise on Insanity and Other Disorders, 14.
547 Maudsley, Physiology and Pathology, 328.
548 Maudsley, Physiology and Pathology, 328.
Maudsley described the various forms of childhood melancholic states and attempted to correlate the type of melancholia with the child’s developmental level at the time of onset. In infants, “feeling going before thought in the order of mental development”, melancholic expression was a “primitive language of cries, grunts, exclamations, tones of sounds, gestures and features.” 549 Children aged four or five years might have “fits of moaning, melancholy and apprehensive fears” and, later, features of typical melancholy could occur, sometimes with suicidal ideas. 550

Throughout much of the Victorian period, descriptions of melancholia tended to lean heavily toward “symptoms” that could be deduced from observing a patient’s general demeanour. “The child suffering from melancholia,” maintained William Ireland, “gives up his play, neglects his lessons, avoids his companions, shows little affection for his parents, seeks to be alone, and in general loses interest in everything, and is in a depressed state of mind.” 551 Deviance from commonly held perceptions of “normal” juvenile decorum were essential traits. Maudsley described such children as “capricious and willful in behaviour, perplexing and distressing parents by perverse whims, outbreaks of temper, rude speeches, and sullen defiance of authority.” 552 This, while other conditions, such as hysteria, involved intense and frantic behaviour, melancholia was characterised by listlessness, a general lack of interest, and depression. 553 Crichton-Browne argued that melancholic children “are given up to ‘black despair’” 554 Understood as one of the types of delirium proper to childhood, for Clouston the diagnosis of “excited melancholia” also involved a subjective symptomatology: the child “talks excitedly, screams, hears terrible voices, sees frightful sights, clings to its nurse or hides under the bedclothes, stares wildly through dilated pupils at its visual hallucinations.” 555 According to the psychiatrist, “painful hallucinations” and a depressed emotional state were the main psychological characteristics of this delirium. Hence, while melancholia was

552 Maudsley, *Pathology of Mind*, 393.
mainly listed as an emotional disease, the links to cognition and the faculties of representation could also appear occasionally.

Despite the attention to behaviour and demeanour, much attention was paid to stature, bodily functions, and physiognomy, and physicians continued to speak of the melancholic “constitution” and “temperament”, using language reminiscent of early modern medicine, well into the second half of the century. However, such terminology was increasingly used within the renewed physiological framework offered by Darwin, who suggested that some emotional expressions would have begun as conscious acts performed often enough as to become wholly preconscious and automated reflex actions persisting through the force of habit, regardless of whether they continued to be useful or not. Darwin cited “Dr. Maudsley”: “reflex movements which commonly effect a useful end may, under changed circumstances of disease, do great mischief, becoming even the occasion of violent suffering and of a most painful death.” Such “exciting” painful emotions that might initially result in impulsive bodily movement and actions could then turn into an opposite, “depressing” state. Melancholia appears here not only as the result of a misbalanced internal life, but as the final stage of a convulsive struggle to escape pain.

A strong link was forged in the mid-to-late nineteenth century between melancholia and mental pain, depression, suicidality, and – to a lesser extent – religious delusions. This relationship proved useful in several ways. It played a key role in the standardisation of melancholia in the medical literature and it helped establish psychological medicine as a modern scientific discipline and branch of medicine. Symptoms of melancholia were observed through the lens of physiology and shaped by biomedical language, which gave prominence to “depression” and “mental pain”, terms also reconceptualised within a modern scientific framework.

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556 See, for example, William Bevan Lewis, *Text-Book of Mental Diseases* (Charles Griffin and company; London, 1899), 115-116; Tuke, *Dictionary*, 220.
The notion of “mental pain” had a long and eclectic history. While it seems that late-nineteenth-century British medical psychologists decoded mental pain as analogous to physical pain, within physiological psychology it had an ambiguous status, as something both literal and metaphorical. Terms such as “irritation”, “reflection”, “tone”, and “pain” were used to explain both cerebral and psychological processes. “If a child ever shows depression or mental pain”, argued Clouston, “then there is certainly something wrong, some organ is disordered, the child is being poisoned by bad food or bad air, or some irritation is going on in its bodily processes.” In other words, both mental pain and depression were associated with somatic or physiological problems.

Javier Moscoso perceives a shift in nineteenth-century medicine whereby the sufferer’s “private experience” was objectified through new ways of constituting, explaining, and labelling pain. There was no room for “unjustified claims and disproportionate laments” from the suffering subject and “the new science of the intimate sense had to be rooted in physiology and physics.” However, as Åsa Jansson has argued, what emerged in psychological medicine was more complex. Psychological pain was constituted as physiological and could be recorded and measured in statistical tables, yet medical professionals could access the nature of this pain only through the testimony of patients. This approach depended on language, which revealed nothing about the internal neural processes believed to be the “real” source of the pain. Thus, medical psychologists not only observed demeanour, bodily state, and behaviour, they also increasingly based their diagnostic decisions on conversations with their patients and on reports from family members, friends, and workhouse officials. Physicians emphasised the importance of taking a comprehensive patient history, in part as a way to reveal possible “hereditary predispositions” to insanity through the discovery of other cases of madness in the family.


Moscoso, Pain, 106.


This approach was strongly influenced by Darwinian-based eugenic theories and, in Britain, reinforced through the work of prominent medical professionals, most notably psychiatrist Henry Maudsley (1835-1918). On eugenics see, for example, Alison Bashford and Phillipa Levine (eds.), The Oxford Handbook of the History of Eugenics (Oxford University Press, Oxford, 2010). For further reviews of the field, see Mathew Thomson, The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870-1959 (Clarendon Press, Oxford, 1998); Peter Bowler, The Mendelian Revolution: The Emergence
When studying the emotional history of insane children and young people, British practitioners paid special attention to the events and circumstances that might have a negative impact on their young patients' reason and emotions. Sometimes a specific incident that provoked an intense emotional response could have a direct effect on a patient's mental health. For instance, a tragedy, fear, religious fervour, excessive study or family problems. The emotional stress provoked by the death of a family member was a common feature. M.B. Ray wrote in the Journal of Mental Science in 1898 of the case of James W., a fifteen-year-old boy who had been diagnosed with mania but who had a clean medical history and no known cases of insanity within his family. The boy was thin, poorly nourished, and showed other symptoms of ill health, and his mental state was characterised by excitement, restlessness and incoherent chatter. Assessing this case, Ray linked the onset of the boy's mania to the death of his mother a few months earlier. Sometimes the traumatic trigger for the onset of mental illness was imaginary rather than real. Thus, M. Brierre de Boismont described the case of “M-- --,” a young boy who was victimised by “an ill-judging father, who was obstinate, and incapable of directing the education of his children,” and who obliged his son to be “a witness of and actor in domestic scenes which reacted only too strongly upon an excitable organization.” By the time he reached twelve the boy was melancholic and sulky, often in trouble at school, and was eventually expelled. “Shut up in his room,” reported Brierre de Boismont, “he became peevish, rude, singular in manner; at length mental alienation clearly showed itself; [...] and with this disposition it was not surprising that he attempted suicide at sixteen years of age.”


564 M.B. Ray, ‘Case of acute mania occurring in a boy’, Journal of Mental Science 44 (1898) 320. 
565 Ray ‘Case of acute mania’, 321 
566 Ray ‘Case of acute mania’, 320. 
Probably the most manifest and extreme indication of children’s melancholia was the suicide attempt. While Sully Shuttleworth has devoted considerable attention to the problem of suicidal children, her focus is based on a comparison between the historical phenomenon and its treatment in Thomas Hardy’s novel “Jude the Obscure”. However, she pays no attention to the relation between suicide and pain, which some contemporary medical authors chose to conceptualize as deliberate acts of self-harm. In that sense, suicide per se cannot be considered integral to the history of pain, while self-harm is, for obvious reasons. In the following pages, therefore, my treatment of suicide as a form of self-harm has to be understood as a circumstantial or partial identification, rather than as synonyms or essentially overlapping categories.


“Whilst speaking of melancholia, we must devote a few words to the consideration of suicide in early life,” argued Crichton-Browne: “Even in infancy and childhood, when cares and sorrows are comparatively unknown, and when sensations and feelings, pleasurable or painful, are transient and evanescent, we frequently meet with deliberate acts of self-destruction.” According to William W. Ireland, there was a strong correlation between suicide and insanity that was related to the sensitive nature of children and could be awoken by emotions such as the fear of punishment or disgrace. Ireland contrasted this sensitive nature


with the zest for life which he considered to be inherent in children. “[B]ut hope is so strong and life so buoyant in the youth breast,” he maintained, “that we may safely conclude most cases of suicide in childhood indicate an insane condition of mind.”\textsuperscript{571} A different view was voiced by Henry Maudsley. Although he also connected suicide to insanity, Maudsley claimed that the suicidal act resulted from unconscious and sudden impulses that were experienced when someone was suffering from melancholia. “The constitutional indifference to life,” he observed, “and the ready impulse to end it betray a distinct neuropathic inheritance whereby, the love of life being lacking, a little jar strikes the life-weary note in the child’s nature and easily precipitates its extinction.”\textsuperscript{572} Another factor was imitation. Thus, Fletcher Beach noted how a fourteen-year-old boy committed suicide after a friend had already done so: “The sight of the cord, the suitability of the place [where his friend had died], struck him, and he realized the idea which he had previously expressed.”\textsuperscript{573}

**Pain, hysterical children, and their treatment**

Children’s hysteria has not been studied in detail. Janet Oppenheim has argued that it was rarely diagnosed, although hysteria – a condition which West did not discuss in his texts on the mental peculiarities of childhood – occupies a central place in the case notes of doctors who at the end of the nineteenth century were working on nervous conditions in the new hospitals such as Great Ormond Street Hospital, in which there are records of some 200 children admitted suffering from hysteria between 1880 and 1900.\textsuperscript{574} Once again, the possibility is raised that practical interest may well have been much stronger and more persistent than might appear to be the case from the relative neglect and even dismissal of this concept within the theoretical literature of the time. In this section, I examine the conceptualization of children’s hysteria in medical theorists, and include some of the most frequently cited remedies and treatments; however, the practice of

\textsuperscript{571} Ireland, *Mental Affections*, 286.
\textsuperscript{572} Maudsley, *Pathology of Mind*, 381.
\textsuperscript{573} Fletcher Beach, ‘Clinical lecture on mental disorders in children (Cont.),’ *Treatment: A Journal of Practical Medicine and Surgery* 2, no. 19 (1898) 589.
\textsuperscript{574} Great Ormond Street Hospital Application and Admission Database, 1852-1921. [http://www.hharp.org/](http://www.hharp.org/) (Retrieved 18/05/2016)
treating hysteria, particularly in the applied field of paediatrics, falls outside the scope of this chapter.

Recent historiography on adult hysteria has argued that, very often, the disease was a vehicle for the expression of emotional pain that found no other form of medical recognition. While the evidence collected in the archival research of this study may not suffice to determine the exact extent to which this performative notion of hysteria, which implies a complex collaboration between medical community and patient in the enactment of the hysterical body, also applies to children, it might serve to start laying the foundations for a better understanding of the interplay between child emotional suffering and its normativity. In discussing the hypothesis of the performative character of hysteria, the realization of an almost infectious quality to hysteria among children, where symptoms were imitated or copied, is an important factor. According to the physician and alienist John Conolly, in addition to their weak nervous constitution, “the proneness to imitation which is observable in all persons in early life” helped to spread hysterical symptoms among children. He noted, “this is particularly seen in schools, which have sometimes furnished remarkable cases of squinting, stammering, and awkward motions, solely occasioned by imitation.” Conolly’s point was not that children were engaging in conscious mimicry, but rather that hysterical convulsions could become infectious among an impressionable audience. Complex learning and imitative processes were involved in the development of hysterical symptoms.

While nineteenth-century texts about childhood insanity devote less attention to hysteria than to other conditions, they do recognise the existence of hysterical disturbances in children. In fact, it seems that hysteria may have been far more frequent than other conditions which received greater attention from theorists. Even though “night terrors” occupied a central position in Charles West’s discussions within the emerging field of paediatrics, it is striking that there are records of only three children admitted to Great Ormond Street suffering from

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577 See Oppenheim, Shattered Nerves, 237.
this pathology between 1880 and 1900. In contrast, hysteria – a condition which West did not discuss in his texts on the mental peculiarities of childhood – occupies a central place in the case notes of doctors who at the end of the nineteenth century were working on nervous conditions in the new hospitals such as Great Ormond Street Hospital, in which there are records of some 200 children admitted suffering from hysteria between 1880 and 1900. Once again, the possibility is raised that practical interest may well have been much stronger and more persistent than might appear to be the case from the relative neglect and even dismissal of this concept within the theoretical literature of the time.

Medical writers explained the phenomenon relying on the contemporary belief that children, like adult women, lacked an adequately developed will. According to this theory, the higher centres of children’s immature brains could not completely control the lower ones, while the unstable nature of children’s nerves – with their tendency to spontaneous discharges – also served to encourage the unpredictable symptoms of hysteria. J. Michell Clarke, physician and pathologist at the Bristol General Hospital and Lecturer on Practical Physiology at the Bristol Medical School, argued that “the greater frequency of the affection in childhood” was to be expected because children’s nervous systems had “not acquired that degree of stability which frequent repetition of the movement ensures in the adult.” According to this view, “the paths for nervous impulses are not so definitely marked out, and there is less resistance to irradiation of impulses along other channels than in the adult”.

As with melancholia, physicians addressed hysterical conditions through the symptoms observed in their child patients and the accounts given by parents or other relatives. The first signals were always physical, and the disease was construed on a physiological basis. However, the clinical paradigm consisting in the bodily location of the disease proved quite problematic when pain flared up in apparent absence of manifest external lesions, such as in hysteria. Throughout the nineteenth century and beyond, hysteria was classified as a disease of nervous organisation. Doctors fixed physical symptoms, treated them with

578 GOS/10/26, Dr. W.H. Dickinson’s casenotes, Great Ormond Street Archives.
physical means, and avoided dealing with the mind. \(^5\) Nerve doctors emphasised the forcefields of the physical, emotional, and intellectual in precipitating hysteria (or, later, neuropathy, neurasthenia, etc.); they defined hysteria, formally at least, as gender nonspecific, independent of gynaecological aetiology – something which was clearer in the cases of childhood hysteria. \(^5\)

Clarke argued that at this period of life, the “ratio of hysterics to the sexes is about equal” but after the age of twelve, “the paths of the two sexes widely diverge, and the educational factor comes into full force.” \(^5\)

As in the case of adult hysteria, the presence of pain or symptoms that did not appear to be related to structural lesion constituted one of the constant manifestations of hysteria. \(^5\) In an 1879 article published in *The Practitioner*, William Roberts, professor of clinical medicine at Owens College in Manchester, recorded the case of a thirteen-year-old boy. \(^5\) In addition to various “hypochondriacal symptoms,” depression and other “undefinable ailments”, the boy developed a “hysterical cough” and a sharp pain in the stomach region. For many months, the boy continued to utter this noise throughout the day, hardly ceasing “except during the hours of sleep,” and there were also piercing screams linked to a pain which became chronic. \(^5\) Like Étienne-Jean Georget, who argued that the continuous experience of chronic pain invariably resulted from the more extreme manifestations of hysteria, late-nineteenth-century texts that referred to hysteria in children also maintained that, while hysterical behaviour could be characterised by convulsive movements or nervous attacks, its symptomology was manifested above all in a constant and intractable pain. William H. Spurgin, for instance, considered “severe pain at the epigastrium” as one of the constant manifestations of hysteria. \(^5\) In the case of the ten-year-old girl patient “S.T.”, with which this chapter began, it was precisely this symptom

\(^{5}\) The pre-Freudian physiological focus in studies of hysteria and related disorders has been documented by, among others, Lilian R. Furst, *Before Freud: Hysteria and Hypnosis in Later Nineteenth-Century Psychiatric Cases* (Bucknell University Press, Lewisburg, 2008).


\(^{5}\) Michell Clarke, ‘Clinical Observations’, 1185–1189.

\(^{5}\) On pain and hysteria see: Moscoso, *Pain*, 172-181; Morris, *Culture of Pain*, 103-124; Boddice *Hysteria or Tetanus?*


\(^{5}\) Roberts, ‘Cases of hysteria’, 340.

\(^{5}\) Spurgin, ‘Case of hysteria’, 555
which led the parents to summon the physician who examined the child, prescribed various treatments that proved ineffective, and then decided upon a diagnosis of hysteria because she “appeared in the greatest agony and misery in spite of all treatment.”

As with night terrors, hysteria was often also considered to result from recent accidents or the lingering effects of old injuries. An 1885 issue of the *Journal of Mental Science* describes the case of A.W., a twelve-year-old boy who was diagnosed and treated for hysteria after receiving a hard blow to the head in the schoolyard. Michell Clarke described the case of a boy aged fourteen whose illness began after he fell from a chair, “striking his back.” Another case described by Clarke featured a girl whose “illness began after a fall on the back, which caused much pain, and since the inability to stand or walk had compelled her to remain in bed except for a day or so for the past three months.” Some of these cases were labelled as hysterical paraplegia and all started after a fall or blow followed by pain but with no sign of organic nervous disease.

British alienists had some measure of success in mapping hysteria onto the body. Like Charcot, they were delighted to discover hysterogenic points, palpitations, and patches of cutaneous hyperaesthesia and hysterical cough. Clarke narrates the case of a twelve-year-old child where “each spasm of ‘cough’ consisted of a loud noise, repeated spasmodically four or five times with expiration, and partly of an articulatory noise made in the throat, harsh, rasping or sawing in character, and so loud as to be heard over the whole house.” The absence of response to pain stimuli, as well as pain itself, was one of the most conclusive symptoms in order to diagnose hysteria. “Patches of cutaneous hyperaesthesia are not uncommon in hysteria,” argued Clarke, “and the patients

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587 Spurgin, ‘Case of hysteria’, 555.
588 Clarke, ‘Clinical Observations’, 1186.
589 Clarke, ‘Clinical Observations’, 1186.
590 The classic lines of enquiry about hysteria, and in particular the ways in which it was gendered, centre on such medical luminaries as Charcot and, later, Freud. The bodily effects of the emotionally traumatised were, through medical universalisation, ultimately directed away from the field of mainstream medicine toward psychoanalysis. It is important to take into account the differences that might have existed between countries in terms of the conceptualisation of hysteria. By 1986 Edward Shorter could assert that ‘the underlying incidence of the disorder may well be constant across the ages but its form changeable, in accordance with […] cultural influences’. See Edward Shorter, ‘Paralysis: the rise and fall of a “hysterical” symptom’, *Journal of Social History*, 19 (1986) 549. See also Nicholas P. Spanos and Jack Gottlieb, ‘Demonic possession, mesmerism, and hysteria: a social psychological perspective on their historical interrelations’, *Journal of Abnormal Psychology*, 88: 5 (1979) 540-1.
591 Clarke, ‘Clinical Observations’, 1187.
are generally aware of their existence.” In a study of ten children with hysteria, he described the case of a “general condition of moderate hyperaesthesia of the whole cutaneous surface,” and in another, “there was hyperaesthesia over the whole anterior surface of the trunk.”\(^{592}\)

In spite of – or perhaps precisely because of – the elusiveness of hysteria, physicians talked of the difference between “true” and false hysteria. For instance, an 1885 article in the *Journal of Mental Science* noted that a doctor who treated the case of a twelve-year-old boy (“A.W.”) who had lost the capacity to speak considered three possible diagnoses: “[T]he diagnosis,” the author reported, “lay between malingering, hysteria, or grave cerebral disease.”\(^{593}\) In this particular case, malingering, that is, feigning illness, was eventually ruled out, and the presence of a severe pain in the head led the doctor to diagnose that the boy was suffering from hysteria. However, hysteria and children’s insanity certainly got caught up in contemporary debate around the concept of malingering which, it was claimed, had “reached a high level of perfection” by the beginning of the twentieth century.\(^{594}\) Cases such as this constantly reiterated the elusive nature of hysteria and other types of insanity, which really tested the knowledge and skills of medical practitioners. Sometimes they were unable to clearly diagnose a child or adolescent as insane, never mind arrive at a diagnosis in accordance with the specific categories of mania, melancholia, hysteria, or moral insanity. In fact, these categories were not entirely separate. For instance, Maudsley and some other British practitioners considered hysteria to be one of the manifestations of moral insanity.\(^{595}\) The process of identifying and categorising mental disorders in their patients required medical professionals to exercise their keenest skills of observation.

Once a patient’s actions and behaviour had become manageable, medical practitioners and asylum staff frequently prescribed chemical remedies to treat symptoms related to hysteria. Muscular pains, for instance, were often treated with sodium salicylate and iodides, while baths were often used as a therapy for

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\(^{592}\) Clarke, ‘Clinical Observations’, 1187.

\(^{593}\) P. Smith, ‘Case of hysteria in a boy’, *Journal of Mental Science* 31 (October 1885) 370.


\(^{595}\) Maudsley, *The Pathology of Mind*, 397.
hysteria. “There are few secondary remedies more useful in the treatment of insanity than bathing,” claimed Bucknell and Tuke. “The use of the warm bath,” they continued, “either alone or in combination with cold to the head, is a most important remedy in the therapeutics of mental disease.” Warm baths were seen as medicinal and a means to calm patients and encourage them to sleep, while cold-shower baths were used both as part of a hygienic regime (in combination with a good diet and fresh air) and as a treatment for those with a “nervous irritability, a tendency to hysterical weeping, or to hypochondriacal notions.” To judge from the quantity of times that baths are mentioned in journal articles and asylum records, it seems that most British practitioners and asylum medical staff adopted this form of treatment, whether on its own or in combination with other therapies. To take one case: in treating a young boy for hysteria in 1885, George Savage combined cold-shower baths with “judicious neglect” and reported that after this “there have been no more screaming fits.”

If pain forms part of the development of illness, it can also be a major component of the curative process. Such is the case with “galvanisation”, the application of electric currents via batteries to patients with mental disorders, which was used to treat hysteria. Introduced to Britain in the eighteenth century, this kind of electrotherapy became legitimised for medical use in the 1830s and 1840s through its deployment at Guy’s Hospital in London by Golding Bird. Iwan Rhys Morus argues that the use of galvanisation at Guy’s Hospital “was confined to the treatment of specific nervous disorders, most frequently chorea and hysterical paralysis. Bird and his associates were keen to emphasise that, unlike many past practitioners, they did not employ electricity as a universal

596 H.G. Langwill, ‘Case of hysteria in a child, with remarkable psychical symptoms’, *Edinburgh Hospital Reports* 2 (1894) 426.
598 Bucknill and Tuke, *Manual*, 479-80. The application of cold to the head prevented overheating and relieved congestion. M. Brière de Boismont promoted the use of combined baths, both warm and cold, although Bucknill and Tuke advised against his practice of confining patients using a wood frame that went over their heads, citing it as too dangerous.
600 George Savage, ‘Case of marked hysteria in a boy of eleven years’, *The British Journal of Psychiatry* (1885) 202.
panacea or a last-ditch resort when other forms of therapy had failed.\footnote{Morus, ‘Marketing the machine’, 38.}

The use of electrotherapy for certain patients appears to be substantiated by various reports published in the second half of the nineteenth century, frequently accompanied by the remark that galvanisation should be used only after other treatments had failed. This was the case with a 10-year-old boy who had been diagnosed with hysteria, according to an account in the \textit{Lancet} in 1883. The child complained of sickness and then “continued to get worse, refused to sit up, and at night disturbed the household with screaming and incoherent talking.”\footnote{Ingle, ‘Cambridge Medical Society: Hysteria’, \textit{Lancet} 2 (21 July 1883) 106.} Finally admitted to hospital, the boy “improved under galvanism.”\footnote{Ingle, ‘Hysteria’, 106.}

William Roberts described a similar case where “the interrupted galvanic current was also directed to be applied daily,” to an eight-year-old boy and where, “under this treatment, the attacks soon became less and less frequent, and finally, in about six weeks, ceased altogether; and the boy has since then remained in perfect health.”\footnote{Roberts, ‘Cases of hysteria in boys’, 342.} Galvanisation was also used to treat the residual effects of hysteria, such as a young patient whose symptoms included the inability to walk. “[She] is now able to walk with crutches,” wrote her doctor, “and, probably, by the aid of galvanism, will be soon set to rights.”\footnote{Spurgin, ‘Case of hysteria’, 555.}

But many British practitioners adopted a different form of treatment – so-called “moral treatment” – which they believed allowed them to get to the emotional or spiritual origins of the illness through the sane mind’s influence on the insane mind.\footnote{Important works on moral treatment in Britain and beyond include Anne Digby, \textit{Madness, Morality and Medicine: A Study of the York Retreat, 1796-1914} (Cambridge University Press, Cambridge, 1985); Michel Foucault, \textit{History of Madness}; Andrew Scull, \textit{The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900} (Yale University Press, New Haven, 1993); Joseph Melling and Bill Forsythe, (eds), \textit{Insanity, Institutions, and Society, 1800-1914: A Social History of Madness in Comparative Perspective} (Routledge, London, 1999); Louis C. Charland, ‘Benevolent theory: moral treatment at the York retreat’, \textit{History of Psychiatry}, 18:1 (2007): 61-80; Marcel Gauchet and Gladys Swain, \textit{Madness and Democracy: The Modern Psychiatric Universe} (Princeton University Press, Princeton, NJ, 1999).} While medical professionals hailed the importance of moral treatment, they also recognised that it was not particularly easy to ascertain precisely what such treatment involved. “No term has of late years been more profusely and empirically employed,” maintained Bucknill and Tuke, “and none has been less understood, than ‘the moral treatment of insanity’.”\footnote{Bucknill and Tuke, \textit{Manual}, 486.}
therapies seemed to involve a series of means to educate patients in the values of Victorian society, whether through instruction and discipline or through the natural effects of patients’ actions and behaviour. “The most inflexible firmness must be combined with never-failing kindness and gentleness and sympathy; the patient is to be taught habitual self-control, by habitual indulgence,” asserted Bucknill and Tuke.609 Thus, moral treatment involved teaching by example as much as any knowledge that could be described as medical. This treatment was also tailored to the perceived needs of individual patients. Bucknill and Tuke note that the use of moral treatment varied from patient to patient: while moral treatment was in some cases of little use, in others it was the very key to the patient’s recovery. In the case of the ten-year-old S.T., Spurgin diagnosed hysteria after the patient failed to respond to various treatments. “I went to see her again a few days afterwards,” he reported “and told the parents I believed there was nothing serious the matter, although they had given her up as about to die many times before. I ordered them to take severe measures and make her get up and walk.”610 In other words, Spurgin recommended moral treatment and he observed that this treatment led to an improvement in the girl whom he expected to make a full recovery.

Removing hysterical children from the domestic environment was a very common form of treatment, especially in cases where parents and doctors had sought unsuccessfully to treat the illness at home. Understandably, there was some resistance to the idea of taking children away from their homes. William Roberts recommended the removal of an eight-year-old boy with hysteria from the home “in order to eliminate that most fruitful of all promoters of hysterical manifestations – home surroundings and sympathy.”611 It was not, however, always parents who resisted medical practitioners’ calls for removal; sometimes medical professionals themselves had doubts about the wisdom of managing cases away from the domestic environment. Savage, for instance, expressed some reluctance in this matter in the case of hysteria in an eleven-year-old boy: “Many will say,” he noted, “why send such a case to an asylum? and I must say I

accepted him with hesitation, and only after being convinced that his friends could not manage him, and that he was steadily going from bad to worse.  

The cases of children’s hysteria discussed in the late nineteenth century can be reread from the point of view of the child in question. Spurgin’s case notes on “Case of Hysteria in a Child Aged Ten Years,” for example, suggest a childhood marked by hardship and cruelty. Likewise, in “Case of Marked Hysteria in a Boy of Eleven Years”, described by Savage, the child was healthy until January 4, 1885, when he attended the funeral of a younger sister who had died as the result of an accident. The following day he did not play, “gave up all his ordinary habits, became dull, his appetite failed, and his bowels became confined.” Savage suggests that the child was deluded about his “motions” because “he did not pass anything; but it was found out that he threw one motion out of the window.” Although refusing to eat with the rest of the family, the child would steal food or eat it “on the sly.” When admitted to hospital on April 23, “he was crouched into a ball, his face tied up in a handkerchief, and both his legs drawn up under his buttocks, and both his feet turned inwards, so that he stood – when forced to stand – on his outer malleoli.” Overcome by his situation, it is unsurprising that the child’s pain manifested in the way it did.

Take the case of nine-year-old Rebecca Novis, the daughter of the pharmacist at the Islington Workhouse, who was admitted in 1871 with the diagnosis of “hysteria”, having spent several weeks as a “voluntary mute”, unwilling or unable to speak or walk and spending long periods in a passive state with closed eyes, although able to use gestures to answer questions. In the case of Rebecca Novis, the physician William Howship Dickinson, assistant physician at Great Ormond Street, applied a robust treatment which included speech and activity provocation by pinching and attempting to prise open her eyelids, together with warm baths and galvanic stimulation. She eventually became more active and was sent home, briefly relapsed, was readmitted, and then discharged when she improved. She was one of the first Great Ormond Street patients to be photographed and one of the images in the case notes was later adapted for use

612 Langwill, ‘Case of hysteria’, 428.
613 Spurgin, ‘Case of hysteria’, 555.
614 Savage, ‘Case of marked hysteria’, 201.
615 Savage, ‘Case of marked hysteria’, 201.
616 GOS/10/26, Dr. W.H. Dickinson’s casenotes, Great Ormond Street Archives.
617 GOS/10/26, Dr. W.H. Dickinson’s casenotes, Great Ormond Street Archives.
in fundraising literature (Figure 12). But the ultimate cause of her behaviour remains a mystery.

