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**THE EXPANSION AND ELABORATION OF THE CATEGORY  
PERSONALITY DISORDERS IN SOUTH AFRICA 1948-1982**

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Declaration

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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## Abstract

This archival study tracks the expansion and elaboration of the category personality disorders in South Africa from 1948 to 1982. Valkenberg Hospital patient files, official documents and professional publications are triangulated with interviews with clinicians. Previous findings that the diagnosis was applied primarily to white, and to a lesser extent coloured, patients in both the early and late 20<sup>th</sup> century are confirmed. The thesis argues that the expansion and elaboration of the category personality disorders occurred in interactional fashion both from the top down (via the state and the psy-professions) and from the bottom up (in interactions between clinicians and patients). It was linked to the professionalization of the psy-professions articulating with the state's need to manage the dangerous individual in the context of fears about white degeneration.

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## INTRODUCTION

A psychiatric diagnosis has serious implications for the way in which an individual is viewed and treated. There are consequences for medical treatment, civil status and access to resources, as well as interactions with family, employers and community (Luske, 1990; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). In the absence of biological markers of mental illness, psychiatric diagnosis rests upon clinical judgements about social behaviour, particularly in the case of the personality disorders. Given that research has established a connection between race, class, gender and diagnosis deployed (Msomi, 1997; Baker & Bell, 1999; Hicks, 2004; Malgady, 1996), it is imperative to understand how diagnostic categories evolve. Swartz (1996a, p. 55) argues that

To suggest that insanity is not simply a social construction, but the product of a dialectical relationship between discursive activity, institutional imperatives (including those promoting the professionalization of psychiatry as a discipline and psychiatric power) and complex somatic, verbal and preverbal events within individuals makes possible increasingly accurate histories of changing forms of mental disease.

This thesis proposes to draw on such an approach to ascertain how the practice of diagnosing personality disorders became instituted in South Africa in its present form during the second half of the 20<sup>th</sup> century. In order to do so it will consider developments both 'from the top down' and 'from the bottom up', a perspective advocated by Hacking

(2004a). Hacking argues that Foucault and Goffman, whose ‘extraordinary works on madness and its institutions’ (p. 287) were published in 1961, should be seen as complementary rather than contradictory. Both are concerned with the ways in which we ‘make up people’ (Hacking, 2004a); but while Foucault views the subject from the top down, looking at discourses and institutions in the depersonalized abstract, Goffman engages from the bottom up, studying the lived detail of social interaction and the shifting roles we adopt as we change context.

Investigating the construction of the category personality disorders in South Africa from the top down implies, for example, examining developments at the level of the state and the major diagnostic systems; exploring trends from the bottom up entails aspects such as tracking the daily interactions of clinicians with patients. The original project on which the current thesis is partly based (Laurenson, 2006) looked at a selection of published archival material, exploring the subject ‘from the top down’; the present project aims to add a complementary dimension by investigating what may have been happening ‘from the bottom up’ as inscribed in contemporary patient folders. The research period of 1948 to 1982 has been chosen because there is a vacuum in research on the personality disorder category in South Africa between the studies of Swartz and Ismail on the early 20<sup>th</sup> century (2001) and Msomi on the late 20<sup>th</sup> century (1997); yet the period of National Party rule post-1948 appears to have been crucial for the development of the psy-professions locally, seeing the first new mental health legislation in over half a century, as well as changes in professional training and registration for psychologists and psychiatrists. The early 1980s terminates the research period not only because in the

Valkenberg archive, files up to roughly 1982 are housed in one room, but because 1981 marked the presentation of the findings of the second investigation into mental health in South Africa by the World Health Organization (WHO). Valkenberg was chosen as a research site for reasons of continuity as it was used in Swartz's and Msomi's studies; in addition, as a teaching hospital, it has been strongly linked to diagnostic teaching.

The argument is set out in the following way.

Chapter 1: Theoretical perspectives outlines the theoretical positions that have been used to illuminate this investigation.

Chapter 2: Archives and method considers the problems inherent in archival research and explains the scope and method of the present study.

Chapter 3: Constructing personality disorders: From the top down begins by exploring the international psychiatric context in order to contextualize local developments. It then considers the South African psychiatric and political framework, setting out developments that would have influenced the evolution of the personality disorder category locally. A section on official documentation reports on archival material produced by the state relevant to the personality disorder category, while an investigation of locally published material indicates the way in which local psychiatrists were theorizing about personality pathology. Finally, a section on the development of the professions in South Africa post-1948 reports on interviews with an influential

psychiatrist and four clinical psychologists, in order to explore training and professionalization within the research period.

Chapter 4: Constructing personality disorders: From the bottom up examines a sample of Valkenberg patient files to describe and analyse the way in which the personality disorder category was being constructed during the period.

Chapter 5: Analysis attempts to synthesize and draw conclusions from the evidence presented in the preceding chapters.

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## **Chapter 1**

### **THEORETICAL PERSPECTIVES**

This chapter will outline the theoretical perspectives informing the thesis. After considering the psy-professions in the light of their utility to the 20<sup>th</sup> century state, it will explore social constructionist views of mental illness, as well as Hacking's theory of 'making up people'.

#### **Perspectives on the history of the psy-sciences**

The history of the psy-sciences has often been presented as either an inexorable forward march towards enlightenment or, less favourably, as the expansion of a repressive form of social control. Minde's fourteen-part account of the history of psychiatry in South Africa (1974-77) is an example of the former; Scull's account of the decarceration of psychiatric patients in the 20<sup>th</sup> century, the latter. Yet there is also a growing body of literature which argues, following Foucault, that power is not so much repressive as productive, not seeking to obliterate but rather calling into being that which it requires.

Jansz and Van Drunen (2004) locate the emergence of psychology in its social context, sketching the rise of individualism in the West since the 15<sup>th</sup> century and tracing its development through the Renaissance, Humanism and Romanticism. Gradually, they argue, the collective was left behind and the individual emerged; this occurred in the

same period that saw the rise of the middle classes and the separation of the 'public' and the 'private'. The 19<sup>th</sup> century experienced economic and social changes that began to necessitate new forms of social control and regulation in areas such as education, poor relief, industry and the penal system. This was the environment that nurtured the new discipline of psychology.

Rose (1990) probes more deeply the process by which psychology gained in influence in the liberal democracies of 18<sup>th</sup> and 19<sup>th</sup> century Europe and North America, where the state needed to manage the multiplicity of human beings upon whom political and economic life depended. In a change in practices of inscription no less influential than the advent of the printing press, psychology offered these states a way of governing the masses of people now entering institutions such as schools, factories, prisons, agencies of government and even asylums. Owing to the unprecedented usefulness of psychology's tools, people could increasingly be quantified in terms of norms that could be mapped in the form of graphs, tables and statistically-based psychometric tests. Citizens could be focused on individually, while simultaneously being observed in a common plane of sight – a concept recalling Foucault's reference to Jeremy Bentham's Panopticon, the prison constructed so that a single warder could observe multiple prisoners while the individual prisoner could see no one but himself.

Instead of mapping individuals physically, like the phrenologists of the 18<sup>th</sup> and 19<sup>th</sup> centuries, psychologists now mapped interior space. Evanescent human qualities could be crystallized and inscribed onto a normalized individual, with increasingly serious

implications for the growing numbers of people who would eventually find themselves located pathologically outside the limits of the normal. Whereas before the 19<sup>th</sup> century the insane had been incarcerated along with the rest of the sick and the petty criminal underclass only if they were socially disruptive (Scull, 1993), a process of classifying and segregating the mentally ill now gathered momentum, with a specialized psychiatric profession being invoked to manage the process. By the late 20<sup>th</sup> century, according to the pre-eminent diagnostic manual, the *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed., *DSM-IV*, American Psychiatric Association, 1994), there were nearly 300 forms of mental deviance.

Rose therefore argues that psychology did not evolve within the philosopher's study or the laboratory, with new insights being applied systematically to the world outside. Rather, it developed in response to the utilitarian requirements of the emerging liberal democracies, as they sought a way to manage their citizens and render them economically and socially useful. This raises the possibility that as new diagnostic categories are called into being, the psy-professions may correspondingly transform themselves so as to help the state with its agenda of governing the diagnosed. This thesis argues that in South Africa in the 20<sup>th</sup> century, the elaboration of the category personality disorder occurred not in a vacuum, but in response to the needs for governance of the modernizing apartheid state and in symbiosis with the growth of the psy-professions.

Among psychology's most useful tools for mapping a population is psychometric testing. (For a history of psychometric assessment, see Foxcroft and Roodt, 2005.) Assessment

progressed rapidly in the 20<sup>th</sup> century owing to the development of theories of human behaviour that could direct the development of assessment measures, as well as the development of statistical methods and psychology's expansion into clinical, educational, military and industrial settings. The need to assess large numbers of recruits in World War I prompted the first large-scale group tests, with the landmark development in personality testing being Butcher's Minnesota Multiphasic Personality Inventory (MMPI, 1943). Psychological testing became a key function of psychologists working in applied settings as assessment grew in popularity after World War II.

The development of testing in South Africa occurred in the context of racial segregation and inequality. Even before 1948 the measures used were standardized for whites only; at times testing was abused to prove the intellectual superiority of whites over other groups. Claassen (1997, in Foxcroft & Roodt, 2005) states that there was a boom in the development of psychological measures in South Africa between 1960 and 1984. For example, the test of intelligence later known as the Senior South African Individual Scales (SSAIS) was published in 1964. These new tests were directed primarily at whites, although in some cases norms were developed for other groups. Frequently, however, white South African or overseas norms were applied to South Africans who were not white, accompanied by a disclaimer that the 'results should be interpreted with caution'. These developments are relevant to this thesis because psychometric test reports, including the results of personality tests, begin to appear in the Valkenberg patient files from the 1960s.

## **Constructing categories of people**

As Foster (2003) explains, in social constructionism and discourse analysis, meaning (particularly as expressed in signs, symbols and language) is valued over the grand rational and empirical ways of knowing. Language is seen not only as referential, but also as constructing, shaping and moulding both people and events. Meaning is accumulated over time through the negotiation of conventions, so that knowledge is tied to the perspective that produced it and not proscribed by environment and biology; consequently, the resulting structures may be understood only by de-constructing them. Finally, social constructionism takes a critical view of conventional dualities such as masculine/feminine, and, indeed, sanity/insanity, arguing that these polarizations are linguistic devices that blur the interdependence of the terms that constitute them. Hence a social constructionist approach rejects a view of the individual as a self-contained, clearly bounded entity. In addition, self-identity does not arise from within the individual, but is constructed through an ongoing dialogue between the individual and the multiple 'voices' of others around us, including the media and society generally (Gergen, 2001).

Parker, Georgaca, Harper, McLaughlin and Stowell-Smith (1995) dissect what they see as a process of social construction of mental illness, arguing that clinical approaches have tried to focus on what goes on inside the 'individual', sweeping aside the roles of language and society in the construction, experience and treatment of psychological distress. This individualization of unhappiness allows one to avoid considering, for example, the race or gender of the distressed person. There is no discontinuity between

sickness and health, these authors contend: instead, a division between them has been constructed through language, practices and institutions to produce these polarities.

According to this line of argument, the DSM-IV, with its reliance on the accumulation of observation and classification, and the minute dissection of an implied typical patient, plucks the sufferer out of their social context to squeeze them into a standardizing pigeonhole. In practice, as Barrett (1988) has shown in the case of the construction of a schizophrenic patient, psychiatric problems may be less well-defined than the manuals suggest. Parker et al. suggest that the manuals' greatest utility may lie in the completion of hospital forms. Rather than describing externally existing psychological categories, the diagnostic manuals may in fact constitute them, so that diagnostic complexes are in fact 'discursive complexes' which 'set up certain positions in which people may place themselves' or 'in which they may be placed by others' (Parker et al., 1995, p. 39). At the same time, simple opposition to the psychiatric system is misguided because it operates within the same conceptual constraints.

Parker et al. do not reject a biological basis for distress, but caution that 'human beings attribute meanings to those biological changes ... and structure what we are allowed to attribute to what. Institutions of power and knowledge structure the way we understand physical health, and the ways in which we understand the relationship between bodily ills and mental discomfort' (Parker et al., 1995, p. 15). In this regard they contend that 19<sup>th</sup> century psychiatry went astray in electing to follow medicine in looking at the form, rather than the meaning, of signs of madness.

Parker et al. claim that psychiatry further positions the 'patient' in terms of gender, race and class. They refer to a vast body of literature testifying to differential rates of psychiatric diagnoses for men and women, as well as people of different races, cultures and classes, but go beyond sociological explanations to argue that historically constructed discourses construct positions for people to adopt and play out. Hence a discourse for madness might mesh with one for race, so that black men become the most likely candidates for involuntary admission with psychotic disorders such as schizophrenia.

An intriguing study of sane/insane identity under construction is found in Luske's 1990 study, *Mirrors of Madness: Patrolling the Psychic Border*. Taking a social constructionist stance, sociologist Luske set out to discover the means by which some people are defined as normal by others. His method was participant observation and his site a halfway house for psychiatric patients in California. Over one and a half years he interacted with, observed and interviewed both clients and psychiatric staff.

Luske observed how the appointed psychiatrist sometimes insisted on imposing a diagnosis when it was not clear that it fitted the client. The clients felt that the staff's dialogue tended to label them as mentally ill and commented that since society had pushed them into the insane role, they had little option but to comply. Many staff experienced similar 'symptoms' to those for which the clients had earned a diagnosis and had their own painful histories of mental illness; however, they remained 'in the closet' for fear of being labelled insane. Given the strong similarities between the two groups, and the insecurities the staff felt about their own lives and coping abilities - plus the

enormous power of the psychological establishment of which they were themselves co-authors - the staff felt compelled to 'patrol the border' between their insane charges and themselves, in an effort to be seen as more normal and coping than their clients. Often this was achieved through dark humour and negative labelling at the clients' expense. Luske adds: 'If one makes one's living and spends most of one's time in relations constructing and maintaining stigmatized identities, it follows that one's own identity will start to show traces of stigma', so that staff 'increasingly hold up the same mirror of insanity to themselves' (Luske, 1990, p. 113).

Hacking (2004a) sets out his theory of 'making up people' by a process of 'looping' as follows (p. 279-80):

It was about interactions between classifications of people and the people classified. But also about the ways in which those who are classified, and who are altered by being so classified, also change in ways that causes systems of classification be modified in turn. I call this the looping effect of classifying human beings ... Classifying changes people, but the changed people cause the classifications to be redrawn ... In some cases our classifications and the classified emerge hand-in-hand, each egging the other on.

Hacking has described these effects in the case of, for example, child abuse (1991). This thesis argues that, lacking biological underpinnings, the personality disorder category has been particularly susceptible to such alteration. The expansion and elaboration of the

personality disorders in the 20<sup>th</sup> century may have been more a function of the attention the category increasingly enjoyed than of an increase, or an increase in the ability to detect, the people who deserved the diagnosis.

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## Chapter 2

### ARCHIVES AND METHOD

This chapter considers some of the problems inherent in an archival study and describes the different types of material that have been examined for this project.

#### Archives

Like any other study, an archival research project must examine its own assumptions. Swartz (2008) states that a deconstruction of the archive has occurred post-Derrida:

‘Facts’ are hardly self-evident, and the idea of histories as multiple – a conglomeration of more (or less) credible narratives, reflecting events, speech acts, geography, the whimsy of archival policies, lines of power and ideology, the selective memory and access to voice of those writing/recording and, perhaps most significantly of all, the perspective of the historian – is common cause (p. 285).

However, Swartz points out, the ‘collapse into radical relativism’ (p. 285) is contradicted by ‘the materiality of the world upon which we do leave traces, no matter how open to multiple interpretation they may be, and the relationship of credibility to intersubjective truths’. Swartz argues further, with Stoler (2002), that it is not enough not simply to read

against the archival grain in search of themes of racism and oppression threaded through with moments of resistance, as does much of the literature on histories of colonial psychiatry and the colonial insane in Africa. Rather, it is essential to become conscious of what one thinks one knows, and then to immerse oneself in the archive, being open to evidence that may challenge one's preconceptions.

Archives are the products of – and, arguably, co-productive of – bureaucracies. In *The Taming of Chance*, Hacking contends that 'there is a sense in which many of the facts presented by the bureaucracies did not even exist ahead of time. Categories had to be invented into which people could conveniently fall in order to be counted' (2004b, p. 4). Reasoning along similar lines in *The Foucault Effect* (1991), he states that 'the erosion of determinism and the taming of chance does not introduce a new liberty. The argument that indeterminism creates a place for free will is a hollow mockery. The bureaucracy of statistics imposes not just by creating administrative rulings but by determining classifications within which people must think of themselves and of the actions that are open to them' (p. 94).

Taking up the same argument, Stoler (2002) positions the archive as a process rather than a thing, a technology of rule in itself:

The issue of 'bias' gives way to a different challenge: to identify the conditions of possibility which shaped what could be written, what warranted repetition, what competencies were rewarded in archival writing, what stories could not be told

and what could not be said ...What constitutes the archive, what form it takes and what systems of classification signal at specific times, is the very stuff of colonial politics' (p. 86).

She adds:

As Ian Hacking says of social categories, archives produced, as much as they recorded, the realities they ostensibly only described ... Nowhere is this history-making work more evident than in the form of the commission of enquiry or state commission. By definition, commissions organized knowledge, rearranged its categories, and prescribed what state officials were charged to know ... They were responses to crises that generated increased anxiety, substantiating the reality of those crises themselves ... they could be credited with having defined 'turning points', justifications for intervention and not least, expert knowledge' ... like statistics, the commission demonstrated the state's right to power through its will to truth (p. 94).

This thesis will attempt to show that documents such as diagnostic texts, standardized hospital records and official reports on mental health went beyond passively mirroring contemporary thought about personality disorders to assist in the construction and elaboration of the personality disorder category in South Africa in the second half of the 20<sup>th</sup> century. In particular, reports produced by government commissions of enquiry were not only pertinent to the construction of personality disorders in general and psychopathy

in particular, but directly influenced the management of patients and the psy-professions.

### **Hospital records**

The shifting, multifaceted truth that may lie behind the apparent order and clarity of hospital records is elusive. Digby (1987) has set out the difficulties inherent in attempting to extract reliable, unambiguous data for quantitative analysis in the case of a small early English asylum, the York Retreat. In her attempt to investigate the link between colonial practice and psychiatric knowledge at Valkenberg from 1930 to 1935, Shelmerdine (2001) described herself as thwarted partly by the limitations of quantitative methods in credibly reflecting the truths that might have lain behind the folders.

A deconstruction of the 'truth' of medical records is found in an analysis by the feminist sociologist, Smith (1990). She explains how, when we read hospital statistics showing differential rates of diagnosis for women, we attempt to read 'back through' them to an assumed reality in the background, without seeing the surface inscription that irredeemably transforms the real experiences of real people into pared-down approximations. Her concern, she says, is not with whether there is in fact a difference in rates of diagnosis by (for example) gender: hence studies such as the landmark diagnostic analyses of feminist scholar Chesler miss a more fundamental point.

The problem, Smith argues, is that studies like Chesler's assume that 'the construction of the individual's illness in the figures has an unmediated relationship to the "real world" '

(Smith, 1990, p. 115). However, these texts are the manufactured products of complex bureaucratic procedures entailing cleaning-up strategies of various kinds, in the process of which, variations and anomalies are ditched for administrative convenience. Further, Smith contends, psychiatric agencies are co-participants in the process by which people become mentally ill and 'The figures can't be decontaminated' from the implications of this mediation (1990, p. 117).

How does such mediation operate? Drawing partly on antipsychiatrists Szasz and Scheff, Smith sets out a model in terms of which an oppressive social situation leads to stress, resulting in a person coming under psychiatric control, as a result of which she is defined as suffering from a mental illness. Unless one's problem has a definite physical basis, she argues, objective criteria for it are necessarily spurious. The fact that symptoms are not observable outside of social settings tends to be forgotten when one of the people in the social setting is a 'detached' professional. Even when these judgements are made in the community, they are informed by ideas originating within and efficiently disseminated by psychology and psychiatry. Once someone has been labelled as mentally ill and plucked out of her lived setting, the prophecy becomes self-fulfilling as we follow the cues for how to respond to her and deny meaning to what she says. Thus a mentally ill identity is constructed intersubjectively and the person's capacity to function as a subject in creating intersubjective order in the everyday world is suspended. The agencies that produce the statistics do not produce the genuine misery that led to this contact with the psychiatric establishment, but they do, Smith contends, produce the distinctive and recordable symptoms of mental illness.

How then, she asks, do we arrive at these cleaned-up, standardized statistics out of the muddle and diversity of subjective experience? The problem for the researcher is that official statistics are produced for the state with its agenda of governance. Records thus reflect the needs of the administration at the time, and the standardized training that mental health professionals receive renders them able to generate precisely these kinds of de-individualized clinical records and participate (with both patients and other professionals) in the standardized discourses that accompany them. In the background is a massive administrative machinery that works the complexity of individual cases up into the standardized records. Hence the extraordinary difficulty of trying to reattach the bits of information contained in the records to 'some kind of simulacrum of the form they had before they went through the meat grinder' (Smith, 1990, p. 130).

While Smith's arguments are of particular relevance to more recent records compiled using internationally sanctioned nosologies and computerized record-keeping systems, they nevertheless apply in their essentials to any attempt to understand the meaning of official records of the management of those diagnosed as mentally ill.

Barrett (1988) and Swartz (1996b) describe this difficulty from the other end of the telescope, namely, the moment in which the original case records are compiled by the clinician observing or interacting with the patient. Barrett minutely tracks an interview with a schizophrenic patient whose lived interaction with a doctor appears in truncated, standardized form in the clinical notes. An encounter beset with ambiguities and cross-

currents is reduced to authoritative, clipped psychiatric code, sweeping aside complexities to confirm the patient's schizophrenic label.

While acknowledging the need for contextual information about a patient's life and for an ongoing record of her story, Swartz describes the process of taking a history as a misleadingly reassuring one for clinicians, characterized as it is by a predetermined structure that purports to elicit everything of relevance to an understanding of the patient. Because the history's selective record of a complex and elusive reality is erroneously viewed as seamlessly complete - and because the clinician is effaced, leaving only the patient in view - a psychiatric history's relationship to any factual reality is problematic. Despite apparent differences in form, 'psychiatric histories function as a means through which patients are constructed as treatable by the theories and techniques available to those that write them' (1996b, p. 151), a process facilitated by the rise of widely used systems such as the ICD, DSM, Maudsley history format and Present State Examination, which draw on a global set of assumptions. A further complication is that it is clinicians who keep records of their own activities, increasing the likelihood that the records will be tailored so as to keep their employers satisfied. Rooted in medical record-keeping, histories apply a disease model to insanity, a feature which psychoanalytic additions such as attention to signs of childhood neurosis extends rather than moderates. Further, they position the note-taker as possessing specialized and privileged knowledge. A stripping of the patient's identity results in an erroneous presentation of a single history as the only possible version. A complex lived individuality is reduced to a diagnostic label, one which as often as not carries stereotypes of age, race and gender.

This perspective serves as a warning that what appears in the hospital files has already been sculpted to foreground some aspects and suppress others, particularly in a post-colonial context. Swartz (2005), drawing on Spivak's (1993) concept of the 'subaltern voice' – the silenced voice of the historical subject - suggests that from historical case records and documents 'the reader learns a great deal about doctors and their systems of self-representation, but almost nothing of the patients of whom they wrote' (Swartz, 2005, p. 507). It is therefore essential to take note of 'who speaks (or writes), when, to whom, and in what system of representation ... Linguistic imperialism in particular, the process through which indigenous languages are replaced by the language of colonizers, is implicated in the silencing of the subaltern' (pp. 509-10). The subaltern may be the patient, the clinician in training, or even the colonial psychiatrist in deferential relationship to the knowledge system disseminated from the 'centre'.

These perspectives suggest that agendas such as the need of psychiatric administrations to generate standardized data may be far more powerful than whatever fugitive truth may originally have lain behind hospital records. The very process of taking clinical notes is a standardizing one that potentially erases the clinician who has actively constructed the patient; the patient, though voiceless, remains on view as an exemplar of a diagnostic category. This has particular implications for the category personality disorder, which relies substantially more on social judgements about behaviour than do, for example, the psychotic disorders, but also for South Africa, with its history of segregation and race-infused conceptions of mental health and illness.

## **The Valkenberg patient folders**

The hospital files investigated for this project were approached from the perspective that they might yield as much information about the state and psychiatric systems that generated them as about the patients around whom they were constructed.

Much of the Valkenberg archive is housed in the Registry in the main administration building on the hospital's grounds. Material from the study period is located in a single room that contains files from the early 20<sup>th</sup> century up to the early 1980s. The files, which are jammed tightly together in groups of about 60 on simple open wooden shelves, are old, dusty and sometimes tattered. Nevertheless the contents are mostly perfectly legible. As Swartz has pointed out (2008), although up to the 1990s patients of different races would have been housed separately, and their files similarly segregated, in the current archive what was previously kept rigorously apart is now jumbled together.

Casenotes in the folders are mostly handwritten, while reports and correspondence are usually typed on a typewriter. It is not immediately obvious who wrote a particular entry in a file. Very few staff signed their names at all; some used initials only. Sometimes it is possible to establish from the nature of the material who was responsible for it – for example, copious medical information suggests a psychiatrist or medical officer. For typed reports and official correspondence, authorship is generally clearly stated.

These folders pre-date computerization at the hospital, so that the only information available to the researcher of this period is that which can be extracted from the files manually. ECT (electro-convulsive therapy) was not always specified in the clinical notes, but sometimes appeared on a separate schedule of ECT treatments, some of which appear to have become separated from the rest of the folder, so that the information about which patients received ECT is not necessarily complete.

The files are not arranged by date. In order to view a particular file, it is necessary to supply the registry clerk with either a file number or a patient name. This makes the task of a researcher who wishes to study a particular period or category of patients very difficult because large numbers of files must be screened randomly in order to make an appropriate selection. For the present project, this initial screening was done either by the clerk or by myself. When searching for files myself I would select a particular shelf and then work gradually through all the files it contained, extracting any that contained a diagnosis of personality disorder for closer investigation. I continued sampling until saturation had been reached, that is, until the information appearing did not seem to be significantly new or different from what had gone before.

Approximately 600 files were eventually screened by myself and the clerk. This research reports on the casenotes of 65 patients who received the equivalent of a personality disorder diagnosis between 1948 and 1982.

It is unlikely that the documentation housed in the room represents all the files from the

period. It is therefore impossible to tell whether the research sample constitutes a representative sample of personality disorder diagnoses at the hospital from the late 1940s to early 1980s. It is probable that some of the old files have been lost, destroyed or archived elsewhere. When permission was being sought to undertake this project, the Hospital Superintendent, Dr B. Eick, expressed concern that it might not be possible to locate all the necessary files as large numbers might have been lost before she took up her post. Her concern about determining the precise composition of the archive is supported by the fact that although files older than approximately 1945 are officially housed at the University of Cape Town's archive, many files dating back as far as the 1920s were found during my search at Valkenberg.

