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### **Victorian medical awareness of childhood language disabilities**

Paula Hellal and Marjorie Lorch

From the mid-nineteenth century, disability in childhood became an issue of increasing interest to the British medical and educational communities as ‘Victorians sought to better identify, categorize and manage those individuals who were unable to conform to society’s expectations’.<sup>1</sup> With the founding of the first paediatric hospitals and the introduction of compulsory elementary education, children’s abilities and disabilities were analysed and assessed on an unprecedented scale. Many of the children admitted to the new specialist hospitals had chronic debilitating conditions, necessitating their treatment on the wards or in convalescent homes for extended periods. This provided the opportunity for physicians to follow up on the progress of their young patients and conduct longitudinal studies of their recovery.

Beginning in the 1860s, there were several decades of research into the significance of acquired disorders of language in previously healthy adults. However, it was not until the end of the century that clinicians began to focus their attention on children who failed to develop speech or learn how to read. This new medical interest in children with language disabilities was driven by the social concern of parents and educators and by the clinical appreciation of the maturational trajectory for the neurological organisation of language. In this chapter, we will explore Victorian attitudes to childhood disability by focusing on how physicians

attempted to describe and explain these newly identified developmental disorders of language.

### **The scientific study of children**

Some tradition of providing institutional support for those with sensory impairments already existed in early modern Britain at the beginning of the nineteenth century. The first public school for the education of deaf individuals opened in London in 1792 with more schools following the capital's lead: Liverpool, Manchester, Exeter, and Doncaster all opened establishments in the 1820s. A school for blind people opened in Liverpool in 1791, and that too was followed by others opening around the country, e.g., Edinburgh, Bristol, London and Norwich had asylums for blind children (and adults) by the beginning of the nineteenth century.<sup>2</sup> By mid-century, a school for 'physically handicapped' girls had opened in London, with a similar institution for boys opening the following decade. Around this time, in response to social, economic, and political pressures on the one hand, and medical and scientific agendas on the other, a growing number of state schools and charitable institutions started to offer some training and education to children with physical or sensory impairment.

However, it was not until the latter part of the century that the sheer number of children affected with some sort of disability became apparent. The turning point was the Education Acts of 1870 and 1880 that made elementary education compulsory in England for all under the age of thirteen.<sup>3</sup> During the nineteenth century, the population of Britain had increased dramatically, and by the time the 1870 Act came into effect it had reached twenty-six million with more than three million inhabitants in London alone. Children from deprived urban areas began to enter school for the first time and the appalling scale of poverty, sickness, and mental and physical impairments were no longer hidden.

Almost immediately, there were growing calls for welfare provision. In an attempt to discover how serious the problem was, the British Medical Association, the Charity Organisation Society, and the British Association for the Advancement of Science set up a committee in 1888. Their objective was to conduct a study into the development of 100,000 school children. Its report, edited by Francis Galton (1822-1911), included recommendations on the type of education and training that would be most suited for 'handicapped' children.<sup>4</sup> In 1893, the Elementary Education (Blind and Deaf Children) Act, establishing special schools for those with sensory impairments, was passed, and in 1899, the Elementary Education (Defective and Epileptic Children) Act made the same provision for physically impaired children.<sup>5</sup>

It was not only within the educational domain where disabled children were examined, assessed and trained.<sup>6</sup> This period also saw new specialist paediatric hospitals founded across the country, even although throughout much of the nineteenth century British medical opinion proved stubbornly opposed to any type of specialisation. Providing separate medical facilities for children was particularly anathema to many.<sup>7</sup> The common concern was that a sick child would fail to thrive if taken from its mother, while allowing mothers to remain with their children in the hospital would, it was thought, cause the spread of infection.