**Figure 4.1**

The harmful child, or moral disease as cause of external pain

Even though in the cases of insane children the pain suffered by the patient served to unravel the diagnosis, alienists such as Maudsley considered that a central factor in determining whether or not a child was suffering from insanity was whether patients seemed to take delight in inflicting pain and physical injury both on themselves and on other children. 618 Maudsley saw homicidal monomania as particularly noteworthy in childhood, describing a “destructive impulse which sometimes reaches such an extreme degree in the madness of childhood is afforded by the instance of homicidal impulse.” 619 The concept of a specific form of insanity which involved the impulse to kill emerged in French research on mental health in the early nineteenth century. Jean Etienne Dominique Esquirol’s Mental Maladies; A Treatise on Insanity (1845), included a detailed account of two young girl patients whom he believed had a form of homicidal monomania. In one case, a seven-year-old girl wished to kill her mother; in the other a girl had an irrational desire to kill her stepmother. In the latter case, there had been no mistreatment of the child by the stepmother yet the girl spoke calmly and with certainty about her homicidal plans. 620

In the second half of the nineteenth century, the press started to apply a new discourse of otherness to children found guilty of killing, as new ideas of child development emerged. Adolescence was increasingly recognised by medical professionals in the late nineteenth century as a distinct phase of life experienced between childhood and adulthood, involving a period of rapid physical and emotional change between the ages of twelve and twenty. In a study of adolescence published in The Pedagogical Seminary in 1897, E. G. Lancaster wrote that, “before this age the child lives in the present a selfish, frank, obedient, imitative life. Now there is a sudden change in body and mind. Things are seen in new relations. Parents lose the confidential grip on youth.” 621

618 An excellent work on self-harm in Victorian times is Chaney, Self-Mutilation and Psychiatry. Also, the same author’s ‘Anaesthetic bodies’. On Maudsley and homicidal insanity see, Betts, ‘From Juvenile Delinquent’, 153.
619 Maudsley, Physiology and Pathology, 283.
620 Etienne Esquirol, Mental Maladies; A Treatise on Insanity (Lea and Blanchard, Philadelphia, 1845), 371.
He noted significant changes in the behaviour of youths, fuelled by extreme passions and desires. Adolescents were driven by “longings for sympathy, deep emotions, moods, love of solicitude, feelings of rivalry, self-sacrifice, etc.” Rebelliousness and misbehaviour were regarded as natural forms of behaviour for youths and it was widely believed among late-nineteenth-century child psychologists that the likelihood of committing crimes increased during adolescence. In 1904, the American educational psychologist Granville Stanley Hall argued that “adolescence is the best key to the nature of crime. It is essentially antisocial, selfishness, refusing to submit to the laws of altruism.”

He noted that, “all boys develop a great increased propensity to fight at puberty,” and maintained that bloodied noses and blackened eyes were all part of the process of growing from a child into an adult. Acts of violence against animals by children were also explained in terms of child development, puberty and adolescence. Nineteenth-century child psychologist James Sully maintained that children were often cruel to animals because of a natural childish curiosity and that inflicting injuries on small defenceless creatures taught children the effects of causing pain. In 1896, The Pedagogical Seminary printed an article by E. W. Bohannon, which argued that cruelty was a natural characteristic of childhood and youth and which discussed the phenomenon of youths who tortured and killed animals. Several case studies were provided. One boy was “continually torturing birds by picking out their eyes. His cat had four kittens which his mother wished to do away with. He partially drowned them and then put them into a hole and chopped them into small pieces with a spade.” Another youth, “cut off cats’ tails inch by inch, cut off the toes of chickens, put out the eyes of birds, cut off the legs of frogs and broke the bills of chickens,” and a sixteen-year-old boy, “tied a stone about the neck of a mother’s cat and threw it in the river. [He] later tried to drown [his] younger brother.” While these actions were more typical of adolescence, there were also cases involving younger children.

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624 Hall, Adolescence, 405.
625 Hall, Adolescence, 356.
626 Shuttleworth, Mind of the Child, 283.
The most common form of insanity put forward by medical professionals in the late nineteenth century to explain violent children and children who killed was “homicidal monomania”. Defined in an 1848 article published in the *Journal of Psychological Medicine and Mental Pathology* as a “peculiar condition of a man in which, without derangement of the intellect, he is hurried away by an irresistible inclination, driven, *impelled* by a blind instinct that cannot be accounted for,” homicidal monomaniacs were either born with, or developed, a predisposition to kill.  

Henry Maudsley attributed a murder committed by an eighteen-year-old boy in 1863 to homicidal monomania. He explained that the boy, “said that he had felt ‘an impulse to kill someone’,,” and tracked the boy’s family for hereditary evidence: “His mother had been twice in a lunatic asylum, having been desponding, and having attempted suicide; his brother was of weak intellect” and “the person to whom he was apprenticed and others gave evidence that he was always strange and not like other boys.”

Esquirol also believed that small children could suffer from homicidal monomania and explained that those who had not been born with a hereditary taint towards insanity could develop a mania to commit murder from accidents at birth or in early childhood. In 1838 he described how, “mucous, bilious, and depraved masses in the stomach,” as well as, “worms in the intestinal canal,” were common causes of insanity in children. The most frequently cited reason for the development of homicidal monomania in childhood, however were – as in some cases of hysteria – falls on the head. Esquirol explained how, “a child of three years of age, falls upon his head. He complains from that time of headaches. At puberty, the pain in the head increases, and mania manifests itself.”

Expert medical witnesses who testified at the murder trial of thirteen-year-old Robert Coombes in 1895 provided evidence of headaches in the boy’s past to suggest that he was insane at the time he killed his mother. They explained that the boy had experienced a fall on his head when he was three, that he had suffered from debilitating headaches since then, and that these were complicated by enduring cerebral damage caused by the use of forceps during

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630 *‘Homicidal insanity’,* 330.
his birth. Medical professionals and criminologists were aware that criminality could be caused by various forms of insanity and they argued that murders committed by children were evidence of this. An article in the *Daily News* stated that “Robert, the murderer, is certainly insane. It is a matter of an accident of birth complicated by heredity.”

M. Brière de Boismont also discussed homicidal monomania as a disease in his 1875 article ‘On the Insanity of Early Life’, in which he narrated the case of a 10-year-old boy who had been treated by a continental physician. The boy appeared intelligent and correctly developed and there was no family history of mental disorder, but he was completely lacking in morality. “From his earliest years,” wrote Brière de Boismont, “he had manifested the very worst instincts; he stole everything to which he took any fancy; he was the terror of his playfellows, whom he pinched, struck, and abused in every way; he obeyed no orders, and wandered incessantly.” The boy’s behaviour became so intolerable that his parents had him committed to an asylum, a move which led Brière de Boismont to speculate about the child’s future: “It will be interesting to know what will result from this innate tendency to evil, against which chastisement would assuredly be inefficacious.”

Reports of monomaniacal children with homicidal impulses were found not only in medical literature but also in asylum records. Eleanor Betts has shown how many of the children admitted to Colney Hatch Lunatic Asylum in the nineteenth century with a diagnosis of mania were also described as violent. In the case of the eleven-year-old Fanny Williams, admitted to the asylum in 1864, the records show how “all day long she is doing mischief, she pulls the hair of the old women or pinches or pricks them with pins, puts pins into her ears, strikes the inmates without any provocation [and] has threatened to cut her throat and at another time to thrust a piece of steel into one of the nurses’ eyes.” Although these violent tendencies had not yet led the child to commit any crime, the asylum believed that she was too dangerous to be placed in a normal ward, so

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she often ended up in a padded cell which was designed both to protect the patient and to punish her for her behaviour.  

The medical accounts of homicidal monomania also note the links between poverty and mental illness. Thus, Maudsley suggested that there was a direct connection between socio-economic status and the development of children with this form of insanity. “Unequal to the social ways and regular work of their fellows,” maintained Maudsley, “they drift apart into idle brooding and sauntering, and, when they belong to the lowest classes, gravitate vagrantly into workhouse or gaol. From time to time one of this class commits arson, rape or even homicide.” These concerns were echoed in medical journals. In 1870, the *British Medical Journal* wrote: “It is only fair to conclude that, with an increased number of such persons [pauper lunatics] at liberty, drawn from a less safe class, we should have a much richer harvest of murders, acts of violence, and legal transgressions, committed by lunatics.” This purported link between poverty, mental illness, and crime was also voiced by John Langdon Down, who argued that children and young people with financial resources were often able to avoid the fate of their poorer peers. Langdon Down gives the specific example of a young patient from a respectable family who had been diagnosed with moral insanity. Although he was described as bright and capable, the youth seemed to relish in mischievous behaviour and “eventually he became a thief and was several times in danger of being brought under the criminal law […] Had he been a member of a lower stratum of society he would have become a jail-bird. Great pains were taken to prevent his getting into the hands of the police.”

**Conclusion**

As previously noted, in *The Body in Pain*, Elaine Scarry argued that psychological pain is present in almost all forms of literature, but physical pain has received very limited attention. Nonetheless, this chapter has argued that

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it is not always possible to make such a clear distinction between the suffering of the body and that of the mind. Studying children’s mental disorders as seen by psychiatrists in late-nineteenth-century England provides a suitable way to examine the intersection of notions of body and mind and contemporary ideas about pain. When we examine the various forms of insanity that were diagnosed in children, it becomes clear that separating physical and emotional pain is impossible. This poses wider questions about how psychological medicine towards the end of the nineteenth century considered the relationship between the body and the mind.

The concept of night terrors was significant in that it was first example of a diagnosis of a mental illness suffered exclusively by children and not by adults. Night terrors sometimes involved delusions that were misperceptions of bodily sensations, thus providing insights into patients’ subjective experiences. Many accounts of night terrors attributed their cause to physical pain, such as intestinal disorders. Thus, this particular diagnosis – whose popularity was never backed up by experimental evidence – highlights the close connection between physical and psychological pain, which were difficult to separate, and whose boundaries were rather vague.

The mental suffering of melancholia was also considered, by researchers following a Darwinist tradition, to have its origins in the somatic, resulting from an irritated brain. Melancholia – a term that dates back to antiquity – was reconceptualised in the nineteenth century as a form of “affective insanity”, a mental disease which did not involve intellectual delusion and whose main characteristic was disordered mood. This new notion of melancholia was also linked to the emergence of ideas of other forms of insanity where it was the moral faculties or the emotions, rather than mental or intellectual capacity, that were considered to be disordered. Children were considered to be particularly prone to “moral” or “affective” insanity.

Pain and the absence of pain were also symptoms of hysteria. Another claim of this chapter is that the hysterical subject was also looking for an expression for pain, in an era in which mere emotional suffering was not yet conceptualized by the medical profession. This pain had no visible sign and therefore no medical rationale.
The question of the desire among some children to inflict physical pain upon others or upon themselves was also considered extensively during the late nineteenth century. These tendencies were considered among the main symptoms of mania, and homicidal monomania. Discussion of children who inflict harm – typically on other children or on animals – or who self-harm led to the emergence of ideas about developmental phases and to the concept of adolescence. There was also a social aspect, as links between this kind of behaviour and childhood poverty were suggested.

It can be seen that pain played multiple roles in discussions about mental illness in the second half of the nineteenth century and that there was such an intertwining of physical, emotional, and psychological pain that it is impossible to separate clearly the somatic and the mental. There were assumptions that disordered mental states in children had physical origins – whether in the intestines, from old injuries, or in the “nerves” – even if these could not be proven experimentally. In cases where patients complained of physical pains that had no obvious organic cause, the umbrella term of “hysteria” was often applied, as with the case of “S.T.” with which this chapter began. At the same time, mental illness also started to be seen as an expression of emotional pain for which there was not yet a frame of reference. As the century drew to its close, Josef Breuer and Sigmund Freud published their studies of hysteria which would lay the foundations for the creation of such a framework. In the twentieth century, through the influence of psychoanalysis, the debates over pain and the respective roles of body and mind would take a new direction.
CHAPTER FIVE

From nervous conditions to nervous disorders: children and somatic pain in British medical discourse, 1900-1939

Introduction

In 1906, an eleven-year-old girl was taken to the medical practice of doctor Thomas D. Savill. After examining her symptoms, the British physician excluded any kind of structural injury. While the child had previously been affectionate and in no way troublesome, some weeks earlier she had started to experience “attacks of crying and depression, two or three times a day.” As well as these symptoms, “her sleep was broken and disturbed by bad dreams, and she wandered downstairs to her parents almost every night on account of the gloom and sadness of her thoughts.” Her appetite was poor and she suffered from a chronic pain in her stomach. According to Savill, the symptoms presented by the child were not related to any injury or visible morphological change, and nor were they related to intellectual retardation. On the basis of the combination of symptoms, the child was diagnosed as suffering from “neurasthenia”.

Thirty years later, the British pioneer of child psychology and psychotherapy Margaret Lowenfeld discussed the same type of chronic pain in her article ‘A new approach to the problem of psychoneurosis in childhood’ (1931). Her conclusions could not have been more different from Savill’s. The latter argued that the child’s symptoms were located in the body and in the general physical condition of the nervous system. His diagnosis presented the somatic location of the nerves as the site of a wide range of conditions which had no obvious organic origin—including lethargy, insomnia, depression, headache, and bodily aches and pains. Lowenfeld, on the contrary, claimed that symptoms such as “vomiting, diarrhoea, constipation, skin eruptions” were merely “the physical side of a mass of fused experiences containing physical as well as mental

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643 Savill, Clinical Lectures, 131.
644 Savill, Clinical Lectures, 131
Lowenfeld embraced psychotherapy and its redefinition of nervous states in mental rather than somatic terms. In attempting to collapse the distinction between physical and emotional pain, Lowenfeld’s article anticipates the debates within psychoanalysis about psychogenic pain – or physiological pain of an emotional nature – that would take place in Britain in the following decades.

This chapter is a continuation of the issues analysed in Chapter 4 as they unfolded into the first half of the twentieth century under the light of two emerging disciplines: the new psychology, and psychoanalysis. The chapter explores the polarised model of children’s pain in the context of British children’s studies, in which similar symptoms were identified and treated according to different theoretical frameworks: the clinical tradition – which still strove for the somatic articulation of maladies – and the emerging field of psychoanalysis. As seen in the first chapter, the Cartesian mechanical tradition held that pain was a strictly physical phenomenon. However, historians of science and pain, especially those who have looked at chronic pain, have argued that the total connection between physical injury and harmful experience “was called into question during the second half of the twentieth century.” As David Biro has documented, by the second half of the twentieth century researchers had observed devastating injuries where pain was absent and excruciating pain with minor or no injuries whatsoever. Together with this evidence, neurologists began to accept that many psychological factors – such as emotions, memories, attitudes, and expectations – could act as major modifiers of the experience of pain. This chapter will build on that body of knowledge to argue that, long before the second half of the twentieth century, affective states that were considered to be injuries to the mind were believed to be able to trigger similar pain to that of physical injuries.

The relationship between body and mind has been widely discussed in the recent historiography of childhood. Historians who have studied the development of child-centred interventions in the interwar period have generally agreed that

645 Margaret F. Lowenfeld, ‘A new approach to the problem of psychoneurosis in children’ (Paper read to the Medical Section of the British Psychological Society on March 25, 1931), British Journal of Medical Psychology (November 1931), 3.
646 Psychogenic pain are non-organic pains associated with psychological factors, see G. Engel, “Psychogenic” pain and the pain-prone patient, American Journal of Medicine, 26, (1959) 899-918.
648 Biro, ‘Psychological Pain’, 53
the transformation of physiological disorders into psychological conditions can be explained by the fundamental shift in medical paradigms that took place in the early twentieth century, with a move from a “hygienist” focus on the bodies of children and on their physical health to an emphasis on their minds and their emotions. Notable works include those of Carolyn Steedman, about childhood and especially about the role of social reformer Margaret McMillian, and the article ‘From bodies to minds in child-care literature: advice to parents in inter-war Britain’, in which Catherine Urwin and Elaine Sharland argue that there was a shift from children’s bodies to children’s minds in the inter-war period. Harry Hendrick also makes the case for this shift and argues that the underlying reasons for new attitudes towards children as psychological persons were political. Hendrick also proposes the dualisms of mind/body and victim/threat as a compass “to navigate a way through the various histories of social policy in search of attitudes towards and treatment of children.” In her recent volume *The War Inside*, Michal Shapira claims that where anxieties previously concerned malnourished and disease-ridden young bodies, in the Second World War they shifted towards the civilisational consequences of disordered young minds. Bearing in mind the comparative conservatism of British medicine, it is perhaps unsurprising that this transition from bodies to minds was, in practice, rather more protracted and tentative than suggested by the concept of a “paradigm shift”. In this chapter, I examine this emergence closely and show how the embrace of psychotherapy and the redefinition of nervous states in increasingly mental rather than somatic terms did not take place overnight. The central claim of this chapter is that during the first half of the twentieth century there was continuing debate over the medical status of children’s somatic pain: neurologists and some paediatricians argued that pain without physical injury


650 Cathy Urwin and Elaine Sharland, ‘From Bodies to Minds in Childcare Literature: Advice to Parents in Inter-War Britain’, in Cooter, *In the Name of the Child*, 44.


was to be located in the nervous system, while other physicians and psychologists asserted that these so-called nervous conditions should be explained in mental rather than somatic terms.

Much of the nineteenth-century literature on nervous disorders refers to harmful symptoms unrelated to structural injuries. Historian Andrew Hodgkiss refers to “pains without Bichatian lesion” – that is, without any morphological lesion. Nonetheless, medical experts and scientists of the time, working under the principle of clinical causality, believed that behind all these pains there was some kind of injury, whether a dysfunction, nervous irritation, or psychological trauma. In her article ‘Killing pain? Aspirin, Emotion and Subjectivity’, the historian Sheena Culley claims that “the broad category of nervous pain and illness encapsulated the dominant discourse of emotional suffering in the Western world of the eighteenth and nineteenth century.” The general historiographical consensus is that during the twentieth century “nervous pain” gradually disappeared from medical and popular literature as a consequence of a fundamental change in medical paradigms. In line with historians who have suggested that this transition was more tentative and prolonged than a “paradigm shift” and with Javier Moscoso’s argument that, in the early twentieth century, both neurology and psychiatry expanded the notion of nervous pain by putting forward the idea of the existence of unconscious cognitive activity and psychological trauma, this chapter’s account of children’s nervous pain in British medical practice assumes that its history ran parallel to that of unconscious pain.

This chapter is organized around two themes. First, nervous pain, a concept that emerged in the nineteenth century as medical professionals sought to

656 See Chapter 3.
657 Andrew Hodgkiss, From Lesion to Metaphor: Chronic Pain in British, French and German Medical Writings, 1800-1914 (Rodopi, Amsterdam & Atlanta, 2000).
659 Thomson, ‘Neurasthenia in Britain’, 79.
660 Moscoso, Pain, 172-190.
explain pain that appeared to have no morphological cause. It explores the use of the term “neurasthenia”\textsuperscript{662}, the battle between accounts that emphasised heredity and those that highlighted environment, and the differences between the perspectives of neurologists, psychologists, and paediatricians.\textsuperscript{663} This section considers the work of experts including George Frederic Still, Gilbert Ballet, Thomas Dixon Savill, Leonard Guthrie, and Archibald Garrod.

The second part focuses on unconscious pain and addresses the paradigm shift that took place at the beginning of the twentieth century, with the decline of ideas about the nervous system as the location of certain illnesses and the growth of new ideas that focused on mental rather than somatic problems. My argument is that, in practice, the change in perspective was more complex than suggested by the straightforward “from bodies to minds” narrative. For instance, the chapter reveals how the concept of neurasthenia or nervousness survived well into the interwar period and how it seemed to be given a new life in the area of children’s health: the figure of the “nervous child” is studied along with the role of the influence of Freud and psychoanalysis and that of the “New Psychology” and the child-guidance clinics.\textsuperscript{664} The claims of such authors as Nelleke Bakker and Mathew Thomson that the terminology of “nervousness” was gradually replaced by “neurosis” will be tested and expanded to the field of child studies in Britain; however, instead of focusing on Thomson’s differentiation between elite and general practitioners, the chapter focuses on interdisciplinary comparisons. This second part of the chapter considers the work of Hector Cameron, Hugh Crichton-Miller, Anna Freud, Melanie Klein, Donald Winnicott, Millais Culpin, and Margaret Lowenfeld.

\textsuperscript{662} In the foundational essay by George Miller Beard, neurasthenia is defined as an entirely somatic disorder, subject to physiological inquiry, but it was caused by the close relationship of body and mind, being brought about by “bereavement, business and family cares, parturition and abortion, sexual excesses, the abuse of stimulants and narcotics, and civilized starvation”. See George Miller Beard, ‘Neurasthenia, or nervous exhaustion’, \textit{Boston Medical and Surgical Journal}, 3 (1869) 47.

\textsuperscript{663} The idea of neurasthenia was introduced by American neurologist George M. Beard as a diagnostic category based on the notion of ‘nerve fatigue’ and came to encompass a wide range of symptoms, including headaches, insomnia, anxiety, depression, neurosis, hysteria, and mania. For details on the work of George M. Beard in the context of nineteenth century psychiatry, see, Trevor Turner, ‘The Early 1900s and Before’, in Hugh Freeman (ed.), \textit{A Century of Psychiatry: Vol 1} (Transaction Publishers, London,1999), 3-29.

\textsuperscript{664} Various studies have examined the use of the term ‘nervous’ in medical approaches, particularly towards women, during this period. See, for example, Showalter, \textit{The Female Malady}. However, the concept was also played a leading role in framing approaches to children, influencing medical theories that focused on the development of children’s brains and which linked the state of a child’s mind to physiology.
This chapter focuses on the published texts of British neurologists, paediatricians, and psychologists from 1900 to 1939. It explores how various concepts proved attractive to different professional groups at different times. The focus is specifically on neurologists because they examined many “nervous” experiences of pain in relation to the brain and the nervous system, and because they also often treated sufferers. According to neurologists themselves, and in strict observance of the anatomo-clinical tradition, the nervous system was found to be the “seat of disease” for different types of pain without lesion, thus such pains came within their own professional purview.

In this context, one article which is of major importance is Mathew Thomson’s ‘Neurasthenia in Britain’, which frames the historical understanding of neurasthenia in adult contexts as a convenient disease negotiated by both doctors and patients, who were relieved from being morally responsible for their situation. Of all the books and pamphlets circulating in Britain on neurasthenia and nervous disorders during this period that are included in Thomson’s analysis, only eight mention childhood and only one of these dedicates a whole chapter to the topic. The emergence of new knowledge led to a reframing of the ways in which this knowledge was structured. Neurologists, as they sought to identify causal factors, came to study children as well as adults. At the same time, paediatricians extended their focus on children to embrace psychogenic pain, to allow for labelling beyond their previous diagnostic models. Two other relevant articles have been Nelleke Bakker, ‘A Harmless Disease: Children and Neurasthenia in the Netherlands’ and Michael Roper’s ‘From the shell-shocked soldier to the nervous child: psychoanalysis in the aftermath of the First World War’. Whereas Roper “investigates the development of child analysis in Britain between the wars, as the anxious child succeeded the shell-shocked soldier as a focus of psychoanalytic enquiry” he doesn’t address the pain of the nervous child, neither the figure of the nervous child in other disciplines.

In addition to scientific sources previously analysed in published works such as Michael Roper’s article on the nervous child and Mathew Thomson’s study of

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neurasthenia and other nervous conditions, this chapter involved an extensive literature search for medical and paediatric publications on children’s nervous pain that began with the Institute of Child Health (UCL) Library Historical Collections on the History of Paediatrics and also included the Archives of Disease in Childhood, BMJ Journals, *The Lancet*, and the *British Medical Journal*. To uncover psychological theories and observations of children’s pain, I have focused on the published texts of British psychologists and psychoanalysts who conducted research on “nervous” children. In particular, I explore the findings of those professionals who worked in the Children’s Clinic for the Treatment Study of Nervous and Difficult Children (above all, its founder Margaret Lowenfeld), The Tavistock Clinic and its founder, Hugh Crichton-Miller, and the Child Guidance Clinic. Thanks to the Wellcome Trust archive and the archives of the Institute of Education, I was able to study other pioneering figures in the development of psychoanalysis in Great Britain, such as Melanie Klein, Donald Winnicott, and Susan Isaacs.

From an examination of these early twentieth-century British treatises, leaflets, and periodicals it might be concluded that the concept of neurasthenia was not in the foreground of conventional medical debates. Only a handful of orthodox British doctors wrote about the subject, and generally only within general descriptions of a wide range of nervous conditions. However, Mathew Thomson has argued that, despite the general abandonment of the concept in theoretical literature, practical interest in neurasthenia might have been considerably stronger and more persistent. British textbooks on neurasthenia went into multiple editions, and books such as those by Ballet and Hartenberg were translated into English, implying demand for practical information about neurasthenia among general practitioners.


668 A different picture might emerge from a survey of articles in periodicals. It has been estimated that more than 300 articles appeared on the subject in American medical journals. See M. Barke, R. Fribush & P. Stearns (eds.), ‘Nervous breakdown in 20th-Century American life’, *Social History*, 33 (2000) 567.

669 Thompson mentions that of the books and pamphlets circulating in Britain during the period, only 36 titles included the term. Eleven of these were published after the First World War and nine were foreign works. Thomson, ‘Neurasthenia in Britain’, 79
Nervous pain

The language of “nerves” and an expanding medical culture concerned with “nerve management” appeared for the first time in the British literature about childhood conditions just after 1900, nearly twenty years after its first mention in relation to adult medicine in Britain. Previously, when medical culture had paid attention to the pathologies observable in children, it did so only in relation to adult physiology. It was not until the beginning of the twentieth century – with the advent of new disciplines such as paediatrics, educational psychology, and child psychology – that a theoretical framework for the study of pain and the nervous conditions that belong to childhood was developed. Thus the debates that had already taken place in the nineteenth century about hysteria, neurasthenia, and the disorders of the imagination flourished once again in the twentieth century within these new disciplines that sought to create a medical dictionary appropriate to the first years of life. At the same time, children with deviant behaviour passed from the domain of morals to that of medicine and became objects of study in paediatrics and psychology. These children were seen not so much in terms of insanity but according to a range of “nervous” behaviours. While many discussions centred on neurasthenia, hysterical pain, and neuralgia, others also included nervous tics, rheumatism (acute and chronic), and the abnormal modification of sensory thresholds.

At the start of the twentieth century, medical practitioners had two versions of the concept of neurasthenia and other nervous disorders: one based on hereditary determinism, the other on environmental factors. There is a fundamental difference between the two perspectives: while heredity was not something that could be treated, external conditions could be altered or altogether removed, which placed an emphasis on prevention and cure through creating a positive environment. The optimism of environmental approaches might have been an influential factor in their success over Morel’s theory of

670 See Chapter 3.
671 See, for instance, George Frederic Still, Common Disorders and Diseases of Childhood (Henry Frowde, London, 1910).
672 See Chapter 3.
673 This issue is discussed in detail in Mathew Thomson, Psychological Subjects: Identity, Culture and Health in Twentieth-Century Britain (Oxford University Press, Oxford, 2006), 5-9.
degeneration. Usually framed within the context of adult physiology, the study of children’s nervous illnesses was also centred on this question: Did the deficiencies of neurasthenia stem from a morbid heredity or from the conditions of modern life? Thus, in one of the biggest and most successful of the volumes about neurasthenia circulating in Britain during the period – Clinical Lectures on Neurasthenia – the doctor Thomas Dixon Savill framed childhood within the nature-nurture debate, denying heredity as the only or principal cause but recognising the influence of innate predisposition. After claiming that “heredity does not seem to play so important a part here as it does in cases of hysteria,” Savill dedicated various paragraphs to describing the three ways in which heredity could play a role in the development of neurasthenia. Firstly, a tendency to develop nervous illnesses “may be present as a general neurotic taint in the family.” In the words of this doctor, “the children of insane parents, for instance, seem especially prone to cerebral neurasthenia.” Secondly, even greater predisposition existed in the children of alcoholics, even when the parents had not gone on to present nervous symptoms. Thirdly, there were children with a family history of tuberculosis, followed by those whose mothers had presented “debility […] at the time of pregnancy.”

While recognising innate predisposition as a “point of entry” or condition of possibility for the onset of nervous imbalance, neurologists did not deny that educational and developmental factors – such as early ill-treatment or school pressure – could turn a nervous child into a serious case of neurasthenia. Neurasthenia as a diagnosis was closely linked to the growing interest in mental as well as physical hygiene in schools. From the beginning of the twentieth century, over-pressure and resulting nervousness was recognised as one of the main risks for the appearance of the illness. Thus, in Neurasthenia, Gilbert Ballet commented that although “the disease is very rare in childhood and old age”, there was a type of neurasthenia that was present only in childhood: “precocious

674 Savill, Clinical Lectures, 59.
675 Savill, Clinical Lectures, 59.
676 Savill, Clinical Lectures, 59.
677 The topic of overpressure has been discussed by Sally Shuttleworth in the chapter ‘Progress, Pressure and Precocity’ see Sally Shuttleworth, The Mind of the Child, 131-150. See also Janet Oppenheim, Shattered Nerves, 244-246.
neurasthenia”. Based on the cases that he had been able to study in his practice, this doctor concluded that the child who suffered from this type of neurasthenia was almost always male, “notably taller than the average, and whose girth of chest and volume of muscles are not proportionate to their height”, and whose nervous system “is endowed with excessive fragility and yields to the slightest shock.” According to Ballet, the aetiology of this variant of neurasthenia was not so much heredity as a problem of “over-pressure” and especially “cerebral over-pressure”, which he claimed must figure “in the front rank of the causes of neurasthenia.” For Ballet, the most extraordinary manifestations of neurasthenia always led to the continuous experience of chronic pain, whether “dull pain”, a constant “pain in the forehand and the back of the neck”, pain in the stomach, “pains all over,” and painful sensations in the back very similar to those that constitute headache and rachialgia.

In *Treatment of Neurasthenia*, Paris society nerve doctor Paul Hartenberg commented in 1871 that together with heredity, “there is another cause which will elicit a response from the nervous system; this is the hyperactivity of brain and spinal cord.” He located the source of this abnormal hyperactivity in the school, its demanding curriculum, and in parents’ expectations of their children, because the first symptoms coincided with the moment in which these tiny patients had been obliged to “put forth an extra effort which often results in the breakdown of predisposed nervous systems.”

Thomas Dixon Savill, who was a physician at the West End Hospital for Diseases of the Nervous System, cited Ballet and argued that there was a specific form of neurasthenia that belong to childhood. The British physician gave the name “cerebral neurasthenia” to this ailment, which he said was produced by over-pressure at school. Thus, he mentions the case of Agnes C., “a healthy-looking child”, eleven years old, who was brought to the doctor by her parents because during the preceding weeks she had presented “attacks of

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681 Ballet, *Neurasthenia*, 3
682 Paul Hartenberg, *Treatment of Neurasthenia* (Joint Committee of Henry Frowde and Hodder & Stoughton, Edinburgh, 1914), 60
crying and depression”, two or three times a day. Her sleep was unstable and disturbed with frequent nightmares. While her appetite was poor and the girl complained of a constant pain in her stomach, her bowels and other organs were in a perfect state. A degree of improvement had been achieved through the administration of quinine, hydrobromic acid, and bromide, but “fits of depression” followed, alternating with attacks of excitation and “silliness”, according to her mother. The immediate cause of her symptoms appeared to have been a “too close application to study,” concluded the doctor.

