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**“OF UNSOUND MIND”:  
A HISTORY OF THREE EASTERN CAPE MENTAL INSTITUTIONS, 1875-1910**

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A dissertation submitted in *fulfillment* of the requirements for the award of the degree of

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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.

Signed by candidate

Felicity Ann Swanson

March 2001

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**ABSTRACT****“OF UNSOUND MIND”:  
A HISTORY OF THREE EASTERN CAPE MENTAL INSTITUTIONS, 1875-1910.**

This thesis investigates the origins, development and consolidation of a regional network of three publicly funded and regulated mental institutions in the colonial Eastern Cape, between the years 1875 to 1910. Fort England asylum in Grahamstown was established in 1875. Port Alfred asylum followed in 1889 and the Fort Beaufort institution was opened in 1894. Each asylum retained its own distinctive character and function based on the nature of its patient population. Although geographically dispersed the asylums were intimately connected to each other, forming one integrated system to treat and manage the mentally ill. This thesis critically examines the changing patterns of care in these Eastern Cape institutions, during an important period of social, economic and political change in the Cape Colony. It traces the social and ideological construction of mental illness that was shaped by the racial, class and gendered hierarchies of colonial society. Based on empirical research, this thesis draws on Foucault's insights into the character and uses of disciplinary power implicated in the production of 'regimes of truth' about the mentally ill. The Eastern Cape institutions provide an important record of the ways in which the power invested in psychiatric theory and practice was exercised in a colonial context. In a moment hailed for its reform and progress in the treatment and care of mental illness, strategies for the exclusion, regulation and control of black mental patients were expanded in these Eastern Cape institutions. The major legacy in the treatment of mental illness in the Eastern Cape was the establishment of a system of control for black patients that was to inform future policy decisions after Union.

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## CHAPTER ONE

### INTRODUCTION

#### INSTITUTIONALISING THE MENTALLY ILL IN THE EASTERN CAPE

I don't know what madness is. It can be everything and nothing. It is a human condition. Madness is present in each of us as is reason. The problem is that society, to be able to call itself civil should accept reason as well as madness....When someone who is mad enters the asylum, he stops being mad and is transformed into a sick person. The problem is how to undo the knot, how to overcome institutional madness, and to recognise madness where it originates, that is, in life itself.

Franco Basaglia (1984)<sup>1</sup>

This thesis traces the origins, development and consolidation of a regional network of three publicly funded and regulated mental institutions in the colonial Eastern Cape, between the years 1875 and 1910. Fort England asylum in Grahamstown (hereafter, the Grahamstown asylum) was established in 1875. Port Alfred asylum situated at the mouth of the Kowie river followed in 1889 and the Fort Beaufort institution was opened in 1894. During this period the dominance of the mental hospital and institutionalised care was established by the colonial state as the most important way of dealing with the mentally ill in the eastern part of the Cape Colony. Each asylum retained its own distinctive character and function based on the psychiatric, racial and gender classification of its patient population. Although geographically dispersed, all three institutions were intimately connected to each other, forming one integrated regional system to treat and manage the insane, each one unable to exist without the other two. The thesis will examine the changing patterns of care in the evolution and expansion of this institutional network as it

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<sup>1</sup> Quoted in A.M. Lovell and N. Scheper-Hughes, 'Deinstitutionalisation and Psychiatric Expertise: Reflections on Dangerousness, Deviancy, and Madness', *International Journal of Law and Psychiatry*, Vol. 9 (1986), pp.361-381.

drew in growing numbers of individuals officially declared insane. While institutional care between 1875 and 1910 was promoted by colonial officials and medical personnel in a spirit of therapeutic optimism and reform, it will be argued that for the majority of patients conditions and treatment in fact deteriorated quite significantly. The Eastern Cape asylums were not so much a humanitarian project but rather a cynical exercise in the long and dismal history of public provisioning for the mentally ill in South Africa.

This chapter will provide an overview of the institutional development of the mental asylums in the Eastern Cape after 1875. The Grahamstown asylum provides a valuable site for analysis in that its establishment and early formative period coincided with broader structural changes taking place within South Africa in the transition from a predominantly agricultural and merchant economy to industrial capitalism.<sup>2</sup> Opening in 1875 this institution emerged at a critical stage of this transformation, effectively straddling two distinct phases in South African history. For the first fourteen years of its existence, the Grahamstown asylum provided mainly custodial accommodation for the indigent insane and chronic dependent sick of all races. Its modus operandi was largely based on the British model but was rapidly transformed and modified in the local colonial context after 1890. The two other asylums in the Eastern Cape (at Port Alfred and Fort Beaufort) emerged in a relatively short space of five years in a period of major restructuring between 1889 and 1894.

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<sup>2</sup> T. Keegan, *Colonial South Africa and the Origins of the Racial Order* (Cape Town, 1996), pp.291-293.

Debates about acute and chronic mental illness were essential to this expansion of psychiatric services in the Eastern Cape. By the late 1880s mental health policies began to crystallise around social welfare debates of how best to manage the increasing numbers of indigent chronic patients suffering from persistent and long term mental diseases. Significant numbers of patients at Grahamstown asylum failed to recover. Their presence subverted the therapeutic aims of the institution and at the same time prevented the admission of patients in the earlier and more hopeful stages of illness. To this end, the Port Alfred and Fort Beaufort asylums were established as self-contained institutions dealing exclusively with long term dependent patients who were unable to care for themselves and who were reliant on state welfare. Port Alfred was reserved for mentally and physically handicapped and elderly patients of all races, while Fort Beaufort was established to care exclusively for black men. In 1897 a separate division for black women was opened at Fort Beaufort.<sup>3</sup> These developments meant that patients could be moved through the system leaving Grahamstown asylum free to admit and treat recent, acute and episodic cases of all races. At the same time the asylum and psychiatric expertise were promoted as the only effective means of dealing with the mentally ill.

Developments in the Eastern Cape were linked to those in the rest of the Cape Colony. In the Western Cape, the Robben Island Infirmary just off the mainland at Cape Town had

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<sup>3</sup> Given South Africa's long history of racial oppression, issues concerned with racial identities and categories are extremely sensitive. Black is used in this thesis as a collective term to describe people who were identified by themselves or others as African, Malay, Indian or Coloured. Similarly the term white refers to people of settler origins, both Northern European and British. See V. Bickford-Smith, 'Black Ethnicities, Communities and Political Expression in Late Victorian Cape Town', *Journal of African History* (1995), pp1-23; V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town: Group Identity and Social Practice, 1875-1902* (Cambridge, 1995), p.xvii; D. Goldberg, *Racist Culture: Philosophy and the Politics of Meaning* (Cambridge, Massachusetts, 1994), p.vii-ix.

been established in 1846 to provide care for the mentally ill, lepers, and the chronic sick. It remained the only asylum in the Cape Colony for thirty years.<sup>4</sup> The Old Somerset hospital in Cape Town offered a few beds for the insane but was never considered a suitable place for mentally ill patients. Valkenburg asylum, reserved exclusively for white patients was opened in Cape Town in 1891. By 1894, the Cape Colony with five mental asylums, provided the most comprehensive public mental health care services south of the Limpopo River. Natal and the Transvaal and Free State Republics had only one asylum.<sup>5</sup>

When the Grahamstown asylum opened in September 1875, the Eastern Cape region was in the process of emerging from a long history of conflict and violence associated with colonial expansion, frontier wars and resistance, conquest, territorial annexation and dispossession.<sup>6</sup> The last frontier war and final dispossession of the Xhosa occurred in 1879. In the 1850s and 1860s, Eastern Cape towns such as Port Elizabeth, Grahamstown and King Williamstown had grown rapidly in size as a result of the expanding economy based on sheep farming and wool production.<sup>7</sup> The discovery of diamonds in Kimberley in 1867 and the later discovery of gold on the Witwatersrand in 1886 provided further impetus for change.<sup>8</sup> This mineral revolution was based primarily on extractive industries

<sup>4</sup> E. H. Burrows, *A History of Medicine in South Africa up to the End of the Nineteenth Century* (Cape Town, 1958), pp. 342-343.

<sup>5</sup> M. Minde, 'History of Mental Services in South Africa, Part IV: Services Since Union', *South African Medical Journal*, 49 (1975), p.406.

<sup>6</sup> See J. Peires, *The Dead Will Arise: Nongqawuse and the Great Xhosa Cattle-Killing Movement* (Johannesburg, 1989); C. Crais, *The Making of the Colonial Order in the Eastern Cape: White Supremacy and Black Resistance in Pre-Industrial South Africa, 1770-1865* (Cambridge, 1992); N. Mostert, *Frontiers: The Epic of South Africa's Creation and the Tragedy of the Xhosa People* (London, 1992); T Keegan, *Colonial South Africa and the Origins of the Racial Order* (Cape Town, 1996).

<sup>7</sup> G. Adler, 'From the "Liverpool of the Cape" to the "Detroit of South Africa": The Automobile Industry and Industrial Development in Port Elizabeth -Uitenhage Region', *Kronos: Journal of Cape History*, November (1993), p.18.

<sup>8</sup> L. Chisholm, 'Reformatories and Industrial Schools in South Africa: A Study in Class, Colour and Gender, 1882-1939', unpublished Ph.D. Thesis (1989) pp.29-31.

and large scale production that relied on a cheap labour force. For the most part this work force was adult and male and consisted of black migrant labour.<sup>9</sup> At the same time, the Cape Colony was granted representative government by the British in 1872.<sup>10</sup> But despite a non-racial constitution and a qualified franchise, the colony was rapidly moving away from assimilationist policies towards racial exclusion, segregation and spatial control of black people.<sup>11</sup> The Eastern Cape had the dubious distinction of producing South Africa's first African urban locations and African reserves, laying the foundations for the racial and segregated order of modern South Africa.<sup>12</sup>

The dislocating effects of these structural transformations were increasingly felt in towns dotted all over the Eastern Cape as impoverished whites and black migrant workers were drawn into the colonial economy and rates of vagrancy, begging and crime increased.<sup>13</sup> Within this disaffected population, sick and dependent persons including the mentally ill were becoming increasingly visible as the informal ways in which families and communities had formerly cared for them were breaking down.<sup>14</sup> The presence of the mentally ill posed increasingly complex dilemmas for colonial society. Mental illness in

<sup>9</sup> P. Harries, *Work, Culture and Identity: Migrant Labourers in Mozambique and South Africa, c 1860-1910* (Johannesburg, 1994).

<sup>10</sup> S. Marks and S. Trapido (eds.), *The Politics of Race, Class and Nationalism in Twentieth Century South Africa* (London, 1987), p.5.

<sup>11</sup> A. Lester, 'The Margins of Order: 1806-c1850', *Journal of Southern African Studies*, Vol. 23 (1997), p.652.

<sup>12</sup> C. Crais, *The Making of the Colonial Order in the Eastern Cape: White Supremacy and Black Resistance in Pre-Industrial South Africa, 1770-1865* (Cambridge, 1992), p.7; A.J. Christopher, 'Race and Residence in Colonial Port Elizabeth', *South African Geographical Journal*, 69, Vol.1 (1987); G. Baines, 'The Origins of Urban Segregation: Local Government and the Residence of Africans in Port Elizabeth, c1835-1865', *South African Historical Journal*, 22 (1990); A. Lester, 'The Margins of Order, 1806-c1850', *Journal of Southern African Studies*, Vol. 23 (1997), pp.647-652.

<sup>13</sup> C. Bundy, 'Vagabond Hollanders and Runaway Englishmen: White Poverty in the Cape Before Poor Whiteism', in W. Beinart, P. Delius and S. Trapido (eds.), *Putting a Plough to the Ground: Accumulation and Dispossession in Rural South Africa, 1850-1930* (Johannesburg, 1986) pp.103-115.

<sup>14</sup> G. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge, Massachusetts (1994), pp.5-6.

all its varied forms eroded the ability of people to care for themselves and led to disability and dependency. It also brought with it suffering, loneliness, despair, economic hardship and the breakdown of interpersonal relationships.<sup>15</sup> A few private houses provided care for individual insane patients, but these were not subject to any official controls or regulations. In the Eastern Cape, jails remained the main places of detention pending removal to Robben Island, but the process of transfer often took months to complete.<sup>16</sup> Although by 1872 over a quarter of all inmates at Robben Island came from the Eastern Cape, it was never considered a suitable place for the mentally ill. It was too far and 'utterly devoid of every condition necessary for the probable restoration for a class of patient which claims our deepest commiseration'.<sup>17</sup>

Conditions for the mentally ill inside colonial jails and prisons were desperate. In 1864 the prison warden of Grahamstown jail provided dramatic testimony of insane prisoners who were restrained in straight jackets and leg irons for long periods of time in order to contain and control their violent behaviour.<sup>18</sup> A district surgeon practising on the diamond fields in the early 1870s described the pathological conditions inside Kimberley jail where the mentally ill, including women were subjected daily to inhumane treatment and neglect. He observed a 'poor white' girl pacing like a 'caged tigress' up and down a small court yard, 'panting for freedom and growling in despair!'. Another black woman remained handcuffed

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<sup>15</sup> W. Gove (ed.), *Deviance and Mental Illness* (London, 1982) pp.7-9.  
<sup>16</sup> Select Committee Report on the Lunatic Asylum in The Eastern Province, CA CCP 2/2/2, C4-64.  
<sup>17</sup> Albany General Hospital Annual Report, 1858: G24 1859.  
<sup>18</sup> Select Committee Report on the Lunatic Asylum in the Eastern Province, CA CCP 2/2/2, C4-64.

for days to prevent her from stripping off her clothes. He found two other women 'clad simply in nature's garb, as naked as when born'.<sup>19</sup>

Clearly colonial prisons were not conducive to any kind of humane treatment for the colony's mentally ill. In 1864 the board of the Albany General Hospital unsuccessfully petitioned the colonial parliament sitting in Grahamstown at the time to erect an asylum in the Eastern Cape. Staff at the hospital were increasingly faced with the unwanted demands of providing care for unmanageable and demanding indigent insane patients, while at the same time trying to provide a suitable environment for treating the sick.<sup>20</sup> In order to provide humane and therapeutic treatment it was seen as essential that the insane were accommodated in the specialised environment of an asylum.<sup>21</sup>

These 'common' discourses about the plight of the insane emanating from both colonial prisons and hospitals tapped into powerful stereotypes that constructed the mentally ill as maniacal, uncontrollable and as less than human.<sup>22</sup> These discourses reflected not only liberal concerns for the well-being of the mentally ill but also served particular purposes in that they created useful distancing effects, reflecting the marginal status of the insane in colonial society. Neither the criminal justice system nor the public hospitals were willing to take on the responsibility of dealing with the mentally ill who were perceived to be a

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<sup>19</sup> Dr J.W. Matthews, quoted in L. A. Hurst and M. Lucas, 'South Africa' in J. Howells (ed.) *World History of Psychiatry* (London, 1975), pp.609-610.

<sup>20</sup> Select Committee Report on the Lunatic Asylum In the Eastern Province, CA CCP 2/2/2, C4-64.

<sup>21</sup> C. Blumberg, 'The Provision of Medical Literature and Information in the Cape, 1827-1973', unpublished MA Thesis, University of South Africa (November, 1974), Chapter One; Dr. L. G. Couch, *A Short Medical History of Grahamstown* (Grahamstown, 1976), pp.24-32.

<sup>22</sup> For a discussion on stereotypes and mental illness see S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1985).

nuisance, time consuming, unproductive and disruptive of institutional routines. As this thesis will demonstrate, it is this image of the mentally ill as violent and uncontrollable that reoccurs in the colonial archive time and again and was used to justify a multitude of policies adopted towards the mentally ill in the colony.

Calls to establish a mental asylum in the Eastern Cape continued to be made by the white middle class settler elite that included a powerful medical fraternity from Grahamstown as practitioners such as Dr.W.G.Atherstone lobbied the colonial government to provide accommodation for the insane in the Eastern Cape.<sup>23</sup> Despite general agreement on the part of the colonial government that there was an urgent need for an asylum, action was prevented by economic circumstances as the colony experienced an economic depression between 1865 and 1869. Moreover, given the partial and incomplete transformation of mercantile and agricultural capital before the mineral revolution, the colonial state was still weak and government policies were often haphazard.<sup>24</sup>

No action was taken until July 1872 when the House of Assembly voted to release funds to establish an asylum in the Eastern Province on a 'modest' scale. After careful

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<sup>23</sup> M. Gibbens, 'Two Decades in the Life of a City: Grahamstown, 1862-1882', unpublished MA Thesis, Rhodes University (1982) pp.232-236. Eastern Cape doctors were a well organised and influential group, trained mainly at Edinburgh University in Britain and Leyden University in Germany. The profession in the Eastern Cape had its roots in the military and formed a particularly powerful lobby group. In comparison to the Western Cape little historical research has been carried out on colonial medical doctors for the Eastern Cape region. See A. Bank, 'Of "Native Skulls" and "Noble Caucasians": Phrenology in Colonial South Africa', *Journal of Southern African Studies*, Vol. 22, No. 3 (September, 1996), pp.391-399, for a discussion on medicine, racial science and frontier violence in the early nineteenth century Eastern Cape Colony; See also H. Deacon, 'Cape Town and "Country" Doctors in the Cape Colony During the First Half of the Nineteenth Century', *Social History of Medicine*, 10, 1 (1997), p.25; E. van Heynigen, 'Public Health and Society in Cape Town, 1880-1910', unpublished Ph.D. Thesis, University of Cape Town (1989); A. Digby, ' "A Medical Eldorado"? Colonial Medical Incomes and Practice at the Cape', *Social History of Medicine*, 7, 3 (1995).

<sup>24</sup> T. Keegan, *Colonial South Africa and the Origins of Racial Order*, p.141.

consideration it was decided not to use Grey Hospital in King Williamstown, but to convert the deserted Fort England Military barracks in Grahamstown into a suitable establishment for the insane.<sup>25</sup> This set a precedent in that none of the region's asylums was custom built as was the case for British institutions. The exception in the colony was Valkenberg asylum in Cape Town which was custom built at a massive cost of 40 000 pounds.<sup>26</sup> The practice of converting unsuitable buildings such as the Fort England military barracks, the deserted corrugated iron convict station at Port Alfred and cavalry barracks and wattle and daub huts at Fort Beaufort into mental institutions was indicative of the level of government interest in providing for the colony's mentally ill.