Among the few who thought otherwise was Dr Charles West (1816-1898). West had trained on the continent of Europe where children's hospitals were already established. The first was L'Hôpital des Enfants Malades, which was founded in Paris for children under the age of fifteen years in 1802. In 1821, the Institute for Sick Children was founded in Dublin and, in the 1830s, specialist paediatric hospital provision had been created in Berlin, St Petersburg, Vienna, and Breslau.<sup>8</sup> By the 1840s, West had returned to England and was working at the Universal Dispensary in Waterloo Road, London, the only institution in the capital that provided outpatient care for mothers and infants. West was keen to establish a

paediatric hospital. That there was a pressing need for such an institution is made clear in a contemporary report criticising the lack of provision for the treatment of the diseases of children:

... neither in this city [London] nor throughout the whole British empire is there any hospital exclusively devoted to their reception. At the same time, the number of children received into the general hospitals is so small, that on an enumeration of the population of those institutions, made in January 1843 ... they were found to contain only 136 children under 10 years of age. Of this small number ... only 26 [had been admitted] for the cure of any internal disease.<sup>9</sup>

In the same year that Ellis's report was published, and after a lengthy struggle, West founded the Hospital for Sick Children in Great Ormond Street, London. Other paediatric establishments soon followed, with hospitals opening in several cities across Britain (such as in Norwich (1853), Manchester (1855), Edinburgh (1860), and Birmingham (1861)). A second London hospital, the Evelina, was established in 1869 through the personal generosity of Ferdinand de Rothschild (1839-1898) to provide for sick children who lived south of the River Thames. By the turn of the century, more than twenty-five paediatric hospitals were established in towns and cities across Great Britain, but there were also specialist institutions, such as the Alexandra Hospital for Hip Disease in London, which cared exclusively for children with congenital musculoskeletal afflictions.

Children were frequently kept as inpatients in the paediatric hospitals for months on end. For example, in the Evelina Hospital the average length of stay in 1876 was sixty days.<sup>10</sup> This long-stay care arrangement may in part have been due to the lack of adequate home support and the general social deprivation of these young patients. Home conditions were often recorded in the Great Ormond Street patient case notes, for example, as being 'poor' or 'unsatisfactory.' Furthermore, it was common practice for hospital staff to arrange

for recuperating children to stay at a convalescent home, usually located in the countryside or at the seaside, for a period of time after being discharged. This ensured they had good food, fresh air, rest, and ongoing medical attention that was typically lacking in their home environment while, at the same time, freeing the limited number of hospital beds for more acutely ill patients. The number of these convalescent homes had been growing in England and Wales from the 1860s and, by the last decade of the century, there were about fifty. Some were independent institutions that contracted beds out to the city hospitals, while others belonged to the urban paediatric hospitals. In 1869, Great Ormond Street Hospital leased its own convalescent home for sick children, Cromwell House in Highbury, which was then a small village four miles outside the city of London.

### **The importance of age as a factor in disease**

As Charles West had hoped, the establishment of the children's hospitals led to a rapid increase in research into childhood disease. Clinical observations from large numbers of children began to be collated and compared. It became apparent that an important variable was the age of the patient at symptom onset. This understanding enabled physicians to investigate new questions and drew original distinctions between perinatal, infant, and later childhood illness.<sup>11</sup> These distinctions were most evident in the investigations of infantile cerebral paralysis and acquired childhood aphasia.<sup>12</sup>

John William Little (1810-1894) was the first to draw significant attention to the developmental difficulties of children with infantile cerebral paralysis, examining the condition initially from an orthopaedic point of view.<sup>13</sup> Physicians caring for large numbers of children in the new hospitals began to publish case series in an attempt to differentiate infantile cerebral paralysis from paralysis due to spinal lesions. William Osler (1849-1919), who popularised the use of the term 'cerebral palsy', presented a case series highlighting the

relevance of the age of the child when their symptoms began to the diagnosis and prognosis of their condition.<sup>14</sup> Osler also pointed out that the effects of cerebral palsy extended beyond difficulties with motor control and general mental development to particular consequences for the development of language.

### **Language impairment**

The neurological underpinnings of speech impairment were brought to medical attention by the French physician Paul Broca (1824-1880) who, in the 1860s, suggested a link between impaired language function and damage in the frontal cortex found at autopsy.<sup>15</sup> Following his reports, numerous case studies started to appear in the literature. Children were typically reported alongside adults without comment.

Tracing these case studies poses specific challenges at different points of time throughout the nineteenth century. There is the watershed moment when the French term ‘aphasie’ was coined in 1864,<sup>16</sup> but before this time, and indeed for some further period following, such symptoms were most likely to be recorded in English hospital patient records and medical publications as ‘loss of speech’ or ‘speechlessness.’ In such cases, an individual’s language would have been developing typically (or at least without apparent difficulty) before a brain injury of some description resulted in noticeable difficulty with speech.