With Ballet, Savill considered that one of the most important aspects of these children was the continuous experience of chronic pain. Like Agnes, a significant number of children suffered pain that could not be explained by any morphological lesion. In defining “functional nervous disorders”, Savill states that the term “functional” – which had often been used as a synonym for “hysterical” – in fact denoted an “absence of anatomical or structural changes to account for the symptoms.” Savill’s account represents a borderline case within the anatomo-clinical model of health and disease, which was based on the ability to localise individual agents of disease within structures and tissues. Since the axiom of tissue pathologies and structural lesions excluded the possibility of conceiving pain without lesion, physicians and neurologists added it, following Savill’s example by suggesting that the lesion was located in the nervous system. Diagnoses of neurasthenia were attractive because they provided a somatic location for a wide range of conditions that no obvious organic cause. Using the analytic framework of the historian and philosopher of science Thomas Kuhn, these diagnoses could be considered ad hoc adjustments in the predominant anatomo-clinical paradigm to realign evidence and theory: in a naïve conception of the experimental method, the existence of non-somatic pain would have rejected the hypothesis that all pain has a location in the body.

The history of these patients showed an overabundance of afflictions, such as nervousness, headaches, disturbed sleep, restlessness, amnesia, agoraphobia, claustrophobia, irritability, inattention and vasomotor symptoms. As with

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684 Savill, Clinical Lectures, 36.
685 Savill, Clinical Lectures, 36.
686 Savill, Clinical Lectures, 59.
687 Goldberg, ‘Pain without lesion’, 4-5.
conditions such as night terrors, pain was not a symptom, in Savill’s opinion, but the cause of “irritable weakness of the nervous system.” Just as in the clinical cases of adult neurasthenia studied by Javier Moscoso, child patients arrived with one illness and left with another. Thus, the parents of the fourteen-year-old William F.C. came to Savill complaining that their son had become more and more nervous during the previous weeks and was gradually losing his memory. After examining the child, who had come to his practice complaining of a fierce headache, the doctor concluded that he was, in fact, suffering a neurasthenic condition. According to the physician, the parents’ belief that the pain was localised in the joints was wrong, as it stemmed from the nervous system as a whole. This translation did not imply scepticism on the presence of symptoms or discomfort. Quite the contrary, no one was in any doubt that the pain was anything other than real. Although patients did not know the source of their own suffering – and attributed it to the wrong location – Savill and other doctors did not question the discomfort. Symptomatic cures were not ruled out despite their palliative character.

In 1904 Michell Clarke, Professor of Pathology at University College, Bristol (now Bristol University), also saw chronic pain, either of the back or of the head, as one of the most important symptoms of neurasthenia. To this, he added other complaints such as dizziness and vertigo, mental depression, inability to carry out mental work, various sleep disorders, irritability of temper, weakness and tremor of the limbs, back pains, palpitation and certain forms of dyspepsia. Clarke describes these children in terms similar to those used by Ballet, as having “had a spell of exaggerated growth” after which the nervous troubles appeared. They were “long and lean”, suffered from headaches, had sluggish memories, complained of sleeping badly and, when getting up in the morning, were tired and “as though palsied.” Along with the pressure of school, Clarke mentioned the development of the imagination, desire, and masturbation as causes of neurasthenia.

689 Savill, Clinical Lectures, 59.
690 Moscoso, Pain, 172-181.
691 Savill, Clinical Lectures, 37.
693 Hartenberg, Treatment of Neurasthenia, 59.
Medical professionals emphasised the importance of avoiding the over-stimulation of the nerves, advocating regular activities, relaxation, and the avoidance of risks and dangers. If in each classroom and each family there was a potentially nervous child, it would be the treatment of the children that would decide their future, affirmed these experts. Doctors did not believe it was in the power of the parents or of education to free a child with a neurasthenic predisposition from suffering the symptoms, but they could help to control them. In *Treatment of Neurasthenia*, Paul Hartenberg recommend open air and tonics, as well as the need to “diminish or entirely suppress all work” in the case of school children or students.\(^{694}\) If the condition was severe, the child should be confined to bed. If all this did not have an effect, the doctor had as a weapon the preparation of a “cereal decoction”.\(^{695}\)

Despite the importance given to the hereditary factor, some experts believed that self-control was a powerful treatment, if not a cure. Michell Clarke recommended eliminating alcohol, tea, and coffee from the child’s diet together with bodily as well as mental training.\(^{696}\) Regular hours as well as the day-to-day control of the emotions could help to prevent the seed of neurasthenia from germinating. Equally, for Gilbert Ballet, the first measure in preventing neurasthenia was to safeguard children who had been born to parents who were neuropathic or arthritic by repressing their hereditary tendencies and trying to strengthen their nervous centres.\(^{697}\) To achieve this, the doctor insisted on putting into practice, “methodically and patiently”, all the means at the disposal of hygiene. In *Treatment of Neurasthenia by Teaching of Brain*, Roger Vittoz suggested that patients who had fewer possibilities of being cured were those who had been ill since childhood and had no “conception whatever of the idea of an effort of will.”\(^{698}\) Despite the central role given to either heredity or higher living standards as causes of the disease, these interpretations of childhood neurasthenia left more room for prevention than the notion that adult neurasthenia was caused by the pace and circumstances of modern life.

\(^{694}\) Hartenberg, *Treatment of Neurasthenia*, 172.
\(^{695}\) Hartenberg, *Treatment of Neurasthenia*, 172.
\(^{696}\) Clarke, *Hysteria and Neurasthenia*, 7. See also ‘A case of obscure fever with pronounced nervous symptoms, apparently due to infection by a leptothrix bacillus’, *British Medical Journal* (13 Jan 1912).
\(^{697}\) Ballet, *Neurasthenia*, 163.
\(^{698}\) Roger Vittoz, *Treatment of Neurasthenia by Teaching of Brain Control* (Longmans, Green, London & New York, 1911), 80.
Gilbert Ballet emphasised the importance of studying “moral over pressure” when considering the aetiology of neurasthenia. For this doctor, states of “sorrow” and “discomfort” from “depressing emotions” that included “vexation” “disappointments” “remorse” and “thwarted affection”, were most crucial in causing nervous exhaustion to children. Ballet’s analysis of children’s neurasthenia did not completely conform to the original concept that arrived in the UK from the USA in the 1880s of adult neurasthenia as a weakness of the nerves. When it was first described, neurasthenia was depicted as a somatic disease provoked by too much strain on the brain and the digestive system, stemming from modern industrial and urban life. However, Ballet’s references to social conditions were usually pushed into the background. Publications such as Ballet’s represented an optimistic approach that emphasised how a favourable environment could prevent or even cure neurasthenia.

As late as 1920 – a date which is often considered as marking the end of the peak of neurasthenia – neurologist Ivo Geikie Cobb, assistant to outpatient physician at the Middlesex Hospital, still defined it as generalised “irritable weakness” of the entire nervous system. Starting out from an article published by Campbell Smith in the Practitioner in 1911, Cobb sustained that while the “early edition of nerve exhaustion” in children – which he designated by the name of “Neurasthenia Minor” – resembled adult neurasthenia, it presented a series of symptoms and characteristics that belonged to this particular period of life. It is interesting that Cobb only outlined this argument, without going on to explain the nature of these differences. His treatise widened the array of symptoms, mentioning afflictions such as hypersensitiveness of the sensorium, the loss of mental and bodily vigour, disturbed sleep, irritability of temper, muscular weakness, restlessness, nervousness, and – above all – “vague pains”. The fact that many of the treatises about adult neurasthenia written at the beginning of the twentieth century referred to a type of neurasthenia characteristic of childhood reflects the influence and growth of arguments that had emerged from the field of paediatrics, which stressed the importance of

701 Cobb, A Manual of Neurasthenia, 29,
702 Cobb, A Manual of Neurasthenia, 29,
studying childhood pathologies as manifestations independent of those that belonged to the adult world.

**Paediatrics and functional neuroses of childhood**

Despite its apparently limited acceptance, the concept of neurasthenia permeated both the medical and educational discourses about children during the first decades of the twentieth century. By then, paediatricians had already taken interest in children’s nervous problems – including illnesses such as hysteria and neuralgia, as well as neurasthenia – as an object of study in their own right. Although treatises about nervous conditions written by neurologists during this period continued to frame the child within debates about adult conditions, paediatrics focused its attention on conditions that specifically belonged to children.\(^\text{703}\) Going beyond earlier diagnostic models, a new nomenclature was taking shape. Childhood neurasthenia, which had been mentioned in some of the foundational studies of adult nervous pathologies, was to be diagnosed in the twentieth century by an expanding medical culture that managed and medicalised children’s nervous disorders.

At the beginning of the century, medical pathology, psychiatry, and psychology all placed an urgent focus on the rigorous study of childhood conditions that did not depend on the adult world. In so doing, these new disciplines also sought to legitimise and consolidate themselves. Manuals about children’s nervous disorders written by medical pathologists and paediatricians were published, covering the physical, mental, moral, and emotional aspects of the weakness of nerves as well as the effect of parental shortcomings, negligence, or bad environment. Although the treatises produced by the new discipline of paediatrics varied in their assumptions and standards, they had one thing in common: both pathologists and paediatricians attacked the authority of neurologists in conceptualising and treating mental illnesses and the child’s nervous system.\(^\text{704}\) The response of paediatricians to neurology – which, at that

\(^\text{703}\) For example: Savill, *Clinical Lectures*; Hartenberg, *Treatment of Neurasthenia*.

\(^\text{704}\) A very similar process has been described by Nelleke Bakker in the context of the Netherlands, see Nelleke Bakker, ‘A Harmless Disease: Children and Neurasthenia in the Netherlands’, in M. Gijswilt-
time, enjoyed a higher academic and professional status – was to emphasise the unique character of childhood conditions and to use this claim as the basis for diagnosis.\textsuperscript{705}

An important figure in this process was George Frederic Still (1868-1941), assistant physician for diseases of children at two hospitals in London: King’s College Hospital and the Hospital for Sick Children, Great Ormond Street, where he became one of Charles West’s successors and a prominent member of the hospital’s second generation.\textsuperscript{706} Still inherited West’s legacy of the “nervous child”, first mentioned in the 1848 \textit{Lectures on the Diseases of Infancy and Childhood} under the section on “nervous disorders”.\textsuperscript{707} Still’s significance lies in a new definition of children’s nervous instability that he called “defect of moral control”, published in \textit{The Lancet} in 1902.\textsuperscript{708} In this work, which was based on his three Goulstonian Lectures “On Some Abnormal Psychical Conditions in Children” at the Royal College of Physicians of London, Still discusses the symptoms that neurologists saw as clear indications of neurasthenia and other disorders of the nervous system. Still divided the cases into two groups. The first comprised children with a “morbid failure in development of moral control.”\textsuperscript{709} The second consisted of children with a “morbid loss of already acquired moral control.”\textsuperscript{710} It is worth noting that Still’s use of the word “morbid” implies the morphological/anatomical claim that the disease entity – the defect of moral control – was linked to a pathological condition. As with the medical conditions analysed by neurologists, the prevailing idea of causation in relation to both groups was that there was an organic cause of the children’s defect of moral control. Still argued that a “lack of moral control may be shown in many ways,” with symptoms including “nervousness”, “passionateness”, “spitefulness and cruelty”, “jealousy”, “lawlessness”, “dishonesty”, “wanton mischievousness and


\textsuperscript{705} Nelleke Bakker, ‘A Harmless Disease’, 311.


\textsuperscript{707} West, \textit{Lectures}, 188.

\textsuperscript{708} For example, Frederic Still’s concept of defect of moral control, which he developed in his Goulstonian Lectures, a series of three lectures to the Royal College of Physicians of London. In ‘On some abnormal psychical conditions in children: The Goulstonian Lectures,’ \textit{The Lancet} 1 (1902) 1008-1012, Still discusses “the particular psychical conditions […] which are concerned with an abnormal defect of moral control in children.”

\textsuperscript{709} Still, ‘On some abnormal’, 1010.

\textsuperscript{710} Still, ‘On some abnormal’, 1079
destructiveness”, “shamelessness”, “immodesty”, “sexual immorality”, and “viciousness”.711

The psychological symptom was related to a morphological condition, which was generally held to be a physical disease affecting the brain during infancy. Still’s demonstration in his Goulstonian lectures of a causal link between damage to the brain and immoral behaviour in children inscribed his theory in the anatomo-clinical predication on local, discrete entities as pathological causes, a perspective he shared with rival neurologists. What set Still apart from neurologists is the fact that he was the first expert to describe neurosis as a specific children’s disease. He thereby anticipated the change that would take place within the literature of nervous disorders.712 At the time of his 1902 lectures, Still was already campaigning for the establishment of a specialist discipline for childhood conditions. Known as the “father of British paediatrics,” in 1906 he became Britain’s first professor of paediatrics (at King’s College Hospital) and in 1933 he was elected as the president of the first international congress on paediatrics.713

Still’s Common Disorders and Diseases of Childhood, a textbook published in 1909, proved successful and by 1927 was in its fifth edition. This work has a chapter dedicated to children’s nervous disorders, which is important for two reasons.714 First, it is one of the first studies to deal with nervous conditions from within the new children’s science. Secondly, it anticipates the paradigm shift that

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711 Still used this diagnostic label in his medical practice as well: GOS/10/229-230: Dr. Frederic Still casenotes (1913-1916), Great Ormond Street Hospital.
712 Still’s demonstration in his Goulstonian lectures of a connection between brain damage and deviant behaviour in children was highly influential in the conceptualisation of maladjustment and, later, of attention deficit hyperactivity disorder (ADHD). Both ADHD’s advocates and those who question its validity trace the lineage of this diagnostic category back to these lectures.
was taking place in the field of the study of childhood nervous conditions and which would be consolidated in debates after the First World War: while other treatises of the time continued to use the heading “peculiarities of the nervous system,” Still called this chapter “nervous children”, thereby formulating a new figuration of childhood that would be subject to subsequent conceptualisation and articulation over the following decades.\footnote{Still, \textit{Common Disorders}, 590.} According to Still, these children demonstrated too much intelligence to be labelled under the established terminology of idiocy and they were too young to be understood as “criminal minds.”\footnote{GOS/10/229-230: Dr. Frederic Still casenotes (1913-1916), Great Ormond Street archives.}

In 1909, Still had to open with an apologetic defence of an “unscientific title”: there was “no technical term which so well expresses the condition which I wish to emphasize here as the homely word ‘nervousness’.”\footnote{Still, \textit{Common Disorders}, 590.} Indeed, the new figure of the nervous child would not establish itself within medical theory and practice until the 1920s, with the consolidation of paediatrics and the emergence of educational psychology. Paediatric treatises published in the first two decades of the twentieth century placed conditions such as neurasthenia, hysteria, neuralgia, and neurosis under the heading of “functional nervous disorders” rather than “nervous children”. Thus, the British physician Leonard Guthrie, senior physician at Paddington Green Children’s Hospital, published \textit{Functional Nervous Disorders in Childhood}, one of the first textbooks on the emerging discipline of child psychiatry in 1907.\footnote{Guthrie, \textit{Functional Nervous Disorders}, 4-5.} Like Still, Guthrie based his account on considerations quite distinct from those that had been held during the previous century and that were still defended within the field of neurology, illustrating the big changes that were taking place in the paediatric, psychological, and psychiatric approaches to childhood. Looking back to the early decades of the Victorian era, when relatively little medical attention had been paid to the child mind, Guthrie noted:

\begin{quote}
Advice was not asked for peevish, passionate children, nor for those who were afraid of the dark, and unnaturally timid, absent-minded, or
\end{quote}
brooding and morose, jealous, spiteful or cruel, nor for mischievous, untruthful, dishonest, or immoral children. All such defects were regarded as moral rather than morbid, and were treated as such.\(^{719}\)

As in Still’s description, this catalogue of traits neatly summarises the very areas of child behaviour that the new science of child psychiatry was claiming as its own. But Guthrie and Still were coming from different places. While Still based his ideas on Charles West and the first texts about children’s diseases, Guthrie drew on the complex debate among late-nineteenth-century psychiatrists and neurologists (see Chapter 4) about the possibility of children’s insanity.\(^{720}\)

Throughout the twenty-one chapters of the book, the narrative remains faithful to two guiding principles: a clear opposition to the tendency to blame parents for their children’s problems and an insistence on the importance of two factors: personality and environment. Following West’s recommendations on the empathetic duties of the paediatrician, Guthrie dictated the need to access a true understanding of childhood and the physical and psychological pain every child endures. In line with the factual acceptance of childhood suffering typical of practising paediatricians, Guthrie claimed its potentially permanent effects on the psyche. Unlike neurologists, he did not believe that the functional neuroses of childhood could be explained by the development of the cerebrospinal system during infancy: “the environment of the neurotic child as well as his personality have always to be considered in relation to his ailments.”\(^{721}\)

Guthrie’s work describes various specific types of deviant behaviour that he observed in children. Although he still suggests a somatic location of these ailments, Guthrie argued that both emotional and somatic factors played a role in the development of neurosis. Thus, in the chapter “Effects of emotions in health” he argued that, when diagnosing neurotic children, doctors should take into account the potential effect of mental problems on the origin and course of illness: “The influence of their mental troubles may be as great as, or greater,


\(^{720}\) Sally Shuttleworth, The Mind of the Child, 16.

\(^{721}\) Guthrie, Functional Nervous Disorders, 17.
than our own, in causing and prolonging their complaints.”

Quoting George Eliot’s novel *The Mill on the Floss* and Eliot’s views on the effect of children’s mental sufferings upon their happiness, he suggests that as health and happiness go together, “if a child is miserable, its health, like that of an adult, suffers. The cause of the misery may seem trivial, but its effect upon health may be prolonged through after life.”

It has been argued that the interwar period involved a “transformation in the understanding of the moral sphere”, with a movement from a “hygienist” focus on the bodies of children and their physical health to an emphasis on their minds and emotions. However, a less linear, more complex, and protracted dynamic starts to appear when disciplines other than child rearing and psychology are added to the analysis, as Guthrie’s account exemplifies. Together with West and other paediatricians, he had acknowledged the influence of emotions on the development of children’s illnesses and nervous disorders, and the radical enmeshment of “physical” and “emotional” pain. When discussing the various functional neuroses of childhood, Guthrie considered “hysteria and neurasthenia are often met together.” Thus, while he defined neurasthenia as “hyper-sensitiveness of higher centres with proneness to general exhaustion of nervous energy”, Guthrie saw mental and physical hysteria as characterized by “excitability and explosiveness of higher centres, associated with local sensory and motor paralysis, and deficient powers of control of emotional display.” In the words of this physician, neurasthenia probably caused more misery and pain than any organic disease. “Children may from very early years be neurasthenic in the highest degree,” wrote Guthrie, adding that it was therefore important to recognise early symptoms and tendencies towards the disease, to deal with them, and check them if possible to save such children from “the life-long ill health which has been the lot of many endowed with the highest order of intellect and genius.”

Guthrie considered that lower abdominal pains, diarrhoea, and vomiting – where there was no specific cause – to be constant manifestations of nervous

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723 Sally Shuttleworth has discussed the work of Guthrie in relation to George’s Eliots *The Mill on the Floss* and Charlotte Bronte’s *Jane Eyre*, see *The Mind of the Child*, 16-17.
724 Urwin and Sharland, ‘From Bodies to Minds’, 44.
725 Guthrie, *Functional Nervous Disorders*, 4-5.
726 Guthrie, *Functional Nervous Disorders*, 4-5.
children. The list of symptoms included repeated night terrors, headaches and migraine, urticaria (hives) and other forms of erythema exudativum, poor circulation, dead fingers, cold extremities, sweating, and cardiac palpitation. They were also prone to habit spasms (tics), rheumatic chorea, recurrent tonsillitis, and cyclic albuminuria. Although they might suffer from epileptiform seizures, cases involving true epilepsy were rare. Neurotic children could even go on to develop all kinds of hysteria or neurasthenia in later life, risked becoming alcoholics or drug-takers, and could be suicidal, homicidal, and insane.  

Guthrie brought together into the single configuration of the nervous or neurotic child all the distinct figures that had been studied by alienists at the end of the nineteenth century: the child with night terrors, the depressed child, the hysterical child, and the insane child; and the different conditions studied by neurologists. For Guthrie, pain was not just a symptom but also an important factor in the aetiology of the condition. Even though neurasthenia, hysteria and children’s nervousness often resulted from a specific organic origin – either “traumatism” or an illness of some kind – for doctors such as Guthrie, the “perpetuation of the mischief” could well be the result of “domestic mismanagement”. In his view, neurotic people were not necessarily neurasthenic, although they were prone to become so. Neurasthenia was the result of the combination of a neurotic temperament and unfavourable conditions and surroundings. Thus, when considering a neurotic child, both environment and personality had to be considered. Guthrie’s text shows the shift in approaches to children’s abnormal behaviour, moving away from the neurologists’ belief in inherent hereditary factors to consider the significance of environmental influences. Unlike Guthrie, Archibald Garrod, writing in 1913, was not “disposed to agree with the modern doctrine that functional nervous disorders, such as neurasthenia, ‘psychasthenia’ and hysteria, are entirely psychic in origin.” On the contrary, they were nervous manifestations of a “psycho-somatic” or “somato-psychic” origin which had their base in a physical or

727 Guthrie, Functional Nervous Disorders, 4-5.
728 See Chapter 4.
729 Guthrie, Functional Nervous Disorders, 4-5.
bodily change, almost always of a harmful nature.\textsuperscript{731} The English physician criticised those psychologists who maintained that “functional nervous disorders in general are affections of the mind, and not of the brain or body” and that the mind “is not a function of the brain nor the brain the organ of the mind.”\textsuperscript{732}

As Sarah Hayes has argued, theories about the influence of environmental versus hereditary factors shaped medical approaches to the mind of the child in the first decades of the twentieth century.\textsuperscript{733} The debate can be followed as closely in paediatrics authors as in neurologists. Still, for example, emphasised hereditary factors and considered that the main causes of childhood “nervousness” included drunkenness by one of the parents at the moment of conception, the intense feelings of the mother during pregnancy, and the presence of mental infirmities in the family.\textsuperscript{734} Many doctors recognised that bad treatment or school overload could transform a child who presented only a disposition of minor importance into a serious case of nervousness. While Edmund Cautley argued that a neurotic heredity was the predisposing cause of neurasthenia, psychasthenia, and hysteria, Guthrie and others accentuated the importance of the child’s environment in the development of these conditions.\textsuperscript{735} Calmness, order, and regularity were prescribed – along with a host of “hygienist” remedies such as physical exercise and fresh air – as ways to help cure this condition. The most optimistic popular version highlighted the possibility of treating and decreasing childhood nervousness through the management of a healthy environment and a sound upbringing. The suffering of a nervous constitution in a child could be avoided, Cautley claimed, through a healthy diet. Good education, acceptance of obedience, and self-control could help combat hereditary predisposition and could act as a prophylaxis against weak nerves.\textsuperscript{736} While neither parents nor schools could prevent a predisposed child from suffering the symptoms, they could nonetheless help to control them.

Although they took hereditary tendencies into account, doctors such as Cautley believed that a balanced and ordered life far away from strong

\textsuperscript{731} Garrod, Batten, and Thursfield, \textit{Diseases of Children}, 666.
\textsuperscript{732} Garrod, Batten, and Thursfield, \textit{Diseases of Children}, 666.
\textsuperscript{734} Still, \textit{Common Disorders}, 628.
\textsuperscript{735} Cautley, \textit{Diseases of Infants}, 756.
\textsuperscript{736} Cautley, \textit{Diseases of Infants}, 8.
impressions could counteract the lively imagination of the child and its nervous tendencies. A tranquil and harmonious environment offered the best chance of avoiding the development of the illness in a child born with this temperament and of helping him develop a stable character, despite the innate propensity towards the contrary was Cautley’s optimistic conclusion. While there were potentially nervous children in every school and family, their future would be decided by how they were treated, according to this perspective. Cautley’s account shows that before the First World War medical professionals had a holistic conception of children’s nervous illnesses. The emphasis on specific material lesions was combined with a notion of the interplay between emotions and tissues, between illness and subject.

**The signs of nervous pain**

Mathew Thomson has suggested that, in the adult context, the success of diagnoses in terms of “nerves” lay in the fact that it covertly created an acceptable space for the development of psychotherapeutic medicine and an escape from the cul-de-sac of asylum-based psychiatry. 737 Seen with some distance, hysteria and neurasthenia have so many common features that it is impossible not to include some remarks on their relationship and transition. However, a closer look at the data suggests a messier landscape. In fact, cultural historian Elaine Showalter has asserted that most neurasthenic patients in the United States were women and that in Britain the diagnosis was associated mainly with young women. 738 Beyond gender distribution, their prolific diagnosis before the discovery of psychoanalysis and modern psychology could be said to have preserved intact the principles of the clinical tradition a little longer. Historians Mathew Thomson and Javier Moscoso have argued that “neurasthenia” and “hysteria” were generally used as a loose umbrella term for “nervous” disorders rather than in any strict or specific way. 739

To a certain extent, a similar process happened in the context of the emerging specialism of paediatrics, as paediatricians such as Still and Garrod

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737 Mathew Thomson, ‘Neurasthenia in Britain’, 79
738 Showalter, *The Female Malady*, 137.
739 Moscoso, *Pain*, 172-181; Thomson, ‘Neurasthenia in Britain’, 79
published textbooks about children’s nervous disorders, including neurasthenia, hysteria, neuralgia, nervous tic, and hyperesthesia. Very often, the distinction between the two conditions is merely nominal, as they came to be used almost interchangeably. On certain occasions, pain without illness diversified into a wide spectrum: neuralgia, nervous tics, and rheumatism, both acute and chronic. One of the works of special significance is Garrod’s Diseases of Children, published in 1913. Garrod, who pioneered the field of inborn errors of metabolism, argued that “all neurotic children are liable to aches and pains.” For this English physician, rheumatism was “generally held to be the chief cause of neuroses in mid-childhood”, but the prominence of the neuroses did not always coincide with the severity of the rheumatism. While “localised pain” was probably at the bottom of all hysterical paralyses and contractures in childhood, the pain was often the result of rheumatism, a slight strain, or “incipient tuberculous disease”. Garrod mentioned other factors involved in the production of functional neuroses: a sudden emotional shock, fear, dread, worry, anxiety, overpressure, a life of unhealthy excitement, an environment that was uncongenial for one reason or another. Again, Garrod’s study links concepts of physical and emotional pain and the interplay of bodies and minds, which calls into question the “bodies to minds” narrative put forwards by recent studies of the history of childhood.

James Taylor also documented the relationship between neurasthenia and rheumatism in his book on Paralysis and Other Diseases of the Nervous System in Childhood and Early Life, published in 1905, specifying the site of pain “in the joints and down the limbs.” Sir Dyce Duckworth, physician to the Prince of Wales, also held that rheumatism played an important role in causing nervousness and a very important part in the causation of children’s nervousness and especially in the proliferation of “various neuralgic affections” in children. In the most serious cases, the illness could degenerate to the point of producing the total paralysis of the child’s nervous system. Robert Hutchison

740 Garrod, Batten, and Thursfield, Diseases of Children, 679
741 Garrod, Batten, and Thursfield, Diseases of Children, 679
742 Garrod, Batten, and Thursfield, Diseases of Children, 728
743 Taylor, Paralysis and Other Diseases, 227.
called this type of paralysis “true hysterical paralysis” and illustrated the diagnosis with the case of one of his patients who presented the complete “loss of power in the whole arm”. The twelve-year-old boy had attended the practice with a previous diagnosis of infantile paralysis. On examination, wrote Hutchison, the patient was found to be a healthy child whose health had previously been good and no cause had been found for the onset of the paralysis. The right arm was quite motionless and showed considerable atrophy, especially in the small muscles of the hand. It was blue and cold, as in a case of infantile paralysis, but it was completely insensitive to touch, pain, and temperature. Hysteria was therefore diagnosed, and “a strong faradic current applied with vigorous suggestion.” This provoked an emotional outburst, but the child regained power of the arm immediately and returned home the next day perfectly well except for atrophy in the arm as a result of its lack of use. In this case it was the existence of the anaesthesia and its characteristic distribution that enabled Hutchison to make his diagnosis. Unlike those doctors who referred to heredity or the failures of modern society, Hutchison preferred to see conditions such as hysteria and neurasthenia as physical illnesses that could be treated successfully within the framework of medicine.

As well as pains of a rheumatic type, the doctor had to consider the presence of a disproportional pain in attending to the diagnostic signs of childhood nervousness. Thus, Garrod considered that the neurotic temperament was characterised by hyperesthesia – excessive physical sensitivity – and “unduly active response to all forms of stimuli”, both physical and mental. An excessive sensitivity of the skin linked to exaggerated reflexes and tendon jerks, tremors, tics, spasms, and convulsions pointed to a diagnosis of physical hyperesthesia. “Emotional Hyperesthesia”, on the other hand, was characterised by exaggerated sensitiveness and reaction to environmental stimuli. Garrod, who described emotions according to the Darwinian paradigm, argued that the neurotic and emotional child presented an excessive sensitivity that made any experience, whether physical or emotional, painfully unbearable. For William

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744 Hutchison, Lectures, 228.
745 Hutchison, Lectures, 229.
746 Hutchison, Lectures, 229.
747 Garrod, Batten, and Thursfield, Diseases of Children, 666.
748 Garrod, Batten, and Thursfield, Diseases of Children, 667.
Osler, hyperesthesia was usually associated with other manifestations of hysteria and neurasthenia, and patients with this condition usually complained of "excruciating pain" in the stomach. The behaviour of the patient with hyperaesthesia could be characterised by a chronic and intractable stomach pain, a pain which, in severe cases, ended up with patient “reduced to an extreme degree by starvation.”