Further complicating the difficulty of ascertaining the representivity of the sample is that until 1970, personality disorders appeared in the annual reports of the Commissioner for Mental Health under the broad category 'defective mental development without epilepsy', which equated roughly to the present Axis II of the DSM. After 1970, little diagnostic information was published in official annual reports. No epidemiological study from the time exists. In the absence of published statistics, it is impossible to arrive at reliable information about prevalence.

In order to access the records, ethical clearance was required from the UCT Departments of Psychology and Psychiatry and permission was needed from the Hospital Superintendent. The hospital specified that records should remain in the registry at all times and that photocopies were not to be made; a strict code of confidentiality was

required by all three parties. For this reason patients are referred to by initials only in this text. Folder numbers have not been included here but may be accessed by applying to the Department of Psychology at the University of Cape Town and the Superintendent of Valkenberg Hospital.

My method was to read each file closely, making brief notes on details such as demographics, diagnostic patterns, differential diagnoses, treatment and psychometric testing, and making additional notes where the material appeared to be particularly rich. Diagnostic terms were recorded and simple calculations of frequency within different time bands were made. I paid attention to the changing ways in which patients were viewed and inscribed, and noted comments reflecting stigma and racial stereotypes.

### **Other textual sources**

While patient folders hint at what may have been influencing the personality disorder category from the bottom up, indicators of the top-down process were sought in official government publications, including the official record of proceedings in the House of Assembly (Hansard); annual reports by the Commissioner for Mental Hygiene, later the Commissioner for Mental Health (up to 1970); annual reports of the Department of Health (from 1971 onwards); reports by government-appointed committees and commissions of enquiry; and the Mental Health Act of 1973. Each of these sources was examined for information about mental health and diagnostic categories in South Africa.

Publications that would have been influential in the training of new psychologists and psychiatrists were examined with particular reference to personality disorders and their equivalents. Journals read by academic and practising psychiatrists were investigated in order to ascertain which debates were shaping thinking about personality disorders during the period. Also of relevance to the profession is a brochure promoting the Department of Psychology at Stellenbosch University (1960).

### **Semi-structured interviews**

Given that the research period is within living memory, it was possible to triangulate the archival sources with interviews with clinicians from the period. Semi-structured interviews were held with a South African psychiatrist and psychologist who were influential in developing professional training in their fields. The psychiatrist, Prof Lynn Gillis (2006), started the Department of Psychiatry at UCT and became responsible for the teaching of trainee psychiatrists both at Groote Schuur and at Valkenberg. The psychologist, Gustav Fouché (2006), was a member of the first elected professional board of the South African psychologists. The interviews were structured so as to elicit the interviewees' recollections of their own careers and the changes that occurred in training and professional registration during the research period.

Interviews were also conducted with three psychologists who were locally trained and went on to work at Valkenberg during the 1970s. Two completed internships at Valkenberg in the mid-1970s, while the third was the senior psychologist at the hospital,

founding and running the therapeutic community, Centrum, from 1975 until its closure in 1979. The interviews were structured so as to elicit the interviewees' recollections of their training (especially in diagnosis and the personality disorders) and their roles as members of their profession in the hospital system. Schedules of interview questions are contained in Appendix A.

University of Cape Town

## Chapter 3

### **CONSTRUCTING PERSONALITY DISORDERS: FROM THE TOP DOWN**

This chapter considers the intermeshing roles of the apartheid state and the psy-professions, both internationally and locally, in bringing personality into closer focus. It sketches relevant historical developments and examines archival materials which helped to structure thinking about personality.

### **THE INTERNATIONAL PSYCHIATRIC CONTEXT**

This section attempts to locate developments in South African psychiatry in the context of relevant developments internationally. It considers the history of the personality disorders and the rise of the diagnostic manuals before outlining developments in British psychiatry and psychology in the 20<sup>th</sup> century, given the historically close links between British and South African psychiatry (Swartz & Ismail, 2001).

### **The history of the personality disorders and the rise of the diagnostic manuals**

Although the DSM of the American Psychiatric Association and the *ICD (International classification of diseases)* of the World Health Organization appear at face value to be ahistorical, impartial documents, there is an important literature on the history of

psychiatric diagnosis (Berrios 1993, 1996) which not only lays bare the relativity of the current system, but also reveals that many contemporary diagnostic categories have a long and sometimes complex history. For example, it was only in the 19<sup>th</sup> century - after character and personality had been defined in psychological terms, and self was considered to be a mental function - that it was possible to conceive of a disorder of character or personality. Thereafter the categories roughly corresponding to the current DSM personality disorders underwent a variety of permutations and expansions, under the influence of various strands of thinking, until they were crystallized in their present form in the second half of the 20<sup>th</sup> century (Berrios, 1996).

The history of the personality disorders begins with Pinel, Esquirol and Prichard in the early 19<sup>th</sup> century - authors who had, with their respective categories of *manie sans délire*, monomania and moral insanity, provided descriptions of patients who appeared mentally ill without displaying what were usually regarded as the core feature of mental illness, namely, hallucinations or delusions. Although each of these early authors was describing very different cases, they opened up a space in which it was possible to talk about insanity without psychosis; other mental symptoms could now be harnessed to arrive at a diagnosis. Significantly, the context was the 19<sup>th</sup> century, the age of the rise of the asylum as a specialist institution for the care of the mad and, along with it, the profession dedicated to the care of its inmates (Scull, 1993).

Subsequent theories based on degeneration were to impart an enduring stigma to the personality disorder category, with specific implications for South Africa in the 20<sup>th</sup> century. Morel (1857, in Berrios, 1993), a Roman Catholic whose faith gave his theories

a strong Lapsarian flavour, believed that noxious influences such as alcoholism or masturbation caused alterations in the human seed, leading to successive degeneration of character and physical stigmata in future generations. Degenerative conditions, in his view, were both pathological and deviant from the normal. It was this influential theory (along with phrenological studies of the criminal mind and Darwinism) that led to the notion of psychopaths as inferior. Degeneration theory also influenced the Italian Lombroso, who in 1876 devised the concept of the *delinquente nato* or born criminal. The criminal, he argued, was biologically flawed and lacking in the higher nervous centres designed to promote moral behaviour. Likewise the famous German classifier, Kraepelin, attributed anomalies of personality to degeneration and later described them as stable personality defects, calling them 'psychopathic personalities' in a 'predominantly socially evaluating sense' (Sass & Herpertz, 1993).

While diagnosticians such as Kraepelin had focused on surface behaviours and tried to theorize underlying causes, Freud and other psychoanalysts focused on internal dynamics. Although earlier editions of the DSM were influenced by psychoanalysis, no visible traces of psychodynamic thinking remain in the DSM-IV's categorization of personality disorders.

In 1923, as the statistical sciences grew, Schneider attempted a value-free definition of psychopathic personalities, identifying twelve types who deviated from an unspecified statistical norm. However, crucially, he did not see psychopathy as mental illness, because it could not be linked to any brain damage or disease process. Schneider's

definition of abnormal as a deviation from the mean has become a major theme in more recent understandings of personality disorders. In 1977 Slater and Roth, authors of the third edition of the influential teaching text *Clinical Psychiatry*, commented approvingly of Schneider's formulation as follows: 'We are taken away from philosophical conceptions back to observations of fact. We are not put in the painful position of distinguishing on philosophical grounds between the psychopath and the eccentric, between the paranoid litigant and the fanatical social reformer' (p. 60). They admire the fact that Schneider's formulation can be 'translated *into biometrical terms*' (p. 61) and plotted to give a normal curve; 'we should look for the cause of psychopathy *in this normal variation*' (p. 61) [emphasis in original]. It was this approach that would later implicitly find its way into the DSM, if not in the diagnostic criteria as such, then in the instruments used to assess them.

In the 1930s, Henderson described 'psychopathic states' as resting on 'constitutional abnormality', thus initiating another move away from ideas of degeneration. According to Slater and Roth, it was during the Second World War that the 'detection of the constitutionally unstable [individual] became supremely important in all questions of selection of personnel' (p. 61). Rejecting old-fashioned classification into types, they celebrated the replacement of 'such crude categories by actual measurements' (p. 63). In order to explain the 'cold and emotionally callous' individual, Slater and Roth therefore posited a dimension along which feelings of sympathy might vary; they acknowledged environmental factors in the development of such a trait.

In 1930 Partridge defined the psychopathic personality as persistently maladjusted and not correctable by either education or punishment. He focused on the psychopath's adverse effect on social life. This marks the beginning of an emphasis on behavioural description and a reduction of importance in supplying aetiology. In other words, psychopathy had become sociopathy (Sass & Herpertz, 1993).

However, psychoanalytic understandings of personality dominated American psychiatry in the mid-20<sup>th</sup> century. Although Freud had not given prominence to his ideas about character pathology (Oldham, 2005), 'character disorders were seen to represent "preoedipal" pathology' (p. 373). A strong psychoanalytic theory base underlay the definitions of personality disorder in DSM-I (1952); the psychoanalytic influence decreased in DSM-II (1968) and was no longer evident in DSM-III (1980).

In 1965 Craft gave the first operational definition of psychopathy as antisocial personality disorder. He saw as the primary features a lack of feeling towards others and a tendency to act on impulse; secondary features included a lack of shame or remorse, aggressiveness, lack of motivation and an inability to profit from experience. Robins in 1966 described the outcome of a study of 500 males whom he had followed for 30 years, yielding a database that underlies the current American conception of personality disorder. His primary finding was that antisocial and aggressive behaviour in childhood is the most reliable predictor of adult antisocial behaviour.

In 1976 Cleckley published *The Mask of Sanity*, describing the psychopath in terms of

antisocial behaviour and delineating him or her in terms of sixteen criteria, most of which are still present in the DSM-IV. Cleckley saw psychopathy as a psychotic disease that had not yet manifested.

From vestigial beginnings in the 19<sup>th</sup> century, personality disorder, particularly in its more antisocial aspects, was coming into sharper focus. This evolution of the diagnostic category needs to be seen in conjunction with the rise of the two major diagnostic manuals. The ICD, now in its tenth edition, has its roots in the adoption of the International List of Causes of Death at a Paris conference in 1900 attended by delegates from 26 countries (World Health Organization, 1967). The delegates committed to regular revisions and the Sixth Decennial Revision Conference in 1948

... recommended the adoption of a comprehensive programme of international co-operation in the field of vital and health statistics, including the establishment of national committees on vital and health statistics for the purpose of co-ordinating statistical activities in the country and to serve as a link between the national statistical institutions and the World Health Organization (WHO, 1967, p. xiv).

This resolution, probably instrumental in South Africa's eventual adoption of the ICD system in 1974, shows the psy-professions, in partnership with the modern states which supported the WHO, attempting to extend and standardize their influence across the globe. The South African government appears to have been a willing partner in these endeavours, although differing political stances were to cause tensions in the South

Africa–WHO relationship in the 1970s and 1980s.

Although the mental disorders chapter was adopted in 1948 with the publication of ICD-6, the ICD failed to achieve popularity among psychiatrists, drawing wide criticism for being confusing as well as ill-suited to generating reliable hospital statistics. (For a full account of the relevant history and debates, see Stengel, 1959). The text of the mental disorders section of the ICD remained largely unchanged until the adoption of the 10<sup>th</sup> revision in 1992 (Bartolome, 1994). The other editions published during the research period were issued in 1955 and 1967.

The other prime agent of psychiatric classification today is the DSM-IV of the APA, a reference work of over 900 pages that aims to delineate each of nearly 300 posited mental disorders. Rather than being the product of the gradual uncovering of pre-existing, clearly defined mental conditions, the DSM is in fact the product of a rather messier evolution that has arguably, in a process of looping, shaped what it has ‘discovered’. The DSM has been highly instrumental in the progressive psychologization of society, dictating which human troubles should be seen as normal suffering and which pathological and in need of management by the psychiatric profession. For a detailed critique of this developmental process and the manual’s influence, see Kutchins and Kirk (1997).

While DSM-I (1952) showed the clear influence of psychodynamic thinking, appearing as it did after an influx of German psychoanalysts to the US during the Second World War, DSM-II (1968) saw a shift towards an allegedly atheoretical presentation of

manifest behaviours. By the time DSM-III (1980) was published, there was no obvious trace of psychodynamic thinking. With each edition, the amount of coverage given to personality disorders expanded (from roughly two pages in DSM-II to 46 pages in DSM-IV), as did the number of ways in which one might be personality disordered. The DSM approach enumerates behavioural criteria for diagnosing the personality disorders, defining them as a social problem. There has been an increasing and intentional convergence between the ICD and the DSM over time.

Berrios (1993, pp. 34-35) summarizes progress in refining the personality disorder diagnosis during the 20<sup>th</sup> century as follows:

Anecdotal observation is no longer considered a guarantee ... instead everything seems to revolve around the plausibility of some pattern-recognition techniques such as cluster and principal-component analysis. The switch in scientific paradigm is perhaps the only difference that the historian can find between 19<sup>th</sup>- and 20<sup>th</sup>-century approaches to personality disorders.

Armstrong (1983) and McCallum (2001) put these developments into a different perspective. In *Political Anatomy of the Body* (1983), Armstrong argues that in general medicine

The anatomical atlas stands between ignorance and medical knowledge. By means of the atlas a confusing mass of cells, tissues and organs is given a pattern

... The atlas renders the body transparent, it is a means of making the body *legible* to an observing eye (p. 1) [emphasis in original].

Thus the psychiatric classification systems may be seen to stand between ignorance and psychiatric knowledge, rendering the overwhelming confusion of human behaviour legible. Armstrong claims that whereas in the late 19<sup>th</sup> century, the body had been created for the exercise of power, in the 20<sup>th</sup> century, the gaze moved onto the undifferentiated space between bodies, seeking to know and govern the social interval between individuals.

McCallum (2001) points out that before the Second World War, classificatory systems related to the needs of public psychiatric hospitals. During the War, only about 10 per cent of cases seen equated to the usual civilian problems of mental illness, necessitating a new framework that took account of stress reactions and personality problems in the ordinary individual. Thus the medical gaze shifted from the diseased onto the normal population – ‘a medicine focused, not on the mind of the mad, but on the mind of the precariously sane’ (2001, p. 26). In the sixth edition of the ICD (WHO, 1948) for the first time mental deficiency (‘retardation’ or ‘mental handicap’) was split off from moral imbecility (‘psychopathy’), which was now grouped with a range of personality problems. In other words, personality became a focus in its own right.

A second wave of scientific theory in the 1930s through to the 1950s moved out from the specificity of the subject to look at relations with others. The sociopath

was increasingly seen as a problem of relationships rather than the deep internal structure of individuals. The term personality fitted this new imperative to map social relations and the spaces between people rather than internal features of a subject. Within this new space was a class of individuals with ‘defective personalities’ whose conduct could not be effectively dealt with through standard psychotherapeutic treatment or through penal law (2001, p. 6).

Internationally, the diagnostic manuals have not only reflected, but also shaped, thinking about the traditionally stigmatized category personality disorders – not only arguing for its existence, but also helping to define its limits, in order to manage the wayward group of people it accommodates. This thesis will attempt to link the evolution of the diagnostic machinery to the need of the South African government and the psy-professions to map the population at large while simultaneously focusing on individuals considered to be particularly dangerous, and upholding racial segregation.

### **British psychiatry and psychology in the 20<sup>th</sup> century**

Historically, psychiatry in England and South Africa have had close links, and new developments in Britain were often rapidly reproduced in South Africa (Swartz, 1996a). ‘Even compared with other settler colonies, colonial South Africa was slow to develop scientific institutions and a home-grown scientific identity ... the Cape medical profession ... in practice was deeply rooted in popular colonial racism but in theoretical orientation remained largely universalist and metropolitan’ (Deacon, 2001, p. 194). Most

South African doctors with an interest in psychiatry trained in Britain and followed progress in psychiatry there after returning. The British Medical Association was active in the Cape (Swartz & Ismail, 2001) and knowledge exchanges between the two centres were common; thus, for example, G. A. Elliott, Professor of Medicine at the University of the Witwatersrand, visited medical institutions in Europe, Britain and the USA for six months in 1953 as a Travelling Fellow of the World Health Organization, and wrote up his recommendations for local improvements in the *South African Medical Journal* (Elliott, 1954). Developments in British psychology and psychiatry in the mid-20<sup>th</sup> century are therefore relevant to this account, as are the wider international developments which in turn influenced them.

Until the Second World War, British asylums had changed very little in a century (Freeman, 1999). With the establishment of the National Health System (NHS) in 1948, British psychiatric hospitals acquired the same status as general hospitals. Although nearly half the national hospital beds at this time were allocated to mental patients, the psychiatric profession hardly existed and hospitals were the domain of superintendents who had largely trained on the job. The psychiatric qualification was a diploma lacking the status of other medical specializations and the Royal Medico-Psychological Association operated out of a single small room in London.

With the NHS came more money for facilities, a great expansion in staff numbers and the growth of a community infrastructure (Crammer, 1996). Miller (1996) points out that it was the founding of the NHS that first established clinical psychologists as a standard

part of the health service by implementing a definite career structure and salary scales for them. However, these early clinicians would have come from a variety of backgrounds and had no formal training in the field. In 1957 the first three British postgraduate courses in clinical psychology were formally recognized, with training initially lasting only a year.

The early psychologists mostly worked in psychiatric settings, doing psychological assessment and relying on psychometric tests or projective techniques. With the rise of behaviour therapy in the 1950s to 1960s, there was an opportunity to become involved in ‘an approach to treatment whose general intellectual justification was firmly based in psychology rather than psychiatry’ (Miller, 1996); psychologists began to practice more independently and to develop their own models. The few psychologists practising in South Africa are likely to have been aware of these developments since most would have trained in Britain (Fouché, 1997).

The 1950s were the era of the new therapies – the neuroleptics in 1952, imipramine in 1956 and the inhibitors of monoamine oxidase in 1958 (Berner, 1999). These had a prolonged and positive effect on psychotic symptoms previously been unresponsive to treatment. Physical restraint was no longer necessary and the use of drastic treatments such as insulin coma, Metrazol shock treatment and ECT could be minimized or eliminated altogether. Outpatient psychiatric services were now possible; as the asylum’s function shifted potentially from custodial to curative, patient numbers dropped dramatically and many asylums were closed or demolished. The asylum was now

intended to be only one component of a community-based service.

By the 1960s and 1970s, academic departments of psychiatry were being established at medical schools and training was becoming systematized. The establishment of the Royal College of Psychiatrists in 1971 enshrined a new status for the profession (Freeman, 1999).

As Porter (1996) points out, there was a corresponding shift in emphasis over this time from severe psychiatric conditions needing hospitalization towards ‘illnesses that many believed – though mostly without firm evidence – were growing more widespread: depression, phobias, alcoholism, substance abuse, and personality problems’ (p. 399). This thesis presents evidence suggesting that parallel developments were occurring in South Africa.

A small but important development for this study is the evolution of the therapeutic community, since a therapeutic community operated at Valkenberg between 1975 and 1979. This was most likely linked to the need to manage an increasingly visible cohort of personality disordered patients. Manning (1989) provides a concise history of the development of the therapeutic community and its growth after the Second World War, following the pioneering work of Rickman, Bion (Mills & Harrison, 2007) and Rees and Maxwell Jones in England. Manning argues that by the early 1960s the therapeutic community’s ‘more inflated claims to be founding a new social psychiatry’ (p. 47) had not been fulfilled and that therapeutic units generally remained specialist referral

resources, rather than having transformed the traditional psychiatric hospitals.

Nevertheless, interest in therapeutic communities remained high. Manning reports that in the early 1970s the Index Medicus recorded the publication of between 20 to 30 articles on the subject per annum, averaging out at 27,6 per annum after 1976, while the Social Sciences Citation Index recorded 19,3 per annum; there was also a steady flow of books on the subject. By 1986 Britain had 93 therapeutic communities with 700 staff, offering a total of 2 000 places. Manning contends that therapeutic communities survived by spreading into specialist areas like drug addiction and by capitalizing on psychiatry's doubts about the efficacy of its medical treatments.

Manning distinguishes three main types of therapeutic community – democratic, educational and concept. The democratic model follows Maxwell Jones (Jones, 1979, in Hinshelwood and Manning) and allows for free communication with family and the rest of the hospital; it is egalitarian and non-hierarchical. The educational community is aimed primarily at disturbed children or adolescents and may take more or less restrictive forms. Of main interest here, since this model informed the Valkenberg therapeutic community, is the concept type. This derives originally from groups run by ex-alcoholics to help other alcoholics in North America. Exemplified by the rigorous Synanon and gentler Daytop Village and Phoenix House programmes, this method sets aside formal treatment in favour of a rigidly structured programme in which contact with friends and family is suspended and adherents routinely denounce each other's personal and social defects. New members have to work their way slowly up a hierarchy in which hard-

earned privileges are forfeited if community rules are breached. This rather drastic regime was regarded as so successful in treating previously intractable problems of substance addiction that by 1980 the umbrella body for this method, the World Federation of Therapeutic Communities, was holding conferences all over the world.

However, the role of the therapeutic community was destined to remain contentious. Myers (1979, in Hinshelwood and Manning) describes the asylum-based therapeutic community as a barely tolerated parasite on the host that is the hospital, '... partly because of the challenge it constitutes to accepted practices of professional hierarchies ... Therapeutic communities that do survive [are] ... criticized but tolerated because they offer a service to those patients not acceptable in the rest of the hospital' (pp. 163-164). The Valkenberg unit was to offer just such a service, but would fall foul of the apartheid government and therefore, too, of the hospital hierarchy.

In summary, in the second half of the 20<sup>th</sup> century, the introduction of the new antipsychotic drugs had brought the personality disorder category into clearer view internationally. Simultaneously, psychology was gradually moving from the sidelines of psychiatry into the hospital mainstream. The therapeutic community was establishing a place for itself as a useful, if sometimes irksomely unconventional, referral destination for the most difficult non-psychotic patients in the psychiatric hospital. This was the international context for professional developments in South Africa between 1948 and 1982.

## **THE SOUTH AFRICAN PSYCHIATRIC AND POLITICAL CONTEXT**

This section examines the South African contextual factors which enabled the personality disorders to come to prominence in the second half of the 20<sup>th</sup> century. It covers the history of race and segregation in local psychiatry, as well as the local history of the personality disorder category. An overview of the political landscape between 1948 and 1982 provides a backdrop for considering mental health provision during the period.

### **Race and segregation in colonial psychiatry in South Africa**

There is a growing body of writing about colonial psychiatry in Africa. Among these are studies by McCulloch (1995), Sadowsky (1999) and Parle (2007). Swartz (2008) points out that the unifying theme of these works is the relationship of colonial psychiatry and its institutions to racism and oppression – what Stoler would regard as a reading against the grain of the grand colonial narrative. However, Swartz suggests that proposing an uncomplicated link between colonial psychiatry and oppression runs the danger of repeating a cliché, and argues instead that

... the construction of a credible historical narrative about lunatic asylums requires a reading of the archive against and along the grain, accounting both for the deep ambivalence of colonial authorities towards those in their care, and for the faint subaltern voices of the incarcerated insane (p. 287).

Such a narrative requires viewing the colonial psychiatrist, and indeed his patient, with a complexity that can balance, for example, the clinician's human concern with his racist thinking. However, such a reading, she comments further, 'must be understood as discursively shaped by psychiatry as a discipline, with the purpose of accounting for an illness, with an aetiology, symptoms and a prognosis' (p. 297). This thesis will attempt to hold both perspectives – along the grain and against the grain – in tension.

Deacon (1996) begins her study of the Robben Island asylum by arguing that racism in psychiatric practice was by no means confined to the Cape, but was in fact widespread in the British colonies. It was also nuanced: for example, lunacy legislation in the Cape in the 1890s did not show evidence of race-discrimination (Lea & Foster, 1990). As in European asylums at the time, there was initially little differentiation among lunatics, lepers, and the chronic sick on Robben Island. Patients were distinguished according to gender, class, race or ability to work, rather than medical status. Although there was a desire to assimilate the black person to the 'civilized' British ideal, the distance between whites and 'respectable' blacks was gradually increased in asylums until by the 1890s, segregation by race was found in sleeping, ablution and eating facilities not only at Old Somerset Hospital, Grahamstown and Port Alfred asylums, but elsewhere in British Africa. Deacon comments that 'the superiority of the colonists could only be maintained if their insane were kept apart from the African insane' (p. 295).

Deacon argues further (2001, pp. 192-3):

In order to understand racism in Western medicine, we should combine analyses of racialization within the profession, discrimination in medical practice, and racism in medical theory ... we should differentiate between racist medicine (the institution of discriminatory practices in medicine based on broader social discrimination) and medical racism (the application of racially discriminatory practices in medicine justified on medical grounds).

Swartz (2006a) demonstrates that the records of the notorious Old Somerset Hospital reflect official anxieties about the mixing of the different categories of people housed there before 1889. For example, in 1825 the Colony's Medical Committee expressed concern about contact between the lunatics and the other patients. The arrival of Dr Dodds as the Colony's first Inspector of Asylums in 1889 meant that moves were made to open new asylums (Valkenberg and Fort Beaufort) in order to impose a greater level of order on the insane population.

Swartz (2008) notes further that two early medical superintendents in the Cape Colony, Greenlees and Conry, believed that a difference in normal mentality for black and white individuals led them to become insane in different ways. In fact, she argues, the black insane proved to be not that different when they became ill, not only by demonstrating their capacity for human suffering, but also by overstepping the bounds of behaviour considered racially appropriate. Conversely, the white insane failed to uphold their civilized differences when they became mad, behaving in non-sanctioned ways that including consorting with people of other races. This thesis will investigate whether the

research period continued to bear traces of such thinking.

Scull has shown how the insane were gradually segregated from other inmates in Britain. 'Architecture itself was moralized' (2004, p. 424) and physical barriers were used not only to enforce class and gender boundaries and separate patients with differing degrees of affliction, but also to create a reward system for good behaviour. Clearly this process occurred in South Africa too, although with an additional dimension of racial segregation. The separating of patients had implications for the allocation of space and the 'spatial turn' in psychology offers intriguing insights into such developments (Foster, 2000; Parr, 2008).

Swartz (1995) and Louw and Swartz (2001) demonstrate these principles at work in Cape asylums between 1891 and 1920, the period during which racial compartmentalization of the local insane was consolidated, and differing treatment practices established. Unlike white patients, black patients were required to perform unpaid labour. White doctors knew little about their black patients, whom they regarded as psychologically less complex than whites. Thus, Swartz argues, 'The colonial gaze on the black insane therefore inscribed bodies rather than mental life ... The "black body", the dominant source of any non white person's meaning in colonial eyes, provided doctors with their "knowledge" about black insanity' (p. 415); constructing black patients as different legitimized their spatial segregation.

That these trends continued beyond Swartz's period is shown by the work of Carver

(2001), whose study of Valkenberg and Komani Queenstown between 1933 and 1956 found that new, expensive treatments such as ECT tended to be reserved for white patients, while black patients were given treatments known to be suboptimal. However, black patients were often the first to receive new treatments on an experimental basis. This thesis will attempt to show that continuing segregation and racist medical practice in the research period were to have implications for the way in which personality and its disorders would be understood.