The Grahamstown asylum, officially known as the Fort England Lunatic and Pauper Asylum was housed in the deserted military barracks vacated by the military in 1870 when they moved to East London, finally bringing to an end Grahamstown's long history as a military town.<sup>27</sup> Accommodating just three patients when it opened, by 1890 the average inmate population numbered over two hundred.<sup>28</sup> Dr Robert Hullah (M.R.C.S. England, 1866; L.S.A. London 1867) was appointed as the institution's first surgeon superintendent. He had served as Assistant Medical officer to the City of London Lunatic Asylum and after emigrating to the colony in 1872 worked as a surgeon at the East London Convict Barracks.<sup>29</sup> For the first fourteen years of its existence, Fort England asylum was the only institution providing care for the mentally ill and the chronic sick in the Eastern Cape

<sup>25</sup> Select Committee, 5 July, 1872: CCP A13-72.

<sup>26</sup> S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No.3 (September, 1995), pp.399-400.

<sup>27</sup> S. Sampson, 'Fort England as a Military Base', *Contree*, No. 8 (July 1980), pp16-20.

<sup>28</sup> Grahamstown Asylum Annual Report, 1890: G37-1891.

<sup>29</sup> M. Gibbens, 'Two Decades in the Life of a City: Grahamstown 1862-1882', unpublished MA Thesis, Rhodes University (1982), p.234.

region and was closely modelled on the Robben Island asylum in the Western Cape. Its main function was to provide public welfare accommodation for the indigent insane of all races and chronic dependent sick who for the most part were white. This early period marked the first tentative steps to clearly differentiate the insane from criminals by according them the status of patients and providing a humane medical environment in the pleasant surroundings of a state supported asylum.<sup>30</sup> Instead of languishing in jails for long periods, patients could now be admitted speedily into the asylum and receive treatment as soon as possible.<sup>31</sup> Practice, however, remained far from ideal.)

Despite regular claims to be a therapeutic institution, by the late 1880s Grahamstown asylum had become an overcrowded, custodial institution. The asylum was home to a heterogeneous collection of people, suffering from a variety of mental diseases such as mental and physical handicap, the actively psychotic and suicidal, senile dementia's and the like.) Classification of patients was circumscribed by spatial constraints and a lack of suitable accommodation. Male and female patients were quite strictly segregated from each other, and the few private or 'better class' who were white patients were separated from non-paying and violent patients. For the most part classification was haphazard and informal and no strict racial categorisation was in place.<sup>32</sup> Hullah's hands were largely tied as the colonial government's mental health policies had not been clearly thought through and remained piecemeal and reactive. Moreover, the government had been generally

<sup>30</sup> A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, 1993), pp.1-3.

<sup>31</sup> CA CO 1028, 27 March, 1876: Correspondence from R. Hullah to the Colonial Office.

<sup>32</sup> CA CO 1050, 27 February, 1877: Correspondence from R. Hullah to the Colonial Office. See H. Deacon, 'A History of Medical Institutions on Robben Island, Cape Colony, 1846-1910', unpublished Ph.D. Thesis, University of Cambridge (1994); S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No. 3 (September, 1995), p.399.

unwilling to allocate the necessary funds to make improvements. In the absence of any alternatives such as nursing homes or old age homes, a backlog of chronic insane patients had built up at Grahamstown. Once again the insane were kept in jails for long periods and several patients were waiting to be transferred from Kimberley jail.<sup>33</sup>

By 1888, Robben Island asylum was facing a similar crisis to Grahamstown. The Colonial Office recognised that in view of the 'crowded state of the colony's two asylums, a large grant for expansion is necessary, if the practice of keeping lunatic patients in gaols is not to be reverted to'.<sup>34</sup> 1888 was a watershed year in that it marked the beginning of a period of major restructuring of colonial government policies towards the mentally ill. A Department of Health was established in the Colonial Secretary's office and the new post of Inspector of Asylums was created to oversee all the colonial asylums. Following a visit to the Eastern Cape by the Colonial Secretary, it was decided that the Grahamstown asylum should be kept solely for recent, curable and convalescent patients of all races and that it was to be managed on the 'more approved modern system of treatment of insane persons'. Grahamstown asylum was to be relieved of all the 'imbecile and utterly hopeless cases'. Additional accommodation for patients was made available at the Chronic Sick hospital in Grahamstown and in 1889 a new asylum was established at Port Alfred, a small seaside village situated on the mouth of the Kowie river to provide accommodation for up to eighty incurable infirm and mentally handicapped patients of all races. Grahamstown asylum then began to admit patients waiting in the Kimberley jail.<sup>35</sup>

<sup>33</sup> CA CO 1429, 20 October, 1889: Correspondence from the Colonial Office to R. Hullah.

<sup>34</sup> CA CO 1403, 26 January, 1888, Correspondence from Colonial Office to R. Hullah.

<sup>35</sup> CA CO 1429, 20 October, 1889: Correspondence from the Colonial Office to R. Hullah.

From its inception, Port Alfred was completely unsuited to the special needs of the handicapped and the elderly who were incurable and largely helpless.<sup>36</sup> Converted into an asylum from an old corrugated iron convict barracks and situated on a riverbank, the entire asylum was flooded in the year it opened, exposing patients to unnecessary risks.<sup>37</sup> The first thirty patients transferred from Grahamstown in May 1889 arrived without any form of identification and remained 'unknown' for months.<sup>38</sup> Because these were all incurable patients it was not considered necessary to appoint a full time medical doctor. The local District Surgeon Walter Atherstone, with no experience in dealing with mental patients, was appointed on a part-time basis to make weekly visits. The asylum was managed by a lay superintendent and untrained nurse aids who were inadequately prepared for the work.<sup>39</sup>

By 1891 conditions for patients at Port Alfred asylum had deteriorated even further. The death rate at the asylum was over 25%, double the rate of the other three colonial asylums. The asylum was overcrowded as increasing numbers of patients were herded together in inadequate facilities. A visit by the newly appointed Inspector of Asylums in December of 1891 revealed the extent of neglect and abuse suffered by patients. Some patients were constantly left lying wet and dirty in their beds, emitting a 'foul odour'. One young epileptic female patient was found tied up in bed with a sheet as a means of restraining her. Conditions on the male side at night were described as 'disgraceful'. Another point of

<sup>36</sup> CA CO 1429, 22 May, 1889: Correspondence from R. Hullah to the Colonial Office.

<sup>37</sup> CA CO 1484, 26 December, 1889: Correspondence from W. Atherstone to the Colonial Office.

<sup>38</sup> CA CO 1429, 16 May, 1889: Correspondence from R. Hullah to the Colonial Office. The transfer list included 21 males: 10 Europeans, 11 'Natives'; 19 Females: 6 Europeans, 13 'Natives'.

<sup>39</sup> CA CO 1429, 15 May, 1889: Correspondence from the Colonial Office to R. Hullah.

contention for the Inspector of Asylums was that Coloured and white patients were not segregated.<sup>40</sup>

Throughout the period under review, Port Alfred asylum remained the most marginalised and under resourced of the three Eastern Cape asylums. The restructuring programmes undertaken from the late 1880s shifted the focus of concern away from what were the most vulnerable and dependent members of society. Isolated in a small seaside village and regarded as socially redundant and as financial burdens, these patients were effectively pushed out of the mainstream system of care as part of a cost saving exercise. Such was the stigma of being both poor and mentally handicapped or infirm. Significantly, in an era that became increasingly obsessed with racial segregation, Port Alfred asylum remained the only asylum in the colony that did not differentiate between black and white patients. (See Chapter Three.)

Fort Beaufort asylum was opened in 1894 as the second institution in the region to care for chronic patients. Initially, only black male patients were accommodated. Bounded by the Kat and Black rivers, the town of Fort Beaufort was situated forty miles north east of Grahamstown and was the centre of a farming district of white settler farms with a large black population.<sup>41</sup> The first patients, who were all black men were housed in an old converted cavalry barracks that had at one time been used as a central telegraph station. The local District Surgeon John Conry was appointed as the part-time medical officer of the asylum which was managed on a day to day basis by a lay superintendent until 1898

<sup>40</sup> CA CO 1490, 21 December, 1891: Correspondence from the W. Dodds to the Colonial Office.

<sup>41</sup> H.T. Matthews, 'A Guide and History of Fort Beaufort', *South African Pamphlets*, Vol. 97 (1958), p.1-5.

when Conry was appointed medical superintendent.<sup>42</sup> A smaller and separate division for chronic black women, situated a quarter of a mile away from the male asylum, was opened in 1897.<sup>43</sup>

Fort Beaufort asylum was established as a result of both internal and external pressures on accommodation at Grahamstown asylum. The fact that it was used solely for the purposes of housing black men marked the beginnings of aggressive segregatory measures that were to intensify in the 1900s. In May of 1890 the *Grahamstown Journal* published a highly critical article on Grahamstown asylum. Serious allegations were made by members of the public at the lack of public accountability, of mismanagement, neglect, poor supervision and the poor standards of cleanliness and sanitation due to the overcrowded state of the asylum. Claims were made in the article that 'no regular curative system of treatment has ever been in practice, but that the insane are left pretty much to take their chance of getting worse or better'.<sup>44</sup> The article also alluded to the fact that complaints had been made by a member of the Grahamstown medical fraternity with regard to incidents of 'great abuses and serious evils of gross immorality'. It warned that it was 'a sacred duty which the sane cannot neglect, to be jealous and watchful as to the treatment accorded to those who are helpless'.<sup>45</sup>

These allegations were not unfounded. The overcrowded state of the black men's dormitory at Grahamstown asylum had been a cause of concern to medical staff for some

<sup>42</sup> CA CO 1572, April 1893: Correspondence from the Inspector of Asylums to the Colonial Office.

<sup>43</sup> In contrast to the extensive archive on the male division at Fort Beaufort the records on the female asylum are scant.

<sup>44</sup> *Grahamstown Journal*, 13 May, 1890.

<sup>45</sup> *Grahamstown Journal*, 13 May, 1890.

time. In May of 1889, the Acting Superintendent had reported to the colonial office that incidents of sodomy had occurred in the dormitory for black men where sixty three patients were crammed into a ward designed for thirty. 'In the case of the natives, such overcrowding, in spite of the greatest vigilance of the native attendants greatly facilitates the commission of nameless offences'.<sup>46</sup> In his view, these overcrowded conditions made 'segregation, classification and general differentiation of patients, so essential according to modern methods', impossible.<sup>47</sup> Further incidents of sodomy at Grahamstown asylum were reported to the Colonial Office in March of 1890. The Acting Superintendent attributed this lapse in good behaviour to the incompetency of the head attendant and staff whom he accused of having no moral influence and where discipline was 'deplorably conspicuous by its absence'.<sup>48</sup> While patients who were suspected of being 'addicted to these and similar habits' were separated and moved out of the dormitory, these measures were reactive and did not address the real problems, namely that black patients were effectively being warehoused in substandard conditions.<sup>49</sup>

Unwanted and negative publicity added to the internal tensions and pressures to provide better quality accommodation at Grahamstown asylum. Moreover increasing numbers of black patients hindered this transformation. At the same time, the asylum was confronted with additional external pressures in that once again considerable numbers of insane were

<sup>46</sup> The use of pejorative terms such as 'kaffir' and 'native' in this thesis is purely historical and not intended to cause offence. Quotation marks are used to indicate the problematic nature of these designations.

<sup>47</sup> CA CO 1429, 14 May 1889: Correspondence from J. Dixon to the Colonial Office.

<sup>48</sup> CA CO 1458, 29 March, 1890: Correspondence from Shiell Collins to the Colonial Office. Robert Hullah died of a heart attack in February, 1890.

<sup>49</sup> CA CO 1458, 30 March, 1890: Correspondence from Shiell Collins to the Colonial Office; See also CA CO 1458, 14 May, 1890: Correspondence from Shiell Collins to the Colonial Office. This will be discussed in more detail in Chapter Two.

incarcerated for extended periods of time in various Eastern Cape jails.<sup>50</sup> This problem was exacerbated by conditions in the Western Cape. The new Valkenberg asylum did not make provision for black patients in the Western Cape. This put pressure on the already overloaded resources on Robben Island to receive black patients.<sup>51</sup> The establishment of Fort Beaufort asylum solved some of the problems in both regions. In addition to the transfer of black male patients from Grahamstown and Port Alfred asylums, twenty seven patients were transferred from the Robben Island asylum.<sup>52</sup> All the black male patients were moved out of the Old Somerset Hospital in Cape Town and transferred to Fort Beaufort and Port Alfred asylums.<sup>53</sup> This racial segregation marked the beginning of a new movement of black mental patients away from the Western Cape back towards the far-flung borders of the Eastern Cape frontier. This was achieved under the pretext that it would be to the benefit of black patients, in particular African patients, to be closer to their families and relatives.<sup>54</sup> In the period under review black patients made up the majority of cases in the Eastern Cape region.

The main functions of Port Alfred and Fort Beaufort asylums as state supported institutions was to provide cheap custodial care for the chronic insane. After 1890, facilities at Grahamstown asylum were gradually upgraded in order to provide a more medically orientated environment for recent and acute cases of all races.<sup>55</sup> This was done under the guidance of Dr. Thomas Greenlees, who was appointed medical superintendent

<sup>50</sup> Grahamstown Mental Asylum Annual Report, 1891: G36-92.

<sup>51</sup> H. Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies*, Vol. 22, No. 2 (June, 1996), p.302.

<sup>52</sup> CA CO 1572, 16 July, 1894: Correspondence from W. Dodds to the Colonial Office.

<sup>53</sup> CA CO 1572, 15 December, 1894: Correspondence from W. Dodds to the Colonial Office.

<sup>54</sup> CA CO 1572, 28 August, 1894: Correspondence from W. Dodds to the Colonial Office.

<sup>55</sup> CA CO 7163, 5 February 1895: Correspondence from W. Dodds to the Colonial Office.

at Grahamstown asylum in 1890. Dr. William Dodds was appointed Inspector of Asylums and medical superintendent at Valkenberg asylum. Both men were appointed from Britain where they had extensive experience in asylum work.<sup>56</sup> (See Chapter Two.)

Greenlees' appointment marked the beginning of aggressive segregatory measures for black patients at the asylum with a corresponding privileging of class interests for white patients as the asylum attempted to attract private patients. He was instrumental in establishing the Institute for Imbecile Children at Grahamstown in 1894, which was the first institution of its kind in Africa, although initially admissions were restricted to white children of 'well-to-do parentage'.<sup>57</sup> Douglas House was opened in 1904 to cater for the needs of private white female patients. It provided individual specialised nursing care in private bedrooms and suites for twenty five patients.<sup>58</sup> It was only in 1908 that Grahamstown asylum became a whites only institution.

By 1898 with increasing numbers of black patients needing accommodation in the Eastern Cape institutions, Greenlees argued that:

There is a burden and it is a white man's burden. For the care of the Native insane in this vast country is really too great a burden on the ratepayers if they are all to be treated in asylums, where the appliances for treatment and the cost of maintaining them are the latest and the highest.<sup>59</sup>

<sup>56</sup> See Drs. Dodds, Strahan and Greenlees, 'Assistant Medical Officers in Asylums: Their Status in Their Specialty', *Journal of Mental Science*, Vol. 36, (1890), pp.43-45.

<sup>57</sup> CA CO 7163, 16 April, 1895: Correspondence from T.D. Greenlees to the Colonial Office. The majority of children admitted into the home came in fact from working class families.

<sup>58</sup> Grahamstown Asylum Annual Report, 1904: G 57-1905.

<sup>59</sup> T.D.Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony' *South African Medical Record*, v, 9 (January, 1898), p.233.

By 1907, in the midst of an economic depression, and with the Colonial government in a state of fiscal crisis, the care of the black insane was reduced to questions of finance. At a meeting of the colony's five medical superintendents held at Grahamstown asylum in April, a decision was taken to segregate all asylums along racial lines.

Under the present conditions Valkenberg and Grahamstown should be entirely reserved for European Patients and that it would neither conduce to economy or efficiency to associate the better class of Coloured patients with Europeans; rather it would lead to great dissatisfaction on the part of many of the European patients themselves and their friends. The decision as to whether a doubtful case should be classified as European or mixed should rest now with the medical superintendent.<sup>60</sup>

To implement these plans, structural alterations were needed and were duly instituted in 1908. The Grahamstown institution was transformed into a whites only institution having finally 'got rid of' all the black patients.<sup>61</sup> Fort Beaufort was reserved for African patients and Port Alfred for Coloured patients. Medical distinctions between acute and chronic cases were dissolved, finally completing the racialisation of mental health services in the Eastern Cape.

This introductory chapter has provided a broad outline of the expansion and consolidation of the three Eastern Cape asylums. Together with these institutional developments, after 1890 a range of interventions from private treatment and care, to neglect and disinterest, to law and order policies of discipline, regulation and control was introduced. A central argument of the thesis is that the discipline of psychiatry played a key role in legitimising these interventions as did the elaboration of scientific ideas. The problematic at the core

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<sup>60</sup> CA HFB, Vol 3, 26 April, 1907: Correspondence from the conference of medical superintendents at Grahamstown asylum to the Colonial Office.

<sup>61</sup> Grahamstown Asylum Annual Report, 1908: G41-1909.

of psychiatry as a specialised body of knowledge was premised on the therapeutic relationship and the ability of medicine to provide solutions for the treatment of mental illness as a disease. At the same time it was required to fulfil a critical social function to confine, regulate and control disordered and deviant behaviour that might pose a threat to society.<sup>62</sup> It is here that psychiatric medicine derived its power and authority to confine people, legitimated by its status and connections to general medicine. These two issues were fundamental to the practice and authority of psychiatry in the late nineteenth century.<sup>63</sup>

This chapter has introduced the idea that in the late nineteenth century as in the present, mental illness in all its varied forms, was one of the most powerful and elemental models of disease pathology. Madness represented the antithesis of reason and carried within it the frightening possibilities of loss of self and the threat of violence.<sup>64</sup> Mental illness was one of the most stigmatising of all diseases and the stereotype of the mad as a threat and a danger created fear and anxiety that took on special meaning in a colonial society increasingly polarised by race.<sup>65</sup> The restructuring of services for the colony's mentally ill after 1890 in the Eastern Cape became a debate about the most effective way of controlling black patients. These issues are explored in subsequent chapters.