For Osler, the most extraordinary manifestations of children’s nervousness — whether they involved hysteria, neurasthenia, or other manifestations of nervous instability — always resulted in "grave sensory disturbances in the region of the stomach, in addition to the general nervous symptoms." Once again, physical suffering is presented as a clear diagnostic sign. Thus, Osler mentions “Achylia Gastrica Nervosa”, a condition often associated with hysteria and neurasthenia and characterised by a lack of the normal amount of acid. And he added to this “Gastralgia” or “severe pains in the epigastrium” which occurred “as a manifestation of a functional neurosis” independent of organic disease and usually associated with other nervous symptoms. For Luther Emmett Holt, the manifestations of Gastralgia or “sudden, severe attacks of abdominal pain” were more marked in older children than in infants. In many cases the pain was so severe “as to lead one to think that the stomach is the seat of disease” when in reality it was a nervous problem. Whereas in mild cases the pain was intermittent without the presence of other symptoms, in severe cases “the pain may be so great as to cause pallor, faintness, cold perspiration, and very marked prostration.” This American doctor recommended a treatment that involved putting the patient to bed, applying a “counter-irritation” over the stomach, by means of turpentine stupe or mustard paste. Patients should be given hot water containing brandy or gin, given together with five drops of spirits of chloroform; all food should be withheld.

Following Holt, Sir James Frederic Goodhart considered that the “gripping abdominal pain of a paroxysmal kind” and the pain in the side experienced by many children he saw in his practice were not caused by temporary conditions,
such as problems with the diet. On the contrary, “these varied pains and aches” were often “an evidence of nervous instability, and they are found in nervous children or nervous families”. According to Goodhart, the insignificance of the exciting causes, the suddenness of the attack, the suddenness of its subsidence, the nature of the attack in many cases, and even the presence of an excess of mucus (if it were a dominant symptom) were all compatible with enfeebled nerve control.

In The Diseases of Infants and Children, Cautley added to the physical pains characteristic of neurasthenia and hysteria those psychological pains that were produced in cases of psychasthenia, “a variety of neurasthenia in which the mental symptoms predominate.” Cautley described psychasthenia as a mental illness that presented a high degree of irritability, caused by an imbalance of the imagination which led to anxious feelings, such as fear, in the child. While in neurasthenia the chief symptoms were somatic and psychical and always of a harmful nature – headache, vomiting, palpitations, and arrhythmia – children with psychasthenia showed a large degree of moral suffering. “The child develops morbid scruples, increasing mental uncertainty and hesitation, lack of initiative power or acting promptly, auto-analysis, and excessive emotional reactions,” wrote Cautley. The next stage, he argued, was that the child either started to carry out “imperious strange acts” – such as frequent handwashing, aimless rummaging, and “verification of unimportant matters” – or remained in a state of rumination or reverie. Finally, the child developed fixed ideas, persistent obsessions and phobias. For Cautley, the child’s uncontrollable actions depended on these uncontrollable ideas and “the will is enfeebled and irresolute, the child being incapable of fixing either attention or energy”. Such children were eccentric in manner and clumsy in action, and the “joyousness of youth is replaced by melancholy or hypochondriasis.”

755 Goodhart, Diseases of Children, 112.
756 Cautley, Diseases of Infants, 776.
757 Cautley, Diseases of Infants, 777.
758 Cautley, Diseases of Infants, 777.
759 Cautley, Diseases of Infants, 777.
760 Cautley, Diseases of Infants, 777.
Unconscious pain

Historians of medicine generally agree that a shift in medical paradigms at the beginning of the twentieth century led to the decline of neurasthenia and to beliefs that the physical condition of the nervous system was the location of a wide range of illnesses. As a result of this shift, the origin of certain physical symptoms was displaced to mental rather than somatic problems. Neurologists continued to try to demonstrate that these illnesses had a specific organic origin and were treatable with traditional medicine, while other doctors recognised the power of the unconscious mind on the body, the malleability of the mind to suggestion, and the psychotherapeutic role played by the doctor. Bodily symptoms were translated into mental problems that resulted from the struggle of an individual to adapt to a changing environment. This had potentially radical implications for the diagnosis and treatment of neurasthenia and other nervous disorders.

With the turn, there was an increasing recognition of the psychotherapeutic role of the doctor. According to the historians of childhood that have described the translation process from bodies to minds, for child welfare work, a “space” was created in British medical science in the interwar period for psychodynamic ideas. This “New Psychology”, which involved new definitions of parental adequacy and led to new forms of family intervention, focused on feelings and emotions rather than behaviourist concerns with health and habits.

From the 1920s, British experts became more interested in children’s emotional problems as manifested in such behaviours as bed-wetting, eating disorders, anger, fear, and – especially – anxiety. At the same time, there was a change in their interpretation. For instance, fear was now seen as a natural feeling rather than as an expression of a child’s lack of self-control. Similarly, treatment shifted from a disciplinary approach of correction towards understanding the motives behind the feeling. Analogously, lying or self-willed children were now seen as potential victims of emotional neglect rather than

761 Moscoso, Pain, 172-181; Thomson ‘Neurasthenia in Britain’, 82.
simply labelled as naughty. However, not all interpretations of this shift see it in positive terms and some note that these changes took place alongside the “psychologisation” of medical discourse. David Armstrong, adopting Foucauldian terminology, sees an extension of the clinical gaze into the intimacy of the mind.

After the Freudian concept of neurosis burst onto the scene after the First World War, the more traditional concept of “nervousness” coexisted with “neurosis”. Freud traced a clear connection between the failure of neurology’s corporeal approach to provide an explanation for the proliferation of symptoms that were being observed by contemporary doctors. He argued that it was impossible to deny that there were many people with an abundance of symptoms that could not be explained by any morphological injury or complaint. Freud held that all patients manifesting an excess of ailments were actually suffering from the same illness, and claimed that they could not be treated as people with located somatic illnesses. Contrary to the anatomo-clinical principle, he saw no reason to claim a connection between the symptoms and nervous or functional illnesses; instead, he shifted the causal logic to infer that all the visible and conscious pathological signs derived from the disrupted (and unconscious) influx of their psychic life. Together with physical discomfort, Freud postulated the existence of unconscious psychological pain which enabled neurotic symptoms and behaviour to be considered.

Two of the main personalities that determined the fate of children psychoanalysis in British society and democracy during the Second World War (see Chapter 6) were present at Freud’s address at the fifth meeting of the International Psycho-Analytical Congress, held in Budapest in 1918 in the context of the First World War, which allowed Freud to tie shell-shock symptoms

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764 See Bakker, ‘A Harmless Disease’, 383-401,
to unconscious conflicts. Significantly, both were women, and both were of Germanic origin. Melanie Klein (1882-1980), after finding herself “enraptured” by Freud’s essay on dreams when she read it in 1914, started an analysis with Sandor Ferenczi in her early thirties that brought her in direct contact with shell-shocked soldiers. She happened to be based in Budapest during Freud’s 1918 remarks. Her arrival in London took in 1926, and she became a pioneer in British psychoanalysis, alongside Anna Freud (1895-1982), Sigmund Freud’s sixth and last child who had been an analysand of her own father, with whom she started an analysis in 1918. Two years later, she started an informal group on child analysis and later took up analysis of children of close friends that provided material for Introduction to the Technique of Child Analysis, published in 1928, ten years before her exile to London.

As she recalled later, Sigmund Freud’s address left a deep impression on Klein who said that, as a result, “the wish to devote myself to psychoanalysis was strengthened”, while Anna Freud believed that by introducing psychoanalysis in the field of child studies she was serving her father’s goal of broadening the reach of psychoanalysis. Soon, the victims of war neurosis disappeared from public view, but there was now a new object of psychoanalytic investigation: the anxious child. Nelleke Bakker has argued that, as a diagnosis for children, “nervousness” became unpopular while Freud’s concept of neurosis grew rapidly. However, before the 1920s, psychoanalysis had paid little attention to children and Freud himself had never conducted analysis on a child. His famous study of little Hans, a five-year-old boy with a phobia of horses, was based on consultations with the child’s father – Freud did not treat Hans himself. Nonetheless, this 1909 essay was used as a benchmark by child analysts.

This section of the thesis accepts the terminological shift from “nervous conditions” to “neurosis”, and will develop it in relation to the history of childhood


771 Young-Bruehl, Anna Freud, 166


775 Viner ‘Melanie Klein and Anna Freud’, 6.
and the history of pain. The sources will be explored to test Thomson’s hypothesis that views of neurasthenia varied considerably between elite clinicians and general practitioners.\textsuperscript{776} However, instead of comparing different levels of expertise within the same discipline, this section explores different disciplines to show that during the interwar period there was considerable debate about the location and causation of nervous illnesses and the interplay between bodies and minds.

The rise of the New Psychology did not immediately lead to the abandonment of long-established concerns about habit, will, and character. In fact, the embrace of psychological medicine in Britain between the wars was rather tentative, as can be shown by the fact that, as late as 1929, paediatrician Henry Dwight Chapin published the book \textit{Heredity and Child Culture}, which still covered topics including “organic inheritance”, “social inheritance”, and “nerve culture”. While some elite clinicians and paediatricians supported the study of psychology as the key to a more holistic style of medicine,\textsuperscript{777} there was much resistance to the new psychological accounts from the British medical profession (particularly certain neurologists,) who continued to emphasise physiological explanations and, with them, the primacy of innate factors.\textsuperscript{778} Nonetheless, the idea that both mental \textit{and} somatic factors played a role was implicitly, if not explicitly, accepted. As we have seen in the previous section, paediatricians were already aware of the importance of emotions and environment in the aetiology of nervous illnesses long before the interwar period, anticipated by Charles West’s work in the last decades of the nineteenth century, where he discussed the importance of taking children’s emotions into account to diagnose illnesses.

The nervous child

Historians have noted that the diagnosis of neurasthenia began to disappear from European and American treatises of psychiatry and neurology around 1920. Despite this, both neurasthenia and hysteria seem to have been given a second

\textsuperscript{776} Thomson ‘Neurasthenia in Britain’, 78.
lease of life in literature about children’s medical conditions and education, although the word “neurasthenia” was soon replaced by popular equivalents such as “nervousness”, which was also used as a loose umbrella term for a wide range of conditions. But, as shown by the title of the section of Still’s book, these conditions would soon move from their roots in the nervous system to pathological signs of a new diagnosis: nervous children.\(^{779}\) “Nervousness” not only survived into post-war paediatric discourse, it gained in popularity.\(^{780}\) There seem to be two main reasons for this. First, the term proved a more useful label for deviant behaviour in childhood than other alternatives. For paediatricians and parents alike, nervousness may have been an attractive label for a problematic child, as it spared children with mental illness the stigma of insanity.\(^{781}\) The second reason is related to the increasing popularity of “mental hygiene” in schools. In the economically depressed years of the 1920s, juvenile delinquency became a major concern in Britain. Educationally backward children were seen as both a drain on resources – either by hindering other pupils or by taking up teachers’ time and energy – and as those most likely to become disruptive and delinquent. According to Ford, Mongon, and Whelan, the medicalisation of deviant behaviour enabled the education service to defend its interests against pupils who interfered with both its “open” and its “hidden” curricula.\(^{782}\) Nervousness was recognised as a major risk from the “mental overburdening” of school children.\(^{783}\)

From the 1920s, paediatricians begun to recognise the impact of children’s unconscious problems and the impact of the environment upon children’s physical and mental health. These medical professionals were interested in the

\(^{779}\) On the nervous child see Roper, ‘From the shell-shocked soldier’, 39-69; Oppenheim, Shattered Nerves, 233-264.


\(^{781}\) Trevor Turner has shown how the word ‘nervous’ increasingly replaced ‘insane’ in an attempt to reduce the stigma, particularly among private patients, of being labelled mentally ill, see Turner, ‘The Early1900s’, 20. Edward Shorter has also emphasised the fact that nervous illness, unlike psychiatric illness, was considered non-inheritable, thus providing an opportunity to avoid the implications of hereditary illness and degeneracy. Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac (Wiley, New York, 1997), 113. Several contributors to the book edited by Marijke Gijswijt-Hofstra and Roy Porter, Cultures of Neurasthenia from Beard to the First World War, have advanced similar arguments.


child’s psychological response both to the normal pressures of growing up and the abnormal strains of serious illness, and they paid particular attention to the nervous child. The most authoritative textbook on nervous children, *The Nervous Child at School*, by the paediatrician Hector Cameron (1878-1958), discussed nervousness in the context of the classroom. 

Published in 1918, it was based on Cameron’s experiences in the children’s department at Guy’s Hospital. As Leonard Guthrie had done previously, he explored the borderline between emotional and physical health arguing that both normal and abnormal children needed to be studied in order to gain a full understanding of children’s nervousness, as it was not possible to separate physical and psychological disabilities, and he further developed the topics of nervous pain and emotional suffering. In the opening section of the book, entitled ‘Doctors, Mothers and Children’, Cameron urged his colleges to take into account a child’s character when making a diagnosis, arguing that many little patients did not recover because the “hygiene of the mind” was often overlooked. For Cameron, it was essential to take into account this other aspect because “of the certainty that physical disturbances of one sort or another will follow upon nervous unrest.” Cameron noted how in most cases, the patients who arrived at hospital wards ended up going home with an incorrect diagnosis, as doctors focused only on physiological signs, forgetting the importance of the child’s environment and the mental and emotional state of the patient in the development of the illness. In an effort to validate the importance of paediatrics in the study of the child, he commented that only the good physician, open to understanding the child as a whole, could appreciate and estimate the “influences which proceed from parents and nurses of different characters and temperaments, and the reaction which is produced by them in the child.”

Cameron placed pain as a privileged object in research and in medical practice with nervous children. Thus, he describes the case of “a child of two or three years of age who was brought to him with the complaint that defaecation was painful” and whose constipation had resisted several remedies.

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785 Cameron, *The Nervous Child*, 2.
786 Cameron, *The Nervous Child*, 2.
787 Cameron, *The Nervous Child*, 5.
Whenever the child was placed upon the potty, he started to cry and it was impossible to console him. “It is not sufficient for the doctor in such a case to make an examination which convinces him that there is no fissure at the anus and no fistula or thrombosed pile,” argued Cameron, who concluded that all the symptoms presented by the child had a psychological origin.  

Cameron held that many diseases involved “a combination of organic disturbance” and “emotional trouble”. For example, an eighteen-year-old girl with on-and-off pain in the left arm dating from her fracture of the olecranon “when she was two years old.” Although she presented an organic injury – stiff joints and deformity in the arm – the pain always increased whenever “she was tired or unhappy”. In cases such as these, Cameron held that the treatment should seek to control both factors: the organic issue should be removed, psychological faults corrected. He believed that all kinds of emotional states including grief, anger, anxiety, and excitement inhibited normal physiological processes or interfered with their action, so that these outbursts were usually followed by symptoms of a harmful character. The child patients who came to the paediatrician’s practice complaining of a nervous condition presented palpitation, migraine and neuralgia, precordial pain, tachycardia of a functional nature, abdominal pains and diarrhoea, and hypersensitiveness of taste, hearing, sight, smell, and touch.

While Cameron’s text shows the influence of the emerging literature that recognised the power of the subconscious mind and the emotions over the body, it nonetheless finds itself halfway between the assertion of the somatic reality of nervous suffering and the psychoanalytical and new psychology literature, which accepted the mental origins of somatic conditions. In fact, Cameron continued to locate symptoms in an unstable nervous system, demonstrating the influence of authors like Maudsley. In 1924, in a discussion on the subject of nervous children that he chaired at the British Medical Association’s annual conference, in spite of taking into account the impact of “intense emotions” in the development of nervous symptoms, Cameron continued to emphasise that the problem resided in the fact that “his nervous system is unstable” and that “this is

789 Cameron, The Nervous Child, 3.
790 Cameron, The Nervous Child, 3.
791 See Chapter 4.
made very manifest in sickness, and certain symptoms thus aroused may long act as a reminder.”

In 1920, many physicians tended to remain more attracted to the older explanatory model of the somatic reality of their patients’ suffering: besides the fact that it was readily understood, it had the advantage of absolving them to an important extent of individual responsibility. This model led to a treatment regime based on somatic therapies, with less overt psychotherapeutic dimensions, which satisfied many of the physical and emotional needs of their child patients. Thus, the doctor J. Stewart Mackintosh sent a letter to the British Medical Journal in 1923 in which he criticised Hector Charles Cameron’s The Nervous Child. For this doctor, the most frequent cause in the aetiology of childhood nervous disorders was “disturbance in the character and distribution of the intestinal flora”, with the most common manifestations involving “chronic gastrointestinal catarrh with recurrent febrile exacerbations.” While Cameron argued that nervous instability was almost always the cause of psychological pain – which is to say, that the emotions had an impact on the body – this commentator held that “this type of nervous instability is a graft on the ‘catarrhal diathesis’.” The letter ended by emphasising this point and criticising Cameron, saying that while he “duly notes this association […] the special opportunities of a family actor have enabled me to observe that the order of precedence is invariable – the catarrh comes first.” In Mackintosh’s view, by the time the state of “malnutrition”, “toxic absorption”, “disturbed digestive functions”, “endocrine perversion”, and “muscular hypotenuse” was established, the child was already deeply immersed in an environment of perpetual concern which created the nervous problems, adding psychic maladjustment “to the other troubles”. He added that even when the cause of psychological unease was physiological, an understanding of child psychology and psychotherapy was needed at this point, “for the sense of inferiority is all too readily acquitted, as are also the various fixations and complexes that impede or pervert psychic

792 British Medical Association, British Medical Journal (24 November 1923) in Roper, ‘From the shell-shocked soldier’, 60.
793 Thomson, ‘Neurasthenia in Britain’, 84.
794 This also happens in the adult context, see Shorter, How Everyone Became Depressed.
development.”  In other words, while Cameron believed that the emotions influenced the development of a nervous character and that this type of character had a greater tendency towards somatic illness, Mackintosh held that the order of causation was precisely the opposite: that physiological weakness created the nervous problems in the child. This difference of opinion is an example of Mathew Thomson’s description of the gulf between expert opinion and general practitioners, many of whom remained ignorant of psychological theories.

In 1927, Cameron published an article in which he discussed the connection between ketonzemia (cyclical vomiting) and certain nervous disturbances. The symptoms which the mothers of these children reported were most usually significant and rapid loss of weight, pallor with puffiness and lividity under the eyes, prostration, muscular laxity, constant yawning or sighing, constipation, bad breath, excessive perspiration and breathlessness on exertion, giddiness or faintness on getting up in the morning, a persistently irregular temperature and, above all “joints and muscular pains”. Cameron described such pains as always intermittent and usually of short duration, “lasting perhaps but half-an-hour at most, and are often relieved by warmth, by lying down, or by any measure which improves the skin circulation.”

Following the model of causality he had defended in relation to nervous children, Cameron argued that often these pains had an emotional origin, as they were apt to be induced by fright, by a visit to the doctor, or by psychological exhaustion. However, he also acknowledged excitement, overexertion, and starvation as possible causative factors. While this doctor commented that those children who presented a nervous metabolism had a greater predisposition to develop this time of ailment, he referred to the teachings of Sir James Mackenzie, saying that what “seems to me most true and most fundamental is the recognition of the importance for each one of us, in our little way, and in the measure of our opportunities, to busy ourselves in studying the trifling beginnings of ill-health.”

800 Thomson, ‘Neurasthenia in Britain’, 82.
802 Cameron, ‘Ketonämia’, 56.
803 Cameron, ‘Ketonämia’ 58.
For the professor of psychiatry and neurology Beverley Tucker, this type of child did not need to go to the psychologist or psychoanalyst but rather to a "competent neurologist". In line with thinking developed at the end of the nineteenth century which held that physical disorders generated mental problems, this medic considered that congenital syphilis was one of the most likely causes of nervousness in children. In the same way, continued illnesses or pain produced nervousness in their aftermath, while some shorter illnesses – such as scarlet fever, measles, whooping cough, malaria and other acute infectious disease – left the child's nerves temporarily or permanently impaired.

In addition, Tucker claimed that injury – whether at birth or later – to the brain, spine, or nerves could make a child nervous or leave it with an organic nervous disease, while constitutional conditions – such as debility, improper food assimilation, rickets, rheumatism, and kidney disease – also played a role in nervous children. It is interesting to note how the same symptoms led to very different diagnoses: there was much variation in the perspective of neurology, paediatrics, and a new type of literature influenced by the emerging discipline of psychoanalysis.

In Vienna and Berlin, psychoanalysis was pioneering the study of children. In 1913, Hermine Hug-Hellmuth had published her first book on the topic and Karl Abraham started to analyse his daughter Hilda. The 1920s saw rapid developments to the extent that, by 1925, Freud was able to remark that "children have become the main subject of psychoanalytic research and have thus replaced in importance the neurotics on whom its studies began." In Britain, David Eder (1865–1936), one of the cofounders of the British Psychoanalytical Association, started to apply psychoanalytic theories to children. Eder's article 'The unconscious mind in the child', written jointly with his wife Edith and published in Child Study in 1918, shocked the readership to the extent that it was withdrawn. Conscious of the terrible physical conditions and poverty in which many children lived, Eder argued that the state could provide

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805 Tucker, Nervous Children, 15.
807 Quoted in Young-Bruehl, Anna Freud, 101
808 Mathew Thomson, 'The solution to his own enigma': connecting the life of Montague David', Medical History 55, 1 (January 2011), 71.
services that would benefit children’s mental and spiritual self-development, with the latter seen as the higher aim of socialism. Although he syringed ears, performed tonsillectomies, and weighed babies, Eder also made notes on “the nervous traumas hidden in the starved little bodies of [his] child patients.” This new emphasis on the self and the emotions offered an alternative perspective on the advance of child welfare during this period.

The rapid growth of psychoanalysis inspired Child Guidance clinics, which started to become established across the Western world from the 1920s to treat children’s mental health. The transformation in the understanding and regulation of childhood physiological and emotional states can be seen in the context of the growth of child-centred intervention, with the development of ideas coming both from psychoanalysis and the various approaches of the so-called “New Psychology”, often in contradictory terms: the latter differed sharply in emphasis from the former, particularly over the centrality and necessity of Freud’s psychoanalytic concepts. Freud’s ideas were not completely accepted in Britain and Child Guidance Clinics usually referred to nervous rather than neurotic children. Unlike the Freudian concept of neurosis, neurasthenia or nervousness was a supposedly somatic condition, which meant that parents were freed from feeling guilt in relation to their children’s distress, a form of “cognitive off-loading” to medical technologies and the complexity of their offspring’s physicality.

In 1926, The Lancet published Millais Culpin’s essay ‘The Nervous Child’ which explored both physical and emotional factors, arguing that nerves were things that could be seen and handled, that diseases which affected these nerves could be called “nervous diseases”, but that the term “nervous” when applied to children meant something quite different. While until recently the lack of medical and psychological knowledge about human “thoughts or feelings


or emotional reactions" had made that when these processes were disturbed experts put these disturbances in the category of bodily events, these nervous signs in fact had nothing to do with nerve tissue, but with unconscious cognitive activities and psychological traumas. Culpin’s perspective on nervousness suggests how broad the influence of psychoanalysis and the idea of the unconscious was: nervousness was an “uncalled-for emotion” beyond the child’s control and awareness. “Nervousness can produce physical symptoms”, Culpin argued, claiming that the sequence had been seen the wrong way round, with nervousness regarded as being caused by the physical complaint when it was the emotional pain that caused the physical trouble. Thus for Culpin, the theory of the unconscious was essential to understanding children neuroses, although he continued to use the term “nervous” rather than adopt “neurotic”. Thus, symptoms such as vomiting, headaches, and back pain arose from a “difficulty of adjustment” and “may be used as a means of escaping that difficulty and thereby become perpetuated”. Even a mental symptom such as night terrors served a purpose, that of “enforcing the presence of a loved person.” Therefore children’s neuroses and the bodily signs that accompanied them were symptomatic of psychological trauma.

Pain and mental illness in neurosis

After the First World War, pain and psychological illnesses began to be related to the field of studies of childhood in different ways. First, physical suffering was present as a clear diagnostic sign and psychogenic pain – physical pain caused by mental, emotional or behaviour factors or increased or prolonged by them – played a central role in debates about neurosis in children.

Already by the end of 1923, Margaret Lowenfeld had obtained a Medical Research Council scholarship and the Muirhead Fellowship which enabled her to work under Professor Leonard Findlay at the Royal Hospital for Sick Children, Glasgow, on a study on the relationship between acute rheumatism in children.

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813 Culpin, “The nervous child”, 785.
and home conditions. This study was one of the first epidemiological investigations to concentrate on illness in children and to attempt to relate it to lifestyle and material circumstances. Ultimately the study gave rise to the monograph Social Conditions and Acute Rheumatism, published in 1927. The survey confirmed a general relationship between rheumatism and the kinds of poor living standards produced by poverty, and that there was no simple hereditary mechanism involved. But Lowenfeld did not go as far as to assert that emotional life had an impact on the development of rheumatic pains. Some years later, she developed the concept of the relationship between physical and mental pain in the article ‘A New Approach to the Problem of Psychoneurosis in Childhood’, which was published in 1931. This article, which presented cases of psychoneurosis at the Children’s Clinic for the Treatment and Study of Nervous and Delicate Children, argued that “neurosis represents the reaction of the whole child to his whole circumstances.” Thus, when treating these children, various factors needed to be taken into account, including bodily constitution, physical heredity, mental capacity, emotions, and desires. For Lowenfeld, the physical constitution of childhood was quite fluid, which meant that disappointment “can be the cause of a severe rise of temperature, and the onset of organic disease can be shown, not in pain, but in depression and tears […] it is often difficult in the case of a child to separate a physical form from an emotional cause.” Unlike an adult, a child does not have a self-awareness that is separated from his or her body, so that pain is felt by the body as a whole. Furthermore, “mental and physical pain” also tend not to be separated, as “the child can give no accurate description of either”. In 1931, the English paediatrician and psychoanalyst Donald Winnicott (1896-1971) tackled the relationship between psychological suffering and rheumatic pain in his first book, Clinical Notes on the Disorders of Childhood. In this first

819 Unwin, Hood-Williams, Child Psychotherapy, 177.
820 Unwin, Hood-Williams, Child Psychotherapy, 178.
821 Unwin, Hood-Williams, Child Psychotherapy, 178.
822 Unwin, Hood-Williams, Child Psychotherapy, 179.
attempt to take account of emotional factors in the study of childhood disorders, Winnicott argued that in the case of children with rheumatism it was possible to look at the problem from "the point of view of other than rheumatic diseases." Thus, "the aches and pains" felt by these children were not rheumatic, argued Winnicott, who held that the “common pains of childhood” – whether they were felt in the thighs, in the calves, groins, loins, across the chest, in the epigastrium, in the back and in the head – “may be taken as part of the picture resulting from common difficulties in emotional development.” Such pains were closely connected to other anxiety symptoms, such as lying awake at night, night terrors, excessive sweating, phobias, and fidgetiness. He provides the example of eight-year-old Frank C., who was sent to a hospital rheumatism clinic “as a case of possible rheumatic heart diseases”. The child, a twin in a healthy family of five children, came to Winnicott’s practice with a history of recurring illness with pains. Winnicott concluded that, considering that the child did not present swollen joints – an organic injury or condition – the diagnosis was incorrect and that these symptoms and attacks were “anxiety phenomena”.

Similarly, C.L. Burns, director of the Birmingham Child Guidance Clinic, argued in his article ‘Neurosis in Schoolchildren’, published in The Growing Child and Its Problems (1937), that one of the most common symptoms of the “nervously ill” child, “is of course pain”. According to this psychologist, the distinction between the pain of rheumatism and “neurotic pain” was of considerable importance in the school environment. Thus, those pains “which come and go, which are felt vaguely in the muscles rather than the joints”, and which were not accompanied by other clinical signs of rheumatism, were more likely to be of a psychogenic type and would warn the specialist that he was dealing with a hypersensitive child.

Winnicott developed Lowenfeld’s theory further in a paper published in the 1939 Survey of Child Psychiatry, edited by Dr Ronald Gordon and published by

824 Donald W. Winnicott, Clinical Notes on Disorders of Childhood (William Heinemann (Medical), London, 1931), 66.
825 Winnicott, Clinical Notes, 66.
826 Winnicott, Clinical Notes, 66.
827 Winnicott, Clinical Notes, 67.
828 Winnicott, Clinical Notes, 67.
830 Miller, The Growing Child, 185.
the Child Guidance Council, and the very first book that used the words “child psychiatry” in its title.\textsuperscript{831} In this survey, several prominent British writers discuss the emerging clinic discipline under the special headings of physical illness, mental illness, sociologic aspects and special syndromes.\textsuperscript{832} This latter category mainly comprised sleep disorders, tics, enuresis, stammering, and sexual difficulties.\textsuperscript{833} The dialectic between the physiological and the psychological weaves its way throughout the book, from the influence of physical factors and diseases on a child’s mental apparatus to the role of the environment in the appearance of mental conditions with physical consequences. In the first section of the book, Winnicott’s paper on ‘The Psychology of Juvenile Rheumatism’ put forward a psychoanalysis of pain, suggesting that the potential depressive child had often been mistaken for a rheumatic and doctors needed to acknowledge in their practices that many of the physical pains of childhood were not rooted in the body, but in the mind and the emotions.\textsuperscript{834}

In ‘The Physiological Approach to Psychiatric Problems’, R.D. Gordon discussed whether it was possible to correlate anatomy, physiology, and physical pathology with children’s psychiatric problems. To illustrate this question, he quoted “certain cases of conduct disorder which were presumably of organic origin, followed closely organic illnesses, but which could be paralleled quite easily in any clinic dealing with psychogenic cases.”\textsuperscript{835} William Moodie, in his book \textit{The Doctor and the Difficult Child} (1941), also drew a distinction between those neuroses which were learnt, and which could be addressed through advice and teaching, and those which resulted from infection or physiological disorder.\textsuperscript{836} In ‘Hysteria in Children’ (1939), John Bowlby (1907-1990) identified

\begin{itemize}
\item \textsuperscript{831} Richard Bowlby, \textit{Fifty Years of Attachment Theory} (Karnac on behalf of the Winnicott Clinic of Psychotherapy, London, 2004), 5
\item \textsuperscript{836} William Moodie, \textit{The Doctor and the Difficult Child} (Commonwealth Fund, New York, 1947), 7-8
\end{itemize}
pain as one of the most frequent symptoms of hysteria, commenting that “as in adults the hysterical pain of childhood can almost be of any variety.” Even when some of these symptoms were acquired by the process of identification, something which made them more transitory, in children who suffer from more serious neuroses, pains may become a serious problem and, if not treated properly, “may interfere with the child’s social and school life.” Thus he mentions the case of a thirteen-year-old boy who had “four attacks of exceedingly severe pain, which caused him to scream.” Sometimes the pain was in the abdomen and other times there were “terrible pain across his eye,” which made him unable to see. Apart from these attacks of pain, the child was chronically neurotic. During this boy’s treatment, the aetiology of his hysteria was unravelled. Bowlby did not see the problem in the child’s nervous system but in the quality of his emotional life. On one occasion, the boy had accidentally smashed an electric light bulb. After his father’s death, Robert assumed that it resulted from the explosion of the broken bulb, a sense of guilt that Bowlby used to explain his symptoms: the emotional trauma had created the physical pain. Bowlby stresses the need when diagnosing this condition to look for physical causes, such as smouldering appendicitis, as well as at the child’s personality and the emotional atmosphere in the home.