### Valkenberg Hospital

In England in the 19<sup>th</sup> century the moral treatment movement had proposed that rest and tranquility could heal the insane. According to this philosophy, which influenced the designs of both Valkenberg (Louw & Swartz, 2001) and Stikland (Green, 1998) in South Africa, asylums were now to be designed as calming, preferably rural, retreats. Located on the grounds of a farm that had once housed a reformatory, Valkenberg was the first purpose-built asylum in Cape Town, opening its doors to white patients in 1891 and admitting black men and women in 1916 and 1919 respectively (Deacon, 2003). By 1950 it housed 2 000 patients and although by 1974 this number had dropped to 1 911, it had 'always been uncomfortably crowded' (Minde, 1974, p. 2232). A brochure produced for Valkenberg's centenary in 1991 states that in 1962 there were 2 352 patients in total and that four new wards were added between 1956 and 1958, as well as prefabs in 1970 (Valkenberg Hospital, 1991). A maximum security forensic unit, Ward 20, was opened on the Pinelands side of the Liesbeek River in 1976, built as an exact copy of a section of Pollsmoor Prison in Tokai (Deacon, 2003).

For the greater part of its history, Valkenberg's white, black and coloured patients were housed separately, with African patients being 'on the black side' across the Liesbeek River. Apart from Ward 20, the latter section is no longer part of Valkenberg, constituting the present Oude Molen area. Deacon quotes Dumbrell (1996) as suggesting that the Black River had long functioned as a form of racial boundary. She points out that this is consistent with 'sanitation syndrome' (Swanson, 1977), the tendency to use management of urban health or sanitation as an excuse for segregation under colonial administration. The area surrounding the present Oude Molen had originally seen the creation of a black township (Ndabeni) using plague legislation in 1901; Valkenberg's 'black side' (after 1913); and later, accommodation for white leprosy patients, white female mental patients and white forensic patients. On the same land stood the Alexandra Institution for the 'mentally defective' (1918).

Deacon notes that, despite segregation, the black Oude Molen asylum was housed in architect-designed, well-built structures (possibly to allay the concerns of white Observatory residents about the presence of the black insane nearby). However, the quality of care was inferior to and cheaper than that on the white side, so that black patients were to some extent protected from treatments like frontal lobotomies (Swartz, 2003). Until the 1970s, care was mostly custodial (Deacon, 2003). Valkenberg was desegregated only in the 1990s.

### **Personality disorders in South Africa in the 20<sup>th</sup> century**

### 1916-30

Swartz and Ismail (2001) show how the use of the diagnostic category personality disorder emerges via the 'psychopathic personality' diagnosis in the early 20<sup>th</sup> century. In the Cape Colony of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, the growing asylum population had widened the grounds for admission, so that patients with diagnoses equivalent to the present-day personality disorders had entered the records. By 1920 'moral imbecility', 'constitutional psychopathic state' and 'psychopathic personality' were found in the mental hospital statistical tables.

The category emerged at a time when white South African eugenicists were anxious about the deterioration of the white race either via the handing down of defective personality traits from one generation to the next, or via miscegenation. Swartz and Ismail found in the 1916 to 1930 period that it was primarily white patients who were diagnosed with 'moral imbecility' or 'psychopathic personality'. Among the reasons for this, they argue, is that there 'was little to be gained in looking for stigmata of degeneracy or failure of intellectual prowess in patients already regarded as deficient' (p. 165). In addition, 'normal' personality was differently understood for the different groups.

This concern about an internal deterioration of the white race led to a high level of diagnoses of (and incarceration for) what would today count as personality disorders. Swartz and Ismail claim that many were so diagnosed because their behavior deviated gendered and racialized expectations. Black people escaped the personality disorder

diagnosis partly because they were seen as occupying a different social and mental compartment; miscegenation with this alien black group was considered unlikely. Instead concern about miscegenation focused on the coloured community, from whom, in the early decades of the 20<sup>th</sup> century, the segregation of whites was incomplete, and who were characterized as combining the worst characteristics of both black and white. In addition, these authors note that ‘... certain sexual crimes, when committed by white men, were both explained and dealt with through psychiatric evaluation in general, and the psychopathic personality diagnosis in particular’ (p. 170). This was a trend which would continue into the second half of the 20<sup>th</sup> century, not only in South Africa, but also in the diagnostic manuals. For example, in ICD-8 (1967) and DSM-II (1968) homosexuality was listed as a diagnosable sexual deviation.

### 1996

Msomi (1997) studied a random sample of over 2 000 patients admitted to Cape Town’s three psychiatric hospitals in 1996. She found that white patients were most likely to be found mood disordered and admitted to neuroclinics for therapy (38,6% of all white admissions); coloured patients were most likely to be found schizophrenic (29,9%) or mood disordered (23,7%); while African patients were more likely to be diagnosed schizophrenic (42,7%), given medication and discharged relatively rapidly. Africans had a far lower rate of diagnosis of personality disorders (6,3%) than did the coloured group (20%), with the white group showing the highest rate (31,2%).

These statistics are consistent with trends in North American studies. Reviews of US data

on psychiatric hospitalization find that blacks and Native Americans are most likely to be hospitalized and that blacks are more likely than whites to receive diagnoses of schizophrenia, but conversely for affective disorders (Snowden & Cheung, 1990; Baker & Bell, 1999; Trierweiler, Muroff, Jackson, Neighbors & Munday, 2005). These diagnostic rates cannot be linked to actual lifetime prevalences of these disorders (Snowden & Cheung, 1990). Trierweiler et al. (2005) point out that whether or not there are actual differences in the rates of occurrence of these disorders, research confirms misdiagnosis as a genuine problem and that diagnostic standards are possibly being differentially applied.

The racial prevalence of the personality disorder diagnosis in South Africa in the period intervening between the studies by Swartz and Ismail and Msomi has not been investigated. This thesis aims to make a contribution to the exploration of diagnostic patterns in this period.

### **South Africa's political landscape 1948-1982**

Worden (2000) provides a brief overview of the major political developments in South Africa during the period under review, as the major elements of apartheid were implemented after the 1948 National Party election victory and were met with waves of resistance.

In the 1950s the National Party moved swiftly to legislate not only the segregation of the

South African population into four race groups, but also a prohibition on marriage or sex between whites and other groups, separate race-based residential areas, separate public amenities and apartheid in education. Communism was outlawed, coloureds were disenfranchised and civil disobedience was penalized. In 1959 the 'homelands' were set up – largely rural, economically unproductive areas that would eventually be the destination for the forced removals of an estimated 3,5 million black people.

The shooting of protestors by police at Sharpeville on 21 March 1960 and South Africa's subsequent departure from the Commonwealth set the country on a course of increasing international isolation; resistance went underground in the form of organizations like Umkhonto weSizwe. In 1963, the year of the introduction of detention without charge and solitary confinement, the African National Congress (ANC) and Pan-Africanist Congress (PAC) were declared banned organizations.

The 1970s saw mineworker strikes and the historic 1976 protests by black school children. Although the government responded with detentions and bannings, these events shocked both South Africa and the rest of the world. As the country entered the 1980s, apartheid began to fail and the government attempted to adjust its policies to the changing social and economic situation, while still trying to retain its grip on power.

One aspect of these decades is of particular relevance for this study. A few weeks after Sharpeville, on 9 April 1960, Prime Minister Hendrik Verwoerd survived being shot in the head at the annual Rand Easter Show in Johannesburg. His assailant was an affluent

white farmer by the name of David Pratt, a man with a troubled psychiatric history. On 6 September 1966 a mixed-race parliamentary messenger, Dimitri Tsafendas, succeeded in stabbing Prime Minister Verwoerd to death in Parliament. The situation that ensued – a series of commissions of enquiry into the management of mental health and dangerous persons, leading to official reports and new mental health legislation – has been described as a moral panic.

Cohen (1972, in Paterson & Stark, 2001), the author who first developed a theory of moral panic following ‘battles’ between ‘Mods’ and ‘Rockers’ in England in the 1960s, described an episode of moral panic as having the following identifiable stages: interpreting a phenomenon (‘a folk devil’) as threatening safety, values, or a way of life; the folk devil’s clearly identifiable representation in the media; rapidly rising public anxiety; a response by policymakers; and social change followed by reduction in the panic. Superficially, the Verwoerd affair appears to meet most of Cohen’s requirements for a moral panic, but the media component is difficult to assess since a study of the media in the 1960s was not part of this project.

### **South Africa’s mental health provision 1948-1982**

Foster and Swartz (1997) have argued that during the period 1948 to 1994, the period of National Party rule, ‘Differences, segregation and discrimination [in mental health care] were now gradually legislated, and not merely reliant on customs, bias and neglect’ (p. 13). However, they describe the period 1966 to 1997 as a period of attempted mental

health reform, even if this occurred within the confines of apartheid race-based policy. Other literature on mental health in the period deals mainly with mental health at a state and institutional level and does not examine clinical material except to extract certain statistics.

Solomons (1980) reviews the development of mental health facilities in South Africa between 1916 and 1976 'in the context of relations between social class forces which have effects at the level of psychiatry' (p. 297). Even before 1916, he argues, there was always a deficit in psychiatric facilities, leading to a steady but inadequate expansion in infrastructure. Increase in demand for beds rose sharply in the 1960s, leading to the outsourcing of mostly black chronic patients to private companies such as Smith-Mitchell for custodial care. Hospitals serving the white community, such as Stikland, were built rapidly, while Lentegeur, serving a largely coloured community, was proposed in 1935 but took 40 years to complete. Until 1976 all psychiatrists in South Africa were white; psychiatric nursing staff were predominantly white for many decades. The total number of psychiatrists in South Africa increased from 70 in 1960 to 168 in 1976.

Solomons finds that for most of the period he reviews, white beds were underutilized and black beds seriously overcrowded. In 1960 state mental institutions were overcrowded by 25 per cent. Whites had 7 per cent more space than necessary, while others were overcrowded by 72 per cent, relative to total population size and assuming an equal incidence of mental disorders across groups. However, by 1976 facilities were underutilized by 4,5 per cent since state inpatient numbers had dropped from 20 000 to 16

800 in 1966 and outpatient attendance had increased from 28 657 in 1966 to 362 372: Solomons attributes this primarily to the new psychoactive drugs.

A 1977 report by the World Health Organization points out that in 1965, involuntary admission for serious conditions like schizophrenia and infection and exhaustion psychoses accounted for 73% of first black admissions, as opposed to 19% for whites. (The implication is either that a black person would need to be far more seriously ill to access psychiatric care, or that misdiagnosis was a grave problem.) The report is scathing in its criticism of conditions in the private chronic care institutions. A report by the World Health Organization, presented at a Brazzaville conference in 1981 (WHO, 1983), records that the 1977 report was repudiated both by the South African government and by the chairman of the local Society of Psychiatrists at the time. The chairman commented:

... We cannot deal with all the issues raised in the WHO report, and some are frankly political, and this is not the function of a non-political professional organization. We do, however, feel that it is unwarranted to tie the apartheid tin to the tail of the psychiatric cat ... Nor is credit given anywhere in the WHO report for the very extensive and advanced psychiatric services given to all South Africans without reference to colour or creed. (p. 232).

The report notes that the chairman conceded five months later that there were in fact differences in facilities for different races, but that these were due to 'cultural and socioeconomic factors in a developing country which have nothing to do with politics' (p.

234), while the Medical Association of South Africa justified the unequal ratio of beds for whites in terms of lower demand by blacks.

In 1978 an investigative committee of the American Psychiatric Association visited South Africa and upheld the findings of the 1977 report (WHO, 1983). It concluded that medical and psychiatric care provided to blacks was inferior in both quality and quantity – at times, hazardous. Black patients were frequently misdiagnosed as psychotic and sent for chronic care to the private institutions, which operated in the old custodial mode and had a disturbingly low discharge rate. However, no evidence of abuse of ECT or psychotropic drugs was found.

The report observes that the new Mental Health Act published in 1973 did not make direct reference to race, but that the regulations governing its application set lower tariffs for accessing state mental health services for higher-earning whites than for lower-earning blacks. While the Commission informing the act had recommended decentralization, central control of psychiatric services had in fact been extended.

Following the visit, the Commissioner for Mental Health, A J Lamont, wrote to the APA that ‘manic depressive illness and especially the depressive phase are relatively rare in the Bantu at this stage of their social and cultural development’. Inferior conditions for black psychiatric patients were inevitable since they were an industrial working class whose physical and cultural characteristics unfortunately rendered them unable to blend in with whites even if they progressed socioeconomically. Echoing the stigmatization of

coloureds noted earlier by Swartz and Ismail (2001), he added that 'In South Africa, people of mixed ethnic origins provide social problems and are physically conspicuous. They have a high alcoholism rate which makes them an unreliable labour force' (WHO, 1983, p. 246).

These justifications of unequal mental health provision are clearly linked to broader social discrimination and therefore exemplify Deacon's category 'racist medicine'. However, a new hallmark of the apartheid years was the attempt to draw an artificial separation between the 'political' and the 'non-political'. Once a phenomenon was flagged as 'non-political', it was off-limits for discussion. It was also clear that psychiatry was willing to align itself publicly with the state.

In summary, in South Africa's colonial psychiatry there had been a long history of segregation and differential treatment justified on racial grounds, with implications for the already stigmatized personality disorder diagnosis. In the second half of the 20<sup>th</sup> century, the apartheid state was attempting to entrench segregation and neutralize resistance, while in the field of mental health, the need to manage and modernize an overburdened system came into sharp focus with the assassination of Verwoerd by a psychotic individual in 1966. That the psy-professions would be its natural allies in helping to regulate this area of national life is confirmed by the Society of Psychiatrists' defence of the racially unequal provision of facilities.

## **OFFICIAL DOCUMENTATION**

This section evaluates a variety of documents produced on behalf of the state on the topic of mental health during the research period. These include parliamentary debates, official commissions of enquiry and legislation, as well as reports by the South African Commissioner for Mental Health and the Department of Health.

### **Parliamentary debates, official commissions of enquiry and legislation**

Transcriptions in Hansard of debates in the House of Assembly reveal that at the beginning of the 1960s and before the first assassination attempt on Prime Minister Verwoerd, mental health was already on the parliamentary agenda, although not as an urgent priority. In February 1960 MP Radford had challenged the minister on a shortage of staff and accommodation for the mentally ill, but the Minister had failed to reply to the criticism. The country was under state of emergency at the time (House of Assembly, 1960, p. 7603).

A few weeks after Sharpeville, on 9 April 1960, Prime Minister Hendrik Verwoerd survived being shot in the head by David Pratt at the annual Rand Easter Show in Johannesburg. In Parliament on the following Monday, there was general shock at what had happened, but no suspicion that the perpetrator might have been mentally disordered.

The attempted murder was seen as a political act and the populace was urged not to panic as the eyes of the rest of the world were on South Africa (House of Assembly, 1960, pp. 5223-6). Some time later, a message of thanks from the Verwoerd family was read out in Parliament, but by mid-year, there had been no further discussion of the Pratt affair.

The influence of the new drugs in the 1950s and the changes they permitted did not escape Parliament's attention. In 1961 the Minister of Health stated that the new drugs and treatments offered the hope of cure, so that early intervention rather than institutionalization should be the rule; he foresaw the setting up of outpatient units and post-discharge community follow-up systems to free up beds in the overcrowded mental hospitals (House of Assembly, 1961). The Minister acknowledged the overcrowding problem, but in a further example of racist medicine, added:

the standard applicable in so far as overcrowding in the case of Whites is concerned is not the same as the standard applicable in the case of the Bantu.

According to the standard of over-crowding in the case of the Bantu there is not such over-crowding as is suggested (p. 1067).

In February 1961 opposition MPs challenged the minister, as they would repeatedly over the ensuing months, over the fact that black mental patients were being detained in police cells (House of Assembly, 1961).

*1966: The Report of the Commission of Enquiry into the Circumstances of the Death of*

*the Late Dr. the Honourable Hendrik Frensch Verwoerd*

On 6 September 1966 a parliamentary messenger, Dimitri Tsafendas, succeeded in killing Prime Minister Verwoerd in Parliament by stabbing him with a knife.

Within weeks, a commission of enquiry into the death had been appointed, reporting its findings the same year. The unsuccessful murder attempt by David Pratt on 9 April 1960 had not prompted a similar flurry of official activity, possibly because Pratt had made the attempt in an extremely public and therefore relatively unsecured forum – the Rand Easter Show – whereas Tsafendas had penetrated the sanctuary of Parliament. However, a close reading of the commission of enquiry into the murder suggests that it was more than just Tsafendas's success that occasioned such disquiet. At a time when the state was seeking to extend its governance, Tsafendas had managed to get through an astonishing series of loopholes in the protective cordon around the Prime Minister.

He had undergone name changes from time to time; he was neither white, coloured nor black, but a 'half-caste' Mozambican of Swazi-Portuguese descent with possible communist leanings. He emerges from the report as a person of no fixed abode, no fixed race or nationality, no reliable family ties and variable psychiatric diagnoses. He drifted, mostly illegally, across countries and continents. Despite being on the 'stop list' of the Department of the Interior he was, owing to bureaucratic incompetence, repeatedly able to sidestep prohibitions on entering South Africa, a failing severely castigated in the report. On 30 August 1965 he applied to be reclassified 'coloured', but on 9 August 1966 it was instead ordered that he should be deported. When Verwoerd was killed on 6

September, nearly a month later, the removal order had not yet been forwarded to the South African Police for execution. On the morning of the assassination Tsafendas bought knives at two separate shops; both were sold to him in contravention of the law. The authorities at Parliament had not established whether he was a security risk and had failed to pick up that he was neither white nor South African – essential requirements for employment as a parliamentary messenger. Not one, but many, bureaucrats had failed in their duties.

Tsafendas escaped the death penalty after a panel of psychiatrists from UCT found that he was schizophrenic. The Commission of Enquiry recommended tighter controls and heightened surveillance over the mentally ill, as well as a review of mental institutions. In October of the same year a commission of enquiry into psychopathy – not in the earlier sense of ‘personality disorder’, but the newer sense of antisocial – was appointed. This marked the beginning of a process in which the state and the psy-professions would collaborate to bring the dangerous individual under closer scrutiny.

Debate in Parliament in the weeks and months following the murder continued on topics that were being pursued before the assassination. These included mental patients continuing to be held in police cells, the appalling state of the mental hospitals, the shortage of psychiatrists and psychiatric facilities, and the growing number of mental patients. On overcrowding, the Minister of Health defended himself: ‘The Government is continually building new accommodation for Whites and Bantu, but the number of mentally deranged persons in South Africa is increasing tremendously’ (House of

Assembly, September 1966, p. 2514). A category of mentally ill persons was, in Hacking's phrase, being 'made up'; the greater the focus on it, the more it would appear to expand.

*1967: The Commission into the Responsibility of Mentally Deranged Persons and Related Matters (Rumpff Commission)*

Given that both Pratt and Tsafendas had been found unable to stand trial in view of insanity, a commission of inquiry was appointed to determine which categories of people could be held responsible for their crimes, resulting in the Rumpff Report (1967). It noted that although both Pratt and Tsafendas had been diagnosed as mentally ill, neither had been prevented from doing harm. Rumpff urged:

it is clear to us that much of the present Act is out of date and that problems in connection with prevention, detention, proper and adequate accommodation and treatment, discharge, and the necessity of integrating psychiatric and psychological services, make urgent revision of Act 38 of 1916 and of the control of mental hospitals essential (p. 71).

Unsurprisingly, during the 1967 parliamentary session (House of Assembly, 1967), mental health was a burning topic. Themes covered included concern about the allegedly alarming increase in mental illness nationally and worldwide; the cost to the economy through loss of productivity owing to mental illness; South Africa's lagging behind the rest of the world in dealing with the problem of mental illness; the need for early

detection in children with problems; and the need for cure rather than incarceration.

1972: The Commission of Enquiry into the Mental Disorders Act (Van Wyk Commission)

Appointed as a result of the recommendations of the Rumpff Commission, the Van Wyk Commission investigated the state of the mental health services. The Commission consulted extensively with leading psychiatrists and psychologists, as well as legal experts, and confirmed that there was an escalation in mental illness nationally and internationally. An acute shortage of psychiatrists, psychologists, social workers and nurses was noted; proliferation and specialization of these services was recommended, and Van Wyk further recommended a special committee of inquiry into the profession of psychology, which the Commission saw as lacking in due recognition. This - the government's anxiety to govern the population effectively - was the prime catalyst for the dramatic growth that occurred in the profession of psychology in the 1970s.

The commission concluded that 'A maximum security hospital for dangerous State President's patients is an urgent necessity (p. 71)'. The data on maximum security cases for 1966 as made available to the commission and appended to the report was grouped as follows: defective mental development with sexual misconduct; paranoid, epileptic and otherwise dangerous patients, including escapers; impulsive and aggressive psychotics; no diagnosis but presenting security risk; and patients treated in closed wards for a wide variety of reasons including shortage of nursing staff. The report stated that one of the requirements of a maximum security hospital would be that 'in the planning, provision must be made for the compartmentation of different diagnostic entities' (p. 69). The

rationale for the existing groupings was clearly administrative utility rather than diagnostic streamlining; the state now appeared to be deferring to the psy-sciences in the matter of how to know and manage the dangerous patient. In an analysis of crime and diagnosis in the report's appendices, defective mental development (which would have included personality disorders) was listed as one of the top three diagnoses for each of nine different categories of crime.

1973: The new Mental Health Act

In 1973 the new Mental Health Act was published, although it was implemented only in 1975. The readings of the Bill engendered intense discussion in Parliament, with the Minister of Health, Dr A. Hertzog, commenting as follows:

Unfortunately we have a great shortage of psychiatrists in South Africa; especially so in the services undertaken by the state ... The commission stated quite correctly that, compared to some Western countries, clinical psychological services are relatively undeveloped in the Republic, and recommended that the clinical psychologist should be given greater recognition as regards his role as psychotherapist. This aspect was stressed by the committee with regard to psychopaths. I wish to give the assurance that this aspect will receive the necessary attention in the development of psychiatric services within my department (House of Assembly, 1973, p. 1787).

Kruger (1980) has pointed out that the Act demonstrated that South Africa was moving away from a custodial approach to the mentally ill and towards a more treatment-oriented approach. The emphasis was on voluntary and consent patients, and the importance of the clinical psychologist was affirmed. However, much of the Act was still focused on measures for dealing with dangerous patients.

*The 1972 (1978) Report of the Committee of Enquiry into Psychopathy*

In 1978 the Report of the Committee of Enquiry into Psychopathy was released by the Department of Health, although it bore the date 1972. Chaired once again by Van Wyk, the committee had been appointed in October 1966 on the grounds that

The undermining of the peaceful life of the community and the social disorganization associated with the phenomenon of psychopathy have prompted various interested persons, bodies and disciplines to call for separate facilities for the treatment of psychopathic persons, since there are as yet no such facilities in the Republic of South Africa (p. 1).

The Commission set out to define the concept of psychopathy (in the sense of the dangerously antisocial patient), consider its aetiology and diagnostic criteria, and establish its incidence among the white population – in the community, in psychiatric hospitals and in prisons. It pondered the roles played by different disciplines and by the government in dealing with the psychopath, as well as looking at medico-legal aspects and prevention. The Commission settled on a modified version of the definition

enshrined in the British Mental Health Act of 1959:

Psychopathic disorder is a mental illness, whether or not including sub-normality of intelligence, which is characterized from an early age (before 18 years) by persistent anti-social behaviour and misconduct. The condition may result in abnormally aggressive or seriously irresponsible conduct (p. 6).

In order to arrive at its findings, the Commission had visited various prisons and other institutions. Inmates were randomly sampled and interviewed using a diagnostic questionnaire. In addition, 'the Committee decided to have certain specific investigations and studies carried out with a view to determining the role of genetic, neurological, psychological and social factors' (p. 2). Indicating the state's receptivity to psychology's tools, the psychological measures used included the Wechsler-Bellvue, the MMPI and the Rorschach, although the latter was found to be unreliable. In addition, a group of 100 psychopathic and a group of 100 non-psychopathic offenders were compared with each other.

Noting that its terms of reference were to determine the incidence of psychopathy among Whites only, the committee stated that it would 'content itself with one or two observations' about 'Non-White population groups', which included the following:

5.39 The Coloured Prison at Bellville was visited and a number of cases were evaluated there. It became clear from the investigation that psychopathy manifests

itself in the same way among Coloureds as among Whites. What was striking, however, was that the degree or severity of psychopathy was considerably higher among Coloureds than among Whites. Some of the worst and most pronounced psychopaths conceivable were found among Coloured criminals. The reason for this is probably the less favourable social and domestic background of the Coloured ...

5.42 ... Owing to differences in the use of language, culture, habits and customs it is extremely difficult to determine the incidence of psychopathy among the Bantu population groups. There can be no doubt that this phenomenon does occur among the Bantu; this has been confirmed by a Bantu social worker ... who believes that psychopathy manifests itself in the same way among Bantu as among Whites (p. 23-4).

The committee recommended that the incidence of psychopathy in the non-White population groups be thoroughly investigated – not by the Department of Health, but by the Department of Prisons, suggesting that this was not a question of community mental health, but a matter of criminal management. The report's comments on 'non-white' psychopathy replicate Swartz and Ismail's earlier finding (2001) that coloured people were seen as unusually degenerate, while blacks were unknowable bodies whose inner life, if any, could be guessed at only with the help of a culture-broker.

The report recommended a team approach for the treatment of psychopaths. The

psychiatrist was to head the team, while clinical psychologists would provide individual, group or behavioural therapy. In other words, psychology was found useful not only for identification, but also for management of the dangerous individual.

### **Reports by the South African Commissioner for Mental Health and Department of Health**

In 1948, South Africa's mental health was the responsibility of a Commissioner for Mental Hygiene, who reported to the Minister of Health and whose title later changed to Commissioner for Mental Health. His portfolio would shift to the Department of Health in 1970. The Commissioner's annual reports on the mental hospitals give detailed statistics for the relevant institutions, with patients being enumerated painstakingly according to categories such as race, gender and diagnosis. Personality disorders were part of a broad category denoted by the Commissioner as 'defective mental development without epilepsy'.

By 1960 the Commissioner's reports were clearly reflecting the impact of the new antipsychotic drugs. In his report for 1960 (Republic of South Africa, 1961) the Commissioner, a psychiatrist by the name of A. Lamont, reported a rise in admissions and discharges for South African asylums, along with an open-door system, improved treatments (especially drugs) and changing community attitudes. Psychotic patients, he stated, had benefited most from the new regime; their length of stay was reducing.

Lamont was concerned, however, about the problems attendant on managing psychopaths

(intended in the broad sense of ‘psychopathic personality’ rather than ‘antisocial’).

In 1961 the trend continued and the Commissioner noted in his report on this year (Republic of South Africa, 1962) that ‘the functional psychoses (schizophrenic and manic depressive cases) which formed the bulk of admissions ten years ago are receding in importance’ (p. 4). The Commissioner mentioned plans for special units to accommodate criminal psychopaths, before adding a comment which demonstrates how the personality disordered patients had come into clearer view owing to the recent changes:

The inadequate psychopath, on the other hand, is availing himself more and more of the free facilities offered in the mental hospitals. This is the person who drifts from job to job and from one welfare organization to another and fails to form or maintain normal affective relationships with his fellows. He lacks foresight, judgment and feeling and shows irresponsible responses to his difficulties. A history of suicidal attempts, alcoholism, indulgence in narcotic drugs, divorce and promiscuity are often found in these cases. They are adept at simulating the symptoms and even the signs of disease. Recognizing the true nature of their condition and setting these people the *task* of making an effort to measure up to the demands of life, is a difficult undertaking [emphasis in original] (p. 4).