It was only towards the end of the century, when the syndrome was already a well-established clinical entity that the link was made between the age of the patient at the time the brain injury occurred and the severity of symptoms, patterns of recovery, and likelihood of lasting deficits in language.<sup>17</sup> This parallels the attention being paid to age at symptom onset in the emerging clinical category of cerebral palsy. Cases of children who had been acquiring language in a typical fashion until illness or trauma resulted in loss or impairment were, by

their nature, relatively rare. Far more common were instances of children who failed to develop language normally. However, until the last decade of the nineteenth century, these children were conspicuous by their absence from hospital records and the published medical literature. Until the 1890s, children with developmental language difficulties might have found themselves in asylums for the ‘feeble minded’ or, if they were fortunate, they might have had some remedial help from specialists in the education of deaf people or even from elocution masters. Also at this time, difficulties in the development of related language abilities such as reading and writing began to be noted by physicians rather than by educationalists.

### **Terminology**

In these late nineteenth-century observations, symptomatic behaviour was described in detail. However, no clear terminology or classificatory system had yet been developed. In contrast to the syndrome of aphasia, which was a well-recognised clinical entity by 1870, the developmental disorders of language or related selective cognitive difficulties did not enter the accepted nosology until a century later. The term ‘congenital word-blindness’ was used for many decades to describe the developmental reading difficulties, which are today referred to as ‘dyslexia’. This term, along with the broader concept of ‘learning disability,’ was not introduced until the 1960s.<sup>18</sup>

The social historians Risse and Warner point out that, in order to understand its social and medical meaning, a diagnosis must be placed within a contemporary classification system.<sup>19</sup> Medical labels have been defined and redefined over time. In the field of developmental language impairments, including reading difficulties, there have been a multiplicity of labels used to describe the same condition. In their review of the literature



from the mid-nineteenth century onwards, Worster-Drought and Allen commented on the plethora of terms used:

The history of the subject of congenital word-deafness and its complications is a reflection of the different phases through which the subject has passed since aphasia was first recognised as a clinical abnormality early in the nineteenth century. Hence it follows that references to the subject are to be found under the headings of idiocy in children, speech defects (and especially idioglossia), congenital aphasia, sensory aphasia, congenital word-deafness, the association of congenital word-deafness and congenital aphasia with speech defects, behaviour defects, studies in psychology and educational problems.<sup>20</sup>

Their view draws on evidence taken from a wide range of monographs, textbooks and medical journal articles from over a fifty year period.

The descriptions of such behavioural symptoms were generally brief, including only a few sentences concerned with medical history, physical appearance, general demeanour, and the nature of the child's understanding and production of speech.<sup>21</sup> At the same time, the selectivity of the cases represented in the medical literature must be acknowledged. The motivation for publishing cases illustrating particular disabilities varied; for example, to establish the existence of a particular symptom, address a contemporaneous theoretical debate, illustrate an unusual reaction to standard treatment, or demonstrate a successful new treatment.

## **Dyslexia**

Initial interest in impaired literacy during the mid-nineteenth century focused on the underlying relation of impairments in spoken and written expression. The theoretical question at stake was whether an individual with a difficulty in producing speech could, or

could not, write. Up until the 1880s, there was an assumption that both spoken and written production relied upon the language faculty, and could not be selectively affected by a cortical brain lesion that preserved speech.<sup>22</sup> This concern with writing may also have reflected the more selective social status of this attainment at the time. In the eighteenth and early nineteenth centuries, wide ranges of individuals from various social backgrounds were taught to read, often in a domestic setting, for the sole purpose of reading the Bible.<sup>23</sup> However, this practice did not represent true functional literacy for such individuals. As Victorian plans for universal education were realised, a greater number of children learned, not only to read, but also to write in a formal school setting. Finally, towards the turn to the twentieth century, concerns about children with such difficulties began to become evident. Anderson and Meier-Hedde make the point that:

Of all the early research that was devoted to dyslexia, the work that was accomplished in the United Kingdom during this time period ... became enormously significant for several reasons. First, the United Kingdom physicians wrote with a clarity and organization that heretofore had not been observed in the literature. Second, they turned attention to the plight of children, and, third, these physicians wrote numerous case reports on word blindness, which resulted in an accumulation of information about this enigma. A virtual explosion of research came out of the United Kingdom in the early twentieth century. Previous research had been sporadic, in part because researchers had not specialized in this disorder. The United Kingdom physicians investigated reading problems as a primary research interest, which enabled them to make a greater contribution in this area ... The early case reports of the United Kingdom physicians would have continuing influence on all work that would come later.<sup>24</sup>