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<sup>62</sup> R. Castel, 'From Dangerousness to Risk' in G. Burchell, C. Gordon and P. Miller (eds.), *The Foucault Effect: Studies in Governmental Rationality* (Chicago, 1991), pp.281-298.

<sup>63</sup> D. Ingleby, 'Mental Health and Social Order', in S. Cohen and A. Scull (eds.), *Social Control and the State* (Oxford, 1983), pp. 115-120.

<sup>64</sup> S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1988), p.24

<sup>65</sup> S. Gilman, *Disease and Representation: Images of Illness from Madness to Aids* (London, 1988) pp.262-268; See also S. Sontag, *Illness as Metaphor* (New York, 1975).

Chapters Two to Five will trace the elaboration of a colonial psychiatry as a body of knowledge and a set of practices that was deeply embedded in the racial, class and gendered relations of colonial power. They will draw on Foucault's insights into the uses of the productive power of knowledge in 'regimes of truth'. They demonstrate that psychiatry in its productive capacity devised categories and practices for handling mental illness that were intimately linked to the political assumptions about each person's place in the colonial social order.<sup>66</sup> The ways in which the dynamics of care and preventative strategies of control were elaborated and developed in the Eastern Cape forms a central focus throughout. In particular, these chapters describe, analyse and interrogate the practice of psychiatry in three Eastern Cape mental institutions. It maps out the inherent power relations embedded in the system of control for black patients in these institutions and examines the extent to which the colonial government was prepared to commit itself in terms of welfare provision for the most marginal members of colonial society.

The next chapter (Chapter Two) describes the emergence of a distinctly colonial psychiatry in the Eastern Cape after 1890. It sets out aspects of colonial relations that were informed by racist and gendered ideologies and practices. It points out how these relations were shaped by British trained psychiatrists practising at the Cape and how their ideas were influenced by the evolutionary theories of Social Darwinism in the metropole.

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<sup>66</sup> M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London, 1991); M. Foucault, 'Chapter Four: Governmentality', in C. Gordon (ed.), *Michel Foucault: Power/Knowledge, Selected Interviews and Other Writings, 1972-1977* (New York, 1980), pp.87-104.

Chapter Three examines the ways in which psychiatry established itself as a source of scientific authority in the Cape colony. It discusses the wider search for the causes of mental illness and includes an examination of the relationship between the science of heredity, degeneration theories and mental illness. It focuses on the role of eugenics and preventative programmes in the maintenance of a healthy colonial society. It raises issues concerned with chronic mental illness such as mental handicap that required long term institutionalisation and the extent of government and medical interest in the Eastern Cape asylums in the late nineteenth century and the early years of the twentieth century.

Chapter Four traces the political relationship between the colonial state, psychiatry and the law in codifying a set of legal procedures for the civil commitment of the mentally ill. It explores tensions inherent in the right of the state to provide care and treatment and at the same time to protect the public from the mentally ill who were deemed dangerous.

Chapter Five provides an overview of the management practices adopted towards the mentally ill. It discusses the differential treatment regimes accorded to patients on the basis of racial, class and gendered distinctions. It links the historical legacy of colonial medical practices in the Eastern Cape to policies adopted after Union with regard to racial classification. It examines the profound effects of this legacy on patients caught up in this system.

## CHAPTER TWO

### RACE AND GENDER IN THE CONSTRUCTION OF BLACK MENTAL ILLNESS IN THE EASTERN CAPE ASYLUMS

The native insane get well sooner than among Europeans of this Colony and this is undoubtedly due to the simpler forms of insanity found in the natives as compared with the more serious forms which it assumes when it occurs in persons of higher mental development, the fall from sanity to insanity being greater. While our means of treating the native insane is quite adequate much must be done before we can say the same of Europeans.<sup>1</sup>

These pronouncements were made by British psychiatrist Dr. Thomas Duncan Greenlees three months after he was appointed to the post of medical superintendent at Grahamstown asylum in 1890, following the death of Dr. Hullah in May of that year. He was immediately confronted with the task of treating black patients and from the outset, regarded their presence in the asylum as a nuisance.<sup>2</sup>

Within the context of Eastern Cape colonial society, biological models of racial difference rooted in Social Darwinism and evolutionary theories produced in the metropole provided a model for understanding both white and black mental illness. All blacks by virtue of their colour occupied a lower and inferior position to whites in colonial society. Ideas about primitive and civilised 'races' were absorbed into colonial psychiatry and used to discover and elaborate the 'truth' about the black insane. As socially sanctioned science, this 'knowledge' was used to justify aggressive segregatory and discriminatory measures in the management of the black insane in the Eastern Cape after 1890.

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<sup>1</sup> Grahamstown Asylum Annual Report, 1890: G37-1891.

<sup>2</sup> CA CO 1458, 19 October, 1890: Correspondence from T.D.Greenlees to the Colonial Office.

At the same time knowledge, about the white insane drew on evolutionary theories and scientific claims elaborated around whiteness, culture and civilisation which defined Western modernity.<sup>3</sup> In the Cape Colony these discourses were used to elaborate racial boundaries and to legitimate the professional status and authority of doctors such as Dodds and Greenlees. More importantly, they provided the rationale for privileging the treatment of white insane. As Swartz argues, colonial psychiatry at the Cape from 1890 was constellated around two central and related themes - the separation of black insane from white insane, and preventative strategies to contain insanity in the white population.<sup>4</sup>

This chapter will trace the historical production of a distinctly colonial psychiatry in the Eastern Cape after 1890. It will demonstrate that colonial psychiatry was profoundly racialised and gendered. Transformed by the colonial relations in which British doctors practised, colonial psychiatry as a body of knowledge and a set of practices pathologised a range of behaviours which had complex social and cultural determinants. New pressures to segregate the mentally ill according to a racial classification rather than by type of mental illness became dominant in the Eastern Cape asylums. Daily management practices of the insane at Grahamstown and Fort Beaufort asylums, as well as medical discourses elaborated in scientific journals, colonial office records and case history files succeeded in distancing and marginalising both the black and chronic insane.<sup>5</sup> In the Eastern Cape, doctors used issues concerned with reforms and early treatment to justify racial

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<sup>3</sup> R. Young, *Colonial Desire: Hybridity in Theory, Culture and Race* (London, 1995), pp 92-93.

<sup>4</sup> S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape: 1890-1920', Unpublished Ph D. Thesis (University of Cape Town, 1996), pp.120-121.

<sup>5</sup> The chronic insane presented particular problems for asylum administrators. Their condition was regarded as irrecoverable, they were a financial burden on the colonial state as they required long term care and they occupied much needed beds for new patients, who needed urgent treatment. Similarly the black insane who formed the bulk of patients admitted into the Eastern Cape asylums were supported by state welfare.

segregation, as well as underresourcing the institutions at Fort Beaufort and Port Alfred which were transformed into virtual ghettos of the mentally ill poor.

The Eastern Cape mental institutions were established in the context of the political maturation and economic modernisation of the colonial state in the late nineteenth century. A range of institutions such as schools, reformatories, hospitals, asylums and prisons at the Cape were established in this period.<sup>6</sup> In 1889, the colonial government disbanded the colonial medical committee which had previously been responsible for the administration of the colony's hospitals and two existing asylums. A special Hospitals Branch was created within the colonial secretary's office to take charge of all the colonial medical institutions.<sup>7</sup> Mental health services were incorporated into this new department.

In the same year Dr. William Dodds, the assistant medical superintendent of Montrose Asylum in Scotland was appointed to the newly created post of Inspector of Asylums. A 'brilliant gold medal graduate' of Edinburgh University, he was charged with bringing the treatment of the insane of the colony in line with the most modern British standards. His duties included monitoring committal procedures, regular inspections of the two Cape asylums, and advising government on all legislative and administrative matters.<sup>8</sup> Dodds was appointed medical superintendent at Valkenberg asylum when it opened in Cape

<sup>6</sup> T. Keegan, *Colonial South Africa and the Origins of the Racial Order* (Cape Town, 1996), p.290-293; L. Chisholm, 'Reformatories and Industrial Schools in South Africa: A Study In Race Class and Gender', unpublished Ph.D. Thesis (University of the Witwatersrand, 1987).

<sup>7</sup> E. Burrows, *A History of Medicine in South Africa Up to the End of the Nineteenth Century* (Cape Town, 1958), p. 345; R. Warwick, 'Mental Health Care at Valkenburg Asylum, 1891-1909: Aspects of its Origins and Operation', unpublished Honours Thesis (University of Cape Town, 1989), p.30.

<sup>8</sup> S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1890-1920', unpublished Ph.D. Thesis (University of Cape Town, 1996), p.1; M. Minde, 'History of Mental Health Services in South Africa: Part III. The Cape Province', *South African Medical Journal*, 2 (November, 1974), pp.2230-2232.

Town in 1891. Another Edinburgh University graduate, Dr.T.D.Greenlees was appointed as medical superintendent of Grahamstown Asylum in 1890, 'guaranteeing that the best traditions of English lunacy practice will be followed at this asylum'.<sup>9</sup> Reforms and improvements of the colony's mental health services were self consciously modelled on British standards and practices that were to have far reaching consequences for the patients who found themselves incarcerated in colonial asylums.

These two colonial medical appointees found that in the absence of any coherent and effective policies to deal with the mentally ill over the previous fifteen years, Robben Island asylum in the Western Cape and Grahamstown asylum in the Eastern Cape had deteriorated into overcrowded, custodial institutions. The lunatic wards at the Old Somerset Hospital in Cape Town were little better. Poorly resourced and managed, both asylums contained significant numbers of chronic and 'hopeless' patients who had little or no hope of recovery. If their families were unwilling or unable to care for them, they were destined to spend most of their lives incarcerated in these public institutions. Writing to the colonial secretary, Greenlees remarked on the deplorable state of the two existing colonial asylums in comparison to what was available 'at home' in Britain.<sup>10</sup> With the general decline in any curative or rehabilitative aspirations at these two asylums, any medical effectiveness was lost. The only common feature was that patients were merely shut away.

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<sup>9</sup> CA CO 1458, 16 August, 1890: Correspondence from W. Dodds to the Colonial Office,.

<sup>10</sup> CA CO 1490, 8 August, 1891: Greenlees was berated by the Colonial Secretary for the objectionable and disrespectful tone of his letter.

Greenlees' comments notwithstanding, the situation 'at home' was little better. By the 1890s, many British asylums were full of poor, chronic insane patients and the outlook for any improvement in the situation was pessimistic.<sup>11</sup> Prior to their appointments in the colony, both Dodds and Greenlees had worked in Britain as assistant medical officers in public institutions containing large numbers of dependent pauper insane, 'the chronic residuum of village half-wits, senile dotards, dements and imbeciles'.<sup>12</sup> These cases were generally perceived by doctors to be uninteresting and time-consuming. Low recovery rates tended to undermine the medical legitimacy and prestige of psychiatrists, reinforcing popular views that insanity was incurable. Moreover, British psychiatric practices in this period were intimately linked to political assumptions about each person's place in the social order and reinforced existing class divisions.<sup>13</sup>

The Cape colony provided Dodds and Greenlees with new professional opportunities and alternative routes to class mobility as civil servants working for the colonial government.<sup>14</sup> Both men were in their early thirties and opportunities for career advancement to the level of medical superintendent were limited in Britain.<sup>15</sup> In the absence of any private asylums in the colony, they were intent on capturing a white middle class settler clientele whose

<sup>11</sup> A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, 1993), Chapter One. For a discussion on the similar situation in America, see G. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge, Massachusetts, 1994), pp.103-124.

<sup>12</sup> T.D. Greenlees, 'Statistics of Insanity at Grahamstown Asylum', *South African Medical Record*, Vol 3, No. 11 (November, 1905), pp.217-218; Drs. Dodds, Strahan and Greenlees, 'Assistant Medical Officers in Asylums: Their Status in their Specialty', *Journal of Mental Science*, Vol 36 (1890), p.49.

<sup>13</sup> D. Ingleby, 'Mental Health and Social Order' in S. Cohen and A. Scull (eds.), *Social Control and the State* (Oxford, 1983), p.181.

<sup>14</sup> A. Stoler and F. Cooper, 'Between Metropole and Colony: Rethinking a Research Agenda', in F. Cooper and A. Stoler (eds.), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, 1997), p.28.

<sup>15</sup> Drs. Dodds, Strahan and Greenlees, 'Assistant Medical Officers in Asylums', *Journal Of Mental Science*, Vol. 36 (1890), p.49.

illnesses were in the more hopeful and early stages, while establishing a professional niche for themselves.<sup>16</sup> Class related issues linked with welfare, treatment and management of acute and chronic illness prevalent in Britain were thus imported into the colony, fundamentally shaping and influencing psychiatric practice at the Cape.<sup>17</sup>

Liberal reform of colonial mental health services after 1890 introduced by Dodds and Greenlees were driven by attempts to assert and legitimate the validity of psychiatric expertise as a medical science. Optimistic claims emphasised that mental illness was a disease similar to other illnesses and that with treatment in a modern asylum, it was possible to effect a cure. Dodds proposed that a new asylum, Valkenberg should be established on the mainland in Cape Town. The existing Grahamstown institution was to be upgraded and reserved for recent cases. These innovations would make it possible to overcome local prejudice and negative attitudes about colonial asylums and bring the colony in line with practices in the 'mother' country.

Two such hospitals would be a powerful factor in the spread of knowledge that insanity is a disease of the brain requiring and benefitting by treatment as much as any other disease and not a hopeless state almost cutting the sufferer off from common humanity and needing only some place of confinement. Safe for the public at least for the natural term of the madman's life. With such institutions available we could hope for an earlier resort to hospital treatment and so make another step forward towards curing the curable; for if there is one fact which has been again and again demonstrated it is that the earlier period of insanity is the hopeful and pre-eminently curable period.<sup>18</sup>

<sup>16</sup> There were a number of licensed private homes, but these only catered for small numbers of the colony's insane. There were no asylums at the Cape similar to Ticehurst Asylum in England. See C. Mackenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London, 1992); G. Grob, *Mental Institutions in America: Social Policy to 1875* (New York, 1973).

<sup>17</sup> H. Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies*, Vol. 22, No. 2 (June, 1996), p.294.

<sup>18</sup> Inspector of Asylums Annual Report, 1891: G39-92.

Treatment itself was to be made more 'scientific'. Colonial psychiatrists such as Dodds and Greenless derived their professional power, status and credibility within the framework of late nineteenth century positivist biomedical knowledge and training that understood mental illness as an organic disease of the brain and nervous system. Mental illness although a fairly distinct phenomenon, was a disease just like any other illness, and with proper treatment in an asylum, it was quite possible to effect a cure for the 'saddest disease flesh is heir to'.<sup>19</sup> This medical model of mental illness provided a useful theoretical base for psychiatry that brought it closer to clinical medicine at a time when psychiatry was trying to establish itself as an accepted discipline within the medical profession itself.<sup>20</sup> According to Greenless the classification of insanity was a complex issue and the care and management of the insane demanded the expertise of specialist physicians. But as doctors they 'still belonged to the great science of medicine, whose sole aim is to educate the people to prevent disease, and to relieve suffering'.<sup>21</sup>

The emphasis on early treatment and curability linked medical expertise to the 'noble and philanthropic' endeavour of healing and the alleviation of human suffering.<sup>22</sup> Dodds' and Greenless' social standing and prestige as experts in the field of psychiatry was enhanced by the juxtaposition of two key symbols, medical competence and caring.<sup>23</sup> This discourse

<sup>19</sup> T.D. Greenless, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, (January, 1898), p 223.

<sup>20</sup> P. Miller, 'Critical Sociologies of Madness' in P. Miller and N. Rose (eds.), *The Power of Psychiatry* (London, 1990) pp.15-16.

<sup>21</sup> T. D. Greenless, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (October, 1903), p.122.

<sup>22</sup> W. Dodds, 'Report of the Inspector of Asylums, Cape Colony, 1892', *South African Medical Journal* (September, 1893), p.88.

<sup>23</sup> B. Good and M.J. del Vecchio Good, 'The Construction of Medical Knowledge at Harvard Medical School' in S. Lindenbaum and Margaret Lock (eds.), *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, (Berkeley, 1993), pp.81-107.

of reform, of 'doing good', served to insulate the entire psychiatric system from criticism.<sup>24</sup> Returning people to their communities as healthy and productive individuals was obviously an important goal for medical personnel, the colonial state and the families of the insane. However, the boundaries of government and medical concerns did not extend to the indigenous population or to the chronic insane who relied on state welfare. Overstated and inflated claims concerned with psychiatric philanthropy, early treatment and cure introduced into the colony merely served as a cover for the introduction of comprehensive racial segregation of black and white patients.<sup>25</sup> Treatment regimes ranged from neglect, disinterest, abandonment, containment and control on the one hand, to care, treatment and even recovery and cure on the other. Selection of treatment was partly dependent upon the diagnosis of mental illness. It was also informed by the broader context of a colonial society replete with racial, class and gendered hierarchies.

Psychiatric practice and knowledge were embedded in the power relations of a colonial society built on racial, class and gendered inequalities. The development and modernisation of psychiatric services in the Cape Colony after 1890 served the interests of both white settlers and the medical profession and incorporated the colonised population only when they posed a threat to colonial order. Provision for the mentally ill in other parts of colonial Africa was to follow a similar pattern. The most elaborate services were established in colonies such as Algeria, Kenya and Southern Rhodesia where there were white settler populations.<sup>26</sup> In the Western Cape, Valkenberg was reserved exclusively for

<sup>24</sup> S. Cohen, *Visions of Social Control: Crime, Punishment and Classification* (Cambridge, 1985), p.173.

<sup>25</sup> Drs. Dodds, Strahan and Greenlees, 'Assistant Medical Officers in Asylums: Their Status in their Specialty', *Journal of Mental Science*, Vol. 36 (1890), p.49.