The Survey of Child Psychiatry thus presents the problems of the children it describes as having been caused by a complex interaction between social, mental, and physical conditions. Furthermore, if each case was the consequence of a unique combination of such facts, then medicine was the only field which possessed the capacity to come up with a diagnosis and treatment. However, practitioners also recognised their limitations with regards to difficult cases: in some situations, psychological suffering had no apparent explanation. Thus, in ‘Psychoses in Children’, R.D. Gillespie refers to children who wish to avoid everybody, who experience short depressive phrases at least three times a year, who refuse to eat and to leave the house, and who at times “would laugh or cry without apparent reason.”

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Gillespie’s account shows how experts started to recognise the difficulty of correcting behavioural problems through education and the cultivation of healthy habits of self-control, and speaks to the gradual change from religious or moral to psycho-medical interpretations of these behaviours as deviations of healthy emotional development. In other words, difficult children were now no longer seen as being guilty of the illness they were suffering from and the importance of the external conditions was recognised. Causation, which until recently had been located in the nervous system, was now externalised. Psychoanalysis, in particular, considered the interaction between parents and children during early childhood to be the most important cause of neurosis. Thus, Winnicott presented “nervousness” as the expression of a neurotic child or one with an Oedipal conflict.842 In ‘Personality Deviations in Children’, Clifford Allen of the Institute of Medical Psychology argued that the path to the development of an adequate personality in a child was a “slow, painful and dangerous one.” 843 For this medical psychologist, certain conditions needed to be fulfilled for a child to develop a suitable personality. Among these was the need for parents with appropriate personalities, so that when the child modelled itself on them it would have a “store of reliable responses obtained from them.” 844 Given its “malleable” condition, the mind of the child was regarded as being particularly vulnerable to infection by “nervous aches and pain” or neurotic ones.

Second, if the main symptom of children with personality disorders was that of pain without any physical injury, one of the causes of such disorders could be that the child lived in an atmosphere “which has been emotionally painful to it.” 845 In not having encountered the conditions for emotional development, the intellect of these children “has never been able to show itself as it really is”, producing the personality disorder of the “sad type”, often regarded as a mentally defective child, and “treated accordingly all its life.” 846

Following Freud, the idea that the repression of traumatic experiences is at the base of neurotic behaviour ran through a good part of the period’s literature about childhood neurosis. Thus, Hugh Crichton-Miller highlighted the importance

842 Papers by Donald Winnicott, 1979, Archives and Manuscripts, Wellcome Institute GC148/21/21.
of exposing fears and addressing the dangers of emotional repression: \(^{847}\) “When we repress, a rather complicated process occurs” in which certain ideas become “for some reason painful to the conscious mind” of the child and cannot be thought of without being accompanied by “some painful emotion”. The repression of these thoughts and emotions leads to a neurotic process, claimed Crichton-Miller, for whom the repression of painful emotions was the main cause of a neurotic child. In *The New Psychology and the Teacher* (1923), the director of the Tavistock Clinic described neurosis as “the choice of physical suffering instead of mental suffering”, showing once again the dynamic complications between emotional and physiological pain, and the relationship between body, mind, and emotions in the causation of neurosis. \(^{848}\) Crichton-Miller believed that psychodynamic methodologies could prevent these first minor nervous disorders from developing into serious long-term mental and social problems.

While emphasising the role of the domestic environment in the aetiology of neurosis, Crichton-Miller also recognised that there was often more than “bad parenting” behind anti-social and undesirable behaviour in the young. He highlighted modernity, arguing in a 1925 paper that many cases of neurosis could have resulted from social changes as Britain moved from strictly defined Victorian behavioural rules and expectations to more liberal values, which created the potential for inter-generational conflict. \(^{849}\) Following this line of thinking, Paterson Brown, the medical director of the North Western London Child Guidance Clinic, considered that the development of manias and nervous habits could be caused by a process through which the child “may compensate for some painful condition in the environment, or in the child.” Some lines later, Brown noted how the “most important” and difficult-to-understand mechanisms which a child has for relieving anxiety is “seeking pain or self-punishment”. \(^{850}\)

The relationship between pleasure and pain takes us to the third way in which psychological illnesses were related to pain. In a paradoxical move that would have been impossible in the clinical tradition, the combination of trauma and recollection appeared connected to a form of pleasure that a modern reader could label as “masochistic” or “self-pity”. In *The Problem of the Nervous Child*

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(1922), the psychoanalyst Elida Evans developed this subject in the chapter "Pleasure in pain", in which she argued that “the habit of experiencing painful emotions is acquired through the pleasure which is associated with pain itself.” For this American psychoanalyst, “any discharge of accumulated vitality is accompanied with a distinct sense of pleasure”. But should the pleasure of discharge be “associated with an adventitious pain administered by parents,” a link between pleasure and pain would be established. Evans deployed this argument to criticise the use of corporal punishment, because if a child learnt to associate unpleasantness with duty, “he is not only given a mental twist which makes him see everything wrongly, but one which prevents him from acting wholesomely in every most intimate relation of a later love life.” She comments that “it cannot be too strongly emphasized that the pleasurable emotions are the creative ones, which build up, or furnish the most favourable conditions for building up, the tissues of the body and thus making for both mental and physical health,” while “the unpleasurable emotions are destructive and make for both physical and mental illness.” Hence, consequences for both physical and mental health in children were established for the negative emotions generated by physical pain inflicted by parental authority.

The theme of negative emotions and their repercussions would be developed in the United Kingdom by Melanie Klein who, initially inspired by Freud, developed her own theory of Object Relations, creating a new school of psychoanalysis. In Kleinian theory, the maternal figure represents a world that is satisfying and frustrating to the infant at the same time. The frustration – when hungry, for instance – arouses “sadistic feelings” and impulses directed to “his external object”, the mother. Klein believed that children should be allowed to express their aggression and violent fantasies and that, to enable this,

852 Evans, The Problem, 30.
853 Evans, The Problem, 30.
854 Evans, The Problem, 45.
855 Evans, The Problem, 30.
it was important for the analyst to tackle the subject of early hatred of the mother. She also suggested that guilt and anxiety, though often manifesting as aggressive behaviour, could also be an unrecognised problem in apparently well-behaved and docile children.

Winnicott, too, acknowledged the importance of Freud’s instinct theory and agreed with Klein that psychoanalysis needed to go further in examining the pre-verbal, pre-Oedipal phase of development. But he also rejected some of Klein’s ideas (on the death instinct, for instance) and developed his own model in which the psychic pain of psychopathology is caused by the failure of the earliest environment, and the vagaries of emotional growth are overcome through the internalisation of a “good enough” psychic environment. Winnicott’s celebrated article ‘Hate in the countertransference’ (1949) portrays hate as a developmental achievement rather than (as Klein would have it) an affect emanating from the death instinct. Winnicott emphasises the responsibility of the mother’s ordinary devotion towards her infant that will facilitate good enough development.

One of Klein’s beliefs was that infants are beset by the fear of being destroyed or losing loved ones and that this preoccupation with destruction and death is expressed in children’s play, where anguish is expressed towards the external object. In ‘The Nursery as a Community’ – published in the book On the Upbringing of Children, edited by John Rickman – Susan Isaacs (1885-1948) returned to this theme, arguing that neurotic aggression was produced in the child who had felt detached from his mother who “thus [became] to him[self] almost entirely an object of disappointment and pain”. Isaacs’ important work will be discussed in the next chapter.

The child then resorts to an excessive hate and defiance against the “internal pain or remorse and guilt,” projecting this aggression towards the being that he loves, his mother. A year earlier, in a lecture entitled ‘Rebellious and Defiant Children’, Isaacs showed how children who displayed a tendency to enjoy

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inflicting pain on others had “a special sensitivity to those issues of love and hate, hidden behind their outer shell of apparent hardness and lack of remorse.” Thus, “the pain and frustration” for the child of hating the person whom he loves is almost unbearable, and is lessened or removed by the aggressive expression of inflicting pain upon others. Like Winnicott and Melanie Klein, Issacs outlined a psychoanalytic theory in which the interplay between body, mind, and emotions can be extremely complex, collapsing the distinction between physical and emotional pain.

Conclusion

Historians of childhood have recently paid attention to the question of the relationship between body and mind from the perspective of diachronic change. In their influential text, “From Bodies to Minds in Childcare Literature”, Cathy Urwin and Elaine Sharland made a stark division between mind and body, the physical and the psychological, by arguing that in the United Kingdom between the wars there was a shift “from bodies to minds” in perceptions of children and childhood. By extending this line of argument to the history of pain, this chapter has questioned the extent to which one can apply a clear distinction between the suffering of the body and that of the mind. It has also explored the intertwining of somatic and psychic pain, the boundaries between which are anything but distinct.

This chapter is predicated on the premise that this transition from bodies to minds was not a sudden “paradigm shift” but rather a slow and sometimes tentative process of change. It has argued that the history of nervous pain (painful symptoms without lesion that are located in the body’s nervous system) and the history of psychogenic or unconscious pain (where the same symptoms were understood on the basis of a psychological localisation in the mind) took place in parallel, across separate but coexisting disciplines. In line with the preceding chapters, this chapter has shown that pain is a concept with multiple meanings that is interpreted by different communities through social practices and rituals that can coexist at the same historical moment. Thus, very different

864 Isaacs, The Nursery*, 187
diagnoses can be made based on the same symptoms depending on whether they are observed from the perspective of neurology, paediatrics, child psychology, or psychiatry. Leading neurologists such as Thomas D. Savill, who subscribed to the general principles of the anatomo-clinical tradition, generally dismissed the idea that pain could exist without material lesion and postulated a “seat of disease” in the nervous system for many kinds of pain without apparent lesion. However, paediatricians such as Hector Cameron and psychoanalysts such as Donald Winnicott came to believe that a psychological illness could cause physical pain unrelated to physical injury – so-called psychogenic pain. Those psychologists and psychoanalysts who, starting from the First World War, studied the subject of psychogenic pain did not work on the basis of a mind-body dualism and did not trace a clear dividing line between body and mind. Like neurologists, they also found extensive evidence that physical pain could not only accompany or exacerbate psychological illness but could also, in some cases, cause it.

The identification of “uncaused symptoms” and their adscription to a scientific nomenclature created a conflict between the predominant anatomo-clinical tradition, and the emerging theories of psychoanalysis, which each sought to understand illness and childhood. While the former still applied the principle that there were correspondences of a morphological nature between symptoms and organic lesions – even to the extent of making ad hoc adjustments to explain an invisible lesion in order to maintain the principle intact – the latter had no hesitation in dropping that principle and shifting causation to the dangers of development amid environmental pressures. However, for psychogenic pains to appear in the study of childhood nervous conditions, it was first necessary that the illnesses were defined by means of functional accidents that led to forms of somatisation or behavioural patterns of a psychological origin. Thus, while running in parallel, the physiological discourses on “nervousness” may have been a major condition for the possibility of conceiving psychoanalytical discourses on “neurosis”.

Concerning childhood, it was necessary that the symptoms of the young patient were studied within a medical and psychological framework specific to infancy, rather than on the basis of theories about adult constitutions. While neurologists studied the figure of the child in relation to the adult, paediatricians
sought to expand their focus to include psychogenic as well as somatic pain, thereby creating new diagnostic models that went beyond those of the neurologists. Meanwhile, psychoanalysts, like paediatricians, studied childhood neuroses from within their own theoretical and diagnostic framework. We should not forget the importance of the figure of the child in the field of psychoanalysis and the Freudian idea that adult neuroses had their roots in childhood traumas. Thus, following the nineteenth century Wordsworthian idea that “the child is father of the man,” a double process came about in which childhood psychoanalysis was promoted as a way to understand adult neuroses, while at the same time adult patients were encouraged to regress to their childhood to solve their problems.
CHAPTER SIX

Traumatic pain: air raids and separation (1938-1945)

Introduction

In March 1941, Patrick, “a boy of three years and two months, of pleasing appearance, well built and rather big for his age,” was sent to the Hampstead War Nurseries – set up by the exiled Viennese psychoanalyst Anna Freud in 1941 to provide foster care for child victims of the war –after a previous attempt at evacuation to the country had proven unsuccessful. The little boy had started to wet the bed and, as a result, the billet to which he had been sent during the Blitz “would not keep him” and he had to return home only a couple of days later. Unfortunately, the reunion with his mother did not last very long. Soon after his return, Patrick went down with measles, forcing a second separation from his mother. After he recovered, the mother took the child to Anna Freud at the Hampstead War Nurseries. Leaving him there, she told him to behave like “a good boy” and said she would come and visit him, but only if he promised not to cry. As in many other similar clinical cases, “the state of affairs that developed after she left ‘was a most unhappy one’.” Young Patrick struggled to keep his word. He did not cry, but he kept nodding his head and repeating a litany, saying that his mother “would come for him, she would put on his overcoat and would take him home with her again.” After a couple of days, the nodding became more compulsive and Patrick started to add to the list of clothes his mother would bring: “She will put on my overcoat and my leggings, she will zip up the zipper, she will put on my pixie hat.” A worker at the clinic urged the boy to change his attitude, so – trying to comply with his mother’s demand that he behave like a good boy – Patrick stopped repeating the formula aloud. But the small movements of his lips demonstrated that the compulsion had not ceased. Soon the spoken words were replaced by “gestures that showed the position of his pixie hat, the putting on of an imaginary coat, the zipping of the zipper etc.”

Finally, Patrick entered a state of nervous compulsion, with a weak and rapid pulse, with no interest in the outside world and “with an absolutely tragic expression on his face.”

Anna Freud and Dorothy Burlingham thus described, in their 1943 book *War and Children*, the shock they felt on seeing an apparently healthy and “normal” boy develops a “compulsive tic” in front of their very eyes. For the exiled Viennese psychologist, who was among the first to document how children suffered when separated from their parents during the war, Patrick’s trauma was directly related to “the pain of separation”. Like most of the literature coming from the sphere of psychoanalysis, *War and Children* was based on the assumption that, if essential needs are not met – such as “the need for personal attachment, for emotional stability, and for permanency of educational influence” – then it is probable that there will be lasting psychological malformations. While the general consensus was that the conditions imposed by the war upon the lives of children would cause lasting bodily malformation in later years, according to Freud and Burlingham, “it is not generally recognised that the same is true for the mental development of the child.” Based on this argument, and combining clinical cases with theoretical suppositions, Freud and Burlingham offered a study that went beyond the material and physical effect of the war on children to consider the impact of loss, separation, and familial break-up on the emotional and psychological development of young children.

This chapter deals with the emotional pain inflicted on children in the UK during the Second World War through the forced evacuation of the underage urban population to rural areas. The topic of evacuation represents a continuation of Chapter 5, because it was psychoanalysis – thanks to the work of some remarkable pioneering women who had been directly influenced by Freud’s practice, particularly during the First World War – which proved to be the medical discipline most able to address the complexity of the problem in its different layers, including social policy, national health, and civic education. If psychoanalysis decoded the figuration of the evacuee, the Second World War proved to be the moment of consolidation for the new discipline. Several

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historical studies have investigated the evacuation schemes and the experiences of children who were relocated. Prominent among these are Richard M. Titmuss, John Macnicol, John Welshman and Jennifer Crane. But while the topic has been widely explored because of the importance of the Second World War, the visible results in social policy, and the catastrophic consequences of evacuation, so far no scholar has seen the issue from the perspective of the suffering of the evacuated children, and how that suffering was framed by the different scientific and medical communities involved.

This chapter is organized around two themes. First, it explores how the sight of children’s suffering – the aesthetics of pain – was used in different ways by the authorities. The second section contrasts such official discourse on children’s suffering with the different ways that the child’s body was rendered in two main domains: traditional medical discourse and psychoanalytic theory and practice. This part of the chapter first surveys the socialised making and remaking of the child image during this agonising wartime period, focusing on the forced evacuations, which were conceived of as a preventive action against the bombings. As Mathew Thomson has argued, the literature of “total war”

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provides two powerful and contrasting images that have frequently been deployed to illustrate what became the dominant narrative of Britain’s war. On the one hand, there is the evacuee, distraught and abused, torn from home and family. On the other, there is the child of the Blitz, playing in the ruins of the city, a symbol of hope and defiance amid destruction.\textsuperscript{874}

This part provides an analysis of the child in Second World War Britain: “the bombed child”, who suffered the physical and mental trauma of the air raids, and “the uprooted child”, who was evacuated away from the bombed cities to rural “safety” but who suffered the pain of separation. These categories overlap: the threat of the bombs was a pervasive danger that inflicted significant psychological damage on children, especially when separated from parents and relatives left behind in the cities that were being bombed. The figure of the uprooted child is explored not only in the medical literature, but also in political discourse and propaganda. In contrast with the debates between different medical professions covered in earlier chapters of this thesis, the discussion on the uprooted child actively engaged public opinion and was closely monitored by—sometimes entering into conflict with—politicians and policymakers. While psychoanalysts saw an image of fragile children suffering from emotional disturbance because of both the bombs and the policy of evacuation, certain social groups in the rural areas that received the evacuees saw only unruly urban children who spread diseases through their dirty habits, and still other circles of opinion saw the same children as victims of poverty and social injustice.\textsuperscript{875}

The chapter then goes on to examine the resulting texts, how they relate empirically to the compiled data, and considers the scientific discourses that framed the understanding of emotional damage from these two different, yet interwoven causes: bombing and separation. Through literary readings and explorations of the scientific and medical discourses of the era, this chapter aims to reconstruct the controversy over the consolidation of the child with emotional pain as an object of study in psychology, psychoanalysis, and medicine. This process involved evaluation, normalisation, symptomology, inclusion in a

\textsuperscript{874} Thomson, \textit{Lost Freedom}, 1-21.
\textsuperscript{875} Sarah Hayes has argued that by 1927 a medical model had developed in Britain relating to maladjusted children who consisted of two polarised categories of children: psychological ‘rabbits’; and delinquent ‘rebels.’ See ‘Rabbits and Rebels’ in Mark Jackson (ed.), \textit{Health and the Modern Home}, 128-52.
taxonomic system, and, finally, attribution of diagnostic value. It started with evaluating signs, which were then converted into symptoms on the basis of which the new medical category of separation anxiety was created, leading in turn to diagnoses of children as suffering from this new illness and to the creation of a new diagnostic category: the child with separation anxiety.

However, there was disagreement about this new diagnostic category, extending the debate over somatic and psychogenic conditions that has been analysed in the previous chapters. Doctors debated whether the physical shock of the bombs provoked psychological disturbances or whether it was the other way around – that the fear and anxiety provoked by the bombing caused organic illnesses. Meanwhile, psychologists and psychoanalysts argued that evacuated children may have been saved from physical harm but they had also been subjected to considerable emotional harm as a result of separation from their homes and family, and in particular from their mothers. Psychoanalysts used their reflections on the nature and consequences of the pain of separation as part of a project to legitimise psychoanalysis as a discipline that could serve the purpose of preserving healthy citizens and their contributions to the democratic regime. A comparison of the discourse of doctors, psychoanalysts, and psychologists shows the depth of disagreements about the extent to which children were affected when separated from their mothers, the relationship between the age of a child and the development of a neurotic behaviour, and symptomology. This diversity of opinion is reflected even more in the analysis of the problems related to the classification, causality, and metrication of signs through which separation anxiety was woven. Similar symptoms provoked different diagnoses, depending on whether they were observed from the position of paediatrics, from the view of exiled continental analysts, such as Melanie Klein and Anna Freud, or by native analysts such as John Bowlby and Donald Winnicott.

Thus, Patrick’s case was read and understood in different ways by different interest groups and scientific bodies. By considering the child’s appearance and how these same symptoms were seen across a range of other cultural sites – such as psychoanalysis and medicine – this chapter argues that the expression of children’s emotional suffering, represented chiefly by signs such as enuresis and behavioural problems, was subject to different interpretations depending on
the different professional bodies invested with the performative authority required to shape its meaning. Thus, there were those such as the Tavistock Institute psychotherapists Theodora Alcock and W.E. Mons who saw these symptoms as indications of “war strain” or “air raid shock”, a form of stress reaction that today might be diagnosed as post-traumatic stress disorder. At the same time, psychoanalysts interpreted the very same symptoms as indicating separation anxiety.

This chapter argues that the new psychological category of the child with separation anxiety was yet another form of disciplinary objectification. While there was rarely a treatment, this category allowed the children to be catalogued and both their public behaviour and private experience to be studied. The following pages define the historical and sociological context of the discussions about separation anxiety in relation to two axiological institutions: family and democracy. While the emerging role of psychoanalysis served the conservative function of preserving the centrality of these two central constructs for social coexistence, it also changed quite radically the notion of a normally functioning individual and the nature of social bonds, serving as an ancillary discipline to the emergence of social democracy. The chapter reconstructs the controversy over the impact of the Second World War on children’s mental and physical health, exploring how children’s signs of emotional pain – enuresis, anxiety, bad habits – were conceived, conceptualised, contested, and diagnosed.

At the same time, a dialogue is established between the sources used by social historians interested in the “slum mentality” of the evacuee and those used by cultural historians and historians of psychiatry interested in the genealogy of separation anxiety, thereby highlighting the coexistence of two different figurations of childhood during the Second World War, both based on the figure of the evacuee. On the one hand, there was the dirty, ill-trained child whose symptoms were framed within the myth of the “slum mentality”; on the other hand, there was the “uprooted” child, whose symptoms reflected a deep

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emotional pain. Yet both figurations were constructed on the basis of the same bodily signs. The different accounts of the symptoms and their inclusion in competing taxonomic systems produced a conflict between rival cultural and social visions of childhood.

In addition to scientific and psychoanalytic sources previously analysed in published works that reviewed the crystallisation of theories of attachment as a result of The Second World War and the evacuation policy – based around such key texts as the *Cambridge Evacuation Survey* (edited by Susan Isaacs) and Anna Freud’s writing – the preparation of this chapter required an extensive literature review of psychological, medical, and other relevant publications on children evacuation, beginning with Katherine M. Wolf’s *Evacuation of Children in Wartime – A Survey of the Literature, with Bibliography.* The aim has been to access perceptions from beyond the higher reaches of psychoanalysis (the likes of Anna Freud and John Bowlby) to include other perceptions of children’s pain, from lay figures as well as specialists. Journals such as *The Lancet, The British Medical Journal, British Journal of Sociology of Education, Journal of Mental Health, The Nervous Child,* and *The British Journal of Educational Psychology* were consulted.

The story of separation anxiety has been written in the context of the “subjectification” that took place in psychoanalytic practice around the time of the 1939-45 war. In fact, a key aspect of what Foucault referred to as “subjectification” was precisely the representation of childhood, motherhood, fatherhood, parental conduct, and family life through expert discourses which “infuse[d] and shape[d] the personal investments of individuals,” This took place not only through government institutions but also through the media of books about childcare, radio broadcasts (an area worthy of further research), and women’s magazines, as well as through mothercraft training.

Some social and cultural historians have investigated the profound interest provoked by the mother-child bond during The Second World War and the post-

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Some of these studies referred to the socio-political interests that underlay the confinement of women to domesticity and maternity, the personal interests guiding professionals, and the cryptic nature of the language of psychology, with its jargon expressions such as “maternal deprivation”, the “bond” between mother and child, and “maternal instinct”. Feminist historians have wrestled with the legacy of some of the psychoanalytic theories that were developed during this period, which seemed to load the collective responsibility for the emotional sanity of the social fabric onto the mother-child dyad. As Juliet Mitchell has noted, the effect of locating the remedy for social ills in a heterosexual, two-parent family, with a traditional division of labour according to sex and with a separation between the private, feminine world of care and the public, masculine sphere of business, “the developments of child psychoanalysis contributed very neatly to the political demands of the epoch.”

Historians have also portrayed the evacuation policy as a defining point in modern British social history. According to James Hinton, placing urban working-class (and often impoverished) children in the countryside “involved the negotiation of profound cultural differences, not only between town and country but also between class and class.” Discussing the attitudes of the Women’s Voluntary Service, an important voluntary organisation, he further argues that the “rifts and chasms of Britain’s social fabric revealed by the early experiences of evacuation had long-term consequences for both working-class and middle-class perceptions of social inequality.” Sonya Rose similarly claims that evacuation process “produced a discourse concerning ‘the social question’ that underscored the dire consequences of urban poverty and brought national attention to its victims.” It also highlighted, in her view, the “focal point between what were

880 Angela Davis, Modern Motherhood, Chapter 5.
881 Denise Riley (1983) notes that feminist interpretations of ‘Bowlbysim’ have taken it as no coincidence that after the war childcare facilities for the children of working mothers were withdrawn at the same time as Bowlby’s ideas were widely promulgated. Denise Riley, War in the Nursery: Theories of the Child and Mother (Virago, London, 1983).
imagined to be two opposing ways of life – urban and rural." The historian of childhood Harry Hendrick remarks that evacuation was “one of those rare moments when prejudice, mainly shaped and articulated by sections of the rural and small-town middle class, unveils itself unashamedly.”

Some recent studies have examined the centrality of theories of attachment to the constitution of the democratic project during The Second World War. Hendrick has argued that “the specific issue of hospital visiting became one of the areas where ‘separation anxiety’, as a psychoanalytic condition in young children, was held to constitute a direct threat to national fitness” and to the idea of the democratic subject. He is not the only one to have drawn such a conclusion. Michal Shapira has recently investigated, in The War Inside, how the major social function for psychoanalysis at this time was to educate British citizens in the effort of recognising and managing the “war inside”, which was seen as a fundamental element of human nature that was also a mirroring experience of the external engagement of democracy against the barbaric forces of totalitarianism. Shapira argues that the mental health and psychology of young children gained extraordinary importance during The Second World War, as “psychoanalytic experts made the understanding of children and the mother–child relationship key to the successful creation of social democracy.” Both Hendrick and Shapira are right with regard to the fact that expert discussion turned its focus to the mental health and psychology of children, yet it is important to note that the figure of the child in pain during The Second World War was not an exclusively nor predominantly a scientific figuration. Instead, the sciences – whether medical science or the newer psychological and social sciences – drew on wider cultural domains to which they also contributed and sometimes contradicted. Attention to the actual symptoms of separation anxiety in connection to the different renderings of the child body in psychoanalytic practices, British medicine, and social discourse and welfare during The Second World War is a novel contribution of this thesis to the academic debate.

887 Hendrick, ‘Children’s Emotional Well-being’, 213-42
888 Shapira, The War Inside, 1-23.
889 Hendrick, Child Welfare: Historical, 149-176.
Pain as propaganda

The cover of the north-American magazine *LIFE* published on 23 September 1940 would not take long to establish itself as one of the great icons of the battle against the giant of the Third Reich. In the picture, a little girl clutches a worn-out stuffed toy while staring straight at the camera in an innocent, slightly sad, almost heart-melting way. The text which accompanies the photograph articulates the narrative and renders the story possible. “The wide-eyed young lady on the cover” is Eileen Dunne, a young victim of the Blitz who is recovering from her injuries in a bed in a hospital in the north of England. “A German bomber whose crew had never met her dropped a bomb on a North England village” and “a splinter from it hit Eileen”. A “plucky chorus of wounded children” had just finished singing “Roon, Rabbit, Roon” [a northern-dialect version of “Run, Rabbit, Run”], when the British photographer Cecil Beaton released the shutter of his camera, immortalising the image of Eileen and of many other British children who lived through the Blitz (Figure 13). At the time the photograph of Eileen was published, Winston Churchill’s Ministry of Information, a fully propagandistic instrument of the government, was behind Beaton’s commission to furnish a positive photographic representation of the struggle on British soil. At that moment, the country was losing the propaganda war against a very well-organised German machine and needed artists who could transmit the pain of military violence and the struggle of the British people through the media of mechanical reproduction. His photographs, which tried to reflect the devastation of the Blitz and the capacity for resistance of ordinary British people, were published in pamphlets and magazines that were distributed both nationally and internationally, as objects of information and consumption.

891 *LIFE Magazine*, 23 September 1940, 21.
892 *LIFE Magazine*, 23 September 1940, 21.
During these years of strife, Kenneth Clark, the director of the National Gallery, established a consultative committee of artists which, for the purposes of propaganda, built up the myth of the Blitz. Created with the blessing of the Ministry of Information, the War Artists’ Advisory Committee (WAAC) sent artists – from painters and printmakers to photographers – to the cities in flames. The ministry believed that the work of the artists would leave a valuable testimony of the difficult times, and that they would in turn give moral support to the British public. The artists and photographers of the WAAC had to portray all that was interesting, from the point of view of propaganda in the UK and in neutral
countries, for the history of art, or for military history. To achieve this, Clark relied on certain guidelines which tried to determine what should be photographed and the way in which it should be done in order to fulfil each of the Ministry of Information’s objectives. Ideas for commissioning pictures of bombed buildings were promoted, especially during 1940, as well as photographs of children and civilians suffering and enduring the consequences of the Blitz. According to a letter published in the British magazine the Connoisseur (1940), such images were both a “permanent record for posterity” and propaganda aimed at the American public, “whose sympathy with Britain’s cause is growing daily, [and who] would have the opportunity of seeing exactly what the enemy has done to our symbols of mutual culture.”

One of these missions led to Cecil Beaton’s visit to the north of England and to his picture of Eileen Dunne. Published more than a year before the USA entered the war, this moving photograph was one of the most potent examples of visual propaganda produced during those years. The image was widely reproduced in pro-war media in the USA and became an icon of the call for help from the United Kingdom to its brothers and sisters on the other side of the Atlantic.

Two days before the publication of LIFE magazine, the Illustrated London News published, on its inside front cover, a slightly different version of the Beaton photograph (Figure 14) In the LIFE photograph, Eileen held the toy forcefully pinned to her body, carrying the pain with stoicism and showing a much more traumatic experience of the Blitz, indicating that there was no justification for the child pain and suffering.