William Pringle Morgan (1861-1934) reported one of the earliest cases of developmental reading difficulties in a child in the medical journal, *The Lancet*, in 1896. Morgan was a general practitioner who also delivered medical services to the nearby preparatory schools in Sussex. He described fourteen-year-old Percy K, who had ‘always been a bright and intelligent boy,’ was noted to be ‘quick at games, and in no way inferior to others of his age,’ but who never learned to read.<sup>25</sup> Morgan suggested by analogy to the pattern found in acute acquired disorders of reading that the boy’s ‘visual word centre’ had failed to develop normally. This hypothesis was a developmental extension of psychophysical models of brain localisations for particular cognitive functions that had been developed to explain adult acquired difficulties with language processes with respect to the auditory, visual, and motor modalities.<sup>26</sup>

Morgan admitted that his notice of this case was prompted by the description, the year before, of acquired reading difficulties in adults by James Hinshelwood (1859-1919): ‘My reason for publishing this case was that there was no reference anywhere, so far as I knew, to the possibility of this condition being congenital’.<sup>27</sup> There was immediate interest in the appearance of reading difficulties in children following Morgan’s case description, with more than two dozen papers on the topic<sup>28</sup> appearing in the first decade of the twentieth century.<sup>29</sup> Hinshelwood began to see increasing numbers of children who had failed to learn how to read at his ophthalmological clinic and published an influential series of papers on childhood reading disability based on a large series of cases between 1895 and 1911.<sup>30</sup>

### **Developmental language disorder**

Like developmental dyslexia, developmental language disorder was only described decades after the adult acquired counterpart. In the early 1890s, a series of papers were published detailing the cases of children whose speech had failed to develop in a typical fashion.

Walter Bough Hadden (1856-1893), a young physician at Great Ormond Street Hospital, brought his first such case to the attention of the medical community in 1891. Hadden described an otherwise healthy child who was treated for a lengthy period as a hospital inpatient for his lack of progress in language acquisition. The boy had an extreme defect of articulation although there was no mechanical difficulty. He could not utter any sounds until he was three or four years old and as he grew older could still not produce even words of one syllable in an intelligible fashion.<sup>31</sup> Hadden drew an initial analogy between the development of walking and speech; both needed special muscular coordination, and would therefore show variation in developmental rates. He proposed that treatment for such speech disabilities must be informed by details of typical language development.

Shortly following this report, other London clinicians presented similar cases.<sup>32</sup> A nine-year old boy was brought to St Thomas' Hospital for advice. His schoolmistress found the child's speech incomprehensible and proposed that he should be sent to the Deaf and Dumb Asylum. The clinicians determined that the boy was not deaf and set about treating his articulation difficulties.<sup>33</sup> These early reports, describing otherwise healthy children admitted to hospital for developmental language impairment, mark the start of modern research into the condition.<sup>34</sup>

### **Studying child language acquisition**

By the latter decades of the nineteenth century, physicians had a number of motives for considering the acquisition of language in the child. As we have seen above, they hoped an understanding of the process would illuminate abnormal development. There was also another consideration: it was generally held that adult aphasics re-acquired speech in much the same manner as a child learned to talk. Therefore, it was suggested that understanding how children proceed to learn language might assist in the development of remedial therapy

for aphasic adults. Within the medical literature, the stages of language acquisition in the child were typically described by reference to research into localisation of function in the brain and observations of acquired aphasia.<sup>35</sup> The initial stage was thought to involve the child learning to associate sounds with particular objects. Medical textbooks of the time describe the infant being taught this recognition directly by the mother uttering a word while pointing to the relevant object.<sup>36</sup> It was hypothesized that the association between utterance and object would become fixed in the child's auditory speech centre by means of repetition. The development of the motor centre would allow the child to reproduce the words heard.

However, it was not only physicians who were interested in child language acquisition. By the latter half of the nineteenth century, child development had become a new subject of empirical research by psychologists and educators with particular interest in language. While the increasing focus on child development was generally coincident with social, economic, and political developments in Victorian Britain, there was an academic motivation as well. These early psychologists considered the emerging complexity of children's behaviour as relevant to the Darwinian theory of human evolution.