<sup>26</sup> J. McCulloch, *Colonial Psychiatry and the African Mind* (Cambridge, 1995), pp.43-44.

the white insane. The new hospital, completed in 1894 at a massive cost of forty thousand pounds was intended to be the showpiece of the colonial government.<sup>27</sup> It was the only asylum in the colony to be designed and built specifically for the needs of the mentally ill. Initially intended for all races, plans to erect a separate facility for black patients at Valkenberg were never realised during the colonial period.<sup>28</sup>

The new hospital at Valkenberg should be for acute and recent cases of insanity, for paying patients and for the better class of chronic cases; and it should accommodate about two hundred patients, all European. Robben Island will be reserved for the criminal insane of the colony and for specially dangerous cases of insanity and for the more demented and hopeless cases. In the meantime it would also have to serve for the coloured patients suffering from acute insanity. These changes would allow a classification according to mental state in whites and coloureds respectively. Receipts from paying patients will effectively cover the initial costs incurred at Valkenberg.<sup>29</sup>

While Dodds argued that every effort should be made to provide quality care for both coloured and white patients in the colony, he stressed that treatment should take place in segregated facilities.<sup>30</sup> During his first visit to the Grahamstown asylum in 1889, Dodds was highly critical of black patients mixing with white patients, and commented on the fact that black patients seemed to 'lie about in the sun doing nothing'.<sup>31</sup> Reforms carried out in the Western Cape effectively segregated white and black insane. When white patients were removed to the mainland in 1891, conditions at Robben Island deteriorated

<sup>27</sup> S. Swartz, 'The Black Insane in the Cape, 1890-1920', *Journal of Southern African Studies*, 21 (1995), pp.399-415.

<sup>28</sup> This was only achieved after Union in 1916 when black patients were admitted into Valkenberg asylum for the first time. See S. Swartz, 'A History of the Black Insane', *Journal of Southern African Studies*, 21 (1995), p.400.

<sup>29</sup> Dr. W. Dodds, 'Report of the Inspector of Asylums, Cape Colony, 1892', *South African Medical Journal* (September, 1893), p.89.

<sup>30</sup> CA CO 1458, 1890: Correspondence from W. Dodds to the Colonial Office.

<sup>31</sup> CA CO 1457, September, 1889: Correspondence from Dodds to Hullah.

even further.<sup>32</sup> Greenlees noted in 1895 that information concerning the black insane in the Western Cape was 'most meagre and unsatisfactory'.<sup>33</sup>

Racialised 'scientific' knowledge about black and white mental illness emanating from the Eastern Cape was produced within the development and consolidation of the institutional network described in chapter one, at a time when internal and external pressures to segregate white and black insane were increasing at the Grahamstown asylum. One of Greenlees' first moves as medical superintendent was to establish more flexible distinctions between the 'recent onset of madness' and the chronic insane. After severely mentally and physically disabled cases of all races were transferred to Port Alfred asylum in 1889, the patient population at the Grahamstown institution remained a heterogeneous and undifferentiated mix of men and women drawn from different racial and ethnic groupings. Epileptics, 'senile dements', the actively psychotic, the chronic insane, and the mentally disabled were all treated and managed together. Many failed to respond to treatment and the asylum was a refuge (of sorts) that provided patients with the basic necessities of food, clothing and shelter. While the colonial psychiatrists did not make this observation, it was patently obvious that as elsewhere, mental illness was often linked to social handicaps such as poverty, inability to work, lack of education, old age and loneliness.<sup>34</sup>

<sup>32</sup> H. Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910', unpublished Ph.D., Cambridge University (1994), pp. 17-19.

<sup>33</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p.72.

<sup>34</sup> R. Castel, *The Regulation of Madness: The Origins of Incarceration in France* (Berkeley, 1988), p.22.

At Grahamstown asylum, the black wards in particular were overcrowded. One dormitory contained sixty three patients when it was designed to accommodate only thirty. Overcrowding 'greatly facilitated the commission of nameless offences'.<sup>35</sup> It also hindered the practice of psychiatry. In September 1891, Greenlees complained to the colonial secretary,

I am admitting all sorts and conditions of patients who are difficult to manage. My job is made more difficult because of the presence of mixed races. The separation, classification and general differentiation of patients so essential according to modern methods is rendered impossible.<sup>36</sup>

Classification issues were less concerned with the application of scientific knowledge than with the need to establish order and control and remove sources of irritation such as the mixing of black and white patients. In order to control social relationships inside the asylum, specific spaces were structured along racial lines. While they were perceived as a single community the asylum spaces were divided, policed and regulated.

Classification of patients in a building like Fort England not originally intended for reception of lunatics is extremely difficult without extensive structural changes. In first place coloured patients have to be separated from the European both by day and by night.<sup>37</sup>

Dodds was magnanimous in his praise for the advances made at the Grahamstown asylum in which there was 'now suitable accommodation for private patients of both sexes and it is satisfactory to find that it is more and more taken advantage of by this class of patient'.<sup>38</sup> This 'class' of patient was white and middle class. Classification was centrally concerned

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<sup>35</sup> CA CO 1429, 18 May, 1889: Correspondence from Dr. Dixon to the Colonial Office.

<sup>36</sup> CA CO 1490, 11 September, 1891: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>37</sup> CA CO 1458, 16 August, 1890: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>38</sup> Inspector of Asylums Annual Report, 1891: G36-1892.

with curbing violence and separating the mentally ill into categories of 'self-destructive' and 'harm to others'.

A clinical classification of wards is especially called for recent and acute cases; suicidal and epileptic cases; noisy and destructive cases; convalescent wards. A first attempt will be to follow out a correct clinical classification, for European male patients; Ward one; private patients and a better class of pauper. Ward Two; Acute cases including epileptic and suicidal patients; noisy and destructive patients.<sup>39</sup>

Patients across and within the three Eastern Cape asylums were classified within a grid of specific categories of mental illness, type of violence and on grounds of colour, gender and 'class', that is on the ability to pay for treatment. The introduction of formal systems of classification laid the foundation for modern institutional health care practice in the Eastern Cape.<sup>40</sup>

The difficulty of diagnosing and classifying the mentally ill is illustrated in the following case: In February 1891, a young Basuto man named Abel Maruma was arrested in Stutterheim. He was allegedly found wandering naked down the main street of the town in a confused and agitated condition. A labourer by occupation, he was certified by the local district surgeon to be 'of unsound mind' and after being processed through the courts and jail was eventually admitted to Grahamstown asylum, where due to his 'excited' state, he was diagnosed as suffering from 'mania'. His father who had travelled from Basutoland to Grahamstown spent two months trying to have his son released from the asylum. He protested that his son's mental breakdown had been caused by his exposure to the Christian religion. His condition had deteriorated even further because of the white man's

<sup>39</sup> CA CO 1458, 16 August, 1890: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>40</sup> Grahamstown Asylum Annual Report, 1890: G37-1891.

medicine that locked him up. As a result of these efforts, Abel Maruma was eventually released into the custody of his father who took him back to Basutoland (Lesotho).<sup>41</sup>

The case of Abel Maruma provides a starting point for a discussion of the construction of a black colonial psychiatry. Black labourers made up the greatest proportion of committals into Grahamstown asylum. Greenlees acknowledged that there was a 'constant and increasing demand for accommodation for the treatment of native males who from the civilising influences of their surroundings seem readily to break down mentally'.<sup>42</sup> Abel Maruma's case history was typical of most black admissions. Black patients generally entered the asylum as involuntary commitments through the legal system of police and law courts when their disturbed behaviour caused a nuisance or posed a threat to white society.<sup>43</sup> As a migrant labourer from Lesotho, Maruma formed part of a floating population of workers that were drawn into wage labour in the colony as agricultural or mine workers.

Abel Maruma's father quite correctly concluded that the asylum was a place of confinement and control for his son. Western psychiatry had relatively little to offer in terms of providing any relief of his son's condition. The medical diagnosis of mania was the most common diagnosis made for all black patients, both men and women in Eastern Cape asylums. This diagnosis provided relatively little information about Abel Maruma's mental condition and was merely a label that provided a convenient classificatory grid to process such cases. The strength of scientific medicine that objectified the body was that it

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<sup>41</sup> CA HGM Casebook 2, No. 780, p.231.

<sup>42</sup> Grahamstown Asylum Annual Report, 1891: G36-1892.

<sup>43</sup> CA HGM Casebook 2, No. 780, p.231.

was perceived to be objective and value free.<sup>44</sup> But the reality was that this medical model reduced all human suffering to lesions within the body and mind, stifling the psychosocial origins and the subjectivity of mental illness.<sup>45</sup> As Foucault has pointed out, the medical model defines a set of practices and power relations through the authority and recognition of these knowledge claims.<sup>46</sup>

Abel Maruma's case history remains incomplete and partial as did all the case histories of the black insane at Grahamstown asylum. (See Chapter Three.) What is unusual about this case is that it provides some insights into the experiences of colonial relations and mental illness from the perspective of a black family. While the reality of Abel's suffering and experience of mental illness is only made accessible through the voice of his father, that a black voice is recorded at all is significant, as in most cases black voices are marginal in the archival sources. While disturbing the conventional power relations operating between white doctors and black patients, this case was not typical and remained hidden in the more private case history texts.

Public Asylums in the Eastern Cape contained more black patients than white, more non-payers than private patients and more involuntary civil committals. Yet, the reforms introduced by the colonial government privileged the treatment of white patients who were able to pay for treatment. The elaboration of a distinctly colonial psychiatry emerged alongside the expansion of mental institutions and was used to establish the racialised and

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<sup>44</sup> D. Ingleby, 'Mental Health and Social Control' in S. Cohen and A. Scull (eds.), *Social Control and the State*, (Oxford, 1983), p.63.

<sup>45</sup> R. Butchart, 'On the Anatomy of Power: Bodies of Knowledge in South African Socio-Medical Discourse', unpublished Ph.D. Thesis, University of South Africa (1995).

<sup>46</sup> M. Foucault in C. Gordon (ed.), *Michel Foucault Power/Knowledge: Selected Interviews and Other Writings, 1972-1977* (New York, 1980), p.113, p116.

gendered otherness of the black insane and justify the unequal provisions. As Foucault observes, 'the interweaving effects of power and knowledge can be grasped with greater certainty in the case of a science as dubious as psychiatry'.<sup>47</sup> The history of mental illness in the Cape Colony was not only a history about the disease and suffering so self-consciously conceptualised by Dodds and Greenlees. Rather, as elsewhere in the colonial world, this is a history of power relationships. While much work remains to be done in this area, in her work on Malawi, Megan Vaughan argues that psychiatry constructs the African as an object of knowledge, and elaborates classification systems and practices that are intrinsic to the operation of colonial power.<sup>48</sup> Dodds and Greenlees, colonial psychiatrists, worked in the same way in South Africa.

Working in new and unfamiliar locations colonial psychiatrists and doctors needed first to have some understanding of what constituted the 'normal' in black colonial society before they could attempt to diagnose 'insanity'. According to Greenlees, the black population in South Africa was made up of two types of races, the 'savage and semi-savage' races. Traditional, rural African tribes, 'pure and uncontaminated natives, the noblest types of mankind' held themselves aloof from civilisation and very little was known about their normal mental condition. Maintaining their original dress and customs, these 'savage races' lived a 'simple mode of life in the open air, in a perfect climate, with plenty of natural food'.<sup>49</sup> In Greenlees' view, insanity was a disease that was caused by the advance of

<sup>47</sup> M. Foucault in G. Burchell, C. Gordon and P. Miller (eds.), *The Foucault Effect: Studies in Governmental Rationality* (Chicago, 1991).

<sup>48</sup> M. Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies*, 9, 2 (April, 1983), pp.218-238; M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), p.7.

<sup>49</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895),

civilisation. ' It is not to be expected that diseases originating in mental worry and anxiety should make themselves evident among uncivilised people.'<sup>50</sup> Rural blacks contained in the traditional spaces of rural custom and child-like states of pastoral innocence would therefore not require medical services.<sup>51</sup> These boundaries of colonial psychiatry that idealised peasant life were secured through a medical discourse that arose out of British class experiences rather than an African context.<sup>52</sup>

When so-called 'tribal' African women from the rural areas began to be admitted to Grahamstown asylum this discourse about the noble savage rapidly fell away to be replaced with a far more pejorative discourse about 'raw uncivilised natives'.<sup>53</sup> This discourse was apparent in 1893 when the Grahamstown asylum could not provide sufficient beds for the black insane who were confined in jails all over the northern and eastern parts of the colony.<sup>54</sup> The wards for black female patients were particularly overcrowded and several women had to sleep on the floor. Greenlees argued that this was the 'natural habit of natives' to coil themselves up in their blankets and sleep on the floor' as bedsteads were unknown to them. Furthermore, 'it is absurd to endeavour to civilise raw insane natives when the mission stations can educate them up to this standard of civilisation'.<sup>55</sup>

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p.71.

<sup>50</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895), p.73.

<sup>51</sup> See R. Young, *Colonial Desire: Hybridity in Theory, Culture and Race* (London, 1995), p.112, for a discussion on the romantic idealisation of pre-literate societies.

<sup>52</sup> A. Stoler and F. Cooper, 'Between Metropole and Colony', in A Stoler and F Cooper (eds.), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, 1997), p.27.

<sup>53</sup> CA CO 7163, September, 1895: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>54</sup> Grahamstown Asylum Annual Report, 1891: G36-92.

<sup>55</sup> CA CO 1570, 22 June, 1893: Correspondence from T.D. Greenlees to W. Dodds.

The 'semi-savage' races were those blacks living close to towns and urban centres who were slowly becoming acculturated into white civilised settler society. Distinctions were made within this group between Africans and 'Hottentots' .

The Hottentots have been for the past three hundred years in intimate contact with whites first with the Dutch, latterly with the English and it is not unreasonable to suppose that they are liable to such mental and physical diseases as they may be considered the most civilised. The Bastard a mixture of white blood and black morally seems to present all the worst characteristics of both races and so degraded is the position he occupies that he is compelled to associate with his coloured half brothers. <sup>56</sup>

Grahamstown and Fort Beaufort asylums admitted black patients from all over Southern Africa.<sup>57</sup> Many black patients were drawn from colonial towns and urban centres where they had contact with white settler society. Yet once admitted into the asylums these patients were identified according to ethnic and tribal categories rather than as individuals. Categories included, Kafirs, Hottentots, Bastards, Fingos, Gaikas, Basuto, Zulus, Tambookies, Malays, Hindoos, Bushmen, Griquas, Koumnas, Batlapin, Makateese and Pondosete.<sup>58</sup> Complex populations were thus reduced to simple tribal groupings. Stoler and Cooper argue that 'tribe' in Africa was in part a colonial construct, 'to render fluid and confusing social and political relationships into categories sufficiently static and reified and thereby useful to colonial understanding and control'.<sup>59</sup> A colonial world divided into tribes and traditional cultures essentialised and homogenised black people to fit into

<sup>56</sup> T. D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p.72.

<sup>57</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p71.

<sup>58</sup> CA HFB, Volume 24, May, 1897: Correspondence from J. Conry to the Colonial Office.

<sup>59</sup> A. Stoler and F. Cooper, 'Between Metropole and Colony', in F. Cooper and A. Stoler (eds.), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, 1997), p.11.

imperial definitions of what it was they ruled.<sup>60</sup> In this instance tribal identities were used to stabilise identities around mental illness and social control.

Social Darwinist thinking was central to this project. The emergence of Social Darwinism and evolutionary theory in Britain in the nineteenth century foregrounded a view of continuity between savage and civilised races. These theories lent scientific status to the view that there were higher and lower races, progressive and non-progressive. Physical, mental and moral characteristics of human beings had gradually evolved over time from ape-like ancestors.<sup>61</sup> In 'progressive' nations like Britain these theories actively promoted the belief in the inferiority of black people and served as a justification for imperialism.<sup>62</sup> Evolutionary theories and racial science were appropriated by doctors in the Eastern Cape as powerful scientific models for understanding race and used to legitimate policies concerning the black insane. The colony provided Greenlees with a unique opportunity to 'grapple with many of the facts of the onset, progress and cause of a disease as 'obscure' as insanity in 'a less evolved and primitive' people'.<sup>63</sup>

Psychiatric discourse was not divorced from social context in Greenlees' discourse. Mental breakdown was cast as an inability to cope with 'the pressures of civilisation'. In the 1890s, Greenlees believed that, 'while the 'Kafir' tribes flourished, the time will come when civilisation will overshadow them with its baneful pall, bringing innumerable

<sup>60</sup> A. Stoler and F. Cooper, 'Between Metropole and Colony', in F. Cooper and A. Stoler (eds.), *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, 1997), p.11.

<sup>61</sup> N. L. Stepan, *The Idea of Race in Science* (London, 1982), pp.53-55.

<sup>62</sup> P. Brantlinger, 'Victorians and Africans: The Genealogy of the Myth of the Dark Continent', *Critical Inquiry*, Vol. 12 (Autumn, 1985), pp. 198-199.

<sup>63</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895), p.75.

diseases in its train and ultimately exterminating all races that oppose its progress.<sup>64</sup> By 1904, the prevailing view had changed. The new discourse was that Africans, unlike the Australian Aborigines and American Indians would not die out. Scientific racism in South Africa shifted from the notion of black people being 'wiped out' by civilisation, to blacks requiring control as a consequence of their innate biological resistance to civilisation. This was to be accomplished by creating geographic and territorial segregation through separate white and black land settlement.<sup>65</sup> Africans flourished because they were coarser and less sensitive due to their 'uncivilised and devolved' status and were 'incapable' of assimilating any aspirations of white civilised society.<sup>66</sup> These discursive changes indicate that the process of constructing a the language of psychiatry in the colonies played an important role in defining a category of 'normal' African and in pathologising that normality.<sup>67</sup>

Greenlees' ideas about black mental illness were rooted in racial science and he disseminated a notion of the biological inferiority of all black people in order to explain just why it was that black people broke down mentally. He believed that, 'the Native brain has its analogue in the European child's cerebrum; in many respects his mental attributes are similar to those of a child'.<sup>68</sup> In order to 'prove' his theories that black people were biologically inferior he conducted post mortem's on the patients at Grahamstown. He was so pleased with his pioneering research endeavours that he wrote to the Colonial Secretary.

<sup>64</sup> M. Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge, 1991), p.187.

<sup>65</sup> P. Rich, 'Race Science and the Legitimization of White Supremacy in South Africa, 1902-1940', *International Journal of African Historical Studies*, Vol. 23, Part 4 (1990), p.667.

<sup>66</sup> P. Brantlinger, 'Victorians and Africans: The Genealogy of the Myth of the Dark Continent' in *Critical Inquiry*, Vol. 12 (Autumn, 1985), p.187.

<sup>67</sup> M. Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge, 1991), p.191.

<sup>68</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895), p.75.