The second image, in contrast, did not present a girl tormented by physical suffering but an icon more in line with the normative representation of romantic childhood. The photograph published in the *Illustrated London News* transmitted a much more combative message, reinforced by the caption: “Bombers Prey. Goering’s attacks on London achieve little but the maiming and slaughtering of
In this way, while the photograph published with the title “Air raid victim” made visible the pain of the child, seeking to make the American population aware of the effects of the Blitz and its impact on the civilian population, the image directed at the British public had a slightly different message: despite children’s suffering, Great Britain would never surrender. This message fitted perfectly with the policy adopted some time earlier by the Ministry of Information, which consisted in creating and maintaining myths through which the British would continue to be committed to the war effort. In his diaries of the war years, The Years Between, Beaton explained his motivation in taking his photographs: “Besides the vandalistic damage we must show the tenacity and courage of the people and we do not have to look far.”

With the advent of aerial warfare, civilians – typically defined as women and children by contemporaries – became primary war targets. The Times reported on April 28, 1941 that Winston Churchill had spoken in his latest broadcast about this home-front battlefield in and around London. The prime minister reportedly said:

“The sublime but also terrible experiences and emotions of the battlefield, which for centuries have been reserved for the soldiers and sailors, are now shared for good or ill by the entire population. All are proud to be under the fire of the enemy. Old men, little children, the crippled, the veterans of foreign wars, aged women, the ordinary hard-pressed citizen [...] the sturdy workman with his hammer in the shipyard or who loads the ships, and the skilful craftsman, the members of every kind of A.R.P. service, are proud to feel that they stand in the line together with our fighting men.”

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895 The Illustrated London News, 21 September 1940, 3.
As the hinge at the centre of Churchill’s long list of citizen soldiers, which ranges from children to air-raid wardens, is the ordinary citizen whose key role in the war effort is thereby emphasised. As with the publication of the photograph of Eileen Dunne, the effect of Churchill’s rhetorical placing the full range of non-combatants on the front line along with traditional combatants is to highlight civilian spaces as a primary location of combat.\(^{898}\) The photograph of Eileen Dunne is one of many notable depictions of civilian suffering during The Second World War. However, in both its versions – even with the second’s direct reference to “mutilated and slaughtered children” – the photograph hardly registers pain. The artificiality of the images is even more evident if they are compared with photographs of injured children in hospital taken by the British press. The idea that children were under attack fuelled resentment that had to be carefully managed to make sure that it was aimed against the barbaric enemy rather than against a state that could no longer protect its own civilian population.

The photograph of Eileen Dunne was commissioned as part of the Ministry of Information’s propaganda activities. Its main objective was to present the British cause in a way which both provided information about the war effort and boosted public morale. The main thrust of wartime literature after the start of the Blitz was the maintenance of public morale by using positive – but never false – propaganda to put the best possible light on a Britain that was “taking it” and surviving the German onslaught, and children played a central role in this dramatisation.\(^ {899}\) Given that the child’s face functions here as a symbol of collective resistance, her pain must be represented according to a series of norms and moral conventions.

The contradictions inherent in the presentation of a real image that also functioned as a kind of icon to strengthen public morale forced Beaton and other photographers to adapt the conventions of studio-portrait photography to create what could be considered as a false world of injured children.\(^ {900}\) In the photograph, the injuries provoked by the war are represented through the

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900 For a discussion on the relationship between portrait photography, medicine and war see Sheehan, *Doctored*, Chapter 1 and Chapter 2.
bandage that the girl wears around her head, one of the most common conventions for the iconography of the wounded since World War I. The spectacle of children’s suffering could not reflect the actual severity of the lived experience. Actual injuries, broken bones, bleeding, and similar displays of bodily damage were never displayed at the time, in accordance with socially accepted sensitivity. Far from reflecting reality, this form of representation constructed an iconic model with highly pedagogic and propagandistic content. This guided manner of representation of the damage to children would remain engraved in the collective imagination. Eileen Dunne was not the only child captured by Beaton’s lens. Her portrait formed part of a series of photographs taken in the children’s ward in a hospital in the north of England (Figure 15).

Beaton made another series, featuring children in Great Ormond Street Hospital in London, which had – as this thesis has already shown – a longstanding tradition in the social utilisation of child photography. Only three of the twelve children portrayed in these two series displayed signs of the wounds of war. However, it is not surprising that it was one of these images that should end up as representing the struggle of Great Britain against Germany. The power of this iconography – and, in particular, of the photograph eventually chosen, that of Eileen – resides in its capacity to combine notions of innocence and suffering. The photograph contains a group of signs proper to the middle class, which helped to awaken the empathy of those to whom it was addressed. At the same time, through the wound of the war, little Eileen embodied not only the experience of civilian victims of the Blitz but also that of all those who were fighting in the war. The pain of little Eileen became an icon of Britain’s fight against the destruction of national-socialism. Over time, it has become one of the most recognised symbols of British civil resilience in wartime.


Roberts, Cecil Beaton: Theatre of War, 25.
As with the photograph of Eileen Dunne, media coverage emphasised the victimisation of children to highlight both the cruelty of the war and the
vulnerability of civilians under the new warfare. At the heart of these photographs is the confidence that this material would convince decent people that the war had to stop, because the end to the conflict would return the most innocent – the children – to their true nature, that of childhood. News accounts showed the effects of the air raids on British children and supported the representation of children’s behaviour mainly as a form of stoicism. On 20 September 1940, The Times told how London was carrying on its daily life despite “destruction wrought by the blind and wanton night attacks of German bombers,” pointing out that the bombs had fallen on “humble suburban homes” and “a maternity hospital.”

Reports of attacks on Merseyside focused on the heartrending story of a four-month-old child who survived in a drawer for 25 hours amid the wreckage of a home where the rest of the family had been killed by falling debris. In the film Christmas Under Fire (1941), “brave little Englanders” were portrayed as defying the Blitz and the privations of war to celebrate Christmas. Press coverage of “Gas Mask Sunday” was nearly unanimous in emphasising the calm that prevailed as families lined up to be given gas masks.

These accounts, like the photograph of little Eileen, portrayed children as living examples of endurance and recovery. Her portrait also showed how pain should be endured. In a normative way, these photographs expressed how children and civilians were expected to behave when in pain, and how they ought to cope with the material consequences of war. That, at least, was the public message. But not everyone agreed with the image that the government and proponents of the myth of the “People’s War” wished to present as a way of boosting morale and encouraging volunteer efforts. While these accounts suggested that children coped surprisingly well with the war and air raids – emphasising the stoicism and good morale exhibited by these children – war generated many alternative responses in the minds and bodies of children.

Beaton’s image of Eileen Dunne and the childhood she represented was read in different ways by different interest groups and scientific bodies. While the government projected a symbol of British resistance and civilian courage,
psychoanalysts saw a much less positive image of fragile children suffering from emotional disturbance as a result of both the bombs and the subsequent process of evacuation. The Second World War, the Blitz, and the evacuation experience produced extensive literature (psychoanalytic and non-psychoanalytic) about its impact on children. While non-analytic writers tended to adopt a straightforward, descriptive tone, psychoanalysts offered more thorough, portrayals of inner life. Their complex theoretical frameworks offered new ways to understand the dynamics of fear, anxiety, and aggression in children who has been separated from their families, while also showing how such children could pose a potential threat to the functioning of a democratic society.  

*Writers from various perspectives talked about the problems created by evacuation and by the air raids, yet at the top of the list – as we shall see – were always enuresis and anxiety. To put this in its context, the huge scale of the evacuation and the conflicts it generated between different social groups need to be understood.*

**Psychoanalytic discourse versus government propaganda**

The outbreak of The Second World War produced an extensive literature on the connection between childhood and democracy, with claims such as: “While we are making a world safe for democracy, we must preserve in children readiness for democracy – these are the people in whose hands the new world order will be moulded.”  

*Psychoanalytical theories on children’s psychological development and the role of the mother within were framed within broader debates about the meaning of democracy and the need to deal with aggression in the age of total war.*  

*By arguing that healthy family dynamics during childhood and – more importantly – the formation of a good bond between mother and child were seen to safeguard British society from barbarism and fascism, “psychoanalysis informed new and changing understanding not only of individuals and their health, but also of broader political questions in the age of*
mass violence and mass anxiety.”

Through the work carried out by the clinics and institutions created to receive these uprooted children, psychoanalysis positioned itself as the science that could resolve the problems of abnormal children and, by raising “democratic” citizens, thereby reduce their potential risk to the community.

Thus, war proved to be a turning point in the history of psychoanalysis, as planners saw the need to understand the mechanisms of mental health and the dynamics of early childhood relationships in order to prevent submission to authoritarian leaders. The claims of psychoanalysts that all modern selves have destructive drives that should be studied and controlled became increasingly widespread in circles of official planners and the public. Michel Shapira has pointed to a process whereby the ideas and practices of child psychoanalysts had a wide impact on public opinion and social policy, by creating a new relationship between the state, the family and the child. These experts in children’s mental health targeted the child’s psyche as a site for expert knowledge and mediated ideas regarding citizenship, democracy, and the family that had very real implications for public debate and social policy. Even though analysts collaborated with other experts, state officials, and citizens in the war effort and in the post-war development of the welfare state – influencing social policy and public opinion – the narrative that emerges from psychoanalytic practice was highly critical of the policy of evacuation. For these experts, the mass evacuation of children from major urban areas meant that “billeted” children were saved from physical harm, but not from the emotional consequences of separation from home and family. Against this background, it was not simply the nature of human aggression and human love that was at issue but the social and political implications of how these emotions were handled in political decisions and practices.

But government policy throughout the war remained impervious to criticism from specialists in psychology of the evacuation policy and the residential

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910 Shapira, The War Inside, 2; Angela Davis, ‘British child psychology and the evacuation’, 1-2.
912 Urwin and Sharland, ‘From Bodies to Minds’, 89.
children’s hostels. In the mass evacuation of mothers and children from the cities, the Ministry of Information never addressed the psychological consequences and avoided representing evacuees’ suffering in photographic and propagandistic discourse. Clark and his WAAC colleagues chose not to portray the material and psychological consequences of the evacuation. The ideas and practices of John Bowlby and his colleagues were far too critical of the government to gain visibility and understanding outside the professional psychoanalytic and psychiatric communities.

In this way, the series entitled “The Civilian Evacuation Scheme in the Second World War” by a photographer of the Ministry of Information photo division captured the lives of children in reception homes, emphasising the cleanliness and happiness of the children portrayed, while staging a series of everyday activities whose intention was to demonstrate their adjustment to new circumstances. In almost all the photographs in the series, children are surrounded by nature and in most cases there are no adults present. The caption of one photograph – “Evacuated children from London dance happily on the lawn at the country mansion of a well-known peer. The house was given over entirely to the children” – already contains the narrative that the image seeks to display (Figure 16). In this image, the psychological distance that the children maintain towards the reasons that have brought them to the security of the camp is reinforced by the decorative arrangement of their shadows and the game they are playing. By conveying the anxiety and excitement of children as they are forced to adjust to a new way of life, the WAAC artists generated a visual rhetoric that was intended to permeate collective imagination. But the issues that were toughest for civilians – the material and psychological consequences of evacuation – were not portrayed.

913 Rose, Governing the Soul, 167.
914 The study of the photographs of evacuated children commissioned by the Ministry of Information has still to take place. For a study of paintings and sculptures on the same subject, see Foss, War Paint Art, 66-68 and Brian Frederick Foss, ‘British Artists and the Second World War’.
915 Foss, War Paint Art, 68.
Figure 6.4

Photographer unknown, *Evacuated children from London dance happily on the lawn at the country mansion of a well known peer. The house was given over entirely to the children* (c.1940), HU 69020, Ministry of Information Second World War Press Agency Print, Imperial War Museum.

However, the WAAC images of home-front children involve more than a simple denial of pain and trauma, elements which were too much in evidence to ignore. These images show British children putting themselves above their circumstances – an attitude which connects with the photographs of the bombed children, such as that of Eileen Dunne, and the myth of the Blitz. The happy, well-adjusted children portrayed by the official artists display characteristics such as resilience, courage, unflappability and humour which were part of this myth. Furthermore, by combining the figure of the uprooted child with the “we can take it” propaganda, the negative effects of separating children from their mothers was obscured, as the war itself was shown to be a grave threat to the family. In the photographs of air-raid victims, children – who can be seen as
representatives of the domestic realm—were portrayed as the main victims of the air attack, and their pain was shown in order to underline the new vulnerability of the home, and how this pain would be endured. In the photographs of evacuated children, there is room for neither physical pain nor psychological trauma, because children—and therefore Britain itself—will “take it”, overcoming the emotional disturbances produced by the war and adapting rapidly to evacuation. A hierarchy of pain was thus created, where some types of pain could be represented and others were invisible. While the physical pain of the bombs—a pain inflicted by the enemy—is resignified as a warlike discourse and resistance, the pain of evacuation—provoked by the government’s own practices—could not be shown.

Evacuation and the moral economy of children’s signs

On 9 September 1939, a leader column in the The Times Educational Supplement delivered its verdict on the first wave of evacuations: “Nor can one recall a greater piece of non-military planning than the transport and administrative arrangements which made the evacuation possible.” The evacuation of British cities at the start of the Second World War, known as “Operation Pied Piper”, was the biggest forced mass displacement in the country’s history. Already by 26 May 1938—15 months before the war began—Home Secretary Sir Samuel Hoare announced that he had invited Minister for Civil Defence John Anderson to chair an Evacuation Committee, with the aim of drawing up plans to evacuate children in the event of aerial bombing by a “belligerent” force. Air-raid precautions were needed because there were insufficient means to prevent or deter aerial attacks. Faced with the impossibility of “envisag[ing] the horrors of intensive air attack,” the satisfactory resolution of this plan was repeatedly questioned. The conservative MP Walter Elliot,

917 The Times Educational Supplement, 9 September 1939, cited in S.J. Hess, ‘Civilian Evacuation to Devon’, 66.
918 Other committee members were Sir Percy Harris, Liberal MP for South West Bethnal Green, Mr George Doland, Conservative MP for Balham and Tooting, and Dr Leslie Haden-Guest, Labour MP for North Islington. Parliamentary Debates (Hansard), Vol. 336, Col 1380, cited in S.J. Hess, ‘Civilian Evacuation to Devon in the Second World War’, (Unpublished PhD thesis, University of Exeter, 2006), 72.
speaking in the House of Commons, commented that “we cannot [...] escape from the fact that in this small and industrialised country, under the possible conditions of air warfare, safety is only relative.” Even so, members of the Committee moved towards the implementation of the plan, in the hope that events that had taken place in Spain and in China “have at least given some indication” as to what was to come and the measures to take. Circulars, albeit very general in nature, started to arrive in local districts. On 25 August 1939, Devon County Council forewarned the Town Clerk of Dawlish by telephone that the Government Evacuation Scheme would be activated on 1 September. Six days later, on 31 August, Okehampton Town Council received a telegram which read: “Most immediate Evacuation commences Friday 1 September. Take Action.” On September 1, Germany invaded Poland, triggering the official evacuations. Two days later, the United Kingdom declared war.

In a matter of days, about 827,000 unaccompanied children were evacuated from evacuated from at-risk areas in England, Wales, and Scotland to a multitude of British reception areas. The possibility that many who had been registered might change their mind had not been foreseen, causing much confusion in reception areas. As numbers were considerably lower than expected, the carefully planned train timetables became irrelevant and well-ordered school parties arriving at mainline stations were pushed onto the first available train. As a result, siblings and parties travelling together became separated in the ensuing rush to get the trains out as quickly as possible. Once the authorities saw that the expected air attacks had not materialised and that danger was no longer imminent, many of the evacuated children were able to return to their homes. In many cases, such reunions would not last very long as a second – smaller – evacuation took place in the spring and autumn of 1940. France had fallen and the first bombs of the Blitz were falling from the English skies. That same year, Cecil Beaton would take the photograph of Eileen Dunne.

922 Okehampton File 3248A/16/1-2, cited in S.J. Hess, ‘Civilian Evacuation to Devon’, 79.
924 Titmuss, Problems of Social Policy, 562.
By June 1941, the devastating aerial attacks had lessened and some children returned, for a second time, to their homes.

Although bombs did not fall in 1939, the evacuation in September of that year created the greatest expressions of concern, both among experts and in the wider social sphere. Medical journals such as *The Lancet* and the *British Medical Journal* gave details of this operation and how it was affecting children. On 9 September, the *British Medical Journal* spoke of the great efficiency with which “the evacuation from London of some 650,000 persons” has been achieved.\footnote{Editorial ‘A successful exodus’, *British Medical Journal* (September 9, 1939), 573.} After comparing the journey of “thousands of Londoners” with that of “the children of Israel, who made a much more leisurely though less comfortable exodus from Egypt,” the article – which was headlined “A successful exodus” – concluded that “the whole procedure has taken place smoothly, expeditiously, and without a single casualty.” While the tone of the article is positive and has a clearly religious tone, the final paragraph predicts what was to come: “There remains to be told, when the time comes, the story of how well the reception areas have risen to their opportunity.”\footnote{‘A successful exodus’, 573.} Despite early expressions of enthusiasm the process of evacuation faced some resistance, and there were many voices which would not describe it as a “successful exodus”.

When the bombing did not occur and people had time to reflect on the evacuation, there were criticisms of the “lack of forethought in high places, and a failure to picture the inevitable results of a rapid, wholesale migration of children.”\footnote{H.C. Dent, *Education in Transition: A Sociological Study of the Impact of War on English Education, 1939-1944* (Routledge & Kegan Paul, London, 1948), 21.} While the process of evacuation, it was reckoned, had been necessary, those who criticised the way in which it had been carried out indicated that scant consideration had been given to what would happen on the other side. Little time was needed to see that the local authorities, the teaching staff, the voluntary organisations, the host families, and the evacuees were struggling to cope with the realities of evacuation in the reception areas.\footnote{The Times Educational Supplement, 9 September 1939.} There were problems caused by differences in social provenance, as well as those of local geography or religion. These examples were only part of the mix-ups which led to tensions and disagreements between children and their foster parents.
Unlike the articles which assured that “the evacuated children were happy and were gaining in health” and that “the hosts, too, were happy,”929 many hosts were resistant to the idea of welcoming a child into their homes, given that they shared prejudices about the conditions in which the children lived and the type of influence – both physical and moral – that they brought from their urban homes.

Particularly during the first wave of evacuation, where medical checks were lax after a long summer holiday and where the “phoney war” period seemed to stifle compassion in some quarters, there were some rather lurid stories about the physical condition and the behaviour of the evacuees.930 Some general practitioners reinforced this myth, warning of such dangers as the spread of parasites, filth, and other undesirable social effects. In a 1939 editorial, in response to the ‘A successful Exodus’ article, E. Evans warned of the misfortunes and dangers faced by country people who opened their doors to children from the city. According to these doctors, parasites and the serious consequences that these entailed would spread across the whole countryside: “When evacuees arrived I was informed many were verminous. One girl volunteer told me she was struck by sores on some children she had to carry and dump on a hostess.” Evans continued, explaining that, as if this were not already serious enough, “there were women among them who soiled their beds with urine and faeces.”931 And he ended by saying that, as a doctor, he was “deeply humiliated by the lack of foresight and sympathy displayed by the Ministry of Health, which is the responsible authority in the matter under consideration.”932

Some lines below, the doctor Esther Carling argued that the plan had failed not only because of the irreconcilable differences between city and country, or the difficulties of adapting “richer to poorer, clean to less clean”, but mainly because of the failure to provide a prompt answer to a simple, fundamental question many affected individuals asked themselves: “what is my duty, where do I belong?”933 Dr Carling continued by explaining that country people had learned “by very uncomfortable contact” how the other half of the nation lived,
“and we have seen that the other half appreciates us as little as we appreciate them”. To sum up, the dominant feeling in the destination zones was that “in many cases the scum of a town has been poured into a clean countryside” with a cruel and extensive indifference towards the consequences of this action and without offering the most basic guarantees for public health.934 “There are limits to what people will stand,” commented another article below, adding that “in too many cases these limits have already been reached.”935

What is interesting about these opinions is that they all have a deliberately ambiguous character. On one hand, everyone assumed that the government was responsible for the terrible situation they were living but, on the other hand, a judgement was made about the suitability or unsuitability of the children, with the mother held to be the one ultimately responsible. The 1940 ‘Town Children Through Country Eyes Report’936 supported the negative claims about evacuees by describing the “real shock” of many of its members on finding that “many of the guests arrived in a condition and with modes of life or habits which were startlingly less civilised that those that had accepted for a life-time.”937 Welcomed by those who had an eugenicist and reformist agenda, the evacuation process reinforced an exaggerated perception that has endured for decades, both in public memory and historical texts, that “the evacuees […] provided a close-up view of the conditions which many of the poor accepted as normal: children with head lice, impetigo and scabies, often unwashed and without any knowledge of elementary hygiene.”938

Before the first wave of evacuation took place, some voices had already been raised by some members of the public about billeting “dirty children”. There were genuine health concerns about the evacuation of large numbers of the population, and viral epidemics were anticipated as well as skin diseases such as scabies (contagious skin infection caused by mites that burrow into the skin) and impetigo (contagious bacterial skin disease) which thrived in war conditions, especially in underground air-raid shelters where people, unable to wash properly, were crowded together. On 24 May 1939, Sir Percy Harris, MP for an

934 Carling, ‘Evacuation of women and children’, 896.
936 Town Children Through Country Eyes (NFWI, Dorking, 1940), 4-5, 10, 17.
937 Town Children, 4.
area of the East End of London, told Parliament that these opinions were based on “pure ignorance”. London children, even those coming from the poorest districts, were, he said, “delightful and charming”, well brought-up, well taught, “clean and tidy”.939

In spite of these opinions, a Ministry of Health circular of September 1939, provided evidence of the existence of problems with the state of some of those evacuated from the most deprived areas: “In a limited number of districts the influx of persons in a dirty or verminous condition or suffering from skin trouble and similar ailments has presented a somewhat serious and distressing problem”.940 The Summary Report by the Ministry of Health for 1 April 1939 to 31 March 1941 acknowledged that in spite of the exaggerations, there were too many children suffering from conditions such as pediculosis and skin diseases which were directly related to the lack of cleanliness and to bad habits. Just as the people who made their complaints on the pages of The Times, the Ministry of Health recognised that living conditions in the big cities were, in part, the cause of the problem, but the report once again ultimately blamed mothers for the health of their children. In this way, the report recommended the introduction of a series of measures and of courses to teach mothers the beautiful and important task of being a “good” mother, with the aim of solving the problem for good.941

Historians of the evacuation have correctly indicated that the event ignited a kind of collective hysteria.942 Despite this, more than a few people during the conflict were aware of the exaggeration of these stories. Some members of Parliament and various publications about the evacuation admonished the unfortunate exaggerations, and the teachers’ guild said that the “exaggeration of the Press has made teachers physically sick.”943 One woman told her vicar of the despair in her village of the mothers of these children when reading “the

940 Ministry of Health Circular 1871 (12 September 1939), found in Okehampton 3248/16/2, cited in S.J. Hess, ‘Civilian Evacuation to Devon’, 72. See also Titmuss, Problems of Social Policy, 125, and Parsons, I’ll Take That One, 195, 197.
wholesale strictures on their [the children’s] condition and conduct.” Although mothers had the possibility of writing to The Times “to defend their children,” the vicar empathised with the frustration of all those women whose reputation was being sullied at the same time as their children were being mistreated. The article adds that the local Evacuation Officer had told the good vicar that of 1,000 children, only 25 presented problems, and concluded: “Pray too for a heart of grace, that you too may look with compassion, and not with criticism, on these children who very possibly are the victims of circumstance.”

The education department of the London Country Council (LCC) recorded that “unfortunately it was always the unusual incident of evacuation that attracted the attention of the press and public” and sources at the Ministry of Health also held Ministry of Information reports stating that a large percentage of children were dirty and verminous to be “a gross exaggeration, expressed in this general form.”

Bad habits, lice, and bed-wetting were bodily signs pointing to a moral problem. It was upon this semiotic duplicity of body and mind that the myth of the evacuated child was constructed. Pediculosis and skin disease were added to the list. In 1940, the Scottish socialist author and journalist Ritchie Calder criticised this kind of collective hysteria, and affirmed that the “louiness” and “dirty habits” of the children has been very much exaggerated. “Dirty habits” is a description of a deliberately ambiguous character. On one side, medical journals and letters to newspapers and periodicals such as The Times and the British Medical Journal saw them as a physical problem. On the other side, commentaries coming from the sphere of psychology and social education understood them to be a natural reaction to a psychological shock. What was for the former a clear motive for reprimand and punishment was understood by the latter as a social alarm which called into question the nation’s stability. In

945 Richard Samways (ed.), We think you ought to go (London Metropolitan Archives, City of London, 1995), 14.
949 Crane, ‘Rethinking how evacuees’.
both cases, whether through education or nature, the child appeared as inept in the control of his habits or sphincter movements.

‘A Cruel Psychological Experiment’: scientific literature on evacuation

The bombing of British cities during the Blitz and the policy of evacuating children from these areas to the countryside provoked considerable medical and scientific debate about the effects on both the behaviour of children and their mental health. The bad behaviour of some evacuees and the spectre of juvenile delinquency raised questions about the psychological mechanisms that might be involved and the role of children’s experience of both air raids and the separation from their families implied by evacuation. The emerging discipline of psychoanalysis challenged much conventional thinking, in particular by suggesting that children who were evacuated might suffer greater mental problems than those who were bombed, precisely because of the effect of separation from their mothers. As it provided a wealth of case studies and a grand experimental theatre with many thousands of subjects, the policy of evacuation provided a fundamental opportunity for the emergence of psychoanalysis as a professional discipline in the UK, and for the engagement of psychoanalysts in the design of social policies.

As early as 1939, the British Medical Journal had reflected the concerns of some citizens about the emotional well-being of children. In a letter to the editor, a certain Yates observed that if many evacuated children presented the grave problems already mentioned in earlier letters – “the chief of these being bed-wetting and unmanageableness” – these symptoms did not belong either to the physiological or the moral arena. On the contrary, the discussion needed to be moved towards psychological disorders and nervous conditions. “So much has been written about the physical advantage to children of being out of big cities”, wrote Mary Bunbury in the article ‘Effects of evacuation and of air raids on city children’ (1941), that it seemed worthwhile to try “in some way to assess and

950 See Shapira, The War Inside, 48-68; Angela Davis, Modern Motherhood, Chapter 5; Angela Davis, ‘British child psychology and the evacuation’, 1-10.
reduce to terms the psychological effects of evacuation on them.\footnote{952} While the main social anxieties provoked by evacuation – and nurtured by sensationalist press coverage – arose from the revelations about urban poverty, psychiatrists and psychologists were more concerned with the effects on children of separation from their parents.\footnote{953}

The experience of evacuation generated an extensive literature about the effects of the process on the mental health of children. In her article ‘Evacuation of children in wartime’ (1941), Katharine M. Wolf considered it “a cruel psychological experiment on a large scale,” although in the arena of children’s mental health the war brought more innovation than in other areas. As a result, there were increased expectations of better services for everyone and an understanding that the state would be more involved in their provision.\footnote{954} Medical professionals – including psychoanalysts – started calling for an enlargement of state responsibility for the welfare of the population and for the betterment of health services.\footnote{955} The changes brought by war had their roots in developments in the 1930s. While general practitioners warned that evacuation would lead to the spread of uncleanliness and vermin, psychologists and psychoanalysts argued that the emotional impact of confronting possible separation from or loss of one or both parents and the break-up of the family unit was of greater concern. Since World War I, psychology and psychoanalysis had developed as disciplines, and children’s mental health and psychology had come into the domain of experts.\footnote{956} While psychoanalysis contributed to this shift “from bodies to minds”, its key role started to emerge just before The Second World War with its insistence on the centrality of the child psyche and of children’s relationships

\footnote{952} W. M. Burbury, ‘Effects of evacuation and of air raids on city Children’, \textit{British Medical Journal} 2 (1941) 660.
\footnote{954} Shapira, \textit{The War Inside}, 56.
\footnote{955} Shapira, \textit{The War Inside}, 57.
with their parents to the normal development of future adult citizens. Before the war had started, British analysts had already begun to examine how they could contribute as individuals to society and help in dealing with panic and mental breakdown caused by the anticipated air raids on the civilian population. The bombing of British cities and the evacuation of British children provided them with an abundance of work with civilians, helping to shift the nature of their profession in a way that crystallised earlier interwar developments.

But the main contribution of psychoanalysts during the war – beyond their general conceptualisation of anxiety and aggression – was the work they did with children, the home front’s most visible victims. Psychoanalysis put itself forward as a science of “normal” mental health which aimed to maximise the abilities of individuals and minimise their debilitating troubles. It also claimed to be capable of solving the problems of the “abnormal” child who posed a potential threat to the community as a whole. The war served not only to focus on existing psychological and psychoanalytic ideas but also provided an arena in which they could be developed in inventive ways. Thus, government officials and other leading figures were inclined to adopt psychological thinking rather than the antiquated class-based vision which emphasised the “bad habits” of the urban poor. Although evacuation did contribute to this classist discussion of juvenile delinquency as being linked to poor living conditions and the lack of parental discipline and to theories about the “problem family”, it also helped encourage a growth in debates about children’s mental health. In particular, the use of evacuation hostels and nurseries – some of which were run by psychoanalysts

959 The perceived psychological effects of The Second World War in general, and on the home front in particular, are understudied when compared to those of World War I. Furthermore, as Sonya Rose notes, despite the central place that evacuation occupied in the popular memory of the war, it has still not been analysed extensively. See Rose, Which People’s War?, 124; John Welshman, Churchill’s Children: The Evacuee Experience in Wartime Britain (Oxford University Press, Oxford, 2010); Titmuss, Problems of Social Policy; and Angus Calder, The People’s War: Britain, 1939-1945 (Pantheon Books, New York, 1969), 35-50.
960 On analysts’ work in the British military, see Tom Harrison, Bion, Rickman, Foulkes and the Northfield Experiments: Advancing on a Different Front (Jessica Kingsley, London, 2000).
961 These ideas are taken from Rose, The Psychological Complex, 1-10.
(including Anna Freud) – spurred the establishment of more progressive institutions that would eventually expand to other vulnerable segments of the population, such as the elderly and the mentally ill, thus anticipating post-war innovations in "community care." 962

Psychoanalysts were among the many critics of the policy of evacuation – and they did not lack arguments. On 2 December 1939, The Lancet published a letter from John Rickman under the heading “Evacuation and the Child’s Mind”, which said that the continuous separations and break-ups to which children were exposed during the process of evacuation could have serious consequences for their mental health. In the words of this British psychoanalyst, “at a time when his need for security, and the comforting assurance of familiar faces, is great,” the child’s separation from his parents “will tax him severely.” 963 For Rickman, separation had a direct impact on the child’s mental health, which would be set off towards the development of a “disaffective character” and “unsatisfactory or unhappy social relationships later in life.” 964 For him, as for other psychologists, evacuation had been anything but a great success when considered from the point of view of the mental health of the children involved. In another letter, to The Lancet, Rickman wrote, “Even a situation of emergency should not be allowed to divert our attention for the basic needs of the mental and social development of our future fellow citizens.” 965

Two weeks later, similar reservations were expressed by John Bowlby, Emanuel Miller, and Donald Winnicott in a letter to another prestigious journal, the British Medical Journal. 966 This trio of psychologists argued that children older than five could cope with both the physical and psychological shock of evacuation, but younger children were marked for life by the shock involved in separation, an experience that was much more than a profound sadness. The inability to find a safe and secure reference provided such a shock to these children that, in many cases, it provoked an emotional “blackout”, fertile ground for the later creation of a serious disorder in personality development and the

964 Rickman, ‘Evacuation and the child’s mind’, 1192.
965 Rickman, ‘Evacuation and the child’s mind’, 1192.
potential for juvenile delinquency. According to Bowlby, Miller, and Winnicott: “If these opinions are correct it follows that evacuation of small children without their mothers can lead to a very serious and widespread psychological disorder.”