Observations of Charles Darwin's (1809-1882) own son, recorded in his personal diary in the 1830s, served the basis for what is typically viewed as the first English publication on infant development.<sup>37</sup> As a scientist of international renown, Darwin's paper attracted widespread attention. English psychologist-fathers were inspired to publish scholarly reports on their own infants' language development. This was a topic that previously was considered to belong firmly to the domestic domain of the nursery.<sup>38</sup> Although literate women had been keeping private diaries of their children's sayings and doings throughout the century and earlier, they were typically not publicly disseminated. This was true even of those written by otherwise respected and published novelists such as Elizabeth Gaskell (1810-1865).

In one further respect, parents contributed to the growing interest in child language acquisition and disorders. They took their concerns that their child was ‘late in talking’ to their physician for advice. In order to respond to this complaint in a clinical context, physicians needed to have a norm against which they could compare their young patient. Determination of what constituted delayed language development was drawn from evidence in reports from the growing paediatric clinics in hospitals and the burgeoning diary studies by the psychologists. The general view of physicians was that, where there was no indication of disease or deformity, and a child can hear and seems ‘bright’, speech may be merely delayed in development. However, they had very little besides their own judgment to bring to the task of determining a child’s mental abilities when speech was not an avenue for assessment.

As West pointed out, ‘a child’s inability to describe its sensations deprives us of another important guide.’<sup>39</sup> The child’s previous history was also seen as a potential diagnostic aid. However, the difficulty of obtaining an accurate medical history was compounded in a number of cases by the onset of presenting symptoms occurring before (in many cases a long time before) the child was seen by a physician. The all-important early history of a condition, vital for accurate diagnosis, was typically acquired second hand, the informant in most cases being the child’s mother.

The medical educator Francis Warner (1847-1926) offered advice in his textbook on conducting the medical examination of a child:

It is convenient to commence with some general conversation on simple subjects – e.g., his life at school or at home, in play and at work; what he reads, his companions and amusements. The faculty of speech is thus ascertained and some idea of the extent of his vocabulary. Various defects of speech may be found; there may be ill regulated intonation, the voice at times almost dying away; there may be thickness of utterance, often in part due to nasal-pharyngeal obstruction; a

few words may be spoken in reply to a question without affording an answer; the question may simply be repeated without any reply. In many other particulars speech or utterance may be defective. ... Particularly notice in conversation whether the child makes comparisons or exercises the faculty of judgement ... The behaviour of the child with common objects may show much as to his modes of dealing with his surroundings ... In children with little or no speech it is more difficult to ascertain whether a judgement is formed.<sup>40</sup>

As well as assessing the language-delayed child's mental capabilities, clinicians appreciated that deafness had to be ruled out first as a contributing factor. West, decades earlier, had commented on how difficult it was to determine the existence of congenital deafness in early childhood.<sup>41</sup> As deafness could be partial, assessment was complicated and physicians might erroneously label the child as intellectually deficient. West had also seen cases where difficulty of articulation, perhaps partly dependent on malformation of the mouth, had resulted in similarly inappropriate classification. However, by the 1890s, significant advances had been made and assessment of developmental language impairment was beginning to be put on a scientific footing, enabling comparison between cases.

As mentioned above, before the end of the nineteenth century many children who failed to develop language normally were assumed to have a general impairment in mental ability or auditory perception. Some were placed in institutes for the deaf or asylums for imbeciles, and, as a consequence, would not receive adequate schooling. This is despite the fact that many patients with developmental language difficulties were described as 'intelligent'. Well into the twentieth century, some institutions for the education of mutes would not admit or even examine children who could hear and were mute, or had very little speech, as it was thought that their condition was hopeless and they were unsuitable for any type of education.<sup>42</sup>

## Remediation

In the late nineteenth century, the only group that typically received therapeutic intervention was deaf mutes. Little had been developed by this point to assist in the recovery of adults with acquired language impairments. In the case of children with acquired language disorders, remedial measures were not considered necessary as it was a widely held medical opinion that these children would swiftly recover their language abilities. However, the growing interest in developmental language disorders led to attempts to devise treatment regimes, some involving intensive one-to-one remediation with specialist staff over long periods.