It was also apparent that the tendency for personality disorders to be diagnosed more frequently in whites obtained as much in the 1960s as in the 1920s and 1990s. The white population was being scanned anxiously for signs of defect and being offered remedial interventions.

Cases admitted from the non-White sections of the population suffer predominantly from psychotic disturbance and mental defect. Neurosis and psychopathy has not yet crystallized out as a national problem for non-Whites. On the other hand these more superficial personality disorders are very prevalent in the White sections and are being admitted in large numbers to our mental hospitals ... it is here that we meet the impact of the extension of psychiatric practice from the management of psychoses and mental defect to include neuroses and psychopathies (character disorders) (p. 4).

If non-psychotic white patients with the equivalent of personality disorders were coming into the system in greater numbers, it follows that personality disorders in the racially structured hospital system would inevitably enjoy increasing prominence, particularly in urban areas where most psychiatrists, almost all of whom were white, were concentrated. In addition, the more personality disorders were being diagnosed, the more professionals – particularly psychologists - would be required to treat them.

In the report for 1962, the Commissioner included a hand-drawn graph (see Appendix B) showing white and 'non-white' admissions between 1953 and 1962 (Republic of South Africa, 1963). White admissions start out at a much higher level and spike dramatically from about 1959/60; 'non-white' admissions start at a much lower level than black admissions and show only a slight rise after 1959, remaining way below white

admissions despite the national demographics. This suggests not only that black patients remained within a custodial frame while white patients were benefiting from the new drugs, but also that the black population enjoyed a lower level of per capita spending. If, as the Commissioner stated, most black patients were psychotic, then they should have been entering and leaving the hospitals at a much higher rate after the introduction of the new drugs if they were receiving the same treatments. This does not appear to have been the case.

In 1967 the Commissioner announced that the provision of extra accommodation, particularly in the 'homelands', had enabled all patients being held in police cells to be moved into the hospital system (Republic of South Africa, 1968). Admissions in general had increased from 3 000 per annum in 1956 to over 15 000 in 1967 and by 1970 South Africa's inpatient figures would be at their highest ever level, at nearly 24 000 (Department of Health, 1977, p. 24). The Department of Health report for 1973 (Department of Health, 1974) would describe an ongoing programme of providing additional accommodation. The creation of a community psychiatric service was clearly not accompanied by a large-scale 'decarceration' project such as Scull (1977) had outlined in Britain.

While the apartheid state is most noteworthy for its repressive implementation of racial discrimination, it was also, ironically – and particularly with a view to the white population - marked by a desire to keep up with the West and implement features of the modernizing liberal democracy. In 1970 mental hospitals were brought under the direct

control of the Department of Health and from 1971 the annual reports on mental health formed a small part of the annual Department of Health Report. In 1970 the Department of Health established a Division of Epidemiology and Statistics. An epidemiologist was appointed, followed by a medical statistician, an ecologist, a human geneticist and administrative staff: thus 'the modern requirements of a Government Department of Health were partially met' (Department of Health, 1972, p. 30). In 1974, South Africa adopted the ICD for purposes of statistical classification of causes of morbidity and mortality (Department of Statistics, 1979). It was in 1977 that 'personality disorders' first appeared on the official South African record in the Department of Health report, in an ICD-compliant table giving a retrospective statistical breakdown of patients in psychiatric hospitals for 1976. However, these statistics notwithstanding, it is generally the case that after the departure of the Commissioner in 1970 detailed psychiatric patient statistics *available in the public domain* dwindled from the rich stream of enumeration provided by the Commissioner to a trickle and, finally, dried up altogether.

In conclusion, mental health, already identified as an area for concern by the state in the early 1960s, came into much sharper focus after the assassination of Verwoerd in 1966. A programme of expansion of the mental health infrastructure was accompanied by attempts both to boost and control the psy-professions through commissions of enquiry and the setting up of professional regulatory bodies. There were concurrent attempts to bring individuals considered to be inherently dangerous under control. These developments coincided with a change in the mental hospital population, both locally and internationally, resulting from the introduction of the antipsychotic drugs in the 1950s.

Non-psychotic patients with problematic behaviour were an increasingly visible part of the hospital population and were primarily white. The government's Committee of Enquiry into Psychopathy (1972) focused on the white population. While the system continued to be characterized by race-based inequalities within the context of the apartheid state attempting to extend its segregationist control over the population at large, infrastructure modernization included the establishment of a Department of Epidemiology and Statistics and the adoption of the ICD.

Somewhat like its old custodial asylums, the psychiatric hospital system had for decades languished quietly on the periphery of national affairs. Now it was being brought into the mainstream of governance, being placed under tighter control and made to articulate with the overarching system, not only nationally, but also internationally.

## **THEORIZING ABOUT PERSONALITY DISORDERS IN SOUTH AFRICA**

This section will look at evidence of attempts to theorize the personality disorder category in South Africa between 1948 and 1952. Journal publications and psychiatric textbooks are investigated for their contribution to the way in which practising clinicians and students were encouraged to think about these patients.

### **Journal publications**

The *Journal of Mental Science* was an influential publication until the early 1960s. Produced by the Royal Medico-Psychological Association, it was required reading for those who wanted to stay in touch with the latest developments in psychiatry in Britain (Swartz, 2006b). The issues published between 1958 and 1969 include ten articles dealing with personality and related matters (see Appendix C). The majority of authors of these articles were based at the Maudsley, where Gillis and many other young South African psychiatrists trained.

Contributions to the *South African Medical Journal* (SAMJ) from the late 1950s to the early 1970s suggest that personality and its disorders were a matter of concern to local practitioners, although theories as to their aetiology and proposals for their classification varied so substantially that it is difficult to extract common themes apart from a strong residue of degeneration theory in a number of the contributions.

Perk (1957), a neuropsychiatrist based at Tara, offered a complex personal formulation of 'the psychopathic personality' based on constitution and environment; it made no reference to a standard nosology, although it clearly draws in part on DSM-II. He proposed four subtypes: misfits (such as inadequate personalities, cranks and sexual deviants); sociopaths (alcoholics, drug addicts, aggressive psychopaths); social pariahs (such as vagrants and prostitutes) and criminals.

In a development whose implications merit wider investigation than the present study permits, Fischer, a medical officer at Sterkfontein Hospital, asked: 'Is there such a thing

as a *Bantu* personality?’ (1962, p. 136, emphasis in original). Pointing to a cultural gulf between blacks and whites, he saw the black person, unlike the individualistic white, as having a ‘tradition-directed personality’ that was under pressure from modernization.

Walton (1962), a senior lecturer in psychiatry at UCT, offered a breakdown of personality disorders framed in terms of traits exaggerated beyond the normal degree. His main categories were abnormal personality (character disorders), where social behaviour is impaired, and sociopathy, where social behaviour is so maladaptive that others are harmed (aggressive psychopaths, drug addicts, sex deviants).

Lamont (1966), while still Commissioner of Mental Health, produced an article on behaviour disturbance in psychiatric patients, using the same classification that he employed in his annual reports. In the same year a Johannesburg-based psychologist, Vorster (1966), wrote an article which relied on the psychodynamic category, ‘character disorders’. Gillis and colleagues published three articles, in 1967, 1968 and 1973, all of which were based on DSM-I categorizations.

There was also an article in the SAMJ on the first national congress of the South African Society of Psychiatrists. In his keynote paper, K. L. Glanville-Grossman of St Mary’s Hospital in London (1975) began a list of new trends as follows: ‘The type of patient being seen is changing: personality disorders seem to be more prevalent in psychiatric practice than previously.’ This is an example of a trend in the Northern Hemisphere being exported directly to South Africa.

## **Textbooks in use by psychiatry students**

The expanding range of personality disorders over time is apparent from an inspection of a number of texts which would have been used to train local clinicians in what they should expect to see when they looked at the patient.

Henderson and Gillespie's 1936 *A Textbook of Psychiatry* (4<sup>th</sup> ed.) was published prior to the research period but would have influenced the training of many of the psychiatrists practising after 1948. It presents the Royal Medico-Psychological Association's aetiological classification which, in the category equivalent to personality disorders, offers 'psychopathic constitution (including paranoia)'. It also describes the symptomatological framework of the American Psychiatric Association, which uses the term 'psychopathic personality'. Henderson and Gillespie's own formulation consists of 'mental deficiency', which may consist of either intellectual defect or, corresponding to personality disorders, 'emotional defect: psychopathic personality'.

Slater and Roth (1977), in their authoritative *Clinical Psychiatry*, favour assessing personality in terms of deviation from statistical norm. They do not offer a breakdown of personality disorders, instead preferring to single out only four 'special forms of reaction and of personality' in their 1975 edition: 'the cold and the emotionally callous', 'the sexually perverse', 'the paranoid reaction' and the 'unstable drifter'.

A copy of *Schizophrenia* (Fish, 1962) is inscribed with the date 1968 and the name of Dr Pascoe, the then medical superintendent at Valkenberg. Fish insists on personality pathology as a category in its own right, as the following example (p. 124-5) illustrates:

Short-lived psychotic episodes are not uncommon in psychopathic personalities when they are in severe environmental difficulties ... Many anti-social psychopaths show little emotion after very violent behaviour ... This dissociation of affect must not be misinterpreted as a blunting of affect and held to be diagnostic of schizophrenia.

The first edition of Kaplan and Sadock (Freedman & Kaplan, 1967), which was used at the University of Pretoria to train clinical psychology master's students in the 1970s, followed the DSM-II.

*Psigopatologie (Psychopathology)* (Geldenhuys & Du Toit, 1971) was a locally published textbook used by students at the University of Stellenbosch. It contained a chapter on 'Die Psigopaat' (the psychopath) which equates to a description of psychopathy as detailed by Cleckley. Revealing the amount of stigma that still attached to personality disorder, the authors state: 'If he commits a crime, he can be sentenced to imprisonment, but otherwise he is free to feed like a parasite off the community in which he finds himself' (p. 232).

In 1982 Eleanor Nash, a psychiatrist whose psychoanalytic interpretations appear in

several of the files in the research sample, co-authored a textbook called *Human Behaviour*. Based on the authors' many years of experience teaching in the Department of Psychiatry at UCT, the book can be assumed to have been influential in shaping the thinking of many clinicians who later practised at nearby Valkenberg. The chapter on personality outlines various theories of personality before covering personality inventories such as the MMPI, as well as projective tests. It ends by offering Kernberg's classification of personality disorders as a diagnostic system: high level of personality pathology (hysterical, obsessive-compulsive); intermediate level (passive-aggressive, passive-dependent); and lower level (schizoid, paranoid, antisocial [psychopath]).

The journals and books reviewed above indicate that the two to three terms Swartz and Ismail had noted for personality disorder equivalents in South Africa in the early 20<sup>th</sup> century had fanned out into an increasingly differentiated view of the ways in which personality could be the site of a sociopsychological problem. Personality was seen as something that could be assessed, measured and possibly even modified through therapeutic means. Although these ideas had originated abroad, they were being actively engaged with and digested in South African clinical settings. In addition, there were several different but co-existing classifications of personality during this period, ranging from the rather antiquated categories of the Commissioner for Mental Health to the 'cutting edge' DSM classifications, with a number of more or less formal variations inbetween. In the absence of an orthodoxy, authors needed to choose – or propose - the classification system that best suited their purposes. Despite the lack of uniformity, there is a common theme to some of the theories, namely, that the personality disordered

patient is a degenerate individual inevitably rejected by society. The assumption is that he or she is white. The 'black personality' - if there is one - remains mysterious.

## **DEVELOPMENT OF THE PSY-PROFESSIONS IN SOUTH AFRICA POST-1948**

There was dramatic progress in the professionalization of both psychiatry and psychology from the mid-1950s in South Africa. Psychiatry appears to have received a boost in status after the success of the antipsychotic drugs, while psychology was both promoted and controlled by the government after 1966. This chapter seeks to track these developments through interviews with a psychiatrist and clinical psychologist from the period who were instrumental in these changes. Two psychologists who were interns at Valkenberg in the 1970s are also interviewed. An interview with the clinical psychologist who founded Centrum is included to demonstrate that the state's alliance with psychology was not an unconditional one. Finally, a brochure promoting a large Department of Psychology at a local university is described.

### **Lynn Gillis: psychiatry in South Africa from the mid-20<sup>th</sup> century**

In the first half of the 20<sup>th</sup> century in South Africa, psychiatry was in its infancy. There had been no formal local training before the first university diploma course, based on the British model, was set up in 1948 at Tara Hospital, attached to the University of the Witwatersrand. Gillis had returned from wartime service and was one of six students in the second intake in 1949. Previously, he recalls, all psychiatric teaching had been done

from the mental hospitals, by hospital superintendents who had spent their entire working lives within a moribund system. These training sessions were, he remembers, like ‘freak shows’ during which insane patients were paraded before the medical students.

By contrast, Tara was an exciting phenomenon. Having evolved from an army psychiatry unit which had overseen the postwar rehabilitation of demobilized soldiers, it was under the care of the province, not the more rigid central government, allowing greater scope for innovation. The staff there were keenly aware of new developments in the Northern Hemisphere and were experimenting with new methods such as group therapy. In 1956 a Society of Psychiatrists was set up in South Africa and a Chair of Psychological Medicine was established at the University of the Witwatersrand in 1959.

At the time South African mental hospitals, still in the old custodial mode, were seriously overcrowded with chronic patients and in Gillis’s view, the staff were ‘equally institutionalized’. When he was completing his internship at Weskoppies mental hospital, near Pretoria, the old medical methods were still in use, including malaria injections for cerebral syphilis. As the intern on the ward round, Gillis was the only person present with any specialist psychiatric training. ‘The patient would come in and someone would give a short history and then someone would suggest a diagnosis and everyone would agree.’

Like many others of his generation, Gillis completed his training in London at the Maudsley Hospital. He returned to Tara as a consultant but continued to travel intermittently for professional reasons and held several fellowships in the USA.

Professionals like him would have served as an active conduit for new ideas from the Northern Hemisphere.

In the context of old-style custodial care, the introduction of the new psychoactive drugs to South African hospitals in the mid-1950s came as a revelation. Larger numbers of patients could receive treatment, and receive it on an outpatient basis. Before the advent of the drugs, Gillis estimates, over 80 per cent of inpatients were 'chronics'. With the arrival of the drugs, those patients who responded to medication needed an average of six weeks' inpatient treatment before they could be treated on an outpatient basis. Those who did not respond were transferred to the institutions run by private companies for custodial care. That the new medications increased psychiatry's prestige is confirmed by the Minister of Health's praise for the new drugs in the House of Assembly (House of Assembly, 1961).

In 1963, Gillis was appointed by the Cape Provincial authorities to start a psychiatry department at Groote Schuur Hospital; the first UCT psychiatry diplomates graduated in 1965.

Although it was not in official use as the standard nosology, Gillis recalls using the ICD-7 in the 1950s and 1960s, and finding it confusing and inadequate. However, the DSM was introduced early to Tara and Gillis used it on his visits to America. In his view, it represented as dramatic a leap forward as had the new psychoactive drugs because of the international standardization it offered.

### **Gustav Fouché: psychology in South Africa from the mid-20<sup>th</sup> century**

In the mid-20<sup>th</sup> century, psychology as a profession enjoyed even less recognition in South Africa than did psychiatry and there was no formal training locally. Psychologists trained outside the country and registered with the South African Medical and Dental Council on a voluntary basis and in consultation with SAPA, the South African Psychological Association, which had been formed in 1948 to represent professional and academic psychology and by 1960 had 164 members (Dumont & Louw, 2001). Marking the increasing professionalization of the discipline, a report in the association's newsletter of February 1959 (SAPA, 1959) insists that the term 'psychologist' should be applied only to professionally qualified graduates. It notes with approval that a professional training course has been instituted at Tara and that courses are being planned at other (white) universities.

In South Africa of the 1960s, problems over the political legitimacy of the government, which demanded race-based organizations, conflicted with the legitimation strategies which psychology as a profession was pursuing: international organizations tended to reject such race classifications. Divided over the 1956 application for membership of a person classified Indian, SAPA split in 1961 and an offshoot left to form the whites-only Psychological Institute of the Republic of South Africa (PIRSA). In 1962 SAPA was accepted as a member of the International Union of Psychological Science (IUPsyS), boosting its members' claim to professional legitimacy (Dumont & Louw, 2001).

Fouché recalls that in 1973 the first major national conference for psychologists was convened at the University of Pretoria by Van Wyk, who had chaired the commission into mental health legislation and had led the drafting of the new Act. The delegates were exclusively white. The Act had made provision for a professional board of psychology, but since there was no comprehensive register of clinicians, the minister appointed three members of SAPA and three members of PIRSA to form the first professional board. The board was supplemented by two medical members – a psychiatrist and a medical doctor. Psychologists were now called upon to apply for registration on the basis of their experience. Meanwhile, the Department of Health boosted the training of clinical psychologists by establishing internships in the mental hospitals in liaison with the university departments of psychology; Fouché was one of the first of these interns at Fort Napier hospital in 1976. Once a body of psychologists had registered, a professional board could be elected. Fouché was a member of this first elected board.

These developments show that the government was the crucial agent in the boosting of psychology as a profession. Given the motivation for the commissions of enquiry that led up to the 1973 conference and subsequent registration of psychologists, it is clear that the growth of psychology was integrally linked to attempts to identify and control the dangerous individual, rather than purely to promote national mental health.

**Andy Dawes and Hans Soltau: psychology interns at Valkenberg in the 1970s**

Andy Dawes was a clinical psychology intern at Valkenberg for 18 months from May 1973 to the end of 1974. He had applied for an internship after completing his honours degree in psychology but his involvement in student politics led to the blocking of his appointment by the then senior psychologist at the hospital. After this person was relieved of his duties after the discovery of false claims to have a doctorate from a university in London, Dawes was appointed. Hans Soltau was an intern and then a staff member at Valkenberg between 1975 and 1978.

Dawes and Soltau recall that the psychology interns shared a room in the main administration building. Constituting a kind of ancillary service, intern psychologists did not rotate through hospital wards until 1977, and there was no formal training: they were simply, in Dawes's words, 'inducted into the ways of the institution' and their primary role was psychometric testing in the wards. It would seem that in South Africa, as in Britain, psychometric testing was the 'thin edge of the wedge' that psychology used to insert itself into psychiatry's previously uncontested domain.

At the beginning of Dawes's internship there was no formal supervision. Both psychologists recall that there were many more medical officers than specialist psychiatrists at the hospital, particularly on the 'black' side across the Liesbeek River from the white and coloured sections. Throughout the hospital, psychiatrists, medical officers and psychologists were white.

Neither intern had received any teaching in diagnosis in his pre-internship training.

Soltau had completed the first part of his master's degree at the University of Port Elizabeth: there he was introduced to different therapeutic models and learnt how to conduct psychometric tests. Dawes arrived at Valkenberg with no prior master's level training, pursuing a relatively informal option for qualifying as a clinical psychologist that is no longer available in terms of current much tighter requirements for registration. Both interns would have to complete a thesis in order to graduate with their degree in clinical psychology. Dawes states that they did not receive training in diagnosis at Valkenberg because their role was never, at that time, to diagnose: they presented test results, not cases, in ward rounds. There was a clear if unstated hierarchy at the hospital. Soltau recalls how it was only late in his time at Valkenberg that the psychologists were allowed to join the psychiatrists in the tearoom.

Both interns recall reading widely in an effort to equip themselves for work in the hospital, using texts like Kaplan and Sadock. Dawes, who worked mostly on the 'black' side, had to learn to administer the MMPI and was disturbed by the absence of norms for black patients, but was told sharply by the consultant in the weekly Grand Round that his responsibility was to present the results and nothing else.

There was little general awareness among interns of personality disorders at this time, apart from the use of the terms 'psychopath' and 'sociopath': Dawes states that they were told to pay close attention to the psychopathy scale when scoring the MMPI. He greatly angered the medical superintendent by arguing for continued therapy with a black patient whom the superintendent characterized as a psychopath unsuitable for therapy. Dawes

was also threatened with expulsion by the superintendent for asking why only black patients were denied an anaesthetic when they received ECT. In an example of Deacon's medical racism, the superintendent told him that 'they respond better to ECT without an anaesthetic'. In addition to testing, Dawes taught psychology to black and white nursing students (separately), ran groups for alcoholic patients and did a small amount of psychotherapy.

The experience of these two interns indicates not only that professional registration as a clinical psychologist is now much more tightly regulated than it was in the early 1970s, but also that psychologists were admitted selectively into the professional life of the hospital when their tools (psychometric tests, therapy) were required. Their work was governed by the racialized structure of the hospital. It is likely that most of the diagnoses appearing in the files comprising the sample, at least up to the late 1970s, were made by psychiatrists, since psychologists were denied a diagnostic function.

**Gerrit van Wyk: senior psychologist at Valkenberg and founder of Centrum therapeutic community (1975-1979)**

Gerrit van Wyk was in the second group of psychologists to be trained at the University of Pretoria, completing his M1 year in 1970. Unlike Dawes and Soltau, he was taught diagnostic categories from the first edition of Kaplan and Sadock (Freedman & Kaplan, 1967), which followed the DSM-II. Although his thesis topic was histrionic personality disorder, he recalls that personality disorders were poorly defined at that time, apart from

psychopathy, as it became enshrined in legislation. In 1972 he relocated to a psychiatric hospital in The Hague in the Netherlands, assisting with the running of a therapeutic unit for drug addicts. Finding the democratic style of the unit 'chaotic', he and his co-director (a psychiatrist) sought more workable models elsewhere, settling on a much more strictly hierarchical model based on Synanon and Phoenix House in the USA. They adopted a medication-free treatment policy and aimed to bypass the traditional therapist-patient dyad, preferring to have addicts help each other as in Alcoholics Anonymous. On this base they built an intentionally rigid model aimed at addressing deeply ingrained behaviour patterns inaccessible to conventional therapies. The programme was seen as highly successful and Van Wyk returned to South Africa hoping that he would be able to start a similar facility in Cape Town.

In 1975 he was appointed as a clinical psychologist at Valkenberg, eventually becoming senior psychologist and reporting to the senior psychiatrist and the medical superintendent. Interest in the success of the Dutch clinic grew because there was a large group of young patients across different wards who had diagnoses of personality disorder and were very difficult to manage. At that time the neuroclinic offered relatively little in the way of a therapeutic programme.

Centrum was started in 1975, with the full support of the hospital authorities, to solve this problem. It was a separately housed inpatient therapeutic community which accommodated up to 30 white residents who ranged from 14 to 30 years old. It was medication-free, run in a tightly structured and hierarchical way (privileges were hard-

earned) and not locked. The residents were co-responsible for running the unit with Van Wyk, a senior nurse and a social worker; residents did all the ward work such as cooking, obviating the need for other staff.

Centrum's style was unorthodox and controversial in its confrontation of patients' defences. The attrition rate was high – up to 50 per cent of patients defaulted.

Nevertheless, the unit immediately began to attract favourable attention, becoming a favourite project of the then Minister of Health and his wife, and resulting in the establishment of a similar unit, Sonstraal, for youth on the 'coloured side'.

However, departures from hospital norms – such as unlocked doors at night when the three clinical staff members went home – caused discomfort to the hospital management. In Van Wyk's words, it was 'an anti-psychiatry unit in a psychiatric hospital'. Another discomfort was that UCT clinical psychology interns had begun to rotate through the unit. In 1976 for the first time there were coloured interns. The hospital cautiously sanctioned this, as long as the practice did not come to the attention of the Department of Health. Some time later the hospital insisted that a nurse would henceforth be stationed at the unit at night; this caused friction with the residents, particularly as some nurses smoked while on night duty and giving up smoking was a condition of entry to the programme. In 1979 a white nurse complained to her husband that she had seen a coloured intern hugging a white Centrum resident after what Van Wyk describes as an emotionally fraught group session. Her husband immediately complained to the Director-General of Health, who within eight hours had closed Centrum down, required the discharge of all the residents

and placed a media ban on Van Wyk. The hospital officials who had encouraged the establishment of Centrum and covertly authorized the placement of the coloured intern withdrew their support. Van Wyk received a poor performance review at the end of the year and left Valkenberg. Although it was a segregated whites-only unit, Centrum's usefulness in taking personality disordered patients off the hospital's hands had clashed with the apartheid agenda, rendering the unit expendable. Uncompromising in the application of its internal rules, Centrum had fallen foul of an even more intransigent set of regulations.

### **Stellenbosch University Department of Psychology brochure 1960**

That psychology was well established in South Africa as an academic discipline with a variety of practical applications is shown by this 32-page brochure, produced in 1960 when the department already had over 1 000 students. The department offered courses in general and social psychology, industrial psychology, vocational psychology, psychological statistics and psychophysical measurement methods. It was actively producing research in the education, psychometric testing and vocational fields, as well as in the allegedly world-class electronic section of its laboratory: equipment from this laboratory, with neatly-dressed white students acting as test subjects, appears in photographs throughout the brochure. Among the photographs of former distinguished teachers, all of whom are white and male, is that of H F Verwoerd, who lectured in the department between 1925 and 1933 (see Appendix D). Three young white children play in the psychology clinic, which had opened in 1946.

In applied psychology, two of the major research directions are listed as personality research and adjustment problems. Personality and the development of the self receive particular emphasis in the general psychology division. While not a dominant theme in the department's research in 1960, personality is nevertheless on the agenda, as indicated by the appearance of eight thesis titles dealing with the topic between 1932 and 1959 (see Appendix E). Confirming Claassen's contention (1997), there is research attempting to determine the difference in intelligence between whites, coloureds and blacks – for example, 'The learning aptitude of the Graaff-Reinet Coloured in comparison with that of the White and the Native' (1940) and 'The relation between the learning ability and the degree of European blood in South African non-Europeans' (1941).

In conclusion, in a development which this thesis sees as integrally related to a closer focus on personality both internationally and locally, from the 1960s South African psychiatry and psychology shifted from being less regulated and comprising clinicians trained primarily in the UK, to having training based in South Africa and locally specified standards of practice and registration. Professional liaison occurred increasingly with the USA as well as Britain. As in the UK, the role of the clinical psychologist in the psychiatric hospital changed from that of psychometric assistant to therapist and co-diagnostician, although psychiatry's position at the top of the hierarchy remained unchallenged. The vast majority of psychiatrists and psychologists were white. Patients were segregated by race and gender and facilities and treatments were differentially provided; challenges to segregation within the hospital system were not tolerated.

## **Chapter 4**

### **CONSTRUCTING PERSONALITY DISORDERS:**

#### **FROM THE BOTTOM UP**

This chapter attempts to show how daily interactions between clinicians and patients were instrumental in constructing personality disorders in a particular way in South Africa in the second half of the 20<sup>th</sup> century.

#### **VALKENBERG PATIENT FILES**

(Please refer to the timeline and patient summary in Appendices F and G respectively for information supporting the following discussion.)