These investigations, he eulogised, were 'a first effort to clear up what should prove in time a very important study in the evolution of brain disease in its evolutionary aspect and we have opportunities for this in this country that are to be found nowhere else'.<sup>69</sup> He was also optimistic about the scientific significance of these findings for colonial psychiatry more broadly. 'I hope to increase the popularity of the asylum among scientific men as an Institution from which may emanate more original work than any other Colonial Institution of a similar character.'<sup>70</sup>

The Grahamstown institution provided Greenlees with raw empirical data on black bodies that fuelled a racial science both in the colony and at home in Britain and proved the innate inferiority of the black people in the colony. Drawing on research methodologies based on comparative anatomical studies, Greenlees attempted to locate physiological markers of racial and gender difference to classify and separate black and white bodies.<sup>71</sup> Dodds and Greenlees were both trained at Edinburgh University medical school which was regarded as one of the most advanced schools in Britain. It was also where, according to Robert Young a 'vigorous racial theory via comparative anatomy' was developed, forming the basis of medical education there.<sup>72</sup> These men and their work bear out Nancy Stepan's observation that the appeal of racial biology was twofold. It gave Europeans a sense of themselves in the world and at the same time it was based on scientific procedures and facts such as statistical data, measurement and knowledge of biological processes and functions.<sup>73</sup>

<sup>69</sup> CA CO 7163, 25 February, 1895: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>70</sup> CA CO 7160, 25 May, 1894: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>71</sup> T.D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, No. 48 (October, 1902), pp.645-666.

<sup>72</sup> R. Young, *Colonial Desire: Hybridity in Theory, Culture And Race*, (London, 1995), pp.122-123.

<sup>73</sup> N. Stepan, *The Idea of Race in Science* (London, 1982), p.53.

Greenlees claimed he was able to locate and measure difference in intellectual capacity in the weight of brains examined during autopsy procedures. Their mass followed a clear racial and gender hierarchy. White male brains were the heaviest, followed by white females, black males and lastly black females. However, when the research revealed that Dutch brains were heavier than British brains, the canny researcher argued that in fully developed white brains, race was not an issue. Rather it was quality of brain tissue and not mass that influenced intellectual capacity. As the brains of black patients measured by Greenlees all weighed consistently less than those of white patients, this proved the innate intellectual inferiority of black people.<sup>74</sup>

These deterministic racial theories of biological difference were taken a step further and applied to psychiatric diagnoses. The most common form of mental illness diagnosed at Grahamstown Asylum for all black patients including Abel Maruma, was 'mania', a disease characterised by mental deterioration, excitement and delusions.<sup>75</sup> Between 1890 and 1904, 1,131 black mental patients were admitted to the institution. 684 cases or 60% suffered from mania on admission.<sup>76</sup> Similarly at Fort Beaufort mania accounted for over 62% of all admissions, between 1894 and 1906.<sup>77</sup> Mania was considered a disease of the

<sup>74</sup> T. D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, No. 48 (October, 1902), pp.650-653.

<sup>75</sup> See M. Donnolly, *Managing the Mind: A Study of Medical Psychology in Early Nineteenth Century Britain* (London, 1983), pp.165-166; E. Hare, 'The Two Manias: A Study in the Evolution of the Modern Concept of Mania', *British Journal Of Psychiatry*, Vol. 138 (1981), pp. 89-99, for a discussion of medical classifications concerning mania, chronic mania and dementia in the nineteenth century. Concepts of mania and melancholia in the nineteenth century included cases that are today known as schizophrenia. Both authors however make the point that one cannot generalise psychiatric categories across different historical eras.

<sup>76</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), p.218.

<sup>77</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, 5, 3 (February, 1907), p.34.

undeveloped brain, where the 'higher mental layers are not yet formed.' Mental breakdown was said to take place in an 'undeveloped mental organisation'.<sup>78</sup> Investigations that produced evidence of smaller brain mass for black patients thus provided fertile ground for the elaboration of what constituted the primary cause of mental illness in the colonised. Black patients suffered from mental breakdown because biologically they were at a different stage of cerebral development and were not equipped to cope with civilisation. Constructed as childish, primitive and less evolved, their illness experiences were considered to be less severe than those of whites and therefore required only the most basic services. This racialised attitude to mental illness was used to justify Greenlees' desire to remove all black patients from the Grahamstown institution to Fort Beaufort. It is somewhat ironic that while Greenlees was using black patients to enhance his reputation as a pioneering scientist, he was in fact desperately trying to 'get rid' of all the black patients.<sup>79</sup>

The Grahamstown institution provides evidence of the ways in which this system of ideas was inscribed in practice. Using the recommendations laid down by the British Medico-Psychological Association, mental illness was classified under eight different categories. These ranged from the functional psychoses of mania, melancholia and dementia to general paralysis, epilepsy, idiocy, imbecility and imbecility with epilepsy. The category of mania included acute, chronic, recurrent and puerperal (mania following childbirth) forms.<sup>80</sup> The following cases were all categorised as cases of chronic mania.

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<sup>78</sup> T. D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, No. 48 (October, 1902) p.652.

<sup>79</sup> Grahamstown Asylum Annual Report, 1894: G16- 95.

<sup>80</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895), p.76.

William January was termed 'dull, stupid and demented, quite harmless, talks a lot of incoherent nonsense'. Mad Moll was described as 'very childish and simple minded, always laughing and talking'. Drie Pond, was 'demented, dull and stupid, at times talkative at other times he will not even answer a simple question'. Samuel Marokeng was 'demented, dull and stupid, won't even speak'. Umlanduli, was 'very demented, hardly ever speaks, takes no interest in himself or his surroundings'. Caffir Makube was at times 'mildly excited and talkative, but is perfectly harmless'. Booi Witbooi, alias Willem Lubbe, stood 'about gesticulating and talking nonsense.'<sup>81</sup> These broad descriptions provided a useful mechanism for medical practitioners to distance themselves from their black patients. Describing the nature of black mental illness to a largely British audience, doctors such as Greenlees knew very little about their black patients who were discursively contained through non-threatening labels such as 'dull', 'stupid' and 'childish'. At the same time the failure of these doctors to give patients their real names was explained as the inability of mental patients to communicate.

Cases at Fort Beaufort, an all black institution that until 1908 only admitted chronic cases transferred from other asylums in the colony, were generally classified under the category of 'simple' mania.<sup>82</sup> Distinctions for this category were made in the content of the delusions expressed by black and white patients. The medical superintendent, John Conry identified 'normal' delusions for black patients as inferior to the delusions of whites. Native delusions concerned stock, such as cattle or sheep that he possesses or that have been taken away from him, or that he has a number of wives and children, when such is

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<sup>81</sup> CA CO 8052, May, 1902: Correspondence from Greenlees to the Colonial Office.

<sup>82</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, 5, 3 (February, 1907), p.221.

not the fact'.<sup>83</sup> Clearly failing to locate individuals in their material and social contexts, Conry maintained that in comparison, European delusions were of a far more 'exalted' nature. While the archive contains little evidence to corroborate Conry's claims at Fort Beaufort, records at Grahamstown provide more substantial information. For instance, white patients expressed delusions concerned with vast wealth and the ownership of large estates. Others while in psychotic states believed themselves to be the king or queen of England or even Jesus Christ.<sup>84</sup> Black patients expressed 'native' type delusions that they were animals such as lizards or horses, or in one case 'a chief flying around in the air'.<sup>85</sup> But other black patients also experienced 'European' type delusions about power and control that were as 'exalted'. Some believed they had amassed great wealth or that they were Jesus Christ.<sup>86</sup>

Megan Vaughan's work suggests similar patterns for African patients in Malawi. Further, she notes that colonial documents on black insanity reveal far more about the creation of colonial categories than they do about madness.<sup>87</sup> There is very little evidence to suggest that psychotic delusions followed any precise patterns of racial difference. Yet for doctors such as Conry it was far more convenient to use generalisations about black society and culture and ignore the complex nature of psychoses in black people. Similarities in delusional content between white and black patients threatened the social order of a colonial society that was underpinned by the myth of black inferiority.

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<sup>83</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, 5, 3 (February, 1907), p. 223.

<sup>84</sup> CA HGM Casebook 10; CA HGM Casebook 11.

<sup>85</sup> CA HGM Casebook 2, No. 784.

<sup>86</sup> CA HGM Casebook 5; CA HGM Casebook 6.

<sup>87</sup> M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Cambridge, 1991), p.100.

Racial differences contained in reductionist biological models were also applied to depressive illnesses. Melancholia or depression was associated with the heaviest and most developed brains. In Greenlees' view, the 'intellectual strata that are highest and the latest developed, are therefore most ready to break down'. These theories helped to explain why simpler forms of mania should be so much more common among 'savage' tribes than melancholia. In the racial hierarchy of this emerging colonial psychiatry, melancholia was usually found only in 'educated', that is civilised natives.<sup>88</sup> Statistics on melancholia covering the years 1890 to 1904 at Grahamstown revealed that 11% of black patients suffered from depressive illness. This led Greenlees to conclude that all blacks in South Africa had not advanced to any extent.<sup>89</sup>

Similarly, at Fort Beaufort only 3% of admissions were attributed to melancholia. There were 26 cases of 'ordinary' as opposed to actively suicidal patients who inflicted slight injuries on themselves. These 'slight' injuries included the case of one woman who after refusing to speak for weeks, 'drove a two- inch nail into her scalp' and on another occasion 'incised a wound on her chest'. Successfully recovered, 'she now talks, laughs and works well'.<sup>90</sup> Interestingly, ability to work was used by all colonial doctors as a criterion for treatment and recovery in both black and white patients who relied on state welfare. In contrast, middle class patients were expected to indulge themselves in rest and leisure activities.

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<sup>88</sup> T.D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, No. 48 (October, 1902), p.652.

<sup>89</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), pp.218-219.

<sup>90</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 (February, 1907), p.34.

Issues around mania, and severe depressive illnesses such as melancholia and colonial psychiatry reveal the extent to which black people were denied an identity as self-aware and introspective individuals. In line with evolutionary thinking, depression in white society was linked to artistic and creative abilities that required high states of intellectual ability. Black adults were positioned in colonial psychiatric discourse as belonging to states of permanent childhood. Mentally and emotionally immature, they were unable to cope with the clashes of primitive culture and European modernity exemplified by white settler society. Ideas that black people were immune to depression ignored and devalued their suffering, alienation and experiences of mental illness. When melancholia was diagnosed in patients in Grahamstown institution, these were dismissed as anomalies.

Depression was often missed in black patients simply because doctors made little effort to find it. When melancholia was diagnosed in black patients at Grahamstown asylum, descriptions of these illnesses covered no more than a few brief phases such as, 'refuses to get out of bed and covers his head with blankets', 'refuses to speak', 'refuses to eat' and 'lies about in the sun and refuses to work.'<sup>91</sup> Depression in African cultures was often filtered through traditional cosmologies concerning fears of bewitchment.<sup>92</sup> Families and communities were more likely to contain and care for people who presented with depressive illness than with the more overt excitable and often threatening behaviour of violent conditions such as mania. Most black patients were admitted into the Grahamstown asylum through the judicial system when they were arrested for unruly

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<sup>91</sup> CA HGM Casebook 2, No. 558; CA HGM Casebook 2, No. 739; CA HGM Casebook 3, No. 821.

<sup>92</sup> See J. McCulloch, *Colonial Psychiatry and the African Mind* (Cambridge, 1995), p.112.

behaviour in public spaces. Colonial psychiatry was designed to control the behaviour of the black mentally ill rather than provide relief for their suffering.

Broad and poorly defined universal categories such as mania and melancholia provided useful screening mechanisms for doctors to appear to take black mental illness seriously when in fact they interacted with their patients on the most superficial level. Colonial psychiatry in most aspects was largely unhelpful to black patients. Profoundly ethnocentric, colonial psychiatry dissociated itself from colonial spheres of power, such as territorial dispossession, pass laws, segregation, migrant labour and poverty. Black pathology was described in crudely racist texts as violent psychosis (mania) and arrested development. It is no wonder that so little was actually known about the colonial insane when black people were discursively contained in generalisations about their innate biological inferiority and as belonging to a-historical, static and unchanging traditional worlds.

Colonial boundaries and identities relating to race and mental illness in the Eastern Cape were profoundly shaped by powerful subtexts of gender and sexuality that delineated the complexity and tensions of the colonial encounter. During the entire period under review black men formed the bulk of admissions into Eastern Cape asylums. Although black women were employed in the region, largely as domestic servants it was black men who entered the expanding colonial economy that was moulded by the mass labour demands of the mines.<sup>93</sup> Migrancy rates increased substantially during the Boer War of 1899-1902, as demands for workers increased dramatically to provide services for the imperial army. But

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<sup>93</sup> J. Cock, *Maids and Madams: A Study in the Politics of Exploitation* (Johannesburg, 1980), p.304-306.

this labour market was unstable and during the depression years of 1903 to 1908, wages fell with the contraction of work opportunities.<sup>94</sup> Institutions such as the Grahamstown and Fort Beaufort asylums interfaced with the fallout of this system, those men who broke down mentally in the face of a host of social problems associated with political, social and economic changes. These asylums became places of last resort in a system that only valued the productive labour of black men, and was not prepared to accept responsibility for the the social costs generated by colonialism.

Gendered questions about masculinity and black male identity were central to an understanding of the power relations between white doctors and black men at Grahamstown asylum. Boundaries of race located through the racialised sexuality and reproductive anatomy of black male and female bodies functioned to buttress the hegemony of white male doctors within a patriarchal system. On one level black male patients were denied any sexual identity at all. Adult black men were 'infantilised' to the status of children and 'kaffir boys'.<sup>95</sup> Morrell argues that the use of the diminutive suggests that the relationship between the white coloniser and black colonised involved emasculation and a denial of adulthood and manhood for black men.<sup>96</sup>

On another level however, constructions around black male sexuality within the context of the Grahamstown asylum produced a range of negative stereotypes about the hyper

<sup>94</sup> C. Bundy and W. Beinart, *Hidden Struggles in Rural South Africa: Politics and Popular Movements in The Transkei and the Eastern Cape* (Johannesburg, 1987), p.20.

<sup>95</sup> See CA HGM, Casebook 2, No. 710; CA HGM, Casebook 2, No. 793.

<sup>96</sup> R. Morrell, 'Of Boys and Men: Masculinity and Gender in Southern African Studies', *Journal of Southern African Studies*, Vol. 24, No 4 (December, 1998), p.616; See also A.R. JanMohamed, 'Sexuality on/of the Racial Border: Foucault, Wright and the Articulation of "Racialised Sexuality"', in D. Stanton (ed.), *Discourses of Sexuality from Aristotle to Aids*, (Ann Arbor, 1992), p.107 for a discussion on the infantilisation and femininisation of black men and the articulation of a racialised sexuality.

sexuality of black male patients. The presence of white female patients at Grahamstown was used by Greenlees to pathologise black male patients as driven by uncontrollable urges and perverted sexual drives. In his view, white female patients were vulnerable to sexual assaults by black male patients.<sup>97</sup> No evidence exists to support these claims for white women.<sup>98</sup> A black female epileptic patient however, was raped and impregnated by the father of a gardener at the asylum. This incident merited only a mention in colonial office records, revealing the extent of the endemic racism and sexism shown towards black women in the asylum.<sup>99</sup>

Sexual perversions in black male patients extended to masturbation, sodomy, and homosexuality.<sup>100</sup> Madolo, a 35 year old Fingo man suffering from mania was admitted into Grahamstown asylum in March 1891. Described as a 'tall well-built native', he arrived in a 'bullock cart' handcuffed because of his violent state. His case history contains almost no information about his medical condition and his status as a mental patient and as a person was reduced to nothing else but to 'depraved habits' and a problematic sexuality. In September of 1892 he was described as 'an inveterate and shameless masturbator' with a penis of 'enormous size'. The treatment for masturbation at the Grahamstown asylum was to blister the penis. Castration was also mentioned as a possibility.<sup>101</sup>

<sup>97</sup> CA CO 1572, 12 June, 1894: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>98</sup> J. Sharpe, 'The Unspeakable Limits of Rape: Colonial Violence and Counter-Insurgency', in *Genders*, No. 10 (Spring, 1991), pp.29-30. Sharpe argues that the stereotype of the black rapist within the historical context of colonial relations provided ideological sanctions for racial segregation.

<sup>99</sup> CA CO 7166, September, 1896: Correspondence from T.D. Greenlees to W. Dodds.

<sup>100</sup> See CA CO 7162, 15 June, 1895: Correspondence from T.D. Greenlees to the Colonial Office; CA CO 7165, 13 February, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>101</sup> CA HGM, Casebook 2, No. 784.

Masturbation was recognised in psychiatric circles as both a cause and a consequence of insanity. According to Greenlees healthy youths could break down if self-abuse was allowed free reign. This habit resulted in some of the most incurable forms of mental disease.<sup>102</sup> All Africans were 'addicted' to these habits and masturbation was a 'well-marked symptom of insanity among the natives while in confinement'.<sup>103</sup> Masturbation in all black people was thus read as an underlying social pathology of 'improperly sexed beings'.<sup>104</sup> Black male bodies were discursively contained through anatomical difference of small brains, exaggerated sexual parts and sexual inversions of white, male, heterosexual, middle class norms. Feminist theorist Judith Butler argues that any inversions of normative sex are automatically pathologised. Sexuality then becomes a site of heightened regulation and control and results in erasure and exclusions.<sup>105</sup>

Let us consider the case of a patient who perceived himself as a man but whom Greenlees labelled either female or hermaphrodite. Greenlees published an article in the *British Journal of Mental Science* in which he described a case of hermaphroditism occurring in an African female patient who was set up as an exhibit at a South African Medical Congress.<sup>106</sup>

She (sic) was admitted as a male and insisted on being treated as such, but there was little doubt as to the prominence of female organs of generation over those of the male sex. She was married to a woman, who for obvious reasons, refused to live with her and while in the asylum she refused to live

<sup>102</sup> T.D.Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No 11 (November, 1905), p.221.

<sup>103</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science* (January, 1895), p.72.

<sup>104</sup> T. Laquer, 'Sexual Desire and the Market Economy during the Industrial Revolution', in D. Stanton (ed.), *Discourses of Sexuality* (Ann Arbor, 1992), p.211.

<sup>105</sup> J. Butler, 'Sexual Inversions', in D. Stanton, (ed.) *Discourses of Sexuality* (Ann Arbor, 1992), p.353.