The government was putting at risk both the health of British children—who ran the risk of developing a “severe disturbance of the personality which may persist throughout life”—and the health of the nation, as this situation could “lead to a big increase in juvenile delinquency in the next decade”.

For Bowlby, the experience of evacuated children served only to confirm what he had already witnessed. Between 1936 and 1939, while working for the Child Guidance Clinic in London, Bowlby had carried out a series of investigations about the family lives of young thieves. All the patients had in common the fact of having been brought up by strangers at different moments within the first five years of life. For Bowlby, the study revealed that it was possible to support a causal link between early separation and juvenile delinquency. The effects of separation created a disaffective character, a personality disorder which was the root of the antisocial behaviour. This antisocial behaviour was a symptom of a psychodynamic disorder which, in turn, was the consequence of a disturbance that occurred in the early stages of the relationship between the child and the mother.

In the opinion of another of the letter’s signatories, the English paediatrician and psychoanalyst Donald Winnicott: “Evacuation is a story of tragedies; either the children are emotionally disturbed, perhaps more than they can recover from, or else the children are happy and it is the parents who suffer, the implication being that they are not needed even by their own children.” Thus, the only success that the scheme could claim “is that it could fail.”

When the war came, Winnicott – who worked as a psychiatric advisor on the government’s evacuation plan in Oxfordshire and, within that plan, on the Oxfordshire Evacuation Hostel Scheme – “could not avoid the delinquency issue any longer.” He was deeply affected by the confirmation of the confusion that the

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967 Bowlby, Miller & Winnicott, ‘Evacuation of small children’, 1202-1203.
968 Bowlby, Miller & Winnicott, ‘Evacuation of small children’, 1203.
971 Donald W. Winnicott, Deprivation and Delinquency (Tavistock, London, 1984), 22.
generalised disintegration of family life had generated, as well as the effects of separation and loss, destruction and death. Together with his future wife, the social worker Clare Britton, he helped to fund evacuation hostels to care for some 300 “difficult children”, whose “anxious” state prevented them from adapting to their foster parents.\(^{972}\) In the framework of these hostels, the gestures and words of these little patients were interpreted in two ways – one individual, the other social. On the one hand, there was concern for the child who was afflicted by anxiety and other ailments of a neurotic character. On the other hand, there was a focus on the potential risk of juvenile delinquency and its effect on the future stability of the democratic regime.

These hostels acted as substitutes for the family and helped to relieve children’s anxiety and to generate the conditions necessary for implanting the desired state of “social adjustment.”\(^{973}\) In the opinion of Winnicott and Britton, the child that did not feel wanted “becomes a burden on society, hardening into an anti-social character, or developing some other sort of mental illness.”\(^{974}\) In the widely distributed pamphlet on ‘Children’s Communities: Experiments in Democratic Living’, Winnicott and Britton expressed their concern for the children whose lives were spent in institutional spaces. Unlike much other research into children interned in clinics and institutions, this study focused on children who had not suffered any previous pathology. The conditions of anxiety and stress in which the lives of these children had developed had demonstrated the fragile emotional life of infancy, the authors claimed. According to these two experts, the child who was deprived by the circumstances of the war of a normal family life, “tends to lack something not only in personal happiness, but also in the development of character and in the qualities of citizenship.”\(^{975}\) The discussions generated by the hostels showed a growing concern about the aggressiveness that was being exhibited by evacuated children. The hostel programme for restore these children’s health included introducing them into a familiar and emotional framework, but for children who presented a strong antisocial


character, the treatment “cannot avoid being dictatorial.” Children “must gradually be brought up against the consequences of their own destructive actions.” The possibility of co-operation between citizens, and the future of democracy itself, was based on the restoration of these values. Emotions, if not managed correctly, posed a problem for democracy. The social relevance of the hostels lay in their instrumentality towards the resolution of this conflict, guaranteeing a stable and healthy emotional life to these future members of democratic society.

The same line of argument was adopted by the article ‘The School and the Child Guidance Clinic’, published in the book Educating for Democracy (1939). Its author, the British psychologist Raymond B. Cattell, wrote that the war had demonstrated that “the variety of abnormality requiring specific assistance and treatment is very great.” After listing the types of disorder that were referred to the “average” Child Guidance Clinic – rebelliousness, disobedience and offences against authority; nervousness and exaggerated or irrational fears; general backwardness in school; chronic stealing; truancy from school and home; excessive lying; emotional instability and inability to get on with other children; difficulties over feeding; difficulties over specific school subjects; enuresis and bed-wetting; tics, nail-biting, and finger-sucking; shyness and withdrawal from social contacts; excessive phantasy; stammering; masturbation; unusual jealousy and destructiveness – Cattell grouped these disorders in three categories of “unusual children”. First, he placed “delinquency and behaviour disorders”, followed by “personality disorders and nervous symptoms in the wider sense”, and finally by “scholastic disabilities and difficulties in learning”. He noted that there were “surprising differences in their relative incidence in various economic and social groups, schools, or residential areas and in various levels of intelligence within the school.” Thus, while personality problems were more frequent among the “brighter” children and those from higher social classes, “delinquency showed the reverse distribution.”

976 Winnicott and Britton, ‘Problem of Homeless Children’, 6. See also, ‘War strain in children’, 124. Winnicott worked closely with the child guidance officer Theodora Alcock, who claimed that, while the physical conditions of children might improve in the countryside, their mental strain was great and resulted from their separation from their homes and from their mothers.
Cattell’s words were written as part of the debate about scholastic backwardness and the fierce disputes as to whether the Child-Guidance clinic should concern itself at all with this third category of academic ineptitude. In Cattell’s opinion, drawing a sharp line between cases of emotional disability and mental defect was impossible until an examination had been made. Thus, it would be “natural” for the clinic to examine, diagnose, and classify all types of psychological and educational abnormality. For Martha W. MacDonald, psychiatric-services advisor to the Children’s Bureau at the US Department of Labor in Washington DC, the fact that the “nations of the world” were becoming concerned about links between war and juvenile delinquency was “indicative of the present-day constructive attitude toward delinquency in children.”

According to Macdonald, the war had shown that both juvenile delinquency and other psychological disorders were symptoms of “nutritional deficiency”, a deficiency in the child’s spiritual nurturing that affected moral development. The delinquent child, the psychiatrist concluded, is a “sick child” who behaviour could be seen as an expression of protest against deprivation – in this case the deprivation of love. Love was not merely a romantic ideal, it was the medium in which children developed as normal or pathological.

Psychiatrists and psychoanalysts had to battle against the view that the origins of crime and vice had to be traced back to the failure of parents to instill morality in their children, combined with contagion from the bad habits of the corrupt environment of urban life. But psychologists such as Winnicott, MacDonald, and Cattell understood that the processes involved in the emotional development of the child were very fragile and delicate, vulnerable to multiple distortions that could lead to pathologies that ranged from bad behaviour and delinquency to sheer madness. As Michel Shapira has indicated, the debate generated by psychoanalysis about the relevance of the mother-child bond for the adequate development of the child not only produced a general re-evaluation of the experience of separation but also generated influential responses to certain questions related to the possibility of maintaining harmonious and co-

operative human relationships in the twentieth century. British psychoanalysis – which from the beginning was tied to social obligations the objective of which was to ensure a specific understanding of social democracy in a period of war and peace – developed as it engaged in treating social problems. War and the development of the welfare state posed moral, theoretical, and practical questions to the psychoanalysts in a way which structured their discipline. At the same time, their responses framed the modern democratic individual in the United Kingdom.

**Alternative views – “war strain” and “air-raid shock”**

But there were other attempts to provide psychological explanations for the delinquent or pathological behaviour of some evacuated children besides the effort to draw a causal link between misbehaviour and the trauma of parental separation. Another school of thought is represented by Theodora Alcock (1888-1980), a child psychoanalyst who introduced the Rorschach test to the UK and worked for the Ministry of Health in the reception area of Huntingdonshire, where she gave guidance to “difficult” children evacuated from London and the East Coast. Alcock saw the problem not in terms of evacuation and separation from the mother, but rather in the physical shock of the bombs which produced disturbances to the psyche. In an address at the Tavistock Clinic on “war strain” in children, she argued that the disturbance of the “difficult evacuated children” was the result of a physical agency, “such as bombing,” and that children who had been bombed “seemed to react much more in the way of unruly behaviour.” Alcock argued that “children whose chief strain was due to separation from home seemed to account for most of the psychosomatic and psychoneurotic cases, while those in whom the principal disturbance was due a physical agency, such as bombing, seemed to react much more in the way of unruly behaviour.” Agreeing with Alcock, Rosemary Pritchart and Saul Rosenzweig also maintained that separation led to psychosomatic or psychoneurotic disorders, while bombing led to unmanageable behaviour and

aggressiveness.\textsuperscript{985} It is worth noting how these experts did not substitute one univocal causal link with another. They did not shift the cause of the bad behaviour of evacuated children from the trauma of separation to the shock of the air-raid experience. Rather, they distinguished between two separate types of pathology. For them, the effects of separation turned against the organism of the child, who experienced the type of somatic and neurotic pathologies discussed in Chapter 5; while the impact of bombing caused the type of misbehaviour that was socially labelled as unruly.

However, in practice the second type of effects were prioritised over the first. One of Alcock’s colleagues at the Tavistock Clinic, W.E. Mons, saw the need to remind parents frightened of evacuating their children to the countryside that “exposure to even a single ‘harmless’ air raid can do great damage to a child’s psyche be he ever so ‘normal’ and ‘fearless’ on the surface.” There were reasons to believe, Mons argued, “that the child who has been exposed to the experience of one or more air raids is in a class by itself.”\textsuperscript{986} Contrary to what happened with war neurosis, which particularly affected those with a strong predisposition, “air-raid shock” was not considered to be a neurosis in the true sense, as it affected children who had not previously revealed the slightest trace of abnormality. In the same way, Mons argued in ‘Air Raids and the Child’ (1941), that after the experience of only a single air raid, “previously good and intelligent children become suddenly obstreperous, destructive, mischievous, lazy, truant from school, and, in short, unmanageable in the billet to which they have been evacuated.” The article maintained that this behaviour reflected a “deep resentment against the adults who have failed to provide that security and protection which is every child’s birth right.”\textsuperscript{987} Faced for the first time with the reality of death, children experienced the most profound agony in realising that “parental authority is no longer a safe shield against this direct threat of extinction.”\textsuperscript{988}

For Mons, the stoic surface of these children had its origin in psychological pathologies rather than in strength of character Considering the impact of raids

\textsuperscript{986} W. E. R. Mons, ‘Air raids and the child’, British Medical Journal 2 (1941) 625.
\textsuperscript{987} Mons, Air raids and the child’, 625.
\textsuperscript{988} Mons, Air raids and the child’, 625.
to be of an essentially unconscious nature, he argued that as the child was unaware of the air-raid trauma: in most cases “he tends to make light of his experiences, denies having been frightened, and behaves in that casual manner characteristic of an adult.” But “these children are no longer what they used to be.”

Mons, along with Alcock, reported that the Rorschach responses of children who had been bombed revealed disturbances in “deeper layers of personality” to a greater extent than the responses of children who had not been bombed. Publications such as The Lancet and the British Medical Journal echoed the opinions developed by psychologists and educationalists that many children had suffered in ways that did not appear on the surface and that were not recognised by parents and teachers. Unlike earlier research on children interned in clinics and institutions, these studies focused on children who had not suffered any previous pathology and did not come from families where such pathologies had been experienced.

But for every argument there was a counter-argument. Mons’ view of the vulnerability of a child’s psyche to the effect of a single air-raid was not shared by educational psychologist Philip E. Vernon, of the University of Glasgow, who in an article devoted mainly to adult reactions argued that “the raids had even less effect on children than upon adults.”

If for Mons the physical shock of the bombs produced psychological disturbances, for Susan Isaacs (1885-1948) fear and anxiety – far more general causes – produced organic illness. Regardless of whether the trauma was physical or psychological, both Mons and Isaacs strengthened the idea that fear experienced by many young children faced with the threat that their homes and their parents might be bombed was unconscious. Susan Isaacs worked at the Malting House School and, from 1933, was Head of the Department of Child Development at the Institute of Education in London, where she shifted her focus from how to manage children to how to understand their inner mental and emotional processes. Isaacs’ work was widely disseminated through the training of infant school teachers to which her department contributed, through pamphlets and through her answers to parents’ questions in the journal Home and School. Her book for parents, The Nursery

991 Urwin and Sharland, ‘From Bodies to Minds’, 190.
Years (1925), was reprinted four times before the outbreak of The Second World War, which suggests its popularity.

According to Isaacs, the child’s limited understanding encouraged the adoption of a selective perception of reality. With the end of resolving the internal anxiety provoked by the lack of safety of their parents and homes, these children clung to the idea that war and air raids were only real in those places which had been evacuated. In turn, argued Isaacs, the significance of the exterior reality of the war was connected for each child with how the ambiguity of their own sentiments had been handled. On the one hand, love and dependence on the parents, and on the other hand impulses of greed, jealousy, and destruction. Following this inner logic, many children deduced that the expulsion from the home was a punishment for their feelings of hatred and jealousy. There were also cases where children blamed themselves for the danger that their loved ones faced, believing that these feelings were what was really threatening the well-being of their parents.992

In contrast to Isaacs, the British psychologist Philip Ewart Vernon was surprised that these children had not reacted in a more drastic manner “to the operation of a ‘fear instinct’ which is stimulated by loud noises.”993 Although they were sometimes scared by sirens and explosions, nearly all the children that he and his colleagues had been able to observe in the clinic went “to sleep again remarkably easily.”994 Like Isaacs, Vernon believed that children had limited capacity to understand and reason, but he believed that it was precisely this lack of awareness that kept them safe from the shock of the war. Connecting the possibility of trauma with the state of the child’s development, the article concluded: “It is hardly possible to say at what age consciousness of the danger to themselves and their relatives arises.”995

There were many arguments against the diagnoses carried out by psychologists and psychiatrists, under the pretext that they impinged against the objectivity of the clinical method. Thus, William A. Brend, in a text entitled ‘Air

993 Vernon, ‘Psychological effects’, 469.
994 Vernon, ‘Psychological effects’, 469.
raid shock’, made a direct criticism of Mons’ article and the new category of “air-raid shock” he had created. This came to join a list of traumatic psychopathologies that went from “railway spine” to “traumatic neurasthenia,” passing through “nervous shock,” “shell shock,” and “bomb shock”. This specialist in clinical neurology concluded by saying: “May I protest against this latest addition to a mischievous and medically meaningless series?”996 Like Brend, for Dr. Felix Brown, “no acute emotional-shock reactions among children have been seen.” Brown, a psychiatrist at Guy’s Hospital, argued that “the excellent prognosis of the civilian air-raid psychoneuroses and emotional-shock” was due to the fact that civilians had “no motive for continuation of symptoms any longer than he can help.”997 However, the arguments about lack of observation do not affect many of the leading practitioners of the time, starting with Anna Freud’s awareness of a scientific opportunity based on the large number of infants available to the scientific eye, and continuing with Ilse Hellman’s reception of Freud’s and Dorothy Burlingham’s reporting methods at the Hampstead Nursery. Hellman felt this method of pooling observations used at the nurseries subsequently developed into an important research tool in psychoanalytic child observation.998 However, as Nick Midgley has noted, there was already a long history of direct observation of children within psychoanalysis, going back to the early twentieth century with the encounter in Vienna between psychoanalysis and “child studies”. Anna Freud’s role in this expansion to Great Britain is not to be overlooked.999

**Evaluating symptoms**

While many doctors refused to read the air-raid symptoms as authentic expressions of mental illness and saw them, rather, as the opposite – as expressions of a purely physiological character – psychologists conducted a conceptual re-evaluation of psychological damage that resulted in the

construction of new symptomologies. Child symptoms were interpreted according to a table of signs, such that an element could take on relevance only in the context of a codified system. Miss M.I. Dunsdon devoted an article to the evaluation of these symptoms. Carrying out a survey of school children following heavy raids on the city of Bristol, this psychologist concluded that of the 8,000 children that were in the city at the time of the bombardment, at least 300 showed clear signs of strain. For Dunsdon, the main symptom in the first phase of air-raid shock was a “pronounced apathy”. This state of indifference gave way, during the following four weeks, to the pattern of symptoms of reactive depression. While children aged between five and seven showed “psychological symptoms”, from nervousness and trembling to aggressiveness and crying, those who were older than 11 tended more frequently to show “psychosomatic symptoms” such as headaches, indigestion, pallor, anorexia, nose bleeding, and incontinence.1000

Like Dunsdon, Mary Burbury, medical director of the Manchester City Child Guidance Clinic, tried to establish a correct identification of the expressive signs of the child affected by air raids and the rest of his physiological circumstances. With regards to the impact of air raids on city children, this psychologist considered that qualifier “immediate should be stressed…since we are not yet in a position to assume that we know what the final effect of living in constant risk of this sort of warfare is going to be on either the adult or the child population.”1001 The group of cases in which symptoms exhibited by children were attributed to raids included sleep-walkers, nervous children, truants, enuretics, stammerers, and pilferers.

Following Burbury’s criteria, Frank Bodman considered that the problem of the symptoms presented by these children was that they did not disappear when the stressful situation ended and could accompany the subject well into adult age.1002 Bodman carried out a two-month follow-up study with 54 children aged between two months and 12 years of age, who had been evacuated from the Bristol Children’s Hospital during a severe bombing. The first reaction “is that to sirens and noise in general”, but while “in the walking child” the reaction is to run

1002 Frank H. Bodman, ‘War conditions and the mental health of the child’, British Medical Journal No. 4213 (1941) 486-488.
to safety, “the talking child” rejects the formulation of the experience.\textsuperscript{1003} This, noted Bodman, is followed by attempts at describing or rehearsing the incident, “the description becoming more elaborate as the child is more mature.”\textsuperscript{1004}

Returning to connect the symptomology with the state of the child’s development, Bodman claimed that “the younger children felt the strain and lack of sleep more readily than the older ones, who have developed more control and can repress their feelings to conform with adult standards with greater success.”\textsuperscript{1005} Overt psychological symptoms were predominant in the five- to seven-year-old group, while the 11- to 14-year-old group showed a much higher percentage of psychosomatic disorders. Interestingly, Bodman noted that older children (seven-and-a-half years of age and above) tended to view the air raids as an adventure, while those aged 11 and above showed a sense of responsibility for others. On the whole, there was remarkably little reaction to subsequent raids. Of eight children with severe later experiences, only two had episodes of anxiety, which eventually disappeared. According to Bodman, “the most striking finding of this survey is the extraordinary toughness of the child, and his flexibility in adapting to potentially threatening situations.”\textsuperscript{1006}

Even when there was no shortage of opinions suggesting a correlation between age and symptomology, there was no agreement about the correspondences or which ages most favoured adaptation. Thus, Bodman argued that the older the child, the greater his understanding of the situation and his adaptability, while Dunsdon concluded that “latent adaptation was strongest” among children aged two to five.\textsuperscript{1007} Studying a group of preschool children who had experienced bombings, Enid John of University College, London, noted after-effects in many “youngsters” six months after the events.\textsuperscript{1008} After the experience of only one air raid, 42 children developed an “abnormal” fear of noises. Concern grew in acknowledging that none of them “had revealed until the moment the slightest trace of abnormality.”\textsuperscript{1009} There was also a big rise in the number of cases of children who showed fear of the dark before and after the

\textsuperscript{1003} Bodman, ‘War conditions’, 486.
\textsuperscript{1004} Bodman, ‘War conditions’, 486.
\textsuperscript{1005} Bodman, ‘War conditions’, 486.
\textsuperscript{1006} Bodman, ‘War conditions’, 486.
\textsuperscript{1007} Dunsdon, ‘A psychologist’s contribution’, 37-41.
\textsuperscript{1008} Enid M. John, ‘A study of the effects of evacuation and air raids on children of pre-school age’, British Journal of Educational Psychology, 11 (1941) 173.
\textsuperscript{1009} John, ‘A study of the effects’, 173.
raids. John noted two curious phenomena. First, after-effects bore a higher relationship to the degree of fear shown at the time of the raid than to the severity of the raid itself. Second, the amount of fear the child manifested seemed in many cases to be influenced by the degree of fear shown by the child’s mother. On the basis of not fully described computations, John reported a correlation between mothers’ and children’s fears at the time of the raid.\textsuperscript{1010} In the same way, Joseph C. Solomon, in an account of the reactions of San Francisco children to an air raid alarm soon after the attack on Pearl Harbour, also noted that a prominent feature in the reaction of children was the contagious effect of adult anxieties. Again, the effect of parental anxiety on the reaction of the child was related to the latter’s developmental stage. Thus, while a young child might be quite affected by the intense emotional reactions exhibited by his elders, children “near or at the teen age may be challenged by the emotional distress shown by a parent or other adult and seek to give help or reassurance.”\textsuperscript{1011} In his opinion, children “have adapted themselves exceedingly well to the unfamiliar sights and sounds of air-raids,” while older children “often actually regard them as a great thrill”. This favourable resolution only took place, Solomon concluded, “in cases where the adults in contact with the children have behaved with self-control.”\textsuperscript{1012}

In 1940, the British educational psychologist Cyril Burt, in his essay ‘The Incidence of Neurotic Symptoms among Evacuated School Children’, tried to demonstrate that, provided the child was not physically injured, the mental shock of being bombed was, in itself, far less serious and persistent than the effect of being with a hysterical adult. Burt had reached the conclusion that the child aged between two and five – rather than the infant – seemed to suffer most severely from raids. While most reported cases consisted of mild emotional disturbances rather than definite neuroses, among the most severe cases the chief disturbances ranged from various forms of anxiety neurosis to hysteria. Although children of elementary-school age were seen as less affected by “contagious panic,” this group ran a greater risk of being affected by their own imaginations. According to Burt, this was even more noticeable in the adolescent, where “the

\textsuperscript{1010} John, ‘A study of the effects’, 173
\textsuperscript{1011} J. C. Solomon, ‘Reaction of children to blackouts’, American Journal of Orthopsychiatry, 12 (1942) 62;
\textsuperscript{1012} Solomon, ‘Reaction of children’, 62.
conflict between outward courage and inward fear is severer and more self-conscious.  

With the aim of encouraging other observers to discriminate more carefully between anxiety as a reaction to “real” danger (which can be overcome fairly quickly) and anxiety caused by the strength of the child’s own instinctual impulses or stage of superego development, Anna Freud identified five different types or aspects of air-raid anxiety. Like Burt and Solomon, she recognised the degree to which a child’s response to air raids was linked to parental reactions, while children who were in the care of their mothers or a familiar mother substitute during the raids did not show signs of traumatic shock, others who had not passed through that experiences but who lived with hysterical mothers developed highly pathological behaviours. Following this logic, the most anxious children were not necessarily those who had experienced being bombed. Anna Freud cites the case of a four-year-old boy who had not experienced the bombings but who seemed to be the most nervous of all the children at the Hampstead War Nurseries. In contrast, a four-year-old girl, who had experienced bombing and the roof of her home being blown off, attempted to comfort him, advising him to pull the bedclothes over his head to block out the noise of the anti-aircraft guns. For Freud, this supported several psychiatrists’ claim that many people – both adults and children – have more anxiety in relation to the idea of being bombed than to the reality: the unknown danger is greater than the known, the fantasy more powerful than the reality. Ultimately, the most tangible threat was not trauma caused by the experience of destruction, but the impracticability of education against destruction once inherited anxieties severed the children’s sense of safety.  

Like Susan Isaacs, Freud and the rest of the staff at the Hampstead War Nurseries believed that these children feared air raids in so far as they could understand what was happening. However, many young children could merely ignore the facts whenever they became unpleasant. For children in the first stage of the development of “conscience” – when outside symbols for “conscience” are

1014 Anna Freud and Dorothy Burlingham, Infants Without Families (International UP, New York, 1944), 163-172.
1015 Freud and Burlingham, Infants Without Families, 185.
still necessary – the feared air raids were new symbols, substitutes for conventional “bogey-men”.

A child at the preschool age, however, understood the fear reactions of his or her mother and shared them: “observers seldom appreciate the depth and seriousness of this grief of a small child.”

At the Hampstead Nurseries, Anna Freud and her staff aimed to observe the mechanisms through which children either expressed or defended themselves against what she defined as “the pain of separation,” and to repair the perceived mental damage already caused to the children. While some children found relief in speech – often after considerable periods of silence – play was a more available form of expression and therapy for others. Many severe cases expressed their maladjustment in deviant behaviour or neurotic regressions to more infantile modes. For example, 17-month-old Carol continually repeated the words “mum, mum, mum in a deep voice for almost three days” after being separated from her parents. At first, she would allow herself to be comforted only by sitting on a nurse’s lap with her head turned away from the unfamiliar adult. “Whenever she looked at the face of the person who held her, she began to cry”, writes Freud. With a slightly older child, aged three or four – in whom ambivalent feelings are a normal part of the parent–child relationship – separation often seemed an intolerable confirmation of negative feelings.

Billie, aged three-and-a-half, responded to the separation from his parents by behaving unusually well, carefully observing all the rules that he had broken so often when at home. When he heard that his mother had gone into hospital with a bad leg, he suddenly remembered a time that he had kicked her and worried whether it was his fault that she had now become ill. In his case, it was as if the separation was a punishment for all his bad thoughts and behaviour, and he now needed to try to compensate for what he had “made” happen. In normal parental settings, a young child’s hostile and aggressive thoughts are counterbalanced by the experience of the parents’ “survival” of such feelings. But a sudden separation from the parents could serve to confirm a child’s deepest anxieties.

1016 Freud and Burlingham, Infants Without Families, 163-172
1017 Freud and Burlingham, Infants Without Families, 183.
1019 For a discussion on regression in the context analysed in this thesis see Bar-Haim, S., ‘Regression and the maternal in the history of psychoanalysis, 1900-1957’, Psychoanalysis and History, 16/1 (2014) 69-94.
1020 Freud & Burlingham, War and Children, 184.
“The child is frightened by the parents’ absence, and suspects that their desertion may be another punishment or even the consequences of his own bad wishes,” argues Freud. “To overcome this guilt he overstresses all the love which he has ever felt for his parents. This turns the natural pain of separation into an intense longing which is hard to bear.”

Like her colleagues, Anna Freud dedicated herself to observing these bodily signs. However, she criticised the fact that the diagnosis of separation anxiety and other children’s disturbances induced by war was highly focused on symptoms while ignoring the age of developmental phase of the children. This “reliance on manifest symptoms, inevitably led into confusion in assessment and subsequently to erroneous therapeutic inferences,” she argued, especially when children were involved, because their symptoms were often transitory and could indicate different things depending on the circumstances. Freud believed that a similar symptom in different children could in one case stem from a developmental disturbance while in other denote an internal conflict. In contrast, different symptoms in different children might be caused by similar underlying pathological dynamics. Anna Freud’s words cast light on the shadow of making an incorrect diagnosis and the consequent poor treatment or care of the child, something which is more evident when the vagueness of the definition of neurotic disturbances is appreciated. Overall, descriptions of changes in children’s behaviour and symptoms were superficial, whether they were merely negative variants of normal behaviour or those variations which had to be recognised as the formation of neurosis.

Anna Freud was a leading voice in the contradiction of the official thesis on evacuation and protection of children from the dangers of wars. Her research showed that much more striking than the way they responded to war was the reaction of these young children to a sudden separation from their families. In fact, there was widespread agreement with Freud’s view that it was a greater shock to a child to be separated from his parents than to experience a bombardment. Thus, Burbury found the formation of neurotic symptoms or an exacerbation of already present symptoms in 52% of evacuated children, while

1021 Freud & Burlingham, War and Children, 189.
only 20% of bombed children showed such a negative influence on their adaptation to reality. Alcock held that “children who showed symptoms induced by the shock of bombing usually lost them quite quickly; on the other hand, the symptoms associated with separation from home were much more persistent.”

Doctor W. J. T. Kimber commented how “he had been struck by the effect on children of the threat to the parents left behind and the feeling of guilt in having ‘run away’.” This fear was vague but nonetheless real, he argued, even in small children and produced continuous anxiety. R.P. Garrow, another doctor, agreed that the evacuated child was in some respects in a worse situation that the child who stayed in London as a result of the separation from the home environment. Following the same logic, Susan Isaacs argued that the effect of the loss of the father on the psychological development of children was more severe than the physical privations that resulted from war. “For vast numbers of children”, she claimed, “the loss of the father is added to all the strain confusion and suffering of war, of ruined homes and divided families.”

When addressing mothers who “succeeded in keeping their evacuee over a period of years,” Winnicott said that although “the bodily care of a child is a big thing”, it is only part of something larger. He emphasised that mothers should take care “of the whole child, the whole child who is a human being with a constant need for love and imaginative understanding”. For Winnicott and for many others “the real worry about bombs was not all.” The other “real worry” was the child’s reaction to loss.