#### **Brief statistical analysis**

The final sample consisted of 65 patients who had received a diagnosis equivalent to personality disorder between 1948 and 1982.

#### **Breakdown by sex**

35 (53,8% ) of cases were male and 30 (46,2%) were female.

Breakdown by race classification

49 (75,5%) patients were classified white, 12 (18,5%) coloured, 1 (1,5%) Indian and 1 (1,5%) black. There were 2 patients (3%) whose race classification could not be determined from their files. The relative absence of black patients from the sample does not imply an absence of black patient files in the Valkenberg registry: rather, the black files found during sampling were of patients who had other diagnoses, primarily psychotic disorders.

Breakdown according to year of first diagnosis of personality disorder

For this analysis, patients were grouped according to the year that saw their first personality disorder-equivalent diagnosis between 1948 and 1982.

| Year of 1 <sup>st</sup> diagnosis of PD or equivalent | No. of patients | Percentage of total |
|---|-----------------|---------------------|
| 1948-1960 (13 years)                                  | 6               | 9,25%               |
| 1961-1970 (10 years)                                  | 19              | 29,25%              |
| 1971-1982 (12 years)                                  | 40              | 61,5%               |

Using 1968 as a cut-off point – this being the first year in which more than two cases receiving a personality disorder diagnosis were found – one arrives at the following breakdown:

| Year of 1 <sup>st</sup> diagnosis of PD or equivalent | No. of patients | Percentage of total |
|---|-----------------|---------------------|
| 1948-1967 (20 years)                                  | 14              | 21,6%               |
| 1968-1982 (15 years)                                  | 51              | 78,4%               |

Bearing in mind the limitations imposed by the small sample size, there is a significant increase in the diagnosis of personality problems after 1968.

### Use of diagnostic terminology

The terms used to diagnose personality most frequently in the sample are ‘psychopathic personality’/’psychopath’, ‘inadequate personality’ and ‘personality disorder’. The frequency of use of these terms (rather than the number of patients referred to) across different time bands is shown in the table below.

| Time band  | No. of patients | Psychopathic personality and variants, including psychopath | Inadequate or inadequate personality and variants | Personality disorder and variants | Other * |
|--|-----------------|---|---|-----------------------------------|---------|
| 1930-1947 (17 years, not within the research period) | 1               | 4   | -   | -                                 | -       |
| 1948-1955 (8 years)                                  | 5               | 3   | 1   |                                   | -       |
| 1956-1960 (5 years)                                  | 1               | 1   | 1   | 1                                 | 1       |
| 1961-1965 (5 years)                                  | 6               | 7   | 2   | 3                                 | 2       |
| 1966-1970 (5 years)                                  | 13              | 8   | 1   | 6                                 | 4       |
| 1971-1975 (5 years)                                  | 13              | 2   | 2   | 12                                | 1       |
| 1976-1982 (7 years)                                  | 27              | 6   | 4   | 26                                | 6       |
| Frequency of use of diagnosis 1948-1976              | -               | 28  | 11  | 57                                | 14      |

\* Other refers to schizoid, schizophrenic, dependent, immature, epileptoid, psychoneurotic, sociopathic or passive personality, or personality problem.

The table shows that the number of patients receiving a personality-related diagnosis roughly doubles after 1966, doubling again after 1976. After 1976 the term 'personality disorder' trumps all others.

*Psychopath, psychopathic personality*

Psychopathic personality and psychopath have a relatively lower incidence up to 1960, after which their incidence increases. The dip in frequency in the period 1971 to 1975 coincides with an increase in the diagnosis of 'personality disorder' at this time, raising the possibility that the new term was beginning to gain popularity. However, it has already been noted that the meaning of 'psychopathic' shifted over time. To illustrate the way in which the term was intended in the years leading up to the research period, JD, initially admitted to Valkenberg in 1930 but still part of the sample in 1948, is described thus in 1932:

She is a case of psychopathic personality ... she is oriented and is now rational in conduct and conversation. She states that she is unhappy at home, that she cannot get on with her mother and that she has decided to do away with herself. There is documentary evidence she has made four attempts at suicide by taking Lysol. She expresses the intention to do away with herself when she leaves the institution. She is not prepared to remain as a Voluntary Boarder. She is mentally abnormal.

This use, consistent with the findings of Swartz and Ismail (2001), shows the term ‘psychopathic personality’ being understood in its earlier, widest sense of non-psychotic psychopathology, with or without the antisocial/criminal connotations that were later to become synonymous with it. By contrast, the majority of patients earning a psychopathic label within the research period were described in terms that would roughly fit the current antisocial personality disorder label. Most of these patients were male; many had a record of criminal charges. A typical representative of this group is SM (1968), a forensic observation patient with a court case pending and a long criminal record. According to the notes, ‘he gives a most unconvincing story ... a manipulative psychopath ++++'.

Within the present sample, the term ‘psychopathic personality’ is used for the last time in 1970; thereafter it appears either as plain ‘psychopath’ or linked to the term ‘personality disorder’ and with associations approximating to the present definition of antisocial personality or psychopathy (Hare, 2003). With time the distinctions become finer: thus EM (1979) earns the descriptor ‘psychopathic’, although the term is circumscribed very carefully in his report discharging her to the police by Prof T Zabow, the psychiatrist who headed the forensic unit at that time as: ‘personality disorder with psychopathic traits but not sufficient to qualify for diagnosis of legal psychopathy’.

In other words, in the course of the research period the term ‘psychopathic’ shifts from being applied broadly to all persons who would qualify for a generic diagnosis of personality disorder, to only those who are more antisocial; and thence to a particular

group of antisocials who meet Hare's definition of the term. This parallels developments informing legislation, where psychopathy in the sense of the dangerous criminal is singled out for definition.

### *Inadequate/inadequate personality*

In 1949 one finds the first appearance in this sample of 'inadequate personality', a term used in ICD-6 in 1948 and DSM-I in 1952. Unlike 'psychopathic personality' and 'psychopath', the term inadequate personality is applied almost equally to male and female patients, relative to the two other main diagnostic categories. It appears at a consistently low rate across the sample, sometimes in combination with other descriptors, for example, 'inadequate personality with hysterical tendencies' (1951) or 'inadequate psychopathic personality' (1963) or 'dependent, inadequate, histrionic personality' (1973).

### *Personality disorder*

'Personality disorder' appears for the first time in this sample in 1957 in a referral letter to Valkenberg for LHP. The private psychiatrist, whose letterhead indicates that he trained in London, diagnoses her with 'personality disorder approximating to a pseudoneurotic schizophrenia'. A version of this term is used again by the same doctor for FM in 1964 ('grossly disordered personality'). From 1964 the diagnosis 'personality disorder' is among the diagnoses of almost every patient in the sample. After 1970 the ICD code 301 is frequently appended, although South Africa adopted the ICD only in 1974, suggesting that the psychiatric profession took up the ICD before it became the

state nosology. No use of the roughly equivalent psychoanalytic term ‘character disorder’ was found in this sample except in the document discussed in the following case.

In 1966 a coloured medical doctor, HS, was called to appear before the SA Medical and Dental Council following his admission to Valkenberg, after having allegedly assaulted his wife and caused a motor vehicle accident as a result of addiction to the prescription tranquillizer, Doriden. The senior psychiatrist at Valkenberg was called to Johannesburg to testify to the Council. He wrote to the Council that he was seeking information about the drug in question, Doriden, from the Department of Pharmacology at UCT and from the manufacturer. He would also be obtaining the opinion of the hospital’s clinical psychologist and another clinical psychologist on the case, suggesting that answers to the personality disorder problem were being sought outside medicine, in psychology. The file contains notes about research into the effects of Doriden and a two-page document entitled ‘Characteristic symptoms of character disorder’ (see Appendix H). These two documents were clearly intended to bring the psychiatrist up to date with contemporary knowledge about both Doriden and character disorders. The character disorder document is formulated much more broadly and loosely than the prevailing category of the DSM-I (1952) and in damning moral terms. It appears to be a catch-all for moral stigma and is in some respects closer to the current concept of psychopathy than to any one other personality disorder.

#### *Additional features of the use of diagnostic terminology*

The timeline (Appendix F) shows that there is a loose correlation between terminology in

the files and usage in the ICD and DSM of the period. For example, most of the terms for personality disturbance used in 1962 also occur in the contemporary editions of the ICD and DSM. The use of the term 'personality disorder' was crystallized in the ICD-8 in 1967 and in the DSM-II in 1968; its use at Valkenberg slightly predates this. It is possible that although some terms corresponded to those in the manuals, they were general terms in current use that were not deployed with direct reference to the manuals. Although these diagnostic manuals offered numerous modifiers for the term 'personality disorder', the modifiers are more often than not omitted in the files, with 'personality disorder' being the only term used. Some of the subtypes offered in ICD-8 (1967) never appear, for example, 'hyperthermic', 'hypothermic' and 'labile' personality. Terms occurring in the DSM-I sometimes occur somewhat anachronistically in the files: for example, 'sociopathic personality' is used in 1972, although it had been removed from DSM-II in 1968 and 'inadequate personality', removed from DSM-III in 1980, is still being used at Valkenberg the following year. In 1978 and 1979 there are a few cases in which a 'softened' version of the personality disorder diagnosis appears – for example, 'personality problems'. Occasionally the diagnosis used has a psychoanalytic flavour. For example, HW is described in 1968 as having a 'hysterical reaction in a psychoneurotic personality'. However, although 'borderline personality' was a term used in psychoanalytic and other circles from the 1930s, and would eventually appear in DSM-IV (1994), it was not found at all in the present sample, although there were several patients (such as JD above) who would have been under consideration for such a diagnosis had they been assessed today.

In summary, it appears that an association between terms used at Valkenberg and the diagnostic systems operational at the time did exist but that it was a ragged one, with clinicians having a certain amount of freedom in employing terminology – in some cases, even after they had to complete a form requiring an ICD code (post-1974).

The only difference in diagnosis according to gender is that both white and coloured female patients were more likely to be given a diagnosis involving ‘hysteria’ or ‘hysterical’ than were male patients, consistent with stereotypes of women as more irrational and emotional. The ratio of women to men designated in this way was 12:2, i.e. 18,4% of women and 3% of men.

Finally, as in Swartz’s earlier period, it is apparent that the personality disorder diagnosis rests on rather vague and unspecified criteria. There is almost no justification in the files for making the diagnosis – it hovers over the patient, seldom being pinned down to any particulars.

### **Differential diagnosis**

Patients received a variety of concurrent or alternative diagnoses, which are summarized in the following table. These figures suggest that depressed and substance-using patients, as well as some psychotic patients or those thought to have a hysterical or neurotic presentation, were more likely to be under consideration for personality disorder. If 20% of these patients were under consideration for psychosis, it suggests that the problem Fish

outlined of distinguishing between the psychotic and the psychopathic person was ongoing.

| Percentage of patients under consideration for: |       |
|---|-------|
| Depression                                      | 33,8% |
| Substance use                                   | 27,6% |
| Psychosis                                       | 20%   |
| Hysterical element to presentation              | 18,4% |
| Neurotic element to presentation                | 18,4% |
| Schizoid element to personality                 | 9%    |
| Low IQ  | 6,1%  |
| Sexual problem e.g. homosexuality               | 6,1%  |
| Epilepsy  | 1,5%  |
| Anorexia  | 1,5%  |
| Organic brain damage                            | 1,5%  |

## Treatment

In most cases, particularly in the earlier part of the sample, there are few if any notes explicating what treatment is being either planned or carried out. The baseline treatment – sometimes but not always explicitly stated as such - would appear from the notes to be ongoing observation. In addition to undergoing observation, in 1932 JD attends sewing class and an undefined ‘therapy class’, as well as helping in the ward. In 1941 AB receives insulin for suspected dementia praecox; in 1951 the only treatment recorded for CC, assessed as homicidal, suicidal and dangerous, is ‘restraint’. From the late 1950s ECT and the antipsychotic drugs appear, although in 1957 her private psychiatrist states that LHP ‘is not psychotic in the sense of being the type of schizophrenic reaction that responds to ECT and insulin’, suggesting that the use of insulin therapy was still current in Cape Town.

For GD in 1963 stelazine and largactil are prescribed along with ‘hypnotic and record relaxation’. Where treatment is specified in the files, medication remains a constant from this point onwards, but from the late 1960s one begins to see the introduction of psychotherapeutic interventions, such as referrals to the neuroclinic, for therapy, to group and for family interventions. Thus in 1973 the only treatment prescribed for GL is ‘attention to communication within the family’ and attendance at the alcohol group. This trend persists strongly through the 1970s and into the 1980s. From 1975 to 1979 the therapeutic community, Centrum, becomes available as a referral destination for therapy.

Patients with a more antisocial diagnosis – such as the forensic patients, who are observation rather than treatment cases – tend not to receive therapy. In some cases this is because they abscond (such as JK, 1982) or refuse to enter treatment.

### **Psychometric testing**

In 1962 KJ, aged 42, is said to have an IQ of 81% and a mental age of approximately 12, but there is no indication in his file as to how this conclusion was reached. It is possible that psychometric testing had been done outside the hospital, as was the case with GJ in 1965, who was assessed at Cape Mental Health.

Psychometric testing at Valkenberg appears for the first time in the sample in 1966. Most patients were tested using one of the Wechsler IQ tests and there were several tests of

‘organic fall-off’, such as the Grassi. The following table summarizes the tests of greatest interest to this inquiry, namely, personality and projective tests, which would have been used in an attempt to gain insight into personality functioning or unconscious attitudes, motivations and conflicts. The total number of patients tested with personality or projective tests between 1966 and 1982 is 17, or 36% of that sub-sample.

| Test   | No. of times used |
|--|-------------------|
| Minnesota Multiphasic Personality Inventory (MMPI) | 7                 |
| Thematic Apperception Test (TAT)                   | 5                 |
| Rorschach  | 4                 |
| Draw a person                                      | 1                 |
| Draw a tree  | 1                 |
| California Psychological Inventory (CPI)           | 1                 |

Unlike the six-page, densely typed psychometric reports that are produced at Valkenberg today, the typical report of the period was approximately 200 words in length and handwritten on a standard yellow form. The full names and publication dates of the tests were not supplied, so that it is not always clear which edition of a test was being used.

While psychometric tests were sometimes used to detect organic problems and apparently simply as a measure of intelligence, the stigma that had long been associated with personality disorders and their equivalents (to be addressed in the following section) is frequently replicated in the test reports. AW is depicted in her test report in 1970 as self-centred, immature, manipulative, demanding and aggressive. HvB is found in 1973 to be ‘not sincere’ in her approach to the test. There are even cases in which the IQ test alone is used to make inferences about a patient’s personality, even though it was not designed for this purpose. For example, MB, diagnosed in 1981 as ‘a 5-star psychopathic

personality disorder’, is tested using the Wechsler Adult Intelligence Scales (WAIS) only. Consistent with a formulation presented by Schafer (1966), his verbal IQ to non-verbal IQ discrepancy alone is cited as confirmation of personality disorder and he is assessed in the report as ‘hysterical, manipulative, psychopathic’.

Psychometric testing therefore sometimes contributed to the diagnosis of a personality disorder and the apportioning of stigma, but also helped to establish the expertise of psychology in cases where personality was identified as the site of a patient’s malaise.

### **Personality disorder and stigma**

That personality disorders are among the most stigmatized of psychiatric diagnoses, retaining a strong taint of early degeneration theory, is an impression confirmed repeatedly in investigating these files. Swartz and Ismail (2001) had already shown how, in a colonial setting, personality disorders were a category in which anxieties about race and degeneration could be amplified. Recalling Luske’s halfway house staff patrolling the border between sanity and insanity, many of the clinicians writing the notes appear to be at pains to establish a moral boundary between themselves and these patients.

#### *Moral failing and an undercurrent of racial stigma*

Just as JD in 1932 ‘shows no remorse or shame for her past childish behaviour’, so patients over thirty years later are sometimes still described as moral failures who refuse to take responsibility for themselves – on occasion, even when the facts make their

diagnosis questionable. In 1962 CD, a coloured medical doctor addicted to hypnotic drugs, was admitted to Valkenberg and diagnosed as personality disordered. The detailed history contains a clear account by his mother of how he underwent personality changes following a serious motor vehicle accident. She reported further that he began taking medication for pain after the accident and that the unmanageable pain and accompanying self-medication eventually led him to close down a number of thriving medical practices. An official report issued by the hospital glosses over the discontinuity in C's history to portray him as follows:

The patient is a readmission for the effects of drug addiction. He is a dependent immature personality who has accepted taking barbiturates as part of his life! He rationalizes about his failures and irresponsibilities. He is unrealistic in his thinking and has suffered from moral and social degeneration.

The writer's overtly negative reaction may have been informed by a view that C had 'thrown away' opportunities 'given' to him – opportunities that he was perhaps seen as not entitled to as a coloured person; that, having been offered a chance to better himself and pursue a professional career, he had chosen to sink back into the degenerate group in which his origins lay.

In another example of personality stigma possibly intersecting with racial stigma, the indignation at HS's sense of entitlement may have been influenced by the fact that he too was coloured, albeit a doctor (see p. 97). The clinical folder gives examples of H's

apparently over-entitled behaviour - such as repeatedly asking to use the telephone. Was he being too demanding for a patient, or too demanding for a coloured patient? In January 1967 the hospital superintendent writes of HS in an official letter: 'From the very beginning he showed that he was poorly motivated and incapable of appreciating the gravity of his predicament ... the impression was gained that he had sought admission ... in order to appease the Medical Council ... [rather] than to be cured of his addiction ... a personality disorder of many years standing who has adjusted in a faulty manner to stresses in the environment by taking drugs'. The psychiatrist later refers to 'ample proof of his unreliability and manipulative qualities'. The presence of the 'character disorder' document at the front of H's file raises a question. Was there a looping effect? Did the damning contents of the character disorder summary compiled before his Council hearing influence the staff in constructing Harold as irretrievably corrupt? Further, were H and C the focus of anger for tarnishing the reputation of the medical profession within the hierarchy of the hospital?

Direct references to race as a distinctive feature of a patient's identity are in fact only an occasional occurrence in the present sample. Race is usually (but not always) entered in the official documentation as required, but seldom commented on overtly otherwise. For example, both CD and HS are coloured doctors, but their race is never mentioned explicitly in the files, even though their race must have been salient for the white clinicians working at the hospital and may in some cases have influenced the attitudes of staff. Nor do these two individuals occupy a special category by virtue of their professional status, because race is seldom noted for other patients who lack their

professional distinction. It is easy to forget, reading the case notes, that this was a racially segregated hospital in which conditions were much worse 'on the black side' across the Liesbeek River.

Consistent with the findings of Swartz and Msomi, however, anxieties about the consequences of crossing the racial barrier do intrude. PT is described as a 'prostitute' to 'Japanese sailors'. A coloured patient, JdV (1967), is censured for 'supplying dagga to a white patient'. A white housewife, HP (1971), is alleged to have been having 'contact with coloureds'. AK (1971) had been arrested for stealing drugs from a doctor's surgery 'with three coloured men'; she 'keeps company at present with coloureds in District Six'. One is reminded that EL is not white when, in 1975, her case manager has to correspond with the Department of Coloured Affairs in order to find a placement for her.

Also consistent with the findings of Swartz and Msomi that black patients are comparatively underrepresented in the personality disorder category, EM (1979) is the only black person in the sample. Her interview by a black social worker in the forensic unit generates a web of questions potentially even more complex than those of voice and silence in the case of white clinicians working with white or coloured patients. Did the social worker interview E in English or Xhosa or another African language? The interview is written up in English, one of the colonial languages and also one of the languages of psychiatry: how did this linguistic frame, adopted from a different knowledge system, affect the way in these two individuals – each, in her own way, a subaltern - understood the meaning of their encounter? To what extent did these women

share understandings that were not reported on? Or did their different positions in the psychiatric interview create a gulf between them? What was the daily experience of this social worker, a subaltern working in a white-, male- and psychiatry- dominated setting?

Anxiety about maintaining class barriers *within* the white group is apparent in this comment about the wife of CC, a 'European' patient (1951): 'She belongs to the lower middle class, neat and wellspoken, though slips in a swearword and a bit of slang, indicating her usual mode of speech.'

#### *The difficult patient*

Other examples illustrate the stigma that attaches to apparently personality disordered patients and to those they associate with. In a referral letter dated 1964 a private psychiatrist describes FM as an 'emotionally immature and inadequate grossly disordered personality'. On discharge, after several episodes of disruptive behaviour and attempts to abscond, and along with a diagnosis of 'psychopath', there is a warning in red ink that the hospital superintendent states that F may never be readmitted to Valkenberg. In 1971 AW is censured for associating with another stigmatized individual, 'a psychopath on Ward 3', 'against advice'.

#### *Sexual stigma: women and sex*

In 1978 PT is referred to Valkenberg by a social work agency for allegedly neglecting and abusing her four year old son, 'born illegitimate of a Japanese sailor'. She is said to be 'drinking, prostituting and living in a brothel' and regularly having hysterical

outbursts. Locating P's difficulties entirely within her own morally flawed personality, and denying any contextual factors, the admitting doctor comments as follows:

She comes from a good home with father, mother stolid [sic] citizens, coping successful siblings. No evidence of epilepsy, mental hospital admissions in family. She appears to have been a person who has been 'lazy', passive, taking the easy way out ... resentment against 'perfect parents' and particularly younger sister ...

While some of the notes create the impression that P conceived her son in the course of her 'prostitution', elsewhere in the file it is stated that she has had an ongoing relationship with the Japanese father of her child, and that she was devastated after he was deported when his visa expired.

*Sexual stigma: homosexuality*

In the context of homosexuality still being listed adjoining personality disorder and as a form of 'sexual deviance' in the relevant editions of both the DSM and the ICD, in 1975 a woman named HC, whose first name was a traditionally male name, was described as 'incurably homosexual so we could offer no help ... she is the male partner and enjoys it'. The file of JR (1977), a 20 year old man with a history of exhibitionism, opens with an undated report from a Pretoria psychiatrist, Dr Robbertze (incidentally, a member of the government committee that compiled the official report on psychopathy in 1972). Robbertze argues that J should be given a suspended sentence (for an unspecified but

presumably sexual offence) if he agrees to go into psychotherapy with a Dr Kotze, who has extensive experience in the necessary field. He also recommends that J attend a special programme at Weskoppies psychiatric hospital to receive medication to suppress his sex drive and alter his sexual orientation. Robbertze states that such programmes have had considerable success in England. In 1977 PC (aged 20) is admitted from a reform school following a 'superficial attempt at killing himself'. The school had complained of his 'monosexual activities'. 'He has struck up a very close relationship with a retarded pupil and the school authorities [forbade] the two to meet so they met secretly. Patient denies that he has been involved in homosexual activities, but the stresses associated with the accusations led him to attempt suicide.' MLM (Centrum, 1978) was stigmatized not only for being homosexual, but also for transgressing the limits of her role as a woman:

A practising lesbian and woman's libber ... very histrionic in groups ... still very destructive in the community esp. as regards the males – she undermines them as males ... also undermines their authority ... manipulative ... has too much influence.

Her diagnosis is 'reactive depression in a woman with psychosexual and dependency problems'; 'personality disorder passive dependent type ICD code 301.804'. Her 'contract' at Centrum requires her to wear dresses at weekends.

*Reading against the grain: humane concern*

Although there is ample evidence that personality disorder continued to be a stigmatized

diagnosis with racialized implications, the files also contain many examples of kindness and humane concern. For example, while AK (1971) was described in extremely negative terms by some of the clinicians working with her, another described her as an ‘unhappy and insecure young girl who may be suffering from “smiling depression”’. The tone of the white psychiatric social work student working with EL (1975) is thoughtful and concerned. VJ (1979) is repeatedly described as being depressed in encounters with her apparently concerned clinician, until one day the file states: ‘Case discussed with Dr Ray, psychoanalyst from Maudsley Hospital, London. He thinks she presents with a personality disorder of long standing’ [underlining in original]. After this the tone of the notes becomes less sympathetic and V’s alleged manipulateness is foregrounded.

#### *Constructing the personality disordered patient*

While none of the above denies the possibility that these patients may have had very troubled histories and were difficult to manage in a hospital setting, the perspectives outlined in Chapter 1 alert one to the possibility of an element of social construction, of making up people, in their depiction in the files. Some aspects were foregrounded – CD’s drug use, PT’s sex work – and others glossed over – CD’s considerable professional success and life-changing car accident, P’s emotional attachment to the father of her child. The aspects foregrounded were those which focused concerns about degeneration. This was a function not only of concern about stigma, as the staff kept vigilant watch over the border between themselves and the patients, but also of the standardizing nature of the clinical interview and clinical note-taking formats.

## **The changing psychiatric gaze on the patient**

A sample of patients from different periods will be used in the following section to illustrate the changing way in which patients were viewed and inscribed.

### c. 1948

JD (detained at Valkenberg for long periods between 1929 and 1948) exists largely in the present tense in her file. There is very little history prior to her admission - only a brief note about the immediate precipitating circumstances. Entries in her file typically note her mental state, behaviour in the ward, attitude to staff and current preoccupations – for example, ‘She expresses her yearning for her mother’s love which she never had’. There is nothing in the file providing a background to this yearning. There are gaps of several months during which nothing is written in her file apart from the brief medical notes. Occasionally there is a brief psychoanalytic formulation not expanded beyond a single sentence, such as: ‘Exaggerated feeling of personal inadequacy, for which she compensates by projecting her shortcomings on her environment’; it is not noted whether this understanding was discussed with J. The result is a very externalized view of J: there is an impression of observation from a distance, rather than a seeking to understand her from within. She appears as a body who does not know how to behave.

### c. 1960

In the late 1950s and early 1960s, LHP, who earned a diagnosis of schizoid or grossly inadequate personality, is inscribed similarly in her file, except that interviews with her

are rendered in greater detail. No detailed early history is taken and her parents' assertion that she was 'completely normal' until 1948 does not appear to be tested against any collateral interview with L. The 1957 referral letter from her private psychiatrist gives a somewhat psychodynamic theory of her personal difficulties – in other words, it gets further under her skin than was the case in JD's file. The doctor ends his letter with a request that indicates this his apparent insights into L, which he is sharing with the staff at Valkenberg, are not to be matched by any reciprocal knowledge of him and his motivations on her part: 'Please do not inform the girl that I have given you any report about her.'

#### c. 1970

In 1971 HP is admitted with a diagnosis of alcoholism and hysterical personality disorder. A two-page history is taken, presumably by the admitting doctor, encompassing the personalities of her parents and their attitudes to their daughter as a child, as well as some information on H's early years. In addition to schooling and employment history, notes are made about her sexual responsiveness and 'premorbid personality'. There is a detailed report from a social welfare officer which also includes information on her family background and recent behaviour. She undergoes a psychometric assessment which includes the MMPI, Grassi and Wechsler-Bellvue. The treatment prescribed is 'drying out and hospital routine'.