<sup>106</sup> There is no evidence of this in the case histories in the time period covered by this thesis. If this case is the product of a fertile imagination, it still illustrates the pervasive influence of scientific thinking of the time.

in the female wards. She menstruated regularly and on occasions it was considered advisable to keep her in a room by herself. She knew there was something the matter with her genital organs and exposed herself readily enough for examination, not from immodesty so much as from real desire that operative interference might be attempted to make her a 'better man'. I am informed that hermaphroditism is by no means unknown among the natives of this country, but this is the first case that has come under my notice.<sup>107</sup>

Following the death of this patient from tuberculosis, Greenlees conducted an autopsy on his (the patients' preferred gender was male) body. He described his outward appearance as that of a woman with 'no hair on her face and mammae being large, with large and prominent nipples'. An examination of his genital organs revealed externally a 'rudimentary penis' some two inches long and internally, evidence of female organs.<sup>108</sup> On this slim 'scientific' evidence, coupled with this patient's unusual behaviour in the asylum Greenlees was able to leap to the conclusion that this patient was a hermaphrodite. Constructed as half man, half woman, this patient represented a figure of sexual ambiguity excluded from the very category of human subjectivity. Less differentiated than the norm (white heterosexual man or women), he emerged as a figure of inconsistency, an evolutionary throwback to an earlier primitive state.<sup>109</sup>

Both masculine and feminine identities for patients at Grahamstown were saturated with sexuality, revealing the tensions and anxieties of an uncertain colonial project concerned with the regulation and control of black mental illness. For Fanon the myths of black men's sexual identity are merely a product of the fears and fantasies of the supposedly all

<sup>107</sup> T.D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, Vol. 48 (October, 1902), p 664.

<sup>108</sup> See S. Somerville, 'Scientific Racism and the Invention of the Homosexual Body' in R. Lancaster and M. di Leonardo (eds.), *The Gender/ Sexuality Reader* (New York, 1997), p.41, for a discussion on the myths created by comparative anatomy and medicine of an unusually large clitoris in lesbian and black women.

<sup>109</sup> J. Butler, 'Sexual Inversions', in D. Stanton (ed.), *Discourses of Sexuality* (Ann Arbor, 1992) p.354.

powerful white male subject.<sup>110</sup> Black men pathologised through racial stereotypes of sexual perversion at Grahamstown asylum were denied an identity as people suffering from mental illness. The serious nature of their illnesses was never acknowledged. The 'over sexed, freak' bodies of black patients were used to control and regulate boundaries between black and white at Grahamstown asylum reinforcing Foucault's observation that sexuality is a dense transfer point of relations to power.<sup>111</sup>

The overtly racialised and gendered nature of colonial psychiatric texts produced by medical practitioners in the Eastern Cape were used to segregate the black and white insane and to justify the under-resourcing of black institutions before 1910. Describing black mental patients as primitive and childlike in journal articles that reached academic circles in both Britain and North America, merely served to enhance and reinforce the professional status and authority of colonial doctors as competent physicians and as pioneers in their chosen field.<sup>112</sup> In the colony, knowledge that named and evaluated mental illness in colonial subjects served to define and regulate specific interests and power relations of colonialism. In the Eastern Cape, medical discourse was carried over into practice as it provided colonial authorities with the means to legitimate the marginalisation of the black insane while at the same time promoting humanitarian ideals.<sup>113</sup>

<sup>110</sup> F. Fanon, *Black Skin, White Masks* (New York, 1967), p.79; K. Mercer, 'Just Looking for Trouble: Robert Mapplethorpe and Fantasies of Race' in A. McClintock, A. Mufti and E. Shohat (eds.), *Dangerous Liaisons: Gender, Nation and Post Colonial Perspectives* (Minneapolis, 1997); R. Young, *Colonial Desire: Hybridity in Theory, Culture and Race*, (London, 1995).

<sup>111</sup> M. Foucault, *A History of Sexuality: Vol. 1* (London, 1990).

<sup>112</sup> CA CO 1570, 13 February, 1893: Correspondence from T.D. Greenlees to the Colonial Office. Asylum doctors such as Dodds and Greenlees regularly circulated their annual reports to colleagues in Britain and America; CA CO7161, 13 March, 1894: Correspondence from T.D. Greenlees to the Colonial Office. Greenlees, while on a three month sabbatical in 1894 visited asylums in Britain, Canada and the United States.

<sup>113</sup> S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No. 3 (September, 1995), p.403.

Racial and gendered boundaries formed the bedrock of colonial psychiatry and of policies adopted towards the mentally ill in the Cape Colony.<sup>114</sup> Public texts produced by colonial doctors categorised black mental illness according to a neat set of biologically determined criteria authenticated by the seemingly neutral field of biomedical knowledge. Black patients, infantilised and constructed as children reinforced the hierarchies and the paternalism of colonial relations. At the same time, black mental illness was discursively contained and stabilised as non-threatening to colonial society, creating the illusion of order and structure within this colonial world. By invoking the parent/child relationship the potential threat of violence and disorder associated with conditions such as mania was contained. The gendered and sexualised identities produced at Grahamstown reveal little about the nature of mental illness in the colonised. The emasculation of black men through the gendered language of 'boys' and castration reveal more about the hegemonic masculinity of white men such as Greenlees and the need to defend that power.<sup>115</sup> The embodiment of racial and sexual difference as natural, biologically grounded entities rendered black patients as lesser or even non-individuals, implicitly differentiated from the white norm. Scientific racism provided a powerful means of establishing in the colony that human beings were to be ordered in a hierarchy of races and sexes. It also justified the segregation of black and white patients.

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<sup>114</sup> See H. Deacon, 'Madness, Race and Moral Treatment: Robben Island Lunatic Asylum, Cape Colony, 1846-1890', *History of Psychiatry*, vii (1996), pp.287-297.

<sup>115</sup> L. White, 'Separating the Men From the Boys: Constructions of Gender, Sexuality and Terrorism in Central Kenya, 1939-1959', *International Journal of African Historical Studies*, 23, 1 (1990), pp.1-25.

### CHAPTER THREE

#### PSYCHIATRY ON THE COLONIAL BORDER: THE SEARCH FOR THE CAUSES OF INSANITY IN THE EASTERN CAPE

This chapter traces some of the ways in which psychiatry established itself as a source of scientific authority in the Eastern Cape before Union in 1910 and is divided into two parts. Firstly it details the search to identify and explain the major physical and moral causes of mental illness and mental retardation at Grahamstown and Fort Beaufort asylums. Examination of the physical causes will include a discussion on the relationship between the science of human heredity, degeneration theories and mental illness. Tied to this focus on heredity is an examination of the issue of alcoholism as a cause of mental illness particularly in men, as well as the role of cousin marriages and inbreeding in the inheritance of insanity in children. The chapter then focuses on women and discusses the notion of female reproductive cycles as underlying biological causes of female insanity and investigates the role of women as bearers of genetic inheritance. This section ends with a discussion on what were known as 'moral' or psychological causes of insanity.

The second part of the chapter traces the elaboration of an early mental hygiene movement at Grahamstown asylum that was based on the science of eugenics. It discusses the shifts in psychiatric discourse that occurred after 1905 in which the focus moved away from curing mental illness to developing preventative strategies in a bid to contain insanity in the white population. It provides an outline of the scientific principles of the eugenics movement and discusses the relevance of heredity, selective breeding, marriage restrictions and education in the reproduction of a healthy colonial society. Finally it considers the role of prohibition and alcohol legislation in the prevention of mental illness. This focus on prevention and eugenics located within the specific context of the Eastern Cape

asylums adds a new dimension to the substantial body of work produced by Swartz on the role of science and intellectual ideas that shaped colonial psychiatry in the Cape colony before union.<sup>1</sup>

In December 1893, a fifty eight year old Dutch-speaking widow named Maria Magdalena van Loggenburg was admitted into Grahamstown Asylum. She was described as a poorly educated woman with no occupation, her first attack of insanity occurring twenty years previously. Certified insane by two district surgeons, she had been living as a vagrant eking out an existence on the streets of Uitenhage. Clearly no longer able to care for herself she arrived at the asylum in a pitiful condition 'so dirty and neglected' that it was difficult for staff to classify her as 'white or bastard'. Eventually she was classified as 'poor white'. Described in her case notes as 'mentally quite demented, her mental flow is completely obliterated' she was diagnosed as suffering from secondary dementia, one of the most serious and intractable forms of mental illness.<sup>2</sup> A cluster of external and visible signs and symptoms relating to this pathological state were seen to indicate some unspecified internal disorder. These observed symptoms included her inability to communicate, disturbances in her thought patterns, defective habits and extreme behaviour which was regarded as both inappropriate and purposeless.<sup>3</sup> She experienced auditory hallucinations hearing voices from the devil and delusions about snakes inside her head.

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<sup>1</sup> See S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No. 3 (September, 1995), pp. 399-415; S. Swartz, 'Changing Diagnosis in Valkenberg Asylum, Cape Colony, 1891-1920: A Longitudinal View', *History of Psychiatry*, vi (1995), pp. 431-451; S. Swartz, 'Colonising the Insane: Causes of Insanity, 1890-1920', *History of the Human Sciences*, Vol. 8, No. 4 (1995), pp.39-57; S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920', unpublished Ph.D. Thesis (University of Cape Town, 1996).

<sup>2</sup> CA. HGM, Casebook 17, No. 1049, p.225.

<sup>3</sup> The term dementia in its nineteenth century sense described various symptoms such as 'confusion of thought, failing memory, dirty habits, purposeless activity, various absurd hallucinations and delusions and odd acts'. See E. Hare, 'The Two Manias: A Study of the Evolution of the Modern Concept of Mania', *British Journal of Psychiatry*, Vol. 138 (1981), pp.89-90.

'Unmanageable and wild at various times', she was also described as 'constantly talking incoherently to herself using foul language', 'dirty in habits', 'eats foods with hands, a nearly blind old woman' who sat 'crouching on the ground in a heap with her dress over her head resisting interference'.<sup>4</sup>

Some four months later in April of the following year, the assistant medical officer at the asylum changed the initial diagnosis of secondary dementia to idiocy.<sup>5</sup> He observed that she had a 'stupid expression' and was unable to speak rationally or distinctly, spending her days crouching on the floor spitting constantly. While these dementia symptoms had remained largely unchanged over the preceding months, he now noted for the first time that she had a deformed, small, narrow head, a low forehead and sallow complexion, physical defects and stigmata that indicated to him permanent mental enfeeblement and degeneration associated with a diagnosis of idiocy.<sup>6</sup> The idiocy diagnosis was made on the basis of her lack of intellectual functioning as well as on a physical deformity, her small microcephalic head. This diagnosis followed the trend in medical circles for physical deformities to be regarded as defining features of idiocy.<sup>7</sup>

With an established family history of insanity spanning three generations, insanity had been previously diagnosed in her father and subsequently in her son, the underlying

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<sup>4</sup> CA. HGM, Casebook 17, No. 1049, p.225.

<sup>5</sup> Throughout the period under review in psychiatric terminology mentally handicapped people were classified as idiots, imbeciles, defectives, feeble-minded, and morons, a group of mental illnesses that were clearly differentiated from functional mental illness such as mania and melancholia. These terms have no current clinical status. Their use in this thesis is purely historical and not intended to cause offence. See N. Anderson and A. Langa, 'The Development of Institutional Care for 'Idiots and Imbeciles in Scotland'', *History of Psychiatry*, Vol. 8, Part 2, No. 30 (June, 1997), pp. 244-245.

<sup>6</sup> CA. HGM, Casebook 17, No. 1049, p. 225.

<sup>7</sup> E. Miller, 'Mental Retardation: Clinical Section' in G. Berrios and R. Porter (eds.), *The History of clinical Psychiatry: The Origins and History of Psychiatric Disorders* (London, 1995), pp. 213-215.

aetiology or cause of Maria's idiocy and intellectual impairment was given as hereditary degeneration. According to a well-defined set of nineteenth century assumptions, mental illness could run in families and any member could inherit a 'predisposition' or weakness towards the disease. As in Maria's case, 'faulty breeding', weak traits or flaws could be passed down through generational lines manifesting themselves in any number of forms of insanity and with increasing severity.<sup>8</sup> The source of Maria's idiocy and her progressive deterioration to complete physical and mental degeneration was rooted in her own inherited biological deficiency. The diagnosis of idiocy combined with an aetiology based on heredity pre-disposition automatically constituted a prognosis of incurable mental infirmity.

Maria van Loggenburgh's case illustrates the ways in which psychiatry routinely theorised, conceptualised and understood mental illness through an interpretative model drawn from general medicine.<sup>9</sup> Using a methodology based on the case history format, doctors at Grahamstown asylum diagnosed the form of Maria's mental pathology by observing and describing a definite symptom complex relating to her behaviour and external appearance which were all seen to be useful indicators of some specific internal disorder. Through this process they ascertained an underlying aetiology and suggested a possible prognosis. Diagnostic activity based on this medical model fulfilled a useful clinical function. In a systematic and structured manner, doctors were able to detect authoritatively and confirm the presence of disease by classifying and naming Maria's

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<sup>8</sup> Taint, flaw and degeneration were all terms derived from the science of heredity and used in psychiatric classification. See C. Rosenberg, 'The Bitter Fruit: Heredity, Disease and Social Thought' in C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1997), pp. 42-45.

<sup>9</sup> P. Conrad and J.W. Schneider (eds.), *Deviance and Medicalisation: From Badness To Sickness* (St. Louis, 1980), pp.43-48.

mental state as pathological.<sup>10</sup> Psychiatry derived its power and legitimacy to provide the best understanding of mental illness from this medical model and in its claims to be empirically grounded in objective, scientific principles that were universally applicable.<sup>11</sup> Strategically this medical model helped position psychiatry within mainstream western medicine legitimating and consolidating colonial doctors professional claims to specific expertise and authority.<sup>12</sup>

Despite claiming a privileged relationship to a biomedical model of disease that could mediate human suffering, in clinical practice psychiatry remained essentially a descriptive discipline and therefore a function of semantic organisation.<sup>13</sup> Insanity ascriptions depended on the collection of clinical data that required recognition and naming of behavioural forms. While not diminishing the reality of Maria's severe mental state that led to her disability and dependency, it is important to note that the meanings attached to mental disease while claiming to be psychiatric fact were far more ambiguous. Classification was also a process by which she was stigmatised, degraded and marginalised. What in fact was produced within the rhetorical structure of her case history notes were denigrating and demeaning images of a deranged and disabled old woman, a pathological other who had regressed to a sub human or animal-like state that automatically disqualified her from any sort of social acceptance.<sup>14</sup> The normalising gaze

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<sup>10</sup> See G. E. Berrios, 'Historiography of Mental Systems and Diseases' in the *History of Psychiatry*, v, (1994), pp.175-190; S. Swartz, 'Changing Diagnosis in Valkenberg Asylum, Cape Colony, 1891-1920: A Longitudinal View' in the *History of Psychiatry*, vi (1995), pp.449-451.

<sup>11</sup> D. Foster, 'Introduction', in S. Lea and D. Foster (eds.), *Perspectives on Mental Handicap in South Africa* (Durban, 1990), pp.8-10.

<sup>12</sup> N. Rose, *Inventing Ourselves* (Cambridge, 1996), p.48.

<sup>13</sup> G.E. Berrios, 'Historiography of Mental Systems and Diseases' in the *History of Psychiatry*, v (1994), p.179.

<sup>14</sup> See S. Lea, 'The Psycho-Social Aspects of Mental Handicap', in S. Lea and D. Foster (eds.), *Perspectives on Mental Handicap in South Africa* (Durban, 1990), p.207.

of biomedicine defined Maria's identity in terms of bodily characteristics and aesthetic criteria constructing her as ugly, old, deformed, dirty and diseased.<sup>15</sup> Risk factors such as old age, neglect, poverty, lack of education, deprivation and the loss of family and community support networks were largely ignored. Any kind of personal identity that Maria might lay claim to was effectively obscured by being labelled a 'dement' and subsequently an idiot, both regarded as extreme types of deviant groups.<sup>16</sup>

Moreover, Maria was treated as an outcast as much for her mental condition as for her 'doubtful' racial credentials. Initially her so-called 'bastard' or mixed blood status and then at a later stage her poor white underclass status.<sup>17</sup> Whites in the colony were not a homogeneous group and tensions and divisions existed along class and ethnic lines between the two main white groups who were English and Afrikaans speaking.<sup>18</sup> Given that there was a general belief in white racial superiority, mental illness in whites in the colony contained a contradiction for it implied the risk of regression, a loss of civilised standards of behaviour and a devolution of power so feared by settler elites.<sup>19</sup> For the deranged lunatic personified by Maria represented the frightening reality of loss of

<sup>15</sup> See I. M. Young, 'The Scaling of Bodies and the Politics of Identity', in L. McDowell and J. Sharpe (eds.), *Space, Gender, Knowledge* (London, 1997), pp.220-224; S. Gilman, *Health and Illness* (London, 1995), p.119.

<sup>16</sup> S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1985), p.23. For a discussion on the effects of psychiatric labelling see T. J. Scheff, 'The Labelling Theory of Mental Illness' in T. J. Scheff (ed.), *Labelling Madness* (New Jersey), 1975, pp.21-34.

<sup>17</sup> V. Bickford Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town* (Johannesburg, 1995), p.7.

<sup>18</sup> For a discussion on poor whites see C. Bundy, 'Vagabond Hollanders and Runaway Englishmen: White Poverty in the Cape before Poor Whiteism', in W. Beinart and C. Bundy (eds.), *Putting a Plough to the Ground* (Johannesburg, 1986), pp.101-128; S. Dubow, 'Mental Testing and the Understanding of Race in Twentieth-Century South Africa', in T. Meade and M. Walker (eds.), *Science, Medicine and Cultural Imperialism*, (London, 1991), p.159; S. Dubow, *Scientific Racism In Modern South Africa* (Cambridge, 1995), pp.167-170; S. Klausen, ' "For the Sake of the Race": Eugenic Discourses of Feeble-mindedness and Motherhood in the South African Medical Record, 1903-1926', *Journal of Southern African Studies*, Vol. 23, No. 1 ( March, 1997), pp.29-35.

<sup>19</sup> A. L. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (London, 1995), p.75.

physical and moral control over the self, the very antithesis of control and reason that defined the nineteenth century self.<sup>20</sup> White mental illness in the colony carried with it not only the stigma of degeneration and loss of moral control associations of disease in the metropole, but the threat of 'going native' and sinking into the same uncivilised state as the colonised.<sup>21</sup> The yoking of heredity, idiocy and family degeneration to a poor white identity in Maria's case inferred that this white underclass was a threatening source of pathology that could only produce degenerate and unstable people.<sup>22</sup> Inferior and unfit whites such as Maria merely reinforced perceptions of the vulnerability of whites in the colony, undermining the fitness of the white race as a whole and threatening colonial hierarchies of rule and order. The continued progress of colonial society could not be sustained unless the unfit were segregated and locked up.

Progressively deteriorating both physically and mentally, Maria was seen by staff members to be a difficult and time consuming patient who needed to be fed, dressed and kept clean like a child.<sup>23</sup> Cared for at the taxpayers expense, unproductive and a non-paying patient, she was perceived as a burden to the system. She formed part of the growing indigent chronic insane population at Grahamstown asylum resented for filling up the wards and preventing more medically hopeful and interesting cases from being admitted and intensively treated. Given that her idiocy was understood as an immutable genetic disorder

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<sup>20</sup> S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness* (Ithaca, 1985), p.23.

<sup>21</sup> S. Swartz, 'Colonizing the Insane: Causes of Insanity in the Cape, 1891-1920', *History of the Human Sciences*, Vol. 8, No. 4 (1995), pp.39-57.

<sup>22</sup> N.L Stepan, *The Hour of Eugenics: Race, Gender, and Nation in Latin America* (Ithaca, 1991), p.114.

<sup>23</sup> Insanity in the elderly, classified as senile dementia was a recognised category but these links were not specifically made in Maria's case history notes. In this instance dementia was linked to mental handicap. See G.E. Berrois, 'Dementia: Clinical Section', in G.E. Berrios and R. Porter, *The History of Clinical Psychiatry: The Origins and History of Psychiatric Disorders* (London, 1995), pp. 34-38.

it was self evident that it was futile and misplaced to waste time and money on expensive treatment.<sup>24</sup>

Following the change in diagnosis to idiocy Maria was immediately transferred to Port Alfred asylum, a custodial or 'minding' institution that only accepted social welfare cases of all races by transfer from the four other colonial asylums. These were for the most part all cases of severe and permanent mental and physical handicap who were not considered to be dangerous or suicidal. Mentally handicapped people had such a marginal status in the colony that Port Alfred asylum did not segregate patients according to a racial classification.<sup>25</sup> The asylum provided very little in the way of medical treatment. There was no full time psychiatrist. The local district surgeon made weekly visits and the day to day management of this asylum was left to a lay superintendent and untrained nursing aides. Given her hopeless medical condition and low status in life, Maria received only the most basic care until her death.<sup>26</sup>

Maria's case is indicative of the limits and boundaries of both medical and state interests towards the indigent institutionalised insane who were regarded as socially redundant and useless people and as financial liabilities. Port Alfred asylum was considered to be quite adequate in the face of the alternative prospect of these asocial and unproductive 'types' becoming increasingly visible on the streets of colonial towns. Psychiatric classification not only produced its own objects providing the links between medicine and illness but

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<sup>24</sup> G. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge, Massachusetts, 1994), p.160.

<sup>25</sup> Refer to Chapter Five for a discussion on attitudes towards the mentally handicapped and racial segregation.

<sup>26</sup> CA HGM, Casebook 17, No. 1049., p. 225.

also helped to encode and establish links to practical administrative initiatives at Grahamstown asylum. The pessimistic and negative discourse about the essential hopelessness of Maria's condition created important links between psychiatric recidivism and a cult of incarceration that legitimated the segregation of people living on the margins of society and provided a useful means for the hospital and colonial doctors to transfer patients such as Maria from Grahamstown to Port Alfred.

Psychiatric discourses despite claims to be scientific and objective were embedded in a mix of cultural bias and social relations that enmeshed its objects, such as Maria, in regimes of 'power/knowledge'.<sup>27</sup> While Maria was accorded the status of a patient at the same time the contempt for her emanating from within the medical profession itself is clearly evident. The prejudices demonstrated towards her severe mental handicap and her poverty, old age, feminine gender and ethnic identity as an Afrikaner were part of the self-serving interests of doctors who created and ran the system. Maria was marked off as an inferior and worthless person through a language that asserted clear and hard lines of difference and distance producing a stigmatised image of the pathological that fundamentally deviated from the healthy and the normal. Maria was faced with the very real consequences of these arbitrary social constructions about the meanings of health and sickness as she was rejected and placed outside of social life and effectively relegated to the margins of psychiatric care in the colony.<sup>28</sup>

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<sup>27</sup> See M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (London, 1991); *The Birth of a Clinic: An Archeology of Medical Perception* (London, 1973); *Discipline and Punish: The Birth of the Prison* (London, 1991); G. Burchell, C. Gordon and P. Miller (eds.), *The Foucault Effect: Studies in Governmental Rationality* (Chicago, 1991).

<sup>28</sup> M. Foucault, *Mental Illness and Psychology* (New York, 1976), p. 63.

These discursive practices unproblematically sanctioned as valid psychiatric knowledge provided the focus for social regulation and control by setting limits and exclusions.<sup>29</sup> The relationship between whiteness and mental illness in the colony was a highly charged terrain that required not only treatment but surveillance, careful monitoring and segregation of the unfit such as Maria. As demonstrated in the previous chapter, increasingly aggressive attempts to classify and segregate black and white bodies in Eastern Cape asylums after 1890 were supported by scientific arguments about the arrested intellectual development of adult blacks who were at a lower stage of evolution and civilisation in comparison to whites who were perceived to be more advanced. From the perspective of professional psychiatrists mental illness in the colonised population of the Eastern Cape Colony was for the most part to be explained, managed and controlled by reducing suffering to innate biological differences elaborated through evolutionary theories and a crude scientific racism. The result was that the inferiority of black people was determined by the selection of 'scientific evidence' from a body of suspect data that could support almost any racial assertion.

The elaboration of a distinctive colonial psychiatry by medical doctors such as Greenlees was inherently a political rather than a scientific act as the needs of the black insane were effectively marginalised and downgraded to control or disinterest and neglect. Significantly, the colonial construction of white mental illness was always defined over and against the construction of colonial identity. In the context of the Eastern Cape at the turn of the century professional psychiatrists' concerns for the white insane were tied to colonial anxieties about the relationship between the health of the white population and

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<sup>29</sup> K. Danziger, *Constructing the Subject: Historical Origins of Psychological Research* (Cambridge, 1990), pp.30-35.

the health of the colony. A healthy and fit population was seen as essential to material wealth and progress. In order for settler society to retain status and self respect with regard to the mentally ill, it was imperative to safeguard against the threat of degeneracy that was contained in all forms of mental illness. Psychiatric medicine practiced in the Cape colony was mainly concerned with the treatment and cure of mental illness in the white settler population and significantly with deep-seated concerns to prevent or at least contain mental degeneration within that community. The Eastern Cape colony at the end of the nineteenth century was a complex society riddled with the 'tensions of Empire.'<sup>30</sup> It was a society coming to terms with the social, political and economic processes of colonial conquest and modernisation. As Stoler points out, colonial communities of the early twentieth century were rethinking the expression of authority and the assertion of a 'distinct colonial morality' in such a way that 'homo europeaus' was equated with 'superior health, wealth and education' which this thesis demonstrates, incorporated mental health and genetic make-up.<sup>31</sup>

Before 1890 psychiatric knowledge in the Cape colony lacked a clear conceptual basis and was not widely disseminated since it was confined largely to annual reports.<sup>32</sup> The appointments of Dodds and Greenlees in 1890 stimulated the growth of a more sophisticated professional discourse on the nature and aetiology of mental illness. The institutional expansion of asylums such as the Grahamstown asylum and to a lesser extent Fort Beaufort in the 1890s provided both context and opportunity for the consolidation of

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<sup>30</sup> A. L. Stoler, 'Carnal Knowledge and Imperial Power: Gender Race and Morality in Colonial Asia', in M. di Leonardo (ed.), *Gender at the Crossroads of Knowledge* (Berkeley, 1991), pp.74-75.

<sup>31</sup> A.L. Stoler, 'Carnal Knowledge and Imperial Power: Gender, Race and Morality in Colonial Asia', in M. di Leonardo (ed.), *Gender at the Crossroads of Knowledge* (Berkeley, 1991), p.74.

<sup>32</sup> H. Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910', unpublished Ph.D. Thesis (Cambridge University, 1994), see Chapter Five.

scientific knowledge about mental illness in the colony. Between 1890 and 1904 nearly two thousand patients were treated at Grahamstown asylum providing a wealth of material for collecting and organising knowledge and standardising psycho-medical practice in the colony.<sup>33</sup> Dodds, in his capacity as Inspector of Asylums introduced an extensive classificatory system that was based on the same categories used by the British Medico-Psychological Association.

Dodds' work was reinforced by that of Greenlees. In his efforts to investigate the aetiology of mental illness at Grahamstown asylum, Greenlees presented an extensive range of quantified evidence that was based on statistical analysis.<sup>34</sup> He disseminated a substantial body of psychiatric literature through annual reports, articles in local and overseas journals and presentations at South African medical congresses. Statistical methods were useful to psychiatrists because they provided a new set of parameters that not only made it seem possible to measure mental illness but also introduced a sense of clarity and order to the basic concepts of psychopathology.<sup>35</sup> Furthermore empirical data implied that there was no reason to doubt their universal application. However biometrics or statistics was a relatively new and unsophisticated science and statistical measurements at Grahamstown asylum involved no more than taking a base average of a very small patient population. Greenlees frequently used these calculations to promote his own standards of 'truth' and to generalise his findings to include the colonial population as a whole.<sup>36</sup> The search for the

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<sup>33</sup> T. D. Greenlees, 'A Statistical Contribution to the Pathology of Insanity', *Journal of Mental Science*, Vol. 48 (1902) pp. 645-666; T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11, (1905), pp.217-224.

<sup>34</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamtown Asylum', *South African Medical Record*, Vol. 3, No.11 (1905), p. 223.

<sup>35</sup> R.A. Soloway, *Demography and Degeneration: Eugenics and the Declining Birth Rate in Twentieth Century Britain* (Chapel Hill), 1990, p.28.

<sup>36</sup> C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1997), p. 57.

underlying causes of insanity should also be seen as part of an internal process of discipline within the local psychiatric profession for securing conceptual stabilisation and consolidation as doctors attempted to build public support and gain intellectual legitimacy both in the colony and overseas.<sup>37</sup>

The discourse of 'recovery and cure' tied to reforms dominated the thinking of Greenlees and his colleagues in the period 1890-1905 as they continued to promote themselves and their own professional interests. The 'curative' medicalised discourse centred on issues of early diagnosis and treatment by a specialist physician in a suitable medical environment that closely resembled a hospital.

The question arises, 'when should a patient be sent to an asylum?' It is a great mistake, but one often made by doctors, to keep their patients at home until some serious symptom arises; until, in fact the patient becomes 'dangerous to himself or others'. They seem to forget that an asylum is a hospital and only recognise it as a gaol. Many now chronic cases of insanity could have been arrested and cured had they been taken in time and the proper treatment applied. Instead, they are only sent to the asylum when, by improper treatment their cases are made utterly hopeless, and this by the ignorant general practitioner, who perhaps had never seen a case of mental disease before!<sup>38</sup>

The very low recovery rates at all three Eastern Cape asylums however confirmed that these were overstated claims and high rates of cures were not realised in daily practice. In fact in the Eastern Cape asylums there was a very poor record of recoveries and chronic mental illness was a serious problem. Statistics for Grahamstown asylum revealed that over a period of fifteen years between 1890 and 1904, the average recovery rate was 33%, a lower recovery rate than metropolitan English rates which were reported to be around

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<sup>37</sup> W.F. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness*, Vol. 1 (London, 1985), pp. 16-17.

<sup>38</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (October, 1903), p.122.

37%. Patients who had been discharged from the asylum either as 'relieved' or 'unimproved' were included in these statistics as 'recovered', so in fact the percentage of patients who did not recover was probably closer to 70%. The recovery rates at Fort Beaufort and Port Alfred asylums were a dismal 5% and 2% respectively but these were considered to be acceptable rates given the large numbers of incurable chronic patients resident at both asylums.<sup>39</sup> Colonial doctors and administrators such as Greenlees and Conry were left to cope with ever increasing numbers of chronic patients at a time when according to Greenlees mental disease was steadily increasing in the colony putting even more pressure on the existing capacity of the asylums.<sup>40</sup> In the fifteen years since Dodds and Greenlees had arrived in the colony government expenditure on mental institutions had exceeded 340 000 pounds yet the numbers of 'unrecovered' cases continued to increase.<sup>41</sup>

The search for the underlying causes of mental disease spoke to a very real sense of crisis within the Eastern Cape institutions and within the local psychiatric profession itself. For Greenlees finding the origins and causes of mental disease was a fundamental aspect of his work in mental medicine. It was believed that just as in physical disease 'to know the

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<sup>39</sup> T. D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), p.223.

<sup>40</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), p.218. Andrew Scull argues that in England steadily increasing rates of institutional populations were more a result of new asylum construction than any increase in mental disease. This seems to be the case at Grahamstown asylum where the number of beds had doubled in fifteen years from 171 to 341. There is little evidence to suggest that insanity was increasing in the colony as other factors such as changes in the law facilitating admissions and the increasing willingness of families to commit their relations to asylums also played a part. The discourse on increasing rates of insanity should rather be viewed in the context of Dodds, Greenlees and Conry continually lobbying for increased government subsidies. See A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain* (New Haven, 1993), pp.363-370.

<sup>41</sup>T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), p.223.

cause of mental disease is half the battle won in curing or preventing it'.<sup>42</sup> According to him, nervous and mental diseases in the colony were the result of three 'great' factors. These were 'hereditary pre-disposition to mental instability, intemperance caused by the use of alcoholic stimulants and 'inbreeding' through consanguineous marriages all conducing to the degeneracy of the (white) race'.<sup>43</sup> Of the three pre-disposing factors, Greenlees clearly identified heredity as the predominant causal explanation for mental disease in the white population of the colony claiming that over a third of all admissions over a period of fifteen years exhibited an identifiable 'hereditary taint'. Heredity as an underlying aetiology of insanity was more prevalent in the colony generally than in England and affected more women than men. His statistics compiled for Grahamstown asylum revealed that heredity was ascertained as a pre-disposing cause in 43% of white women and 24% of white males. According to Greenlees heredity was of such serious proportions that even Africans were not entirely free from it. His racially corresponding statistics were 6% for black men and 12% for black women.<sup>44</sup>

Greenlees argued that insanity was an irreversible brain condition and a product of cumulative hereditary degeneration that was initially caused in 'great measure by our modern form of civilisation and the penalty we have to pay for infringing the simple laws of nature'.<sup>45</sup> Mental instability tended to run in families and was initially precipitated in the first generation by a wide range of social and environmental pressures such as the

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<sup>42</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), pp.219, 223.

<sup>43</sup> T. D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (January, 1907), p. 20.

<sup>44</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905),p. 220.

<sup>45</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), p. 223.

pathogenic environment of urban slums, through excess and over-indulgence, through substance abuse, through physical diseases such as tuberculosis and 'through mental worry and anxiety in the struggle for existence in the cities'. These exogenous factors could all act as triggers or exciting causes adversely affecting and weakening the brain and nervous system and resulting in mental instability. Acquired 'traits' or 'taints' were subsequently transmitted through defective heredity from parents to their progeny as pre-disposing genetic causes.

Both Dodds and Greenlees identified heredity as a predominant pre-disposing cause of insanity in the early years of their superintendencies. In the early 1900s, Greenlees identified a second clinical configuration that defined a new large 'grey' area known as neurosis, a precursor state of mild mental disturbance out of which the more serious psychotic states of mental derangement might develop.<sup>46</sup> According to one of the 'great laws of heredity' it was not the disease itself that descended to the child but rather that the child inherited a 'neurotic diathesis' or constitutional pre-disposition or tendency to problems of the nervous system.<sup>47</sup> Greenlees argued that the development of the neurotic was the natural outcome of 'highly specialised modes of living'. The brain and nervous system in a person of neurotic or anxious temperament rendered him too unstable and delicate for his surroundings pre-disposing him to disease. Greenlees identified two

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<sup>46</sup> Neuroses were considered in this period in a narrow sense as emotional disorders of the autonomic nervous system. See G.E. Berrios, 'Obsessional Disorders during the Nineteenth Century: Terminological and Classificatory Issues', in W. F. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness* (London, 1985), p.172; E. Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London, 1987), p.105; J. Goldstein, 'Medicine in Society: Psychiatry' in W.F. Bynum and R. Porter (eds.), *The Companion Encyclopedia of the History of Medicine*, Vol. 2 (Cambridge, 1992), pp.1363-1366; C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1997), pp.43-45; E. Miller, 'Mental Retardation: Clinical Section', in G.E. Berrios and R. Porter (eds.), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London, 1995), pp.215-218.

<sup>47</sup> T.D. Greenlees, 'Medical Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (October, 1903), p.123.

neurotic types: 'Those who react very rapidly and delicately to their surroundings amongst whom we find geniuses and those who are unstable without being brilliant who react destructively to their surroundings.'<sup>48</sup> A family with a hereditary pre-disposition to neurosis could produce children of high intellectual development alongside children with 'degenerate stagnation' such as mutism, deafness, imbecility or idiocy.<sup>49</sup> For example an undeveloped brain associated with the neurotic tendency might result in idiocy.<sup>50</sup> Idiocy could then skip a generation, appearing in descendants again as one of the neuroses such as mental instability.

Intellectual ideas seeping into the Eastern Cape colony linking mental illness to an aetiology of 'hereditary predisposition', 'neurotic diathesis' and family 'degeneration' reflected similar themes and trends present in scientific circles in Europe, Britain and America.<sup>51</sup> This aetiology formed part of a conventional model of psychopathology that drew on the new science of human heredity and genetics. It assumed a substantial degree of inheritance of acquired characteristics as an essential causal mechanism that could account for a wide variety of social ills.<sup>52</sup> These ranged from problems relating to crime and poverty to chronic medical conditions such as diabetes, heart disease and tuberculosis.<sup>53</sup> The idea that certain types of mental illness could be traced through family histories and pedigrees to an hereditary diseased constitution was readily embraced by

<sup>48</sup> For a discussion on the links to genius and inheritance see D. Kevles, *In the Name Of Eugenics: Genetics and the Uses of Human Heredity* (New York, 1985), Chapter One.

<sup>49</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5. No. 2 (1907), p.17.

<sup>50</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (1903), p.124.

<sup>51</sup> C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1997), pp.42-44.

<sup>52</sup> Influenced by French degenerist theorists such as Morel, Francis Galton, a cousin of Darwin, was involved in pioneering work in establishing the relationship between the science of heredity, human ability and statistics. See D.B. Paul, *Controlling Human Heredity: 1865 to the Present* (New Jersey, 1995), pp. 3-5.

<sup>53</sup> N. L. Stepan, 'The Hour of Eugenics': *Race, Gender and Nation in Latin America* (Ithaca, 1991), p.22.

mainstream psychiatry in its search to explain and find causes for mental diseases.<sup>54</sup> Human heredity, combined with vaguely defined processes of biological and social degeneration and decline across generations, also fitted in with the fashionable nineteenth century theories of evolution and devolution. Mental disorders were conceptualised in Social Darwinist terms of the evolution and dissolution of nervous hierarchies.<sup>55</sup> These ideas all constellated into the discipline of 'evolutionary' psychiatry which dominated the English scene, marking an important intellectual shift from an earlier largely speculative philosophical tradition to a biological and scientific model of human behaviour which was to last from the 1870s until the First World War.<sup>56</sup>

Psychiatric trends of the day based on heredity, degeneration and devolution proved to be useful to the more specific interests of a psychiatric profession that was still seeking to establish its claims and prerogatives in the colony. For doctors such as Greenlees, heredity provided a pragmatic means of explaining the greater susceptibility of civilised 'man' to mental illness while at the same time providing coherent explanations for the high rates of non-recovery at Grahamstown asylum. For inheritance of acquired characteristics assumed an innate and irreversible biological disposition to disease with individual experience and social environment becoming less important. Heredity implied a deterministic focus on nature rather than with an 'interactionist' relationship with nature and used biology to construct a rigid 'theory of limits' where faults were identified within

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<sup>54</sup> See E. Showalter, *The Female Malady: Woman, Madness and English Culture, 1830-1980* (London, 1987), pp.104-120.

<sup>55</sup> D. Pick, *Faces of Degeneration: A European Disorder, c1848-c1918* (Cambridge, 1989), p21.

<sup>56</sup> I. Dowbiggen, 'Degeneration and Hereditarianism in French Mental Medicine' in W. F. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, Vol. 1 (London, 1985), pp.190-193.

the patients themselves.<sup>57</sup> This model of biological determinism had its own political uses for it provided a useful tool to explain both the racial and mental deterioration of 'unfit' whites such as Maria van Loggenburg by locating the cause of disease in her own inherited biological inadequacies. This enabled Greenlees to 'blame the victim' while at the same time protecting himself against any accusations of professional incompetence in failing to cure the disease.

Although heredity as a pre-dominant cause of insanity seemed to have been generally accepted in medical circles as a fundamental truth, it should be pointed out that at this time human heredity was an over-worked and ill-defined concept that was often used in unsophisticated ways to advance simplistic notions of genetic inheritance.<sup>58</sup> Virtually nothing was known at this stage about the complex nature of genetic diseases and scientists were never able to identify the specific mechanisms involved in the intergenerational transfer of disease.<sup>59</sup> In order to ascribe heredity as the cause of mental illness, Greenlees needed to have some information about the personal and family histories of the patients that he dealt with. This information was initially obtained from the medical certificates which accompanied each patient on admission into a colonial asylum. The legal process of certifying the insane demanded that two medical doctors, usually district surgeons or general practitioners, provided the certifying magistrate with the

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<sup>57</sup> For a discussion on the debates about the relative influences of nature and nurture see S.J.Gould, *The Flamingo's Smile: Reflections in Natural History* (New York, 1985), pp.319-332, who argues for an interactionist approach between varied environments and genetics rather than a rigid biological determinism.

<sup>58</sup> E. Fox Keller, 'Nature, Nurture and the Human Genome Project' in D. Kevles and L. Hood (ed.) *The Code of Codes: Scientific and Social Issues in the Human Genome Project* (Cambridge, Massachusetts), 1992, pp.288-290.

<sup>59</sup> For example imbecility in a child, Laura Adelaide Jones at Grahamstown Asylum was reported by Greenlees to have been caused by a fall, but the photograph contained in her case notes clearly indicates that she suffered from Downes syndrome, a condition that was not recognised at the time as an inherited genetic disorder. See CA. HGM, Casebook 24, Reg. No. 28.

medical history of the insane person. However, both Greenlees and Conry at Fort Beaufort asylum complained that this information was frequently so unreliable, incorrect and even occasionally completely misleading that in many cases no practical use could be made of it.<sup>60</sup> A glaring lacuna in the case of Greenlees' work was the absence of family histories for mental patients at the Fort Beaufort asylum. Despite this, heredity and the borderland states of latent brain disease identified as neuroses formed two key elements in a broadly defined and flexible aetiological model that strengthened and endorsed Greenlees' claims to social authority as an expert on the laws of genetics and inherited mental disease. Medical practitioners who promoted the link between heredity and mental illness were at pains to discredit alternate explanations. Launching a direct attack on his medical colleagues, Greenlees maintained that absurd ideas and superstitions regarding mental illness often appeared on medical certificates. In one case at Grahamstown asylum, the cause of insanity was described as a 'loss of nerves' a pathological state that according to him was both unscientific and incorrect as no such classification existed.<sup>61</sup>

Collecting family histories at the Grahamstown asylum was more successful, if flawed. At Grahamstown asylum Greenlees relied on relatives and family members to provide him with a second source of information about the backgrounds of his patients. He warned however that physicians should be very guarded in accepting this information at face value. In cases where heredity was suspected as a probable cause of insanity it was quite common for relatives, biased by ignorance or feelings of shame, to deny any knowledge of a family history of mental disease. While mothers often ascribed idiocy in their children to

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<sup>60</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), p. 220.

<sup>61</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), pp.219-220.

falls in childhood he had found that not infrequently a 'pre-disposing neurotic diathesis' existed in the child which the mother was anxious to hide.<sup>62</sup> If the physician wanted to 'get at the truth' about the underlying causes of mental disease the only method available to him was to obtain reliable information through 'judicious examination' and by asking 'leading and sometimes misleading questions' which only a trained specialist in mental disorders was qualified to do.<sup>63</sup>

With this emphasis on individual case histories, Greenlees was able to demonstrate the supposed links between heredity and mental illness through a simple model based on genealogy, kinship and family lineages.<sup>64</sup> This construction worked very well as a general technique for understanding that 'like engendered like' so that it became less important to question the role of social factors or environment in the causation of insanity.<sup>65</sup> But collecting personalised information concerning family genealogies was a time-consuming task that was almost exclusively confined to white patients. Most black patients were admitted into Grahamstown asylum through the prisons and the courts and then transferred to Fort Beaufort or Port Alfred if their condition was chronic. Incomplete medical certificates affected black patients particularly adversely. In his annual report of 1898 Greenlees noted that difficulty seemed to exist in cases sent to Grahamstown, especially with regard to African patients. He urged the magistrates to 'ascertain this information in every case so far as is practicable'.<sup>66</sup> Conry at Fort Beaufort admitted that finding the

<sup>62</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (1907), p. 20.

<sup>63</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), p.220.

<sup>64</sup> N. L. Stepan, *The Hour of Eugenics: Race, Gender and Nation in Latin America* (London, 1991), p.22.

<sup>65</sup> P. Mazumdar, *Eugenics, Human Genetics and Human Failings: The Eugenic Society, Its Sources and Its Critics in Britain* (London, 1992), p.5.

<sup>66</sup> Annual Report, Grahamstown Asylum: G28-1898, p.3.

causes of mental disease in his black patients was more a matter of guesswork than anything else. In the majority of cases the medical certificates sent with these patients to Fort Beaufort asylum contained such meagre information regarding their previous 'habits and circumstances' that it was almost impossible to assign any cause based on definite facts.<sup>67</sup>

While Greenlees conceded in 1905 that even Africans were affected by heredity he was using this in the context of emphasizing how serious and pervasive heredity had become as a predisposing cause in the colony.<sup>68</sup> Content to fall back on blaming the flawed legal process for the lack of personal information about his black patients he noted that very little was known of the neuroses as they specially affect the 'savages'.<sup>69</sup> Although there were interpreters at Grahamstown asylum it is abundantly clear from the case history notes that very little effort was made by asylum doctors to engage on any personal or individual level with their black patients.<sup>70</sup> Conry at Fort Beaufort argued that Africans were naturally

<sup>67</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3. (1907), p.35.

<sup>68</sup> Dubow writes that it was generally accepted within South African scientific circles in the early 1900s that heredity was not considered to be a significant factor in rural blacks because of their perceived innate physical vigour and healthy rural existence. Scientific dogma also put forward the view that black societies killed off any babies born with physical deformities or defects. The same argument reoccurs in 1915 when the Commissioner of Mental Health for the Union Dr. J. Dunston observed that very few cases of idiocy or imbecility occurred in the 'raw natives' because they regulated breeding and destroyed defective children. It seems likely that in this context Greenlees was using heredity to demonstrate the corrupting effects of the city on black people but he does not provide any detailed evidence. See S. Dubow, *Scientific Racism in Modern South Africa* (Cambridge, 1995), p.169; J.T. Dunston, 'Mental Hygiene', *South African Medical Record*, Vol. 13 (1915), p.302.; J.T. Dunston, 'The Problem of the Feeble-Minded in South Africa', *Journal of Mental Science*, (October, 1921), p.456-457.

<sup>69</sup> T. D. Greenlees, 'Medical, Legal and Social Aspects of Insanity', *South African Medical Record*, Vol. 1 No. 8 (October, 1903), p.218.

<sup>70</sup> See CA. HGM, Casebook 19, No. 1054, the case of a 'Native' female admitted into Grahamstown Asylum in December, 1893, whose personal details such as her name, occupation, educational status, religion and relatives are all listed as unknown. She died in August of 1894 and was given a paupers' burial, her identity still listed as unknown; Margaret Trotskie, a "Hottentot" servant from Port Elizabeth was also admitted in December 1893. Her case notes record no further information about her. See CA. HGM, Casebook 19, No. 1057.

averse to describing what they felt would be 'repugnant to civilised people'.<sup>71</sup> It was always easier for these colonial doctors to fall back on their racialised arguments that positioned most black people at an arrested stage of intellectual development. In her work on colonial psychiatry in the Cape colony Swartz argues that white patients' identities were embedded in individual and family narratives that were connected both to the history of the colony and to the history of 'home' in Britain. She puts forward the view that the failure of colonial doctors to provide black patients with adequate personal histories or to ascribe heredity as a major cause of insanity should be seen as a deliberate act of colonisation. Black patients constructed collectively as 'unknown and unknowable' were placed outside of history and automatically precluded from participating in colonial life.<sup>72</sup>

Greenlees identified 'intemperance in alcoholic stimulants' as the second most common cause of insanity at Grahamstown asylum, but unlike heredity ascription with its racialised bias towards white patients, alcohol abuse was diagnosed in both black and white patients, was class related in that it was more 'prevalent in poorer people than among the well-to-do' and affected more men than women. Alcohol was the ascribed cause of insanity in a quarter of all male admissions with the racial breakdown given as 29% for white men and 22% for black men over the fifteen year period. In contrast to this only 6% of white female patients and an even lower 2% of coloured women were admitted with alcohol related disorders.<sup>73</sup> It was Greenlees' opinion that these 'statistics at Grahamstown asylum, as well as of all the asylums of the civilised world prove without a shadow of a

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<sup>71</sup> J. Conry, 'Insanity Among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 (1907), p.33.

<sup>72</sup> S. Swartz, 'Colonising the Insane: Causes of Insanity, 1890-1920', *History of the Human Sciences*, Vol. 8, No. 4, 1995, pp. 50-52.

<sup>73</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol.3, No. 11 (1905), p.223.

doubt that intemperance in alcoholic stimulants is a most potent factor in the production of mental disease'.<sup>74</sup>

In line with the dominant disease concept of substance dependence, Greenlees believed that the excessive use of alcoholic stimulants produced toxic effects in the body which could affect almost every organ and tissue 'reducing and retarding both mental and physical action and diminishing the capacity to work'.<sup>75</sup> According to him the action of alcohol on the brain worked as a poison, that first induced irritation, then congestion and if continued over a period of time resulted in gross pathological changes to the cerebral tissues and blood vessels. It was these final changes that produced mental symptoms and alterations in behaviour that were characteristic of insanity. Greenlees opposed the view that depraved drinking habits in a person were caused by a lack of self-control or a failure of the will 'no matter how sodden their brains might be'. Greenlees wrote that alcohol related insanities classified as dipsomania (compulsive bout drinking), delirium tremens (alcohol withdrawal syndrome) alcoholic dementia and *mania a potu* (acute transitory mania) should be considered pathological insanity just as any other form of this 'protean' disease.<sup>76</sup>

While Greenlees identified alcohol abuse as a specific psychiatric disease it was also closely interlinked with heredity pre-disposition and together these two factors were

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<sup>74</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol.3, No. 11 (1905), p.224.

<sup>75</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No 8 (October, 1903), pp. 122-123.

<sup>76</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (October, 1903), pp.122-123; While alcohol was generally recognised as a factor in rising crime rates not all colonial doctors subscribed to the view that the 'abuse of liquor' caused insanity. For a dissenting view see W. Bisset Berry, 'Editorial on Lunacy Legislation', *South African Medical Journal*, Vol. 5 (January, 1898), p.224.

identified as key factors in progressive hereditary weakness and family degeneration.<sup>77</sup> Alcohol was not only a cause of this degenerative process but was also an effect in a chain of degeneracy as the damage to the nervous system caused by the habitual use of alcoholic stimulants was passed on to the next generation as an inherited trait.<sup>78</sup> As Greenlees espoused 'under the laws of heredity the drunken father may beget the epileptic, idiot or imbecile child or the epileptic mother the drunken son'.<sup>79</sup> It was a common assumption that parental drunkenness was a major cause of idiocy and imbecility in children.<sup>80</sup> Greenlees was of the opinion that the children of 'drunkards' could also inherit a pre-disposition to an unhealthy nervous system, were often 'weak, unsteady and excitable and exhibited a diseased craving for spiritous liquors'.<sup>81</sup>

Intemperance in drink in the aetiology of mental disease also extended to black patients at Grahamstown asylum and although there is no conclusive evidence it does seem that the small percentage of black cases identified by Greenlees as insanity due to heredity could have links to alcohol related insanity. As early as 1894, Greenlees identified the 'terrible curse of drink as found in the Natives of South Africa as a prominent cause worthy of

<sup>77</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol.3, No. 11 (1905), p.223.

<sup>78</sup> At the present time it is known that alcohol abuse can reduce male fertility and that alcohol consumption by the mother during pregnancy does affect the foetus but the other connections are not valid. See E. M. Brown, 'Substance Use Disorders', in G. Berrios and R. Porter (eds.), *A History of Clinical Psychiatry: The Origins and History of Psychiatric Disorders*, (London, 1995), p. 660.

<sup>79</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol 1, No 8 (October, 1903), p.123.

<sup>80</sup> See CA. HGM, Casebook 24, No. 9, the case of a ten year old child, Johan Christian de Villiers who was admitted into the Children's Home for Imbeciles in 1895 and diagnosed as an idiot, a condition said to be inherited from his father who was described as a 'drunkard'; CA. HGM, Casebook 24, No. 79, Dorothy Violet Brown, a four year old child admitted in 1907 with epilepsy, father said to drink, with hereditary pre-disposition on the mother's side.

<sup>81</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (1907), p21.

note'.<sup>82</sup> He was however careful to qualify this by stating that in contrast to the more complex insanity in whites, these were all cases of simple dipsomania.<sup>83</sup> In his annual report of 1898 he again expressed concerns over the increasing rates of black patients presenting with alcohol related disorders.

There is no doubt that bad brandy is a fruitful cause of insanity among the natives of this country and when it is known and appreciated by the public that intemperance especially in bad drink is at the foundation of not only degeneration of the morals but also of the mind and it is filling our gaols and asylums with criminals and the insane then and not until then will drink be looked upon as a curse and not a blessing and its consumption controlled by legislation.<sup>84</sup>

In 1902, to prove this point Greenlees noted that after prohibition had been introduced during the Boer War to curtail the sale of liquor, African admissions due to dipsomania at Grahamstown asylum had almost halved to 6% from the previous years' total of 11%.<sup>85</sup>

Claiming the high moral ground, he warned that if Africans continued to indulge their 'appetite for this luxury' government would be forced to provide increased asylum accommodation. To avoid such a costly exercise he advised that the colonial government should legislate to restrict the sale of 'dop' by imposing an excise duty.<sup>86</sup>

Taking a different view, Greenlees' colleague at Fort Beaufort asylum discounted alcohol abuse as a common cause of insanity in his black patients. Conry claimed that he had not admitted a single case of alcohol related insanity during his eleven years as superintendent

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<sup>82</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p.24.

<sup>83</sup> T.D. Greenlees, 'Insanity among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p.24.

<sup>84</sup> Grahamstown Asylum Annual Report, 1897: G28-1898.

<sup>85</sup> Grahamstown Asylum Annual Report, 1902: G60-1903.

<sup>86</sup> Grahamstown Asylum Annual Report, 1902: G60-1903.

at the asylum.<sup>87</sup> As far as he was concerned, delirium tremens was unheard of among the black population. He argued that alcohol was too expensive for most farm labourers whose average wage was only ten shillings a month and that according to the farmers of the district they used their money to buy stock rather than indulge in liquor. Kaffir beer, although banned in the locations of the colony was brewed on the farms but according to him this was not abused as it was regarded as a food as well as a drink. While acknowledging that drink was a factor in the mining centres of the country, he argued that there was no evidence to suggest that this caused insanity in patients who were admitted into Fort Beaufort asylum.<sup>88</sup>

This difference of opinion between Conry and Greenlees arose as a result of the different functions of each asylum and the tendency of both doctors to draw general conclusions from their individual asylum populations. With so much pressure on asylum accommodation at Fort Beaufort to provide long term care for the most hopeless cases, black patients suffering from alcoholism would be discharged from Grahamstown asylum and so