The Scottish physician John Wyllie (1844-1916) employed a child's father to treat his son's developmental language disorder by means of 'the physiological alphabet'. Wyllie initially described such an approach with reference to an adult aphasic case:

We did not trouble the patient with the names of the letters, but taught him from the beginning the letter-sounds of the physiological alphabet. In doing so, we adopted what may be called the 'Mother's Method'. Beginning with the Labials, we taught him to say papa, apap, appa, thus giving him the consonant P as an initial, a terminal and a mid-letter ... and so on throughout the alphabet. He was shown by 'lip-reading' how to place the lips, tongue, etc., for the pronunciation of each letter-sound.<sup>43</sup>

Hadden, in contrast, made use of the Oral Method that originated in Germany in his efforts in speech remediation. The method had been established in some London schools for deaf children from the late 1860s.<sup>44</sup> The practice directed the teacher to face the pupil and show, by exaggerated movements of his own lips and tongue, the positions to form each particular sound. Sight and touch were used in place of the defective sense of hearing.<sup>45</sup>



Hadden used this method to treat a boy hospitalised for seven weeks. At the end of this remediation period, Hadden noted that the boy could successfully produce individual letter names, but only had a repertoire of a few simple words and phrases. However, Ashby and Wright point out that successful treatment of defective speech depended on the cause of the condition. The mother of another patient of Hadden's was trained in the Oral Method for the deaf and attended the treatment sessions, between the nurse and her child, at the hospital.

Involving parents in therapy for childhood speech disorders was an innovation that was less practiced as speech and language therapy became a fully-fledged profession in the mid-twentieth century. Possible therapies for word blindness were also being put forward only a few years later. At the turn of the century, Hinshelwood recommended strengthening sight-sound association for children afflicted with word blindness through the use of touch. He proposed using block letters that the child could feel as well as see to assist in overcoming reading difficulties.<sup>46</sup>

In general, longitudinal descriptions of an individual's pattern of recovery were rarely reported in the medical literature as cases were typically published shortly after the child's admission to hospital. Moreover, often in the nineteenth century, once a patient left the hospital there was little or no follow-up care. However, some Victorian paediatricians made great efforts to follow up their patients' progress, observing the children's development or lack thereof over periods of months and sometimes years. Their work led, from the last decade of the nineteenth century, to attempts being made to formalise assessment procedures and to improve and develop speech transcription methods. Hale White and Golding-Bird even made use of the recently invented phonograph to make recordings (now lost) of their patients' pre- and post-treatment speech samples.<sup>47</sup>

Although individual clinicians had developed their own investigative procedures, these methods were yet to be widely adopted and standardised.<sup>48</sup> Linguistic science, upon

which a rigorous understanding of language is based, was still in its infancy, although in the latter part of the century books on phonetics and grammar were beginning to appear. Throughout the century, the Victorian physician had to rely on his own, and his colleagues', clinical judgment and experience when presented with cases of impaired language function. Their descriptions of linguistic impairments were, therefore, somewhat idiosyncratic. Given that the clinical examination of grammatical aspects of language was very rudimentary even in adult aphasia until later in the twentieth century, it is unsurprising that the assessment and remediation of speech difficulties in children focused almost entirely on the phonetic analysis of speech.

### **Conclusions**

During the Victorian period, a new focus on childhood disabilities of language developed. Hospitals, asylums, schools, and specialist establishments were opened throughout Britain. There were growing efforts to systematically describe the prevalence, cause, prognosis, and treatment of such disabilities. Though, as Starkey points out, 'if the experiences of physically disabled children can be said to have improved by the end of the century ... children afflicted with epilepsy or mental health difficulties were less likely to benefit from greater understanding.'<sup>49</sup>

Initially, children were served by the same social and medical systems as adults. However, as the century progressed, it became increasingly common to consider the needs of children separately from issues that concerned the adult population: Acts of Parliament focusing on childhood issues were passed; paediatric hospitals treated childhood disease and assessed child development. There was a steady increase in specialist terminology and models of developmental language disabilities, while the patient's age at the onset of

symptoms came to be recognised as a relevant determining clinical factor in the compromise of speech and literacy.