#### Mid- to late 1970s

In 1975 EL, aged 15, is admitted from an orphanage with a diagnosis of hysterical

personality disorder and hysterical neuroses, as well as headaches and possible epilepsy. Her case manager is a psychiatric social work student who writes extremely detailed notes and holds daily psychotherapy sessions with Elizabeth. The notes explore Elizabeth's feelings in detail. She is referred to the adolescent group and given roleplay sessions to help her deal with anger; there is a social work intervention in an attempt to reunite her with her dying mother. Her case manager formulates her problem as repressed feelings finding somatic expression, and adds: 'E has intellectual understanding of all this but has not integrated the knowledge into herself. Is resistant to looking into herself and at feeling.' There are lengthy review notes about the case post-discharge in addition to ongoing ward notes tracking E's progress. The tone of the social worker's notes in general is empathetic rather than clinical. After discharge E continues to be seen once a week for supportive therapy.

The file of MLM (1978) is typical of Centrum. The file opens with the Centrum contracts which the patient signs on entry to the programme. In her own handwriting, M agrees 'to break off contacts with friends for a year, to also not contact B. Give up cat'. She further agrees to 'wear dresses over week-ends, including Public Holidays' and give back a vest belonging to B. There is a list of the roles that she will have to carry out as a resident. There are ongoing entries in a list of 'haircuts' – code for confrontations of patients by staff about deviations from the behavioural code of Centrum (Van Wyk, 2009). M agrees to wear a dummy on a string around her neck and to put it in her mouth every time she feels threatened; she also consents to wear signs around her neck, one of which reads, 'It's *my* pain – not yours'.

The staff evaluate the way in which she manages herself in relation to others and she is repeatedly confronted about the counterproductive patterns in her behaviour. Typically of Centrum, the patient is required to document herself extensively for her file. M does a great deal of soul-searching in her own handwritten notes about her interactions with other patients in groups and other settings and writes a lengthy autobiography. After the curtains catch fire in her room, she has an interview with a doctor and is required to write her account of the interview afterwards. In these notes, she comments of the doctor – although she had not done so in person in the session: ‘He is being very patronizing ... I said I did *not* feel *sick*.’ This is a rare instance of a patient’s view of a clinical encounter being recorded in the files.

### 1980s

Following the closure of Centrum, HH (1982, diagnosis of passive aggressive personality disorder) is admitted to the Valkenberg neuroclinic via Groote Schuur, where a clinical psychology intern typed up a detailed report including family history, family atmosphere, neurotic symptoms in childhood, menstrual history, sexual inclinations and social relationships, ending with a psychodynamic formulation. The intern recommends antidepressant medication, milieu therapy and supportive individual therapy. Once H is at Valkenberg she attends projective art group, therapy group and individual therapy sessions. The therapy notes contain comments such as ‘interpreted to her the mechanism of her passive aggressivity – how she equally contributed to the situation by making others feel her anger’. The therapist notes of the patient’s father: ‘personality disorder

with projections +++ psychopathic personality – severe’.

What is apparent from tracking this shifting gaze on the psychiatric patient is that the patient is initially (1930s-40s) viewed as a rather distant object, seen from the outside as a troublesome body. Her behaviour is described externally, in terms of mental state as assessed by the observer, and there is only an occasional attempt to guess at her inner motivation. Her speech is reported at second hand; it is neatly framed by the observer’s clinical commentary. With time, this rather distantly held magnifying glass moves closer to the object, seeing her personality through the diagnostic mesh with a finer grain, seeking to penetrate her skin and expose her innermost secrets. Her entire life from conception onwards becomes the subject of enquiry. She is seen in an increasingly psychological light as her interior space is mapped. The problem being diagnosed is intrapsychic, familial and social: she is given treatments aimed at healing the psyche and improving her ability to regulate interpersonal contact, such as individual, group or family therapy. She is invited to speak and challenged if she will not; her words are reported in detail in the casenotes. Finally, in the era of milieu therapy, she is invited to inscribe herself in her own hand, in autobiographies and experiential reportbacks. Here there may or may not be a fleeting opportunity for her view of the clinician to be recorded.

In a striking evocation of Bentham’s Panopticon, however, the gaze remains almost exclusively unidirectional. The staff (from a growing number of disciplines) and the patient, and sometimes the other patients, all look at the patient. It is almost never

possible for her to gaze back in the other direction and say what she sees; what she thinks and feels about the clinician has almost no place in the record. (There is one example in the records, in 1976, in which a therapist reflects on her own uncomfortable feelings after a session, and resolves to take them to supervision, but this is not the same as the patient returning the clinician's gaze.) It is usually only in letters directed outside the ward that the otherwise silent patient speaks directly – for example, MI's note (1949) appealing to have her status changed from Governor General's Decision Patient to 'ordinary patient' and HS's eloquent letters arguing his case with the SA Medical and Dental Council (1966).

Nevertheless, there are moments when the patient appears to resist; and as a result one frequently becomes aware of a power struggle between staff and patients. Thus a senior nurse – whose notes repeatedly confirm the impression that she sees the patients as essentially given to manipulative power play - writes of RG, a resident in Centrum in 1977: 'Admitted today ... a real Mr Nice Guy. Appears well motivated but ingratiating in his manner ... he has very quickly become the joker in the community ... ' The following month she added: 'He has become very lost now that his joker image is broken.'

In conclusion, rates of personality disorder diagnosis in this sample climbed in the 1960s, increasing dramatically after 1968. After 1970 the term 'personality disorder' was used almost to the exclusion of other terms. Patients diagnosed with the equivalent of a personality disorder at Valkenberg were slightly more likely to be male than female and overwhelmingly more likely to be white – figures totally at odds with the national

demographics. There was no clear difference in the diagnoses given to white and coloured patients, but women were substantially more likely than men to earn a label denoting hysteria. The use of terminology bore a loose relationship to the diagnostic systems in international use.

The most prominent treatment during the period appears to be continued observation, followed by medication and ECT, but after about 1970 therapeutic interventions become far more common. Psychometric testing appears in the sample for the first time in 1966, but, unlike psychotherapy, does not become a standard intervention, appearing to peak in the 1970s before tailing off – perhaps reflecting psychology’s changing role in the hospital.

There is strong evidence that personality disorder continues to be a highly stigmatized diagnosis, being linked in the casenotes to socially ‘deviant’ behaviour and inherent ‘moral failing’, including homosexuality. While patients’ race is not discussed overtly in the file, anxieties about their crossing of racial boundaries and association with members of other stigmatized groups is evident.

There is a marked shift in the way in which the patient is viewed over time. At the outset of the period, the patient is viewed externally and clinically, as a body who does not know how to behave. With time the focus shifts closer to the patient’s psyche: his earliest formative experiences and innermost motivations are subjected to scrutiny. Along with these attempts to explore inner psychological space come treatments, such as therapeutic

interventions, designed to treat the problems that these enquiries yield. However, the gaze remains unidirectional – it is aimed almost exclusively at the patient, hardly ever back at the clinician. These developments inside the walls of the hospital cannot be seen in isolation: they correlate to concerted efforts by the state and the psy-sciences to identify and manage the difficult or dangerous patient.

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## Chapter 5

### DISCUSSION

The evidence suggests that during the research period, a category of people was brought increasingly into view in a manner that operated, to use Hacking's formulation, both from the top down and from the bottom up. Although this was a process that happened in a unique way within South Africa, it occurred in concert with developments overseas.

From the upper end, the apartheid government, the professions of psychiatry and psychology and the international diagnostic systems were all, for different but intermeshing reasons, trying to identify and manage those individuals who were unwilling to govern themselves in accordance with the prevailing social code. From the lower end, a group of people was being constructed on a daily basis in the hospital files. In looking at archival evidence at the level of the state as well as evidence of interactions with individual patients, this thesis has attempted to consider both aspects in unison, acknowledging that there would always be interactive effects between the two – with the state, for example, ultimately dictating what diagnostic system should be used but also being advised by practising clinicians appointed to official commissions as to how to define concepts such as psychopathy. At both levels, the process articulated with institutionalized racism. What emerges is a dovetailing of priorities, with the South African government on the one hand selecting dangerous but not necessarily psychotic individuals as in need of earlier identification and tighter control, and the psychiatric

hospital on the other struggling to manage non-psychotic but troublesome patients after the introduction of the antipsychotic drugs. This situation boosted the professionalization and expansion of psychology, which was seen both by the state and by the hospitals as offering interventions that psychiatry possibly could not.

By 1948 the Cape already had a long history of racism in medicine. Black and white patients were seen as mentally different and tended to receive different diagnoses and treatment; the psychopathic personality category was a site for the working out of anxieties that the white race was at risk of degeneration, particularly should there be miscegenation with coloureds. But while psychopathic personalities had been singled out as troublesome, they were regarded as a broad and fairly undifferentiated category, comprising various social 'misfits'.

In an international context, attention was increasingly being focused on the same category of people - not necessarily with South Africa's racial agenda, but because, following Rose's argument, the liberal democracies had a vested interest in knowing the individual and being able to map him or her, both externally and in terms of interior space, in relation to the population as a whole. Thus, in international diagnostic systems like the ICD and DSM, the category of personality disorders expanded steadily over time, being differentiated into a growing number of ways to be personality disordered. These systems tended to decontextualize 'pathology', locating it purely within the individual.

Given the links between British and South African medicine and, later, American

medicine, local clinicians were aware of and picked up on these new trends, although the evidence in local journals and training or diagnostic texts, as well as clinical folders, suggests that this occurred in a slightly staggered, ragged way, with individual practitioners being able to adapt the nosology and terminology with a relative freedom that is unthinkable today, as the DSM approaches its fifth edition. Psychologists working as interns at Valkenberg in the 1970s recall having had little prior training in diagnostics, since their role was not to diagnose, that being the sole province of the medical staff. However, by the end of the research period, psychologists to begin to edge out of this marginalized position as psychometrists to play a greater role in governing the patient, not only in joining the medical staff in diagnosing, but also in offering therapeutic treatment. Patients diagnosed as personality disordered arguably made a significant contribution to boosting the profession of psychology because where all else had failed, therapy – individual, group or family - might help.

While the apartheid state is infamous for its implementation of racial discrimination, it was also, paradoxically, marked by a desire to implement key features of the modernizing liberal democracy. An example in the field of health is the setting up of a division encompassing epidemiology and statistics, and South Africa's adoption of the ICD in 1974. This can be seen as intersecting with earlier evidence from the time of the British administration that it was the white population who were to be anxiously screened for evidence of disordered personality. This is a thread that continues through the reports of the Commissioner for Mental Health and finds its perhaps most striking expression in the Report on Psychopathy of 1972, whose authors were not only restricted to a white sample

for studying the phenomenon of psychopathy, but described coloured individuals as exceptionally psychopathic and black individuals as essentially opaque to scrutiny. This is consistent with the finding that white patients were the most likely to be diagnosed with personality dysfunction in the early decades of the 20<sup>th</sup> century, as well as in Msomi's 1997 study and also in the present study of the second half of the 20<sup>th</sup> century: 75% of those in the present sample with a personality disorder diagnosis were white. This finds visual expression in the Stellenbosch brochure, in which the children photographed in the play therapy area are all white. It is as if the white population stands under the spotlight, while the rest of the population occupies a shadowland outside. This had direct implications for the allocation of mental health resources, with the group under the spotlight receiving the best accommodation and newest interventions, while black patients languished on the periphery of innovation and resource allocation.

There is a curious disjuncture between the relative absence of racial description in the hospital files of the period, and the highly racialized hospital and national context. As noted in the findings, race came overtly into the files primarily as a marker of anxiety about contact with other races. One possibility is that there was no need to mark race, since the patients had already been segregated along racial lines. It is also possible that norms among the possibly 'liberal' middle class professionals who wrote in the files did not permit crude expressions of racial marking, or that individual clinicians in some cases held different views from the norm – a genuine empathy does after all come through in some of the files. The diagnostic systems, locating illness within the individual as they do, also make it easy to see individual pathology while losing sight of the wider context.

Another possibility is that professionalism was equated with being 'non-political' in the sense that the chairman of the Society of Psychiatrists used the term in repudiating the WHO report – in effect, a way of attempting to deny that apartheid lent any taint to the apparently liberal-minded speaker, who therefore did not need to question or defend their assumptions or the ways in which they benefited from the status quo. The fact is that, outside the white and coloured wards whose patients provided the present sample, conditions 'on the black side' of the same hospital had more than a little in common with the situation depicted in the WHO reports. The mostly white and coloured patients in the sample were enjoying a higher level of intervention – one involving increasing numbers and kinds of staff as the period went on, in addition to ECT administered under anaesthetic – than black patients a few hundred metres away 'on the black side'. Within the available budget, their ability to be diagnosed and treated for their apparent personality problems depended, in effect, on the unequal allocation of resources. The absence of overt racial markers in the files thus serves to draw attention away from the inequalities in the system – as if the psychiatric system was looking the other way.

Although the parliamentary record shows that there was concern about inadequate mental health service provision as early as 1960, the assassination by a mentally ill individual of Prime Minister Verwoerd is clearly directly linked to subsequent attempts to boost as well as regulate the psy-professions. It is ironic that although Tsafendas narrowly escaped the gallows when a team of Cape psychiatrists declared him to be schizophrenic, that is, in the grip of an intractable psychotic illness, it was his dangerousness - as an individual who had managed to slip through the official net on many occasions and at many levels -

that led to official endeavours to identify and control non-psychotic but dangerous individuals, namely, psychopaths. In other words, although Tsafendas was not necessarily personality disordered, he inadvertently helped to bring personality disorders onto centre stage nationally at a time when they were already receiving closer attention within the psy-professions. Although there had long been forensic observation patients at Valkenberg, the timing of the opening of the new maximum security unit in 1976 is significant.

The need of the state to identify and control the unmanageable individual was matched by that of the psychiatric institution, where staff had the daily problem of dealing with patients who were not psychotic, and therefore not manageable on medication, but who behaved in disruptive ways that threatened the established norms for their gender, race or even class. Thus it was relatively easy for Van Wyk to persuade the Valkenberg authorities to open Centrum, and for the Minister of Health himself to become an admirer; but it turned out that this was not the only or highest imperative, because as soon as the unit challenged the higher priority of racial segregation, it was summarily terminated.

It seems, therefore, that in the period 1948 to 1982 in South Africa, the consolidation and elaboration of the category personality disorder happened in a top-down direction as well as a bottom-up direction, but not necessarily in an uncomplicated way immune to other dynamics. Both within and without the hospital, a looping process appeared to be under way: the closer the focus on the personality, the larger the category seemed to grow and,

like a giant trawler scouring the seabed, the diagnostic machinery was hauling up a mass of diverse beings whose most unifying feature was perhaps that the psy-professions, and the state, found it expedient to have them safely confined within the net.

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## REFERENCES

- American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders* (1st ed., *DSM-I*). Washington, DC: Author.
- American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed., *DSM-II*). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (3rd ed., *DSM-III*). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4<sup>th</sup> ed., *DSM-IV*). Washington, DC: Author.
- Armstrong, D. (1983). *Political anatomy of the body: Medical knowledge in Britain in the twentieth century*. Cambridge: Cambridge University Press.
- Baker, F., & Bell, C. (1999). Issues in the psychiatric treatment of African Americans. *Psychiatric Services, 50*, 362-368.
- Barrett, R. (1988). Clinical writing and the documentary construction of schizophrenia. *Culture, Medicine and Psychiatry, 12*, 265-299.
- Bartolome, J. (1994). Classification of mental diseases. From Bertillon to ICD-10: A century of international collaboration. *Actas Luso-Espanolas de Neurologia, Psiquiatria y Ciencias Afines, 22*(5), 193-9.
- Berner, P (1999). European psychiatry. In H. Freeman (Ed.), *A century of psychiatry* (pp. 149-54). London: Harcourt.
- Berrios, G. (1993). Personality disorders: A conceptual history. In P. Tyrer & G. Stein (Eds.), *Personality disorder reviewed* (pp. 17-41). London: Gaskell.

- Berrios, G. (1996). *The history of mental symptoms: Descriptive psychopathology since the nineteenth century*. Cambridge: Cambridge University Press.
- Carver, M. (2001). Racial discrimination in the treatment of psychosis in Cape mental hospitals, 1933-1956. Unpublished honours dissertation, University of Cape Town.
- Claassen, N. (1997). Cultural differences, politics and test bias in South Africa. *European Review of Applied Psychology*, 47 (4), pp. 297-307).
- Cleckley, H. (1982). *The mask of sanity*. New York: New American Library.
- Cohen, S. (1972). *Folk devils and moral panics*. London: McGibbon & Kee.
- Craft, M. (1965). *Ten studies into psychopathic personality: A report to the Home Office and Mental Health Research Fund*. Bristol: J. Wright.
- Crammer, J. (1996). Training and education in British psychiatry 1770-1970. In H. Freeman & G. Berrios, (Eds.), *150 years of British psychiatry, Volume II: The aftermath* (pp. 209-242). London: Athlone.
- Dawes, A. (2009). Interview with H. Laurensen, 27 February.
- Deacon, H. (1996). Madness, race and moral treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890. *History of Psychiatry*, vii, 287-297.
- Deacon, H. (2001). Racism and medical science in South Africa's Cape Colony in the mid- to late nineteenth century. *Osiris*, 15, 190-206.
- Deacon, H. (2003). Oude Molen: Historical research report. Unpublished report for Baumann & Winter, heritage impact assessment, Oude Molen precinct.
- Digby, A. (1987). Quantitative and qualitative perspectives on the asylum. In R. Porter & A. Wear (Eds.). *Problems and methods in the history of medicine* (pp. 153-174). Beckenham: Croom Helm.

- Dumbrell, K., & The Urban Conservation Unit (1996). Preliminary historical investigation into the Oude Molen site. Unpublished paper, Revel Fox Architects.
- Dumont, K. & Louw, J. (2001). The International Union of Psychological Science and the politics of membership: Psychological associations in South Africa and the German Democratic Republic. *History of Psychology*, 4, 388-404.
- Elliott, G. (1954). Psychiatry in a general hospital. *South African Medical Journal*, 561-567.
- Fischer, P. (1962). Cultural aspects of Bantu psychiatry. *South African Medical Journal*, 133-138.
- Fish, F. (1962). *Schizophrenia*. Bristol: John Wright & Sons.
- Foster, D. (2000). Race, space and civil society. In F. Cochrane & B. Klein (Eds.), *Sameness and difference: Problems and potentials in South African civil society* (pp. 57-78). Washington, D.C.: Council for Research in Values and Philosophy.
- Foster, D. (2003). Social psychology. In L. Nicholas (Ed.), *Introduction to psychology* (pp. 233 – 280). Cape Town: UCT Press.
- Foster, D., & Swartz, S. (1997). Introduction: Policy considerations. In D. Foster, M. Freeman, & Y. Pillay (Eds.), *Mental health policy issues for South Africa* (pp. 1-32). Cape Town: Medical Association of South Africa.
- Fouché, G. (2006). Interview with H. Laurenson, 15 September.
- Foxcroft, C., & Roodt, G. (2005). *An introduction to psychological assessment in the South African context*. Cape Town: Oxford.
- Freedman, M., & Kaplan, H. (1967). *Kaplan and Sadock: Comprehensive textbook of psychiatry* (1<sup>st</sup> ed.). Baltimore: Williams & Wilkins.

- Freeman, H. (1999). Psychiatry in the National Health Service. *British Journal of Psychiatry*, 175, 3-11.
- Geldenhuys, B., & Du Toit, S. (1971). *Psigopatologie*. Pretoria & Cape Town: HR-Academica.
- Gergen, K. (2001). *Social construction in context*. London: Sage.
- Gillis, L., Lewis, J., & Slabbert, M. (1968). Psychiatric disorder amongst the coloured people of the Cape Peninsula. *South African Medical Journal*, 1575-87.
- Gillis, L. (1967). Improvement in psychiatric illness: Report on 400 cases treated in a psychiatric hospital. *South African Medical Journal*, 217-22.
- Gillis, L. (2006). Interview with H. Laurenson, 8 September.
- Gillis, L., & Stone, G. (1973). A follow-up study of psychiatric disturbance in a Cape coloured community. *South African Medical Journal*, 279-83.
- Glanville-Grossman, K. (1975). Psychiatry of the seventies: Clinical aspects. In First National Congress of Psychiatry: Abstracts of Papers. *South African Medical Journal*, 980-6.
- Green, E. (1998). An architectural anachronism: Stikland Mental Hospital in Bellville, Cape Town. Unpublished honours dissertation, University of Cape Town.
- Hacking, I. (1991). *The Foucault effect: Studies in governmentality*. Chicago: University of Chicago Press.
- Hacking, I. (1991). World-making by kind-making: Child abuse for example. In M. Douglas & D. Hull (Eds.). *How classification works: Nelson Goodman among the social sciences* (pp. 180-238). Edinburgh: Edinburgh University Press.
- Hacking, I. (2004a). Between Michel Foucault and Erving Goffman: Between discourse in the abstract and face-to-face interaction. *Economy and Society*, 33 (3), 277-302.
- Hacking, I. (2004b). *The taming of chance*. Cambridge: Cambridge University Press.

- Hare, R. (2003). *Hare Psychopathy Checklist - Revised* (PCL-R; 2nd ed.). Toronto: Multi-Health Systems.
- Henderson, D., & Gillespie, R. (1936). *A textbook of psychiatry for students and practitioners* (4<sup>th</sup> ed.). Oxford: Humphrey Milford, Oxford University Press.
- Hicks, J. (2004). Ethnicity, race and psychiatry: Are we colour-blind? *Journal of the American Academy of Psychiatry and the Law*, 32, 21-33.
- Jansz, J., & Van Drunen, P. (2004). *A social history of psychology*. Oxford: Blackwell.
- Jones, M. (1979). The therapeutic community, social learning and social change. In R. Hinshelwood & N. Manning (Eds.). *Therapeutic communities* (pp. 1-9). London: Routledge & Kegan Paul.
- Kruger, A. (1980). *Mental health law in South Africa*. Butterworth: Durban.
- Kutchins, H., & Kirk, S. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*. New York: The Free Press.
- Lamont, A. (1966). Predictability of behaviour disturbance in patients presenting with psychiatric symptoms. *South African Medical Journal*, 87-90.
- Laurenson, H. (2006). The proliferation of personality disorders in South Africa 1948-1976. Unpublished honours dissertation, University of Cape Town.
- Lea, S., & Foster, D. (1990). *Perspectives on mental handicap in South Africa*. Durban: Butterworths.
- Louw, J., & Swartz, S. (2001). An English asylum in Africa: Space and order in Valkenberg asylum. *History of Psychology*, 4 (1), 3-23.
- Luske, B. (1990). *Mirrors of madness: Patrolling the psychic border*. New York: Aldine de Gruyter.

- Malgady, R. (1996). The question of cultural bias in assessment and diagnosis of ethnic minority clients: Let's reject the null hypothesis. *Professional Psychology: Research and Practice*, 27, 73-77.
- Manning, N. (1989). *The therapeutic community movement: Charisma and routinization*. London: Routledge.
- McCallum, D. (2001). *Personality and dangerousness: Genealogies of antisocial personality disorder*. Cambridge University Press: Cambridge.
- McCulloch, J. (1995). *Colonial psychiatry and 'the African mind'*. Cambridge: Cambridge University Press.
- Miller, E. (1996). Twentieth century British clinical psychology and psychiatry: Their historical relationship. In H. Freeman & G. Berrios (Eds.), *150 years of British psychiatry, Volume II: The aftermath* (pp. 156-68). London: Athlone.
- Mills, J., & Harrison, T. (2007). John Rickman, Wilfred Ruprecht Bion, and the origins of the therapeutic community. *History of Psychology*, 10 (1), 22-43.
- Minde, M. (1974, 1975, 1976). The history of mental health services in South Africa. Parts I-XIV. Cape Town: *South African Medical Journal*.
- Msomi, N. (1997). A descriptive study of the racial distribution of diagnoses in the three state psychiatric hospitals in the Western Cape. Unpublished masters thesis. Cape Town: University of the Western Cape.
- Myers, K. (1979). The mental hospital therapeutic community in recent years. In Hinshelwood, R., & Manning, N. (Eds.) (pp. 143-157). *Therapeutic communities*. London: Routledge & Kegan Paul.
- Nash, E., Stoch., M., & Harper, G. (1982). *Human behaviour*. Cape Town: David Philip.

- Oldham, J. (2005). Personality disorders. *Journal of Lifelong Learning in Psychiatry, III (3)*, 372-382.
- Parker, I., Georgaca, E., Harper, D., McLaughlin, T., & Stowell-Smith, M. (1995). *Deconstructing psychopathology*. London: Sage.
- Parle, J. (2007). *States of mind: Mental illness and the quest for mental health in Natal and Zululand, 1868-1918*. Scottsville: University of KwaZulu-Natal Press.
- Parr, H. (2008). *Mental health and social space: Towards inclusionary geographies*. Malden, MA: Blackwell.
- Paterson, B., & Stark, C. (2001). Social policy and mental illness discourse in England in the 1990s: Violence, moral panic and critical discourse. *Journal of Psychiatric and Mental Health Nursing, 8*, 257-267.
- Perk, D. (1957). The nature of the psychopathic personality: Some observations. *South African Medical Journal, 590-4*.
- Porter, R. (1996). Two cheers for psychiatry! The social history of mental disorder in twentieth century Britain. In H. Freeman & G. Berrios (Eds.), *150 years of British psychiatry, Volume II: The aftermath* (pp. 383-403). London: Athlone.
- Robins, L. (1966). *Deviant children grown up: A sociological and psychiatric study of sociopathic personality*. Baltimore: Williams & Wilkins.
- Rose, N. (1990). *Governing the soul: The shaping of the private self*. London: Routledge.
- Royal Medico-Psychological Association (1958-1960). *Journal of Mental Science*,.
- Sadowsky, J. (1999). *Imperial bedlam: Institutions of madness in colonial Southwest Nigeria*. Berkeley: University of California Press.

- Sass, H. & Herpertz, S. (1993). Personality disorders: Clinical section. In G. Berrios & R. Porter, (Eds.), *A history of clinical psychiatry: The origin and history of psychiatric disorders* (pp. 633-644). London: Athlone.
- Schafer, R. (1966). The expression of personality and maladjustment in intelligence test results. In B. Semeonoff (Ed.), *Personality assessment: Selected readings* (pp. 203-218). London: Penguin.
- Scull, A. (1977). *Decarceration: Community treatment and the deviant*. New Jersey: Prentice-Hall.
- Scull, A. (1993). *The most solitary of all afflictions: Madness and society in Britain*. Yale University Press: New Haven and London.
- Scull, A. (2004). The insanity of place. *History of Psychiatry*, 15, 417-436.
- Shelmerdine, S. (2001). Psychiatric knowledge and the oppression of stigmatized groups at Valkenberg, 1930-1935: Research methods and ideology. Unpublished honours dissertation, University of Cape Town.
- Slater, E., & Roth, M. (1977). *Mayer-Gross Slater and Roth: Clinical Psychiatry* (3<sup>rd</sup> ed.). London: Ballière Tindall.
- Smith, D. (1990). *The conceptual practices of power: A feminist sociology of knowledge*. Boston: Northeastern University Press.
- Snowden, L., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist*, 45, 347-355.
- Solomons, K. (1980). The development of mental health facilities in South Africa 1916-1976. In G. Westcott & F. Wilson (Eds.), *Economics of health in South Africa* (pp. 265-311). Ravan Press: Johannesburg.

- Soltau, H. (2009). Interview with H. Laurenson, 26 January.
- South African Psychological Association (1959). The training and professional practice of psychologists. *Psygram, 1*.
- Spivak, G. (1993). Can the subaltern speak? In P. Williams & L. Chrisman (Eds.). *Colonial discourse and post-colonial theory* (pp. 66–111). New York: Harvester Wheatsheaf.
- Stengel, E. (1959). Classification of mental disorders. *Bulletin of the World Health Organization, 21*, 601-663.
- Stoler, A. (2002). Colonial archives and the arts of governance: On the content in the form. In C. Hamilton, V. Harris, J. Taylor, M. Pickover, G. Reid & R. Saleh (Eds.), *Refiguring the archive* (pp. 83-101). Cape Town: David Philip.
- Swanson, F. (2003). 'The sanitation syndrome': Bubonic plague and urban native policy in the Cape Colony, 1900-1909. *Journal of African History, XVIII (3)*, 387-410.
- Swartz, S. (1995). The black insane at the Cape, 1891-1920. *Journal of Southern African Studies, 21*, 399-415.
- Swartz, S. (1996a). Colonialism and the production of psychiatric knowledge in the Cape, 1891-1920. Unpublished doctoral dissertation, University of Cape Town.
- Swartz, S. (1996b). Shrinking: A postmodern perspective on psychiatric case histories. *South African Journal of Psychology, 26 (3)*, 150-156.
- Swartz, S. (2003). Telephone interview (20 March) and tour of Oude Molen site (2 April) with Harriet Deacon.
- Swartz, S. (2005). Can the clinical subject speak? Some thoughts on subaltern psychology. *Theory and Psychology, 15(4)*, 505-525.

- Swartz, S. (2006a). The great asylum laundry: Space, classification and imperialism in Cape Town. Unpublished chapter.
- Swartz, S. (2006b). Personal communication, October.
- Swartz, S. (2008). Colonial lunatic asylum archives: Challenges to historiography. *Kronos* (34), 285-302.
- Swartz, S., & Ismail, F. (2001). A motley crowd: The emergence of personality disorder as a diagnostic category in early twentieth-century South African psychiatry. *History of Psychiatry*, xii, 157-176.
- Trierweiler, S., Muroff, J., Jackson, J., Neighbors, H., & Munday, C. (2005). Clinician race, situational attributions, and diagnoses of mood versus schizophrenia disorders. *Cultural Diversity and Ethnic Minority Psychology*, 11, 351-364.
- University of Stellenbosch (1960). *Universiteit van Stellenbosch: Die Departement van Sielkunde*.
- University of Minnesota (1943). *The Minnesota Multiphasic Personality Inventory*. New York: Psychological Corporation.
- Valkenberg Hospital (1991). *Valkenberg: 100 years of devoted care*. Brochure produced for Valkenberg centenary.
- Van Wyk, G. (2009). Interview with H. Laurenson, 17 June.
- Vorster, D. (1966). Psychotherapy and the results of psychotherapy. *South African Medical Journal*, 934-6.
- Walton, H. (1962). Psychiatric disorders in general practice. *South African Medical Journal*, 148-50.
- Worden, N. (2000). *The making of modern South Africa*. Blackwell: Oxford.

World Health Organization. (1948). *International classification of diseases* (6th ed.). Geneva, Switzerland: Author.

World Health Organization. (1957). *International classification of diseases* (7th ed.). Geneva, Switzerland: Author.

World Health Organization. (1967). *International classification of diseases* (8th ed.). Geneva, Switzerland: Author.

World Health Organization (1977). *Apartheid and mental health care*. Geneva: World Health Organization.

World Health Organization (1983). *Apartheid and mental health*. Geneva: World Health Organization.

University of Cape Town

## GOVERNMENT REPORTS, COMMISSIONS AND LEGISLATION

Department of Health (1972). *Department of Health, 1971*. Pretoria: Government Printer.

Department of Health (1972). *Report of the Committee of Enquiry into Psychopathy*.

Pretoria: Government Printer.

Department of Health (1974). *Department of Health, 1973*. Pretoria: Government Printer.

Department of Health (1977). *Department of Health 1976*. Pretoria: Government Printer.

Department of Statistics (1979). *Statistical Classification of Diseases, Injuries and Causes of Death (Based On the International Classification of Diseases, ICD, Ninth Revision, 1975) For the Use and Guidance of the Medical Profession in South Africa*. Pretoria: Author.

House of Assembly (1960). *House of Assembly Debates (Hansard), 1960*. Cape Town: Government Printer.

House of Assembly (1961). *House of Assembly Debates (Hansard), 1961*. Cape Town: Government Printer.

House of Assembly (1966). *House of Assembly Debates (Hansard), 1966*. Cape Town: Government Printer.

House of Assembly (1967). *House of Assembly Debates (Hansard), 1967*. Cape Town: Government Printer.

House of Assembly (1973). *House of Assembly Debates (Hansard), 1973*. Cape Town: Government Printer.

Republic of South Africa (1961). *Annual Report of the Commissioner For Mental Health: Year Ended 31 December 1960*. Pretoria: Government Printer.

Republic of South Africa (1962). *Annual Report of the Commissioner For Mental Health: Year Ended 31 December 1961*. Pretoria: Government Printer.

Republic of South Africa (1963). *Annual Report of the Commissioner For Mental Health: Year Ended 31 December 1962*. Pretoria: Government Printer.

Republic of South Africa (1966). *Report of the Commission of Enquiry into the Circumstances of the Death of the Late Dr. the Honourable Hendrik Frensch Verwoerd*. Pretoria: Government Printer.

Republic of South Africa (1967). *Report of the Commission of Enquiry into the Responsibility of Mentally Deranged Persons and Related Matters*. Government Printer: Pretoria.

Republic of South Africa (1968). *Annual Report of the Commissioner For Mental Health: 2 Year Period Ended 31 December 1967*. Pretoria: Government Printer.

Republic of South Africa (1972). *Report of the Commission of Enquiry into the Mental Disorders Act*. Pretoria: Government Printer.

Republic of South Africa (1973). Mental Health Act no 18 of 1973.

## Appendix A

### Semi-structured interview schedules

#### **Lynn Gillis and Gustav Fouché**

What was the state of the profession when you began your career?  
What were the major developments in the profession during your career?  
When and where did you train?  
What training did you receive/what texts did you use for diagnosis?

#### **Andy Dawes and Hans Soltau**

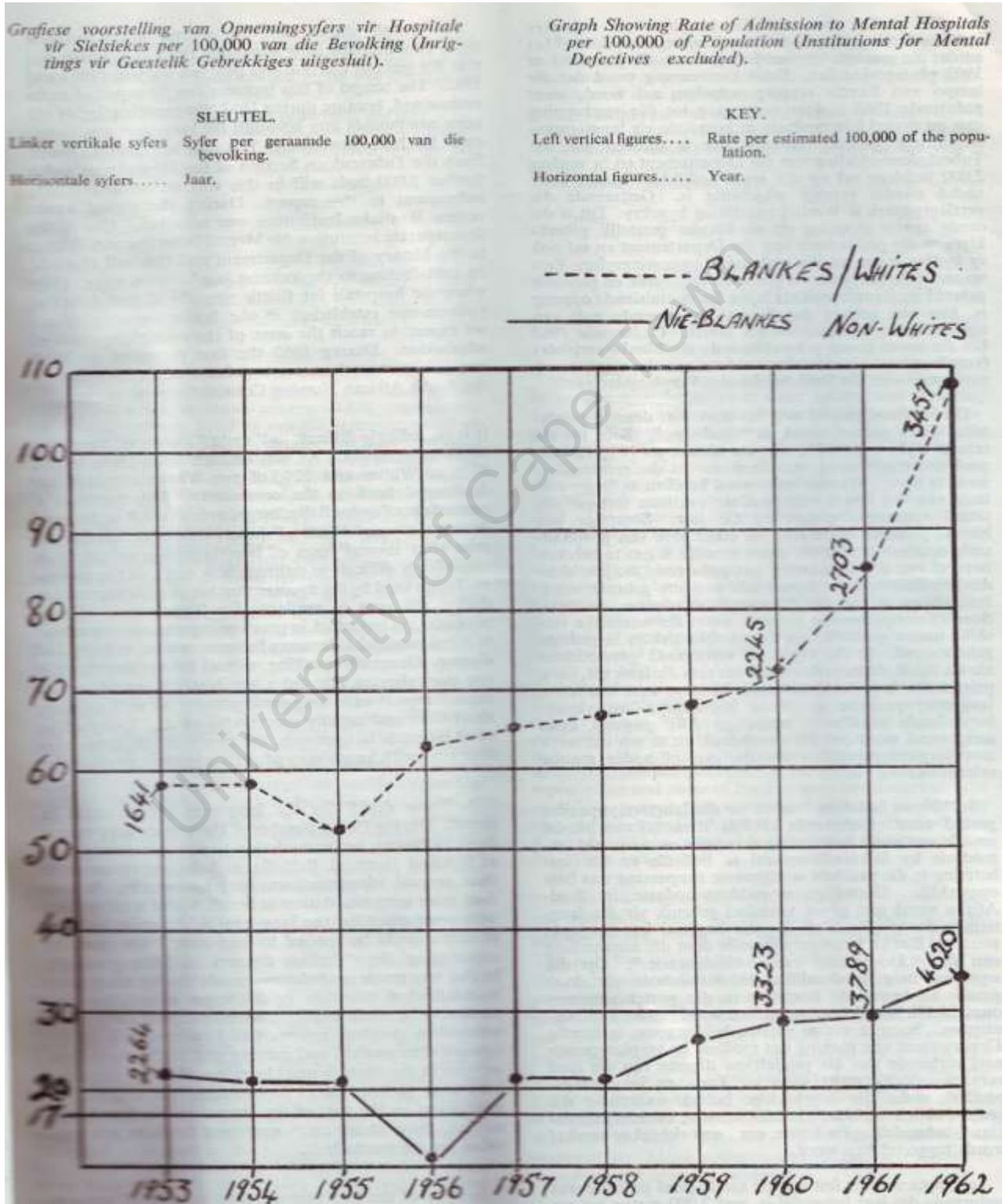
When were you at Valkenberg?  
What training, particularly in diagnosis, did you receive before arriving at Valkenberg?  
What was your role as a clinical psychologist at Valkenberg?  
What was your experience of working there?  
Do you remember being aware of the category personality disorders?

#### **Gerrit van Wyk**

Where did you train?  
What kind of diagnostic training did you receive? Do you remember any textbooks?  
How did you become aware of personality disorders as a category? Was there much talk about/interest in them?  
Why did you want to start Centrum?  
What other therapeutic facilities did Valkenberg offer at the time? What other institutions were models for you? What were the guiding principles?  
Was it easy to get permission to start the unit?  
What was the staffing composition?  
How many beds were there?  
What was the typical length of stay?  
What proportion of the patients would have had a personality disorder diagnosis?  
What was the typical treatment programme?  
Why was Centrum shut down?

## Appendix B

Graph provided by Commissioner for Mental Health



## Appendix C

### Article titles from the *Journal of Mental Science*, 1958-1960

Mental abnormality and military delinquency

Discrepancies between factor analysis and multivariate discrimination among groups as applied to personality theory

The inadequate personality in psychiatric practice

A follow-up study of criminal psychopaths

Abnormal and personality correlates of certainty

Some recent criticisms of the dimensional analysis of personality

The temporal reliability of the Maudsley Personality Inventory

Symptom clusters and personality types among psychoneurotic men compared with women

The relative stability of personality measures compared with diagnostic measures

Dimensions of personality, psychiatric syndromes, and mathematical models

## Appendix D

Excerpt from brochure for Department of Psychology, Stellenbosch University, 1960

gepaste Sielkunde, en hy het hom veral weë hoofrigtings beywer: eerstens vir die ontwikkeling van die Kliniese Sielkunde, en tweedens vir die toepassing van sielkundige kennis in die bedryfslewe — die rigting waarin hyself gepromoveer het. Deur sy toeloen het die Departement in 1943 met 'n besonderlike kursus in Bedryfsielkunde B.Comm.-studente begin. Onder leiding van dr. P. A. Theron is hierdie rigting in daaropvolgende jare tot 'n selfstandige jaarlange kursus in die Departement Sielkunde ontwikkel.

In 1945 is dr. A. B. van der Merwe, B.A., Ch.B. (Kaapstad), M.A., D.Phil. (Stell.), met die oog op die onderrig van Kliniese Sielkunde in die Departement ingestel. Onder leiding van prof. Van Rensburg is nie net die teoretiese kursusse in die Abnormale en die Kliniese Sielkunde uitgebrei nie, maar is daar ook 'n kliniek ingestel waardeur nie net sielkundige dienste aan die gemeenskap gerieflik word nie, maar wat ook geleentheid bied vir gevorderde nagraadse opleiding. Die leiding van die werk binne die Departement en die steeds toenemende studentehede het die aanstelling van nog 'n dosent



*Dr. H. F. Verwoerd*

noodsaaklik gemaak, en in 1948 is dr. I. J. van Biljon, M.A., M.Ed., D.Phil. (Stell.), aangestel. Die Afdeling Bedryfsielkunde het ook addisionele hulp vereis, en dr. F. Jacobsz, M.A., D.Phil. (Stell.), tans hoof van die Personeelafdeling, Unie-Staalkorporasie, is as lektor benoem. Met sy vertrek het dr. R. G. Kriel, M.Sc. (Potch.), D.Phil. (Stell.), tot die personeel toegetree, en toe hy as senior lektor aan die U.O.V.S. aangestel is, het mnr. H. P. Muller, Hons.-B.A. (Stell.), hom opgevolg.

### C. DIE TYDPERK NÁ 1952



*Dr. R. W. Wilcocks*

Met die uitrede van prof. J. A. J. van Rensburg is dr. J. M. du Toit, M.Sc. (Stell.), Ph.D. (Kaapstad), as dosent aangestel. Met sy basiese opleiding in die suiwer Wiskunde, en ondervinding van navorsingswerk (hy was voorheen lid van die personeel van die Nasionale Navorsingsraad) is hy vir die Departement 'n groot aanwinst op die gebied van die Statistiese Sielkunde, sowel as navorsing. Fundamentele laboratoriumwerk het gaandeweg in omvang toegeneem: elektroensefalografiese, pletismografiese en miografiese navorsing het al meer en meer die aandag geniet.

Die kliniese dienste het uitgebrei. Op



*Dr. S. Biesheuvel*

versoek van die Kaapland Departement is hierdie dienste hulle skole gestel. Al di Jan Kriel-Skool vir Epileptiese leerlinge van die Instituut in Durbanville, is vir roetine en aanbevelings na die K

Toe die Universiteitsraad het om 'n Studentevoorstel, is die sielkundige v grootste deel van die he aan die Departement Siel

Ten einde te voorsien hoefte aan skoolsielkunde is besluit om 'n afsonderlike ligtingsielkunde in te stel. Dit is mnr. H. G. van Niekerk, M.Ed. (Stell.), in 1958 aa

Die Afdeling Bedryfsielkunde is saaklik ter wille van die van studente, navorsing in die fabriekse begin onderneem

Hierdie uitbreiding het met 'n steeds toenemende aantal in 1953 tot 1958 het die I skryfwings verdubbel. Toe in 1944 na die Ou Hof was daar 350 studente. In 1958 het die totaal op

## Appendix E

### Stellenbosch theses on personality and related topics, 1932-1959

The possibility of setting up an objective personality determination schema for scholars and students (1932)

An investigation into the desirability of distinguishing between the forms of the personality traits diligence and laziness based on the reliable judgements of associates, with the additional goal of setting up valid tests (1933)

Factor analysis in the study of personality (1945)

The measurement of blood pressure changes as indicator of emotional tension in a normal group and a group of maladjusted people (1947)

Emotional lability and tension as they find expression in certain personality functions (1954)

Personality differences between theology and law students (1954)

Schizophrenics and epileptics: a personality study (1956)

The homeostatic reaction curve as index for the determination of certain personality characteristics (1959)

Appendix F  
Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files  | Theorizing personality  |
|------|--------------------------|------------------------------|-------------------------|---|---|
| 1930 |                          |                              |                         | <i>The personality is hysterical with schizoid element</i><br><i>Personality psychopathic</i>   | 1930s: Henderson's 'psychopathic states' resting on constitutional abnormality<br><br>Partridge's description of the psychopath's adverse social behaviour  |
| 1932 |                          |                              |                         | <i>Psychopathic personality</i>   |   |
| 1935 |                          |                              |                         | <i>1935 Mental deficiency with psychopathic personality;</i><br><i>psychosis with psychopathic personality</i><br><i>1945 Mental deficiency with psychopathic personality</i><br><i>1949 Psychosis in psychopathic personality on discharge</i> |   |
| 1937 |                          |                              |                         | <i>Psychosis with psychopathic personality</i>  |   |
| 1936 |                          |                              |                         | <i>Psychopathic personality</i>   | Henderson and Gillespie:<br>1. Royal Medico-Psychological Association: 'psychopathic constitution'.<br>2. American Psychiatric Association: 'psychopathic personality'<br>3. Henderson and Gillespie's own formulation: 'mental deficiency' ('intellectual defect' or 'emotional defect: psychopathic personality') |
| 1940 |                          |                              |                         | <i>Paranoid personality</i>   |   |

## Appendix F Timeline

| Year | Government/<br>political                      | Psychiatry and<br>psychology   | Psychiatric patient nos         | Personality disorder (PD)<br>diagnoses given in hospital files              | Theorizing personality  |
|------|---|--|---------------------------------|---|---|
| 1943 |   | Publication of MMPI<br>(not used at<br>Valkenberg until<br>1960s)  |                                 |   |   |
| 1948 | National Party<br>wins SA general<br>election | Formation of SAPA<br><br>1 <sup>st</sup> international<br>classification of mental<br>disorders and ICD-6<br><br>Establishment of NHS<br>in UK<br><br>1 <sup>st</sup> university diploma<br>course in psychiatry<br>established at Tara<br>Hospital/University of<br>Witwatersrand |                                 | Recurrent depression in a<br>psychopathic personality                       | ICD-6<br><u>Disorders of character, behaviour<br/>and intelligence:</u><br><br>320 Pathological personality<br>(schizoid, paranoid, cyclothymic,<br>inadequate [including<br>constitutional inferiority],<br>antisocial [including<br>constitutional psychopathic state<br>and psychopathic personality],<br>asocial, sexual deviation<br><br>321 Immature personality<br>(including emotional instability,<br>passive dependency, aggressiveness,<br>other symptoms such as enuresis<br>symptomatic of immature<br>personality)<br><br>322-326 Alcoholism, other drug<br>addiction, primary childhood<br>behaviour disorders, mental<br>deficiency |
| 1950 |   |  | 2 000 patients at<br>Valkenberg |   |   |
| 1951 |   |  |                                 | Schizoid psychopath<br>Inadequate personality with<br>hysterical tendencies |   |

## Appendix F Timeline

| Year | Government/<br>political   | Psychiatry and<br>psychology   | Psychiatric patient nos  | Personality disorder (PD)<br>diagnoses given in hospital files | Theorizing personality  |
|------|--|--|--|--|---|
| 1952 |  | DSM-I<br><br>Introduction of<br>neuroleptics   |  |  | DSM-I:<br><u>Personality pattern disturbance</u><br>(inadequate, paranoid,<br>cyclothymic, schizoid)<br><u>Personality trait disturbance</u><br>(emotionally unstable, passive<br>aggressive – dependent or<br>aggressive type, compulsive)<br><u>Sociopathic personality<br/>disturbance</u> (antisocial, dissocial) |
| 1953 |  |  | White admissions<br>1 641<br>Non-white admissions<br>2 264<br>(whites = approx 13%<br>of total population) |  |   |
| 1956 |  | Establishment of SA<br>society of psychiatrists<br><br>Introduction of<br>imipramine |  |  |   |
| 1957 |  | ICD-7<br><br>First British<br>postgraduate courses in<br>psychology established      |  |  | ICD-7 largely follows ICD-6   |
| 1958 |  | Introduction of<br>inhibitors of monamine<br>oxidase                                 |  | Psychopath   |   |
| 1959 | Establishment of<br>'homelands' by<br>National Party<br>government | Chair of Psychological<br>Medicine established at<br>Wits                            |  |  |   |

Appendix F  
Timeline

| Year | Government/<br>political   | Psychiatry and<br>psychology   | Psychiatric patient nos  | Personality disorder (PD)<br>diagnoses given in hospital files | Theorizing personality |
|------|--|--|--|--|------------------------|
| 1960 | 21 March<br>Sharpeville<br><br>9 April Pratt<br>attacks Verwoerd | SA has 70 psychiatrists  | State institutions<br>overcrowded by 25%<br>(Solomons), with<br>blacks overcrowded by<br>72%, whites 7%<br><br>White admissions<br>begin to rise steeply<br>(Commissioner)<br><br>White admissions<br>2245<br>Non-white admissions<br>3323 |  |                        |
| 1961 |  | Publication of<br>Foucault's <i>Histoire de<br/>la Folie</i> and Goffman's<br><i>Asylums</i><br><br>SAPA splits; PIRSA<br>formed | White admissions<br>2 703<br>Non-white admissions<br>3 789   |  |                        |

## Appendix F Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology                   | Psychiatric patient nos  | Personality disorder (PD)<br>diagnoses given in hospital files   | Theorizing personality   |
|------|--------------------------|--|--|--|--|
| 1962 |                          | SAPA accepted as member of IUPsyS              | 2 352 patients at Valkenberg<br><br>National white admissions 3 457<br><br>National non-white admissions 4 620   | Schizoid personality<br>Inadequate psychopathic personality<br>Inadequate personality<br>Psychopathic personality with antisocial tendencies<br>Grossly inadequate personality<br>Schizoid<br>PD approximating to a pseudoneurotic schizophrenia<br>Schizoid but not schizophrenic | Fish's insists that personality pathology must be distinguished from psychosis |
| 1963 | Banning of ANC and PAC   | Psychiatry department started at UCT by Gillis |  | Dependent immature personality<br>Schizophrenia or schizoid personality<br>Inadequate psychopathic personality with reactive depression & hysteria   |  |
| 1964 |                          | Publication of SSAIS                           |  | Grossly disordered personality<br>Psychopathic personality<br>Psychopath<br>PD with hysterical features  |  |
| 1965 |                          |  | Involuntary admission for serious conditions like schizophrenia and infection and exhaustion psychoses accounted for 73% of first black admissions, as opposed to 19% for whites (WHO, 1977) | PD   | Craft: psychopathy as antisocial personality                                   |

Appendix F  
Timeline

| Year | Government/<br>political  | Psychiatry and<br>psychology                                  | Psychiatric patient nos         | Personality disorder (PD)<br>diagnoses given in hospital files                    | Theorizing personality   |
|------|---|---|---------------------------------|---|--|
| 1966 | 6 September<br>Assassination of<br>Verwoerd by<br>Tsafendas<br><br>Commission of<br>inquiry into the<br>murder                          | First psychometric test<br>appears in sample at<br>Valkenberg | 20 000 inpatients<br>nationally | PD  | Robins: deviant childhood<br>behaviour predicts deviant adult<br>behaviour   |
| 1967 | Commission of<br>Inquiry into the<br>Responsibility of<br>Mentally<br>Deranged Persons<br>and related<br>matters (Rumpff<br>Commission) | Publication of ICD-8  |                                 | Psychopathic personality<br>Inadequate personality<br>Aggressive psychopath<br>PD | ICD-8:<br><u>Personality disorders</u> , several of<br>which have further subtypes.<br>Main categories are paranoid PD,<br>affective PD, schizoid PD,<br>explosive PD, anankastic PD,<br>hysterical PD, asthenic PD,<br>antisocial PD.<br>Sexual deviation adjoins PD but is<br>listed separately. |

Appendix F  
Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files           | Theorizing personality  |
|------|--------------------------|------------------------------|-------------------------|--|---|
| 1968 |                          | Publication of DSM-II        |                         | Epileptoid personality<br>PD<br>Psychoneurotic personality<br>Psychopath | <p>DSM-II:<br/><u>Personality disorders:</u><br/>Paranoid PD, cyclothymic PD (affective), schizoid PD, <b>explosive PD (epileptoid)</b>, obsessive-compulsive PD, <b>hysterical (histrionic) PD</b>, <b>asthenic PD</b>, antisocial PD, passive-aggressive PD, inadequate PD<br/>(those in bold are new additions)<br/>Also personality disorders of specified types (immature personality, passive-dependent personality, etc)</p> <p>Changes from DSM-I:<br/>1. DSM-I had distinguished between pattern disturbances and trait disturbances.<br/>2. Sociopathic personality disturbance is removed, and four of its five subtypes (sexual deviation, alcoholism, drug dependence, dissocial reaction) are now listed elsewhere.<br/>Antisocial PD stays with PDs.</p> |
| 1969 |                          |                              |                         | PD<br>Psychopathic of a mixed nature<br>Grossly inadequate personality   |   |

Appendix F  
Timeline

| Year | Government/<br>political   | Psychiatry and<br>psychology  | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files   | Theorizing personality |
|------|--|---|-------------------------|--|------------------------|
| 1970 | Department of Health establishes Division of Epidemiology and Statistics   | Last annual report of the Commissioner of Mental Health<br><br>Kaplan & Sadock (based on DSM-II) in use at Pretoria University for clinical psychology students |                         | Schizoid personality PD<br>Schizophrenic personality<br>Psychopathic<br>Psychopathic PD<br>Hysterical PD<br>Psychopathic personality |                        |
| 1971 |  | Establishment of Royal College of Psychiatrists in UK   |                         | Hysterical psychopath (diagnosis given at Tara for later VBH patient)<br>PD<br>Hysterical PD   |                        |
| 1972 | The Commission of Enquiry into the Mental Disorders Act (Van Wyk Commission) Report of the Committee of Inquiry into Psychopathy |   |                         | PD 301<br>Sociopathic personality  |                        |

Appendix F  
Timeline

| Year | Government/<br>political  | Psychiatry and<br>psychology  | Psychiatric patient nos         | Personality disorder (PD)<br>diagnoses given in hospital files  | Theorizing personality   |
|------|---|---|---------------------------------|---|--|
| 1973 | Mental Health<br>Act published                                  | 1 <sup>st</sup> national conference<br>for psychologists,<br>appointment of 1 <sup>st</sup><br>board<br><br>1 <sup>st</sup> national congress of<br>local psychiatrists |                                 | PD<br>PD, antisocial type<br>PD of a psychopathic type<br>Psychopath<br>PD with hysterical features<br>Passive-dependent PD 301<br>(psychopathic?)<br>Passive dependent PD 301<br>(psychopathic?)<br>Dependent, inadequate, histrionic<br>personality with reactive<br>depression<br>Passive dependent PD 301 |  |
| 1974 | SA adopts ICD   |   | 1 911 patients at<br>Valkenberg |   |  |
| 1975 | Year of actual<br>implementation of<br>new Mental<br>Health Act | Opening of Centrum<br>(therapeutic<br>community) at<br>Valkenberg   |                                 | PD – passive aggressive<br>PD - inadequate, schizoid<br>Hysterical PD<br>PD with antisocial traits<br>PD<br>(?psychopathic traits)<br>Dependent traits  | Mayer-Gross, Slater and Roth<br>favour assessing personality in<br>terms of deviation from statistical<br>norm |
| 1976 | Soweto uprisings  | Opening of maximum<br>security ward at<br>Valkenberg<br><br>SA has 168<br>psychiatrists<br><br>First coloured<br>psychology interns<br>from UCT at<br>Valkenberg        | 16 800 patients<br>nationally   | PD<br>PD hysterical type<br>PD 301<br>Hysterical personality  | Cleckley's <i>Mask of Sanity</i>   |

## Appendix F Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology   | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files  | Theorizing personality  |
|------|--------------------------|--|-------------------------|---|---|
| 1977 |                          | <p>WHO report criticizes mental health provision in SA, particularly Smith-Mitchell facilities</p> <p>Intern psychologists at Valkenberg begin doing ward rotations</p> <p>Report issued by Department of Health in 1977 uses the term 'personality disorder' for the first time in summarizing the 1976 inpatient population</p> <p>ICD-9</p> |                         | <p>PD</p> <p>Personality problems</p> <p>Inadequate dependant personality</p> <p>PD 301</p> <p>PD (passive-dependent)</p>   | <p>ICD-9:</p> <p><u>Personality disorder</u> includes 'character neurosis'. The subtypes, each of which has further subdivisions, include paranoid PD, affective PD, schizoid PD, explosive PD, obsessive-compulsive PD, histrionic PD, dependent PD, antisocial PD</p> |
| 1978 |                          | <p>APA delegation visits SA</p>  |                         | <p>Immature PD</p> <p>Cyclothymic PD</p> <p>Severe PD of a psychopathic type</p> <p>PD passive aggressive type</p> <p>PD</p> <p>PD 301</p> <p>PD passive dependent type</p> <p>301.804</p> <p>Personality dysfunction</p> <p>Personality problems</p> |   |

Appendix F  
Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology  | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files  | Theorizing personality   |
|------|--------------------------|---|-------------------------|---|--|
| 1979 |                          | Closure of Centrum  |                         | PD with psychopathic traits but not sufficient to qualify for diagnosis of legal psychopathy<br>PD passive aggressive type<br>Personality problem<br>PD<br>Dependent personality      |  |
| 1980 |                          | DSM-III published   |                         | PD<br>PD 301<br>Depressed dependent personality<br>Inadequate unassertive passive dependent personality<br>Passive dependent personality<br>301.6<br>Inadequate dependent personality | DSM-III<br><u>In children:</u> Conduct disorder (undersocialized or socialized type, either of which may be aggressive or nonaggressive). Also oppositional defiant disorder. Children could also be schizoid or avoidant or have identity disorder.<br><u>In adults: personality disorders:</u> paranoid PD, schizoid/schizotypal PD, avoidant PD, antisocial PD, passive-aggressive PD, borderline PD, histrionic PD, narcissistic PD, dependent, compulsive, passive-aggressive |
| 1981 |                          | Reportback to WHO in Brazzaville on mental health provision in South Africa upholds findings of 1977 report |                         | PD 301<br>Inadequate personality<br>Inadequate dependent personality<br>Avoidant PD 301.6<br>'5-star psychopathic personality disorder'<br>PD 301 (psychopath)                        |  |

## Appendix F Timeline

| Year | Government/<br>political | Psychiatry and<br>psychology        | Psychiatric patient nos | Personality disorder (PD)<br>diagnoses given in hospital files   | Theorizing personality |
|------|--------------------------|-------------------------------------|-------------------------|--|------------------------|
| 1982 |                          |                                     |                         | PD with strong hysterical and<br>passive-aggressive traits<br>Passive-aggressive PD<br>PD 301 (psychopathic traits)<br>Possible PD – psychopath<br>Dependent personality 301.6<br>Juvenile delinquent with inherent<br>PD traits<br>Conduct disorder |                        |
| 1983 |                          | Publication of second<br>WHO report |                         |  |                        |

### Notes

1. Diagnoses are listed according to the year in which they were made rather than according to patient.
2. Diagnoses made prior to 1948 appear in italics.

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation     | Psychometric testing? | Diagnoses   | Management/ treatment (other than ongoing observation) |
|---------------|---|-------------------------------------|-----|------|----------------|-----------------------|---|--|
| JD            | 1930  | 30                                  | F   | W    | Shop assistant | -                     | <p>1930 <i>the personality is hysterical with schizoid element</i><br/>           Personality psychopathic<br/>           1932 <i>psychopathic personality</i><br/>           1937 <i>Psychosis with psychopathic personality</i><br/>           1948 Recurrent depression in a psychopathic personality</p>      | Not specified<br>1932 'Attending therapy class'        |
| MI            | 1935  | 15                                  | F   | C    | Housewife      | -                     | <p>1935 <i>Mental deficiency with psychopathic personality; psychosis with psychopathic personality</i><br/>           1945 <i>Mental deficiency with psychopathic personality</i><br/>           1949 Psychosis in psychopathic personality on discharge; changed to manic depressive 3 days after discharge</p> | Not specified  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                 | Psychometric testing? | Diagnoses   | Management/ treatment (other than ongoing observation) |
|---------------|---|-------------------------------------|-----|------|----------------------------|-----------------------|---|--|
| AB            | 1940  | 22                                  | M   | W    | Technician (locks & safes) | -                     | <i>1938 &amp; 1939 defective mental development with epilepsy</i><br><i>1940 paranoid personality</i><br><i>1941 dementia praecox hebephrenic</i><br><i>1947 psychoneurosis</i><br><i>1958 psychopath</i> | 1941 insulin for dementia praecox                      |
| CC            | 1951  | 33                                  | M   | W    | Nurse                      | -                     | Schizoid psychopath   | 'Restraint'  |
| PdP           | 1951  | 16                                  | M   | W    | School pupil               | -                     | Inadequate personality with hysterical tendencies<br>Psychoneurosis<br>File notes previous diagnoses of dementia praecox, delusions and negativism  | Not specified  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation   | Psychometric testing?   | Diagnoses  | Management/ treatment (other than ongoing observation)       |
|---------------|---|-------------------------------------|-----|------|--------------|---|--|--|
| LHP           | 1957  | 34                                  | F   | W    | Unemployed   | -   | 1957 personality disorder approximating to a pseudoneurotic schizophrenia (referral letter)<br>Personality disorder 1962 schizoid but not schizophrenic (referral letter)<br>Schizoid personality<br>1969 Grossly inadequate personality | 7/11/67 further detention<br>1970 stelazine, melleril<br>ECT |
| KJ            | 1962  | 42                                  | M   | W    | Lorry driver | Mental age given as approx 12 years but no test protocol or report provided | Mentally retarded but not feeble minded<br>Inadequate personality<br>'he is a typical psychopathic personality with antisocial tendencies aggravated by an IQ of only 81%  | Not specified  |
| GD            | 1963  | ?                                   | F   | W    | Midwife      | -   | 1963 Schizophrenia or schizoid personality<br>Inadequate psychopathic personality with reactive depression & hysteria  | 1963 Stelazine<br>Largactil<br>Hypnotic & record relaxation  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                          | Psychometric testing? | Diagnoses  | Management/ treatment (other than ongoing observation)  |
|---------------|---|-------------------------------------|-----|------|-------------------------------------|-----------------------|--|---|
| CD            | 1963  | -                                   | M   | C    | GP                                  |                       | 1962 infection and exhaustion psychosis<br>1963 dependent immature personality<br>Drug addiction<br>Psychoneurosis<br>Organic psychosis - drugs  | Not specified   |
| FM            | 1964  | ?                                   | M   | W    | Railway employee/<br>police officer | -                     | Referral letter: 'grossly disordered personality'<br>drug addiction in a psychopathic personality;<br>infection and exhaustion psychosis in a psychopathic personality<br>withdrawal delirium (?alcohol & drugs)<br>Psychopath | Medication (paraldehyde, sparin, glucose, vitamins, penicillin, glycothymol, phenobarbitone)<br>Later largactil |
| WS            | 1964  | 24                                  | M   | W    | Research officer                    | -                     | 1964 personality disorder with hysterical features 1973<br>Personality disorder of psychopathic type<br>Psychopath<br>Hysterical dissociation  | Transfer to Groote Schuur psychiatry department   |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation              | Psychometric testing?   | Diagnoses   | Management/ treatment (other than ongoing observation)                                     |
|---------------|---|-------------------------------------|-----|------|-------------------------|---|---|--|
| GJ            | 1965  | 14                                  | M   | C    | Unemployed              | (Done by Cape Mental Health Society prior to admission)<br>Wechsler-Bellvue Sentence completion | Upper limits of high grade mental defective classification (or feeble-minded)<br>Personality disorder   | Medication (largactil)   |
| HS            | 1966  |                                     | M   | C    | GP                      | Wechsler-Bellvue, IQ 128  | Personality disorder<br>Prescription drug addiction (doriden)   | Observation  |
| JdV           | 1967  | ?                                   | M   | C    | Labourer (construction) | -   | [1955 feeble-minded; Toxic psychosis]<br>1967 On admission: schizophrenia<br>Acute toxic confusion (Psychopathic personality)<br>inadequate personality<br>Toxic psychosis (dagga)<br>Toxic confusional state<br>Aggressive psychopath<br>Toxic psychosis dagga and alcohol with personality disorder | Medication (largactil, melleril, neulactil, [illegible])<br>ECT<br>Referred to neuroclinic |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                       | Psychometric testing?   | Diagnoses  | Management/ treatment (other than ongoing observation)  |
|---------------|---|-------------------------------------|-----|------|----------------------------------|---|--|---|
| NdW           | 1968  | 27                                  | F   | W    | Housewife                        | -   | Endogenous depression in an ?epileptoid personality<br>Personality disorder<br>Hysterical reaction | Medication (librium, tryptanol)<br>Referred to neuroclinic  |
| HW            | 1968  | 35                                  | F   | C    | Housewife                        | -   | Hysterical reaction in psychoneurotic personality<br>Psychoneurosis – reactive depression          | Medication (tryptanol, Librium, trilofen)<br>A few sessions of therapy<br>Referral to neuroclinic |
| JIR           | 1968  | 28                                  | M   | W    | Motor mechanic/clerk/salesperson | -   | Personality disorder   | Not specified   |
| SM            | 1968  | -                                   | M   | W    | Unemployed                       | -   | Personality disorder (psychopath)  | Not specified   |
| JM            | 1969  | 29                                  | M   | W    | Painter                          | -   | Personality disorder   | Not specified   |
| NL            | 1969  | 37                                  | M   | W    | Various semi-skilled             | MMPI<br>Grassi<br>Wechsler<br>Assessed as high on hypomania & psychopathy | Personality disorder   | Not specified   |
| AH            | 1969  | 29                                  | M   | W    | Various                          | Wechsler-Bellvue<br>MMPI  | Personality disorder<br>Psychopathic of a mixed nature   | Not specified   |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation           | Psychometric testing?  | Diagnoses   | Management/ treatment (other than ongoing observation)   |
|---------------|---|-------------------------------------|-----|------|----------------------|--|---|--|
| AW            | 1970  | 28                                  | F   | W    | Partly trained nurse | Wechsler<br>Grassi<br>MMPI<br>CPI<br>(self-centred, immature, manipulative, demanding, aggressive) | Personality disorder, drug addiction  | Medication (mogadon for one night)   |
| DM            | 1970  | 32                                  | M   | W    | Railway worker       | -  | Chronic alcoholic with schizoid personality<br>Drug dependence in a schizophrenic personality   | Medication (antabuse, largactil)   |
| GF            | 1970  | 34                                  | M   | ?    | Unemployed           | -  | Schizophrenia (social worker)<br>On admission: psychoneurotic<br>On discharge: psychopathic<br>Psychopathic personality disorder                      | Social worker<br>OT<br>Psychotherapy<br>Relaxation<br>Medication (serepax)                           |
| AD            | 1970  | 20                                  | M   | W    | Various              | -  | 1970 psychopathic personality<br>1974 Passive dependent personality disorder 301 (psychopathic?); alcohol dependence; self-mutilation; alcoholism 303 | Medication ('antidepressants')<br>Alcohol rehab<br>Family intervention<br>OPD – individual and group |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation          | Psychometric testing?   | Diagnoses  | Management/ treatment (other than ongoing observation)  |
|---------------|---|-------------------------------------|-----|------|---------------------|---|--|---|
| HP            | 1971  | 48                                  | F   | W    | Housewife           | MMPI (high on psychopathy, social introversion, depression, low on hypomania)<br>Wechsler-Bellvue (normal intelligence)<br>Grassi (no organic fall-off) | 1971 Alcoholism, hysterical personality disorder<br>1975 chronic alcoholism  | 'Drying out and hospital routine'   |
| AK            | 1971  | 13                                  | F   | W    | Unemployed          | WAIS<br>Memory for designs<br>TAT<br>Finds family problems, immature personality development, 'psychopathic features'                                   | 1971 Tara 'hysterical psychopath', drug and suicidal problem<br>23/9/75 drug addiction, personality disorder<br>25/8/75 'No evidence of psychopathy or psychosis'<br>'Unhappy and insecure young girl who may be suffering from "smiling depression" ' | Neuroclinic   |
| BIR           | 1972  | 44                                  | M   | W    | Painting contractor | -   | Personality disorder 301<br>Chronic alcoholism 304<br>A sociopathic personality with a very severe drinking problem  | 'recommend that he be sent to a psychopathic hospital if it is felt he should not serve a sentence'<br>OT |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation  | Psychometric testing?                                  | Diagnoses   | Management/ treatment (other than ongoing observation)                            |
|---------------|---|-------------------------------------|-----|------|-------------|--|---|---|
| PC            | 1973  | 26                                  | M   | W    | Mechanic    | MMPI 'has supported diagnosis of personality disorder' | Depressive reaction in personality disorder   | Medication (surmontil replaced with tryptanol, melleril, mogadon)<br>Refer to OPD |
| RK            | 1973  | 21                                  | M   | W    | Salesperson | Grassi MMPI ('psychopathic deviate profile')<br>CPI    | Personality disorder, antisocial type   | Medication (melleril)<br>Refer to OT  |
| GL            | 1973  | 37                                  | F   | W    | Housewife   | -  | Drug dependent (trancopal, mandrax) 304<br>Passive-dependant personality disorder 301                 | Attend alcohol group  |
| HvB           | 1973  | 25                                  | F   | C    | Unemployed  | Alexander performance scale, MMPI, TAT                 | Dependent, inadequate, histrionic personality with reactive depression                                | Medication ('tablets from OPD')   |
| HC            | 1975  | 27                                  | F   | W    | Various     | -  | Reactive depression 300<br>Personality disorder – passive aggressive<br>Sexual disorder 302 - lesbian | Not specified   |
| CB            | 1975  | -                                   | M   | W    | -           | -  | Alcoholism<br>Personality disorder (?psychopathic traits)<br>Dependent traits                         | Not specified   |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                     | Psychometric testing?   | Diagnoses   | Management/ treatment (other than ongoing observation)                                   |
|---------------|---|-------------------------------------|-----|------|--------------------------------|---|---|--|
| JB            | 1975  | 25                                  | M   | W    | Unemployed apprentice mechanic | -   | Alcoholism, personality disorder<br>Inadequate, schizoid  | Medication (antabuse)  |
| EL            | 1975  | 15                                  | F   | C    | Unemployed                     | Alexander<br>Benton<br>Bender<br>Graham Kendall<br>Rorschach<br>TAT<br>'limited intelligence or restricted personality or both'<br>'borderline/ below average intelligence' | Hysterical personality disorder, hysterical neuroses<br>Reactive depression & hysterical dissociative reaction<br>Schizophrenia | Transfer to Ward T<br>Adolescent group<br>Individual therapy<br>Social work intervention |
| LG            | 1975  | 18                                  | F   | W    | W                              | Graham Kendall<br>memory for designs<br>Rorschach   | Personality disorder with antisocial traits – depressed and angry   | Not specified  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                       | Psychometric testing?                        | Diagnoses   | Management/ treatment (other than ongoing observation)         |
|---------------|---|-------------------------------------|-----|------|----------------------------------|--|---|--|
| CS            | 1975  | 18                                  | F   | C    | Unemployed                       | WAIS<br>Graham Kendall<br>memory for designs | 1975 Stikland: 'propf-schizophrenia, i.e. defective mental development ... & schizoform psychosis'<br>1976 personality disorder 301<br>Borderline mental retard 310<br>Schizophrenia?<br>Epileptiform?<br>Hysterical conversion?<br>Temporal lobe epilepsy?<br>On discharge: hysterical personality, obsessional neurosis | Medication (neulactil)<br>Therapy (family & individual)<br>ECT |
| VA            | 1976  | 16                                  | M   | W    | Post office employee (dismissed) | -  | Personality disorder  | Psychotherapy<br>Centrum?<br>Liaison with parents              |
| LM            | 1976  | 19                                  | F   | C    | Unemployed casual worker         | -  | Personality disorder with baby battering and drug addiction   | Neuroclinic  |
| HP            | 1976  | 24                                  | F   | W    | -                                | -  | Psychoneurosis – purgative abuse<br>personality disorder<br>Anorexia nervosa  | Not specified  |
| LH            | 1976  | 22                                  | F   | W    | Singer, casual jobs              | -  | Personality disorder hysterical type with hypochondriasis   | Centrum programme  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                     | Psychometric testing? | Diagnoses   | Management/ treatment (other than ongoing observation)                          |
|---------------|---|-------------------------------------|-----|------|--------------------------------|-----------------------|---|---|
| JR            | 1977  | 20                                  | M   | W    | Government employee            | -                     | 'Domnormale IQ' – referring psychologist<br>Personality disorder and sexual deviation 301<br>Personality problems and behavioural abnormality | On anquil on admission Centrum  |
| RG            | 1977  | 27                                  | M   | W    | Unemployed                     | -                     | Personality disorder & alcoholism<br>Inadequate dependent personality   |   |
| PC            | 1977  | 20                                  | M   | W    | Resident in place of safety    | -                     | Reactive anxiety and depression, with suicidal behaviour 300<br>personality disorder 301  | Medication (paraldehyde, valium)<br>Psychometric testing, but patient absconded |
| PM            | 1977  | 23                                  | M   | W    | SA navy (discharged for theft) | -                     | Personality disorder (passive-dependent)  | Centrum   |
| JJvR          | 1978  | 21                                  | F   | W    | Unemployed nurse               | -                     | Immature personality disorder<br>Cyclothymic personality disorder<br>Manic-depressive psychosis   | Centrum   |
| PT            | 1978  | 33                                  | F   | W    | Many different jobs            | -                     | Severe personality disorder of a psychopathic type<br>Alcoholism<br>personality disorder passive aggressive type<br>Neurotic depression       | Medication ('antidepressants')<br>OT<br>Problem-centred supportive therapy      |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation                 | Psychometric testing?   | Diagnoses  | Management/ treatment (other than ongoing observation)  |
|---------------|---|-------------------------------------|-----|------|----------------------------|---|--|---|
| EO            | 1978  | 20                                  | F   | C    | Unemployed                 | -   | Personality disorder<br>Schizophrenia  | Medication (valium, paraldehyde)  |
| AE            | 1978  | 36                                  | F   | W    | Housewife                  | -   | Depression 300<br>Personality disorder 301   | 'sedation'<br>OT<br>Psychiatric social worker for family intervention   |
| MLM           | 1978  | 24                                  | F   | W    | -                          | -   | Personality disorder 301 with depression<br>Reactive depression (in a woman with psychosexual and dependency problems)<br>300.400<br>Personality disorder passive dependent type 301.804 | Centrum<br>Individual therapy, group therapy, medication (unspecified)  |
| SL            | 1978  | 28                                  | M   | W    | Legal training, unemployed | -   | Personality dysfunction<br>Personality problems<br>Passive aggressive PD   | Centrum   |
| EM            | 1979  | 30                                  | F   | B    | Housewife                  | WAIS<br>MFD<br>DAP<br>Rorschach (assessed as having a passive aggressive personality) | Personality disorder with psychopathic traits but not sufficient to qualify for diagnosis of legal psychopathy<br>? Schizophrenia<br>Depressive illness (reactive?)                      | Medication (largactil, paraldehyde)<br>Refer to psychologist in hospital<br>After aggressive outburst – sedation, seclusion; patient then absconded & was reported to be considered dangerous |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation        | Psychometric testing?   | Diagnoses   | Management/ treatment (other than ongoing observation)   |
|---------------|---|-------------------------------------|-----|------|-------------------|---|---|--|
| VJ            | 1979  | ?                                   | F   | C    | Unemployed mother | -   | Personality disorder passive aggressive type<br>Reactive depression<br>Personality problem  | Medication (amitryptiline, mogadon)<br>Dr states that antidepressants contraindicated as she will abuse them |
| MC            | 1979  | 63                                  | F   | ?    | Unemployed mother | WAIS<br>Bender<br>Memory for designs<br>Found no evidence of organic problems; personality not assessed | Hysterical dissociative episodes?<br>Personality disorder<br>Neurotic depression<br>Hysterical symptoms in a dependent woman<br>personality disorder<br>Depression<br>Dependent personality (paranoid psychosis under stress) | Medication (largactil, melleril, tryptanol)  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation | Psychometric testing? | Diagnoses   | Management/ treatment (other than ongoing observation)   |
|---------------|---|-------------------------------------|-----|------|------------|-----------------------|---|--|
| SN            | 1980  | 43                                  | M   | I    | Unemployed | -                     | Chronic alcoholism<br>Mild depression<br>Personality disorder   | Medication (largactil, antabuse)<br>Group & individual therapy<br>Role play and assertiveness training |
| MH            | 1980  | 71                                  | F   | W    | Pensioner  | -                     | 1980 & 1981 Reactive depression & inadequate dependent personality  | 1980 Medication, supportive counselling.<br>Neuroclinic<br>1981 Tryptanol, melleril                    |
| JH            | 1980  | 28                                  | F   | W    | Unemployed | -                     | Personality disorder 301<br>Depressed dependent personality<br>Inadequate unassertive passive dependent personality<br>Neurotic depression 300.4<br>Passive dependent personality 301.6 | Neuroclinic<br>Medication (stelazine, doloxene, mogadon)   |
| EP            | 1981  | 31                                  | M   | W    | Various    | -                     | Psychoneurotic depression 301<br>Personality disorder 301<br>Homosexuality 302<br>Inadequate personality  | Medication (amitryptiline)<br>Refused neuroclinic  |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation    | Psychometric testing?  | Diagnoses   | Management/ treatment (other than ongoing observation)  |
|---------------|---|-------------------------------------|-----|------|---------------|--|---|---|
| LB            | 1981  | 43                                  | M   | W    | Clerk         | SAWAIS<br>Graham Kendall memory for designs<br>Williams test for delayed recall                                  | Schizophrenia 295<br>Avoidant personality disorder 301.6<br>Depression with schizoid features<br>Depressive affective disorder with schizoid features       | Neuroclinic<br>Medication (pimozide, disipal, arzane; fluaxol)                                      |
| MB            | 1981  | 21                                  | M   | W    | Salesman      | WAIS – VIQ & PIQ discrepancy seen as evidence of personality disorder – ‘hysterical, manipulative, psychopathic’ | ‘5-star psychopathic personality disorder’ personality disorder 301 (psychopath)  | Neuroclinic OPD<br>Refer to Centrum with diagnosis of psychopath (note: Centrum had closed in 1979) |
| HH            | 1982  | 23                                  | F   | W    | Trainee nurse | -  | Personality disorder with strong hysterical and passive-aggressive traits<br>Prolonged depressive reaction 308.1<br>Passive-aggressive personality disorder | Medication (prothiaden)<br>Group therapy and milieu therapy<br>Individual therapy                   |

Appendix G  
Patient summary

| Name/file no. | Date of 1 <sup>st</sup> admission earning personality disorder (PD) diagnosis | Age at 1 <sup>st</sup> PD diagnosis | Sex | Race | Occupation  | Psychometric testing?   | Diagnoses   | Management/ treatment (other than ongoing observation)       |
|---------------|---|-------------------------------------|-----|------|-------------|---|---|--|
| JK            | 1982  | 34                                  | F   | W    | Pathologist | -   | Personality disorder 301 (psychopathic traits)<br>Possible personality disorder – psychopath  | Absconded  |
| SF            | 1982  | 25                                  | M   | W    | Dentist     | TAT<br>Rorschach<br>Assessed as having immature and dependent personality | Toxic and stress-related paranoid psychosis<br>Acute schizophreniform psychosis 295.4<br>Dependent personality 301.6<br>Non-dependent abuse of drugs 305 (cannabis & alcohol) | Medication (etomine, valium)<br>Referred for private therapy |
| DC            | 1982  | 17                                  | M   | F    | Unemployed  | Ravens<br>Bender<br>Draw a Tree<br>TAT                                    | Juvenile delinquency with inherent personality disorder traits<br>Psychopathic<br>Conduct disorder<br>Juvenile delinquent<br>? Organic brain damage                           | Not specified  |

**Notes**

1. Patients are listed in order of their first admission earning a diagnosis of personality disorder. Thus, for example, a patient who was given a diagnosis of schizophrenia in 1976 and a first diagnosis of personality disorder in 1978 appears in the table under 1978. Personality disorder diagnoses made at institutions other than Valkenberg are included on the same basis as diagnoses made at Valkenberg.
2. Diagnoses made prior to 1948 appear in italics.

## Appendix H

Text of document found in front of the file of HS (1966)

### CHARACTERISTIC SYMPTOMS OF CHARACTER DISORDER

1. Freedom from any form of mental disorder.
2. Intelligence range from borderline defective to I.Q. range of 120-130% plus conspicuous lack of wisdom – not infrequently the latter.
3. Lack of normal moral sense of conscience with lack of concern for the welfare or feelings of others.
4. Lack of empathy or ability to feel for others or place themselves hypothetically in the position of others.
5. Lack of guilt or remorse with positive callous and non-caring, indifferent attitude towards those who have become the victims of the antisocial conduct.
6. Habitual tendency to act impulsively and repetitively, acting out whims of antisocial type which can arise on the spur of the moment with total disregard for the consequences thereof, although the intellectual mechanism for fore-thought is present and not because

they are incapable of distinguishing what is legally as right and wrong but as a result of sheer indifference or lack of concern.

7. Lack of ability to profit from experience – they condition poorly – or a change in the line of conduct is frequently shortlived and again directly related to self-gratification or escaping bodily discomfort.

8. The presence of the foregoing points resulting in failure to adjust satisfactorily in-

(a) interpersonal relationships which require deeper emotional requirements, e.g. marriage;

(b) work situations – work-shy – get rich quick, etc;

(c) social sphere – at least where lasting and satisfying relationships are to be found;

(d) sexual spheres – perversions.

9. Extremely resistant to medical treatment e.g. psychoanalysis – psychotherapy – chemotherapy – behaviour therapy, but results possibly with the latter e.g.

(a) England – group therapy about 2.5% improvement;

(b) Denmark – relearning or conditioning to a pattern of behaviour acceptable to society while based on gaol with a life sentence about 20-40% result – Stürup.

10. Often there is supreme conceit which may cloud their calculations regarding the role of punishment or incarceration – frequently associated with pointless antisocial acts which provide only a brief and transient satisfaction often showing a lack of elementary self-preservation and of purpose.