Preventing this kind of harm became the object of social policy, and featured in much literature about parenting, in the post-war period. A widely-held interpretation of Titmuss’ argument in his 1950 book Problems of Social Policy is that evacuation led to governmental, professional, and public awareness of the problems faced by working class children in the cities, which led to the creation...
of the National Health Service, although this claim has been object of debate among historians.\textsuperscript{1028}

The scientific method during wartime: a “natural experiment”

Not only did Anna Freud become an authoritative reference in the exposure of the psychological perils of evacuation: she was also a clever proponent of the adoption of the scientific method in the historic opportunity yielded by war. Although primarily responsible for serving the urgent need of the victims of the Blitz and the evacuation, Anna Freud was convinced that creating a nursery to care for children affected by war was a “natural experiment” of which advantage should be taken.\textsuperscript{1029} Among the aims of the War Nurseries was the care of the little victims of the war, but also research and training.\textsuperscript{1030} Looking back, Anna Freud described the research conducted at the Nurseries as “no more than the by-product of intensive, charitable war work”, and, as all attempts to raise funds specifically for this research were unsuccessful, the observing, recording, and classifying of material “had to be relegated to the spare off-time of the workers and was undertaken as their voluntary effort.”\textsuperscript{1031} Yet, Freud recognised that the War Nurseries were “ideal for the purposes of observation”:

\begin{quote}
The variation in the case material made it possible to see children, almost from birth, in contact with their mothers or deprived of mother care, breast fed or bottle fed, in the throes of separation or reunited with their lost objects, in contact with their mother substitutes and teachers, and developing relations with their contemporaries. The stages of libidinal and aggressive development, the process and the effects of weaning and toilet training, the
\end{quote}

\textsuperscript{1028} Titmuss, Problems of Social Policy, 507-8.
\textsuperscript{1030} Anna Freud and Dorothy Burlingham, Young Children in War-Time: A Year’s Work in a Residential War Nursery (George Allen & Unwin, London, 1942), 12.
acquisition of speech and of the various ego functions could be followed closely.\textsuperscript{1032}

Anna Freud was not the only one who understood the war and children’s bodies as laboratories of observation and experimentation. In The Cambridge Evacuation Survey, Susan Isaacs explained the two main aims of the study. Firstly, the authors wanted to alleviate some of the short-term problems of evacuation. “If it were necessary to sustain this family separation, how could it be done with the least damaged and the most benefit to those who were involved.”\textsuperscript{1033} However, as in the Hampstead War Nurseries, their second aim was more long-term. They were interested in adding to existing knowledge about children and about family life in order to “improve social service provision after the war.”\textsuperscript{1034} Although in the resulting report, which Isaacs edited, she criticised government agencies for being so concerned with the practical details of evacuation they had not envisaged the psychological impact it would have on the children involved, she also felt that policymakers and could learn from the experience of evacuation:

This sharp lesson in the ineffectiveness and waste of a partial approach to a great human issue, one which from its very nature touches every side of human life, applies by no means only to the temporary crisis of dispersing urban populations during a war. It has an equally direct and urgent bearing upon the whole field of education and of social reconstruction during and after the war.\textsuperscript{1035}

As well as indicating areas for improvement in government policy, Freud, Isaacs and many of their colleagues thought the experience of evacuation was revealing about two core areas of interest: the description of normal child

\textsuperscript{1032} Freud and Dann, ‘An Experiment in Group Upbringing’, 146.
\textsuperscript{1033} Isaacs, ‘Cambridge Evacuation Survey’, 10.
\textsuperscript{1034} Susan Isaacs, ‘Cambridge Evacuation Survey’, 47.
\textsuperscript{1035} Susan Isaacs, ‘Cambridge Evacuation Survey’, 11.
development and the boundaries and social recognition of their own discipline. Both the residential and day-care nurseries for children became laboratories for child observation. As Nikolas Rose has argued, “For the first time the everyday life of (normal) children could be visualised through the perceptual grid of psychoanalysis.”¹⁰³⁶ The vagueness of descriptions of children’s behavioural changes, and the symptoms through which the figure of the disturbed child was defined, reflects not only a discipline that saw itself as a laboratory but also a new body of knowledge that was seeking legitimisation.

Psychoanalysts’ experimentation in clinics, nurseries, residential houses, and hostels for children during the war produced a dominant conceptualisation of the emotions and of family life. The exploration of anxiety in the context of total war was tied to the need to explain the emergence of murderous regimes, the eruption of war, and the possibility of maintaining democracy and containing human aggression. Healthy family dynamics during childhood and, more importantly, the formation of a good bond between mother and child were to safeguard British society from barbarism and disintegration.¹⁰³⁷ Before the start of the war, the British analysts had already started to analyse how they could contribute to the correct management of panic and the mental collapse of the civilian population. But the bombardment of the cities and the experience of evacuation produced a change in the nature of their profession and helped to consolidate a discipline that was still in its infancy. Beyond the general conceptualisation of anxiety and aggression, the key contribution of psychoanalysts during the war was the work that they carried out with children, the most visible domestic victims.

Through the work carried out by the clinics and institutions that were designed to receive these uprooted children, psychoanalysis positioned itself as the science that could resolve the problems of abnormal children and thereby reduce their potential risk to the community. By focusing on child psychology, psychoanalysts were able to stress the vulnerability of subjectivity and highlight the link between childhood emotions and anxieties and the unconscious life of adults. Their discussion of selfhood was no longer centred only on the individual but also on the fragility of relationships between individuals and on the self in

¹⁰³⁶ Rose, Governing the Soul, 161.
relation to others – the paradigmatic case being the mother and the child. Psychoanalysts were at the forefront of a contemporary literature that had implications for the newly formed connections between the psychology of individuals and groups and moral and political choice, and they investigated the relationship between culture, politics, and mental health. The war not only encouraged a new focus on the psychological development of children and the role of the mother in this development, but also the signs and behaviour of these same children and therefore the construction of the figuration of the child with “air raid shock” or separation anxiety were fundamental in the process of legitimising psychoanalysis.

Conclusion

Catherine Urwin and Elaine Sharland have argued that, in the decade after World War Two, “the mother as the primary source of emotional stability was established as a sine qua non.” This came with an acceptance of infancy as a period in which specific emotional needs are paramount and the war served to encourage a new focus on the psychological development of children in their first five years and on the role played by the mother in this development. While ideas about the importance of maternal care for children’s physical development go back to the nineteenth century and the negative effects of poor mothering had long been acknowledged, now the mere act of separation from the mother was recognised as a pathogenic factor. This idea had its antecedents in the pre-war years, but this chapter has shown how the war crystallised such thinking by providing an unprecedented opportunity for studying the effects of separation from the mother. These theories had practical implications for child-care policy and had a much wider effect in the creation of different social and cultural ways of understanding childhood.

The figure of the evacuated child became central to multiple debates and disputes between different political, social, and cultural perspectives. This chapter has explored three of these conflicted areas. Firstly, the contrast between the bombed child and the evacuated child, between the child who

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1038 Urwin and Sharland, ‘From Bodies to Minds’, 192.
1039 For a discussion on the emergence of child psychoanalysis see Chapter 5.
1040 Unwin and Sharland, ‘From Bodies to Minds’, 159.
suffered the physical and mental effects of the Blitz and the child who suffered the effects of separation from parents who remained in the cities. The figure of the evacuated child also brought to light the city-countryside dichotomy, in which families in rural areas received children from the East End of London and other poor areas and thereby encountered the social reality of poverty. This provoked disputes about delinquency, poor hygiene, dirty habits and whether these were the result of poor parenting or of social conditioning. Secondly, the contrast between the forced displacements imposed by the wartime government and the role of care institutions such as the Hampstead War Nurseries. Thirdly, the contrast between traditional medicine, which remained focused on the somatic, and the emerging discipline of psychoanalysis which prioritised mental and emotional development and which used the experience of the evacuated children to articulate and research its theories about separation anxiety. As this chapter has shown, the war provided an opportunity for psychoanalysis to establish itself both as a means to heal individuals and to safeguard society by countering juvenile delinquency and encouraging the development of healthy democratic citizens. All this shows how childhood and the figure of the child suffering from physical, mental, and emotional pain was a much-contested area and how there were multiple and often contradictory figurations of childhood within British medical discourse in the years around the Second World War.

Outside of the realm of medicine, the uprooted child became a figure onto which was projected various social and political meanings and which was used for propaganda purposes as a call to action. The photographs of the children of the Blitz commissioned by the Ministry of Information help us explore the ways in which images of youth were consciously composed and manipulated for the purposes of boosting morale, as democratic Britain confronted the “darkest hour” of the threat to its existence from Nazi Germany. These images also expressed in a normative way how children should behave when they were in pain. Home-front children were presented as being simultaneously ordinary and heroic in the way they coped with physical and emotional havoc. In psychoanalytical discourses, the child figures as an adult in the making and psychoanalysis reified the child’s psyche and parental relationships as central to the normal development of the future adult citizen. In social discourses, the child is
portrayed as an adult in training, so that through the acquisition of good habits and morals he or she will become a good adult and citizen.
CONCLUSION

This study has brought to light, for the first time in academic debate, the use and understanding of children’s pain in British medical discourse. Manuscript sources such as records from hospitals, lecture notes and medical texts, and non-textual sources such as photography have been mobilised in an investigation of a subject that has never before been the exclusive attention of an historical analysis. Previous historiography has explored some of the topics discussed in this thesis – such as the relationship between children and evacuation and psychoanalysis (Michal Shapira, *The War Inside*), children and mental illness in Victorian England (Sally Shuttleworth, *The Mind of the Child*), or the topic of infant pain denial (Joanna Bourke, *The Story of Pain*) – but never before have these debates been assessed together and considered in relation to the historiography of pain. In exploring medical perceptions of children’s pain in late nineteenth and early twentieth-century British medical discourse, I have aimed to rescue this topic from historical obscurity, indicating that it is a much more complex matter than has often been supposed. It is in the endeavour to explain the pain of children that this thesis becomes more than the sum of its parts. It is not a thesis that covers first physiology, then paediatrics, and then psychiatry, but rather a study of what these diverse areas of medical and scientific theory and practice have in common as justifying and functioning practices in relation to children’s pain. Although there was no uniformity of opinion among all scientists, medical researchers, and the popularisers of science during this period, what does emerge is a clear disciplinary economy of science that informs and delimits both intellectual debate and the possibilities for children’s emotional expression and affective practice.

The construction of a history of childhood pain is enmeshed in three complex problems. The first problem concerns the conceptualisation of pain: the question of how to define, understand theoretically, and frame pain pragmatically is not a simple one. As this thesis has shown, there have been a multitude of responses, sometimes overlapping and often contrasting – particularly regarding the credibility of infant pain. The complexity of this first problem is related to the second issue: the lack of scientific unity, which has been analysed throughout
the study. The third problem relates to the “politics of pain” and the articulation of the disciplinary framings of pain into structures of power.

Concerning the first question of the conceptualisation of pain, the problems start with the disagreement about what pain is. We recall that, in the nineteenth century, Darwin and Preyer described pain as a reflex action and based their conclusions on the observations of infant reactions to pain. As behaviourism became entrenched among later psychologists, researchers concluded that even a clear response of displeasure was irrelevant to the question of whether babies experienced pain because the response was no more than a reflex action, an automatic response to a stimulus. Well into the twentieth century, we encounter the oft-cited IASP definition that pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” and that “pain is always subjective. Each individual learns the application of the word through experiences related to injury in early life.”

If the virtues of this model – which understands pain as a complex subjective phenomenon that stems from the interaction of the self and culture – have been highlighted because they allow the visibility and medicalisation of patients with chronic or terminal pain (whose pain had been invisible for such a long time), this new model of pain also codifies a prejudice against the non-verbal expression of pain. The IASP definition means that the experiences of individuals unable to express themselves verbally cannot be classified as painful, because self-expression is considered necessary for the attribution of pain.

The IASP amended its definition in 1994, adding an important additional note which relates to childhood pain: “The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain-relieving treatment.” Even so, as late as 1996, Harold Merskey continued to defend the view that “we can only know if someone has pain if they tell us truthfully that it is present.” The problem of childhood pain shows the need to question our notions about pain and sensitivity, as well as those relating to the period we call childhood.

1041 The first definition is from Pain, 6, 3 (1979) 249-252.
1044 Merskey, Response to editorial ‘New perspectives’, 209. Merskey had already, in 1970, suggested that the perception of pain by children was immature and that this capacity was acquired with age.
Regarding the second problem, that of the lack of scientific unity, the various texts and practices analysed in this thesis show how there was a lack of scientific consensus throughout the whole historical period under discussion.\textsuperscript{1045} In Chapters One and Two, we saw how at the same time as the scientific method was turning the child into a scientific and mechanistic object – with the consequent denial of infant pain – paediatricians were looking at sick children as “children without childhood” and considered that their professional role, therefore, was not only to re-establish the health of the child but also to re-establish the values of innocence and goodness appropriate to a romantic conception of childhood. Like the experimental physiologists of Chapter Two, the evolutionary psychologists of Chapter Three and the psychoanalysts of Chapter Six did not consider the study of childhood only because they were interested in children; they also harboured the hope of discovering facts that would shine light on their own disciplines. The ascent of the historical sciences and their alliances with diverse theories – such as that those of recapitulation, degeneration, and psychoanalysis – granted the child an unprecedented position in the field of knowledge: the child ceased being a secondary or superfluous question and became a source of fundamental knowledge for a good number of disciplines. Nonetheless, it is surprising how at the very same time the child became a matter of considerable interest to these disciplines, its individuality also seemed to disappear – the child becoming an object of science more than a subject – and how along with this, in some cases, the child’s pain also disappeared. The detailed scientific notes about the child’s first movements and expressions in relation to sensations and pain (Chapter Two), or the studies of the mind of the child (Chapter Four) did not derive from an interest in the child as such but rather from an interest in its function as an index of evolutionary development or in relation to understanding the adult mind.

The main conclusion of this study is that the construction of medical and scientific models of childhood pain reflects and creates a series of paradoxes and tensions in relation to the emergence and consolidation of the scientific disciplines analysed. In the first place, the strategies which emerged to care for and treat children with pain were formulated around and dependent on the

\textsuperscript{1045} See Biagoli and Galison, \textit{The Disunity of Science}. 
interaction of different professionals from very varied disciplines – such as psychiatrists, psychologists, physiologists, paediatricians, politicians, and photographers. As has been highlighted in Chapter Five, the research and analysis of children with behavioural and emotional problems produced a coming together of a series of people with different ideas, methodologies, experience, and knowledge who tried to work together for the benefit of children. However, despite the emphasis on working in a harmonious team, childhood pain was a field of highly controversial professional competition. Diagnosis, the medicalisation of the pain of children, and the creation of various figurations of the child served as a means for individuals to acquire professional power, status, and recognition for their disciplines. This study has highlighted the intense professional rivalries between different professions, such as those between neurologists and psychologists when accrediting themselves as experts recognised for the care and treatment of nervous children (Chapter Five). The construction of various theories and methodologies, presented as essential for the treatment and control of the different figures of the child with pain, was used by professionals of different fields to develop and strengthen their professional and scientific status within the medical and educational systems. The changing responsibilities in the identification, care, and treatment of children with pain reflected complex professional relationships between psychiatrists, psychologists, educators, the judiciary, government departments, central and local authorities, and lay charitable organisations.

As a tool of social and professional power, the medical conceptualisation of pain reflected important areas of conflict between different groups: medical professionals and parents; the state and parents; paediatricians and physiologists; psychiatrists and psychoanalysts; professional and non-professional organisations; and rival medical professionals. In addition, the concern and increasing professional interest in the emotional and physiological well-being of children gave way to an evolution in the understanding of emotional development and behaviour in childhood and infancy. This, in turn, implied a greater control of childhood, creating tension between the individual experience of the child in pain and the medical figuration of childhood. For instance, psychology and child psychiatry (studied in Chapter Six) developed around the unquestioned assumption that the new psychological and educational theories
signified progress. A greater understanding was equated with an improvement in social and medical well-being, an assumption illustrated by figures such as the child analyst Anna Freud, who affirmed that the better we understand children, the better we can care for them. The assumption continued to be a characteristic of approaches to child development throughout the twentieth century, reinforced by the constant historical and contemporary references to the “pioneering” nature of the theoretical achievement, with accounts centred on the role of medical professionals in the development of new theories rather than on the real experiences or perceptions of children with pain. Nonetheless, this study has shown that a greater understanding of the behaviour patterns of both “normal” and “pathological” childhood did not necessarily result in an improvement in the circumstances or behaviour of children with problems. Attempts to solve one problem often created problems of a different nature, which were unnoticed or not recognised by medical professionals. The focus of psychiatry on the study of childhood illnesses examined in Chapter Four, for instance, resulted in the growing pathologisation and marginalisation of children with behavioural disorders. One of the main findings of this thesis is that the process of evaluating, treating, and managing the pain of children was very variable and inconsistent. Children could be classified as having pain by various figures, including parents, medical professionals, and medical institutions. Depending on the route by which they were classified, children with pain could be interned in a wide range of institutions, including hospitals, asylums, and clinics. The responsibility for their supervision, medical assistance, and social well-being could fall upon any one of various types of agent, including psychiatrists, psychologists, psychoanalysts, progressive educators, and parents or carers (adoptive parents).

In relation to the above, the debate about the pain of childhood also provides information about the cultural weight of certain ideals about childhood. In part, this wide variety in the strategies of care and treatment of the child reflects the malleable and porous nature of concepts of both pain and children. Another paradox which this study has highlighted is that, despite a process of medicalisation, the identification and categorisation of children with pain depended on factors other than the criteria of medical diagnosis. To a large extent, the identification and presentation of the various figurations studied in the
thesis – whether that of the sick child, the insane child, the wild child, or the child with separation anxiety – reflected social and moral norms, the expectations and aspirations which the adults who surrounded them had about childhood. The social value of children was evaluated in normative developmental terms that were physiological, behavioural, and – in some case – moral. This thesis has described the presence of the child with pain in different discourses with the aim of showing how the concept of the child in pain is given specific forms – the sick child, the insane child, the savage – and how these figurations speak to us of the making of scientific worlds and adult cultures. Accounting for the media through which the child is created – and the bodies and words which this figure generates through a plurality of forms – this thesis has placed the child with pain within a wide set of interconnected transformative trajectories that point to the uses of its mutability. Among the most important of these trajectories is that of “development”. Through its bodily interactions with the world, including its entry into language, the child is observed developing and becoming an adult. In other words, childhood’s value is in its potentiality. But this potentiality is set within a normative framework, which leads to the generation of pathological figures. The vast variety of psychological theories, governmental policies, and social-care programmes aimed at achieving the adequate development of the child indicate the enormous capacity of this teleological model of the child for penetrating biological, social, and cultural areas. And yet, within the economy of mutability, childhood can also be considered as a very valued characteristic of the adult age. For example, the regression to childhood to repair the adult or recover the “inner child” – as occurs in many psychotherapeutic techniques – has become a familiar response to adult problems, both within psychotherapeutic practices and in wider popular discourses. In this case, the child is valuable mainly to the extent in which the condition of childhood can be revisited with the aim of being left behind once more.

A key argument in this thesis is that the figure of the child accumulates power and value through its multiple figurations in distinct disciplines and contexts, and that only by tackling this multiplicity can its cultural power be understood. The distinct representations of the child with pain are historically and culturally specific. The study of the child as a material entity has brought the child to the centre of discussions relating to the making of “facts” about nature and human
To confront the question of the child in this way, I have juxtaposed scientific figurations of the child with equally distinct figurations from other cultural fields. This selective juxtaposition emphasises the power of scientific discourses in the everyday understanding and uses of the child at the same time as it insists on the cultural specificity of these scientific claims.

In turn, this thesis has encountered certain variables that are repeated in different periods and disciplines. In the various contexts studied, children were not a homogeneous group: within the period of childhood, they were distinguished by size, individual strength and, occasionally, by sex. These results direct attention towards the general importance of age as a category in modern medicine: children are compared with the ages of the whole life cycle, including youth, adulthood, and old age. As Hannah Newton has argued, historians of medicine have often tended to overlook age as a category, prioritising sex as the organising principle of modern medicine. New work should be carried out on this subject and, in particular, on the medical perceptions of adolescence, youth, and old age, and the forms in which sex and age intertwine in medical perceptions and treatments. When they described the constitution of children, the cause of their illnesses, and treatments for them, doctors did not usually distinguish between boys and girls. This is significant because historians have generally assumed that differentiation according to sex took place from around the age of seven. The reason why gender rarely appears in the medical observations and treatments of children was probably that the characteristics which define children in medical opinion are largely related to puberty. In making this argument, I am not seeking to suggest that gender did not affect other areas of children's lives. Historians such as Brigitte Glaser have convincingly shown how the way that boys and girls were brought up was often very different. Likewise, in the recent volume *Learning How to Feel*, several authors discuss the intersection of gender and the socialisation of

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1046 Newton, *The Sick Child*, 224.
children in different emotional realms. What this thesis demonstrates is that, in the context of pain, gender distinctions lack importance.

The third problem considered by this thesis is the politics of pain, a concept that has recently led to new theoretical frameworks in which the history of emotions has collided with political claims. If, as Lucy Bending has shown in The Representation of Bodily Pain in Late Nineteenth-Century English Culture, the appropriation of physical pain by different interpretations opens the door to potential abuse by the authorities, pain is subject not only to cultural conditioning but is also susceptible to be represented or distorted by these power groups.

The research on infant pain denial examined in the first two chapters – to highlight one example – can be considered as a paradigm of the forms in which pain can be manipulated and defined by those who wield power. Each time that the communicative power of language is weakened or linguistic communication disappears, Elaine Scarry’s thesis that the lack of expression of personal pain converts those who suffer it into beings “more vulnerable to exploitation, oppression, or torture” at the hands of those who hold power takes on a special importance.

This thesis has traced how the question of the pain of others – of children – became a recurrent political battlefield (within both the various medical disciplines and other power groups). The reality of childhood pain in the period studied was not only a clinical or scientific problem. On the contrary, the understanding of childhood pain required the mobilisation of many different sources and communities.

The history of pain implies a political dimension, as that which counts as pain depends not only on the testimony of those who complain – the children – but also on the criteria that are agreed (by medical professionals, by the culture) regarding our patterns of trust. Visualising pain and accepting the complaints of others requires a combined effort of agreement not only among doctors but also between the various disciplines, individual professionals, medical associations, and families. The political dimension of pain is not simply a social characteristic which should be added to other physiological or psychological characteristics.

1048 In her article ‘Piggy’s Shame’, Ute Frevert shows how transformations in the uses and valuations of shame and shaming reveal and sustain changes in gender prescriptions, notions of authority, and childhood ideals, see Ute Frevert, ‘Piggy’s Shame’ in Olsen, Frevert and Eitler, Learning, 134-154.

1049 Bending, Representation of Bodily Pain, 1-11.
1050 Scarry, Body in Pain, 27.
On the contrary, the public dimension of pain implies that pain finds itself embedded in the political concerns and social values of a specific historical context. In Chapter Four, for instance, we saw how in evaluating the children with mental illnesses doctors faced various considerations of a political dimension, including the question of whether a particular level of incapacity should require them to be institutionalised, whether in asylums or paediatric institutions. In turn, given that the problem of pain is, to a certain extent, a question of trust, its assessment and treatment is always embedded in the discourses of those who define what pain is. This thesis has indicated that these parameters, which determine not only the understanding of pain but also the experience of pain, can be different in distinct medical disciplines at the same historical period. This implies that the historical analysis of this harmful experience involves both those afflicted by pain and the observer, including – and this is the key point here – the group of historians and social scientists who, through their description of the invisibility of pain and the experiences of pain, contribute to the discovery of a new form of social conscience. This thesis has described a meandering history in which pain emerges through multiple debates. The question is not only about whose pain should be important to us but also which pains should be borne in silence and which can be expressed and accepted socially. The politics of pain, as a complement to the study of pain’s theatricality or the rhetorical tools used to generate conviction, is not just another example of historical scrutiny: the scopic regimen of pain and its history affects the very nature of historical writing.

Only through the experiences of the defeated can we transform experience into knowledge and accept historical or cultural change, wrote Germany philosopher Reinhardt Koselleck.\(^{1051}\) The study of pain is a case in point. The influential works of David B. Morris and Rosalyne Rey recover – and sometimes discover – the experiences of the losers in clinical medicine, taking the words of patients at face value (that is, literally) while paying attention to their expressions,
These historians not only questioned the biomechanical model of pain but also a mechanical understanding of history. If the discovery of chemical anaesthesia in the mid-nineteenth century was strongly related to the understanding of the modern concept of pain as something sharp, peripheral, and bio-mechanical, the appearance in the middle of the twentieth century of pain as an object of medical theory and practice was related to the notion of pain as something chronic, central, and bio-cultural. In both cases, there was a clear correlation between pain and history, between pain and trauma. Finally, the history of pain, like any other history of experience, requires a historical awareness that can reduce the gap between the past and the present. Despite the difficulties implied in approaching the experiences of the past, “emotional history” must be capable of exploring and discovering the invisible emotions of the defeated, the solitary suffering of those whose pain has been forgotten, such as children.

Twenty-first-century historical accounts have generally ignored the reasons why, until recently, the histories of pain had left to one side the changing and always complex social attitudes in relation to the pain of children – an indication of the way in which we have constructed our history on the foundations of an enlightened humanitarian politics. We pay more attention to certain phenomena that affect a small part of the population – conditions such as phantom limbs, for instance – than to something as fundamental and universal as pain in childhood. Just as there is a hierarchy of pain in the medical world, there is also one in the history of pain which must be questioned and resolved.

German philosopher Friedrich Nietzsche’s *The Gay Science*, published in 1888, made the strong claim that historians had abandoned the very things that give colour to existence.\(^\text{1053}\) Emotions, for instance. Academics generally cite the starting point of the history of emotions as French historian Lucien Febvre’s 1941 text *La sensibilité et l’histoire; comme reconstituer la vie affective d’autrefois* [Sensibility and history: How to write the emotional life of the past], which argued that narratives about politics and economics had wrongly failed to include

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\(^{1053}\) “So far, everything that has given colour to existence still lacks a history,” Nietzsche, *The Gay Science*, quoted by Burke, ‘Is there a cultural history of emotions?’, 35.
elements such as fear, hatred, cruelty, and love, which are fundamental to social
count. For Febvre, all these emotions, including those that are, in principle, the
most irrational, lay behind both individual decisions and collective actions.\textsuperscript{1054}

Like Nietzsche before him, Febvre saw history as something that simply could
not be severed and distanced from the present or seen as something separate
from life.\textsuperscript{1055} The highly rational approach of Enlightenment philosophers such as
Locke, Hume, and Kant had to return to the real blood that flowed through the
veins of real human beings. When Febvre called for extensive research into the
fundamental feelings of humanity, there was a clear political inspiration in his
demand. Since Febvre wrote his oft-cited article on the history of the emotions,
the connection between the past and the present has become more and more
pressing.\textsuperscript{1056} The advantages and uses of history for modern life, to use
Nietzsche’s expression, are even more telling when writing the history of
emotional experiences such as pain, particularly in the case of those individuals
– such as children – who lack the ability or the cultural right and legitimacy to
speak. The history of pain in children contributes to these new theoretical
frameworks which include the political dimension of “sentimental history”.\textsuperscript{1057}

Thus, I hope to have brought the history of childhood into line with the current
debate among historians of pain and the generally accepted view that pain is
subject to historical changes. This thesis has sought to explain what these
changes involved and how differences were configured. It has argued that there
is no such thing as “pain”, there are only beings (in this case children) who feel
pain, who are joined to a specific society through their own feelings and
emotions, and whose experience is subject to different regimes of visibility,
expression, and repression – depending on who delimits these experiences and
who imposes discipline.

This thesis is by no means a definitive study of pain in childhood. It has not
explored the experiences of children in pain or of the families with children in

\textsuperscript{1054} Lucien Febvre, ‘Sensibility and History: How to Write the Emotional Life of the Past’, first published
in 1941, in Lucien Febvre (Peter Burke, ed.), \textit{A New Kind of History from the Writings of Lucien Febvre}

\textsuperscript{1055} “History is not something separated from life or remote from the present,”: Wilhelm Dilthey, \textit{The

\textsuperscript{1056} Febvre, ‘Sensibility and history’, 26.

\textsuperscript{1057} Febvre, ‘Sensibility and history’, 26.
pain, nor has it examined other types of pain outside a medical context, such as the pains of flogging and other forms of corporal punishment in schools or the physical pain of children during World War I. Further research needs to be carried out on the experiences of children in pain to fully capture the history of pain in childhood in British medical discourse. More research needs to be done on the impact of theories and methodologies developed and implemented by medical professions and progressive educationalists, from the perspectives of both children and their parents. Further oral-history projects would provide evidence of the impact of other strategies, such as the child guidance clinics. Future analysis of these accounts would enhance our understanding of the effectiveness of the many strategies employed, potentially aiding the construction of medical and state approaches to the large numbers of children in pain both today and in the future. More work needs to be done to explore the use of photography by medical institutions in order to establish whether there was a common approach to photographing patients or whether hospitals adopted different ways.

Throughout two chapters of this thesis, photographs have been considered in relation to written discourses, and the links between the two have been explored. Only when we look at these sets of images together do we realise quite how varied the representations of the child in pain were, and in how many different ways photography was used in medical contexts. What this research has revealed so far is that there were markedly different ways of photographing and visualising child patients in the late nineteenth and early twentieth centuries, so that as soon as we think we know what a child in pain “looked” like, another image will appear that throws this into doubt. While a comprehensive account of all the styles of patient representation may be lacking until further research can be completed, it is clear that photography and the camera occupied an important and complex place in both the everyday running of a hospital and medical institution and the discursive and printed world that existed around it. It has been difficult at times to conduct this research. Delving into personal and sensitive records of suffering individuals does not suddenly ease with the lifting of a one-hundred-year ban on accessing the archive. Moreover, the immediacy and power of a distressing photograph can make such work even harder. But these visual records tell an important story, of how the camera became not only part of
popular commercial and domestic culture but was also was used as a scientific and medical tool – and as means for of labelling and repression. Future research in this area could include combining the image and scientific writing in a more systematic way, investigating in depth the politics of pain in childhood and exploring pain in childhood at other times, in other places, and during puberty and adolescence. There remain many avenues for fruitful historical enquiry concerning the figure of the child in pain.
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