The nineteenth-century interest in child language acquisition had been initiated in England by Charles Darwin with larger scale group studies following throughout the latter decades of the century such as that of the psychologist James Sully's (1842-1923) *Studies of Childhood*.<sup>50</sup> As well as the publication of individual patient reports, medical textbooks began to describe both developmental and acquired language disorders in childhood such as language delay, stammering, stuttering, and aphasia. This increased interest within the medical profession in typical and deviant child language acquisition made it possible for physicians to begin to compare their patients' language development with the perceived standard. Conditions now termed developmental dysarthria, specific language impairment, and dyslexia were investigated around this time. As the first papers on such disorders started to appear, many physicians realised that they too had seen similar cases. This is a specific instance of the general experience that, once a new phenomenon is formally identified, it is subsequently found to be surprisingly common. Investigations of language disabilities grew in number following publication and discussion of the first few cases. Many researchers, both in Britain and abroad, followed the work of these early Victorian pioneers.

At the turn of the twentieth century, child development and particularly child language disorders were being studied on a large scale both in the English-speaking world and on the Continent by those involved in medicine, psychology, education, and social welfare. By examining this early modern period of research into childhood language disorders, we can trace the development of contemporary concerns and debates. The late Victorians were interested in many of the same questions that we are preoccupied with today: what constitutes language delay?; what can be done to assist children with delayed or impaired speech?; or, why do some children struggle to read or pay attention? The Victorian

era can be credited with ushering in reforms in any number of important areas concerning disabilities, from childhood developmental disorders, including but not limited to problems with language acquisition, to mental health issues that affected both young and old. These early steps in recognising age as a factor of clinical importance were responsible, in large part, for eventual legislation in Great Britain, Continental Europe, and the United States that provided equitable treatment of children and adults alike.

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<sup>1</sup> Amy R Rosenthal, 'Insanity, Family and Community in Late-Victorian Britain' in Anne Borsay and Pamela Dale (eds), *Disabled Children: Contested Caring 1850-1979* (London: Pickering and Chatto, 2012), p. 29.

<sup>2</sup> Derek Gillard, *Education in England: A Brief History* (2011).

<sup>3</sup> Compulsory education for children aged between five and thirteen was introduced to Scotland by the Education (Scotland) Act of 1872.

<sup>4</sup> D S Galton, *Report on the Scientific Study of the Mental and Physical Conditions of Childhood, with Particular Reference to Children of Defective Constitution: And with Recommendations as to Education and Training*, Committee on the Mental and Physical Condition of Children (London: British Medical Association, 1895).

<sup>5</sup> The 1893 Act for England and Wales was preceded in Scotland by the 1890 Education of Blind and Deaf-Mute Children (Scotland) Act.

<sup>6</sup> Andre Turmel, *A Historical Sociology of Childhood* (Cambridge: Cambridge University Press, 2008).

<sup>7</sup> William F Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994).

<sup>8</sup> Angel Ballabriga, 'One Century of Paediatrics in Europe,' in B L Nichols, A Ballabriga, and N Kretchmer (eds), *History of Paediatrics 1850-1950* (New York: Raven Press Ltd, 1991).

<sup>9</sup> Richard Ellis, *Diseases in Childhood* (London: G Cox, 1852), p. 8.

<sup>10</sup> E Lomax, 'Small and Special: The Development of Hospitals for Children in Victorian Britain', *Medical History Supplement* No. 16 (1996).

<sup>11</sup> For example, see Henry Charlton Bastian, *On Paralysis from Brain Damage in Its Common Forms* (London: Macmillan, 1875); William Osler, *The Cerebral Palsies of Children. A Clinical Study from the Infirmary for Nervous Diseases*, reprinted edition, Vol. 1, Classics in Developmental Medicine. No 1 (Philadelphia: Mac Keith Press, 1889; reprinted 1987); S Freud, *Infantile Cerebral Paralysis [Die Infantile Cerebrallähmung]*, trans. Lester A Russin (Miami: University of Miami Press, 1897).

<sup>12</sup> Paula Hellal and Marjorie Perlman Lorch, 'Darwin's Contribution to the Study of Child Development and Language Acquisition,' *Language & History*, 53:1 (2010).

<sup>13</sup> W J Little, 'Hospital for the Cure of Deformities: Course of Lectures on the Deformities of the Human Frame', *The Lancet*, 41:1053 (1843).

<sup>14</sup> William Osler, *The Cerebral Palsies of Children. A Clinical Study from the Infirmary for Nervous Diseases*, Vol. 1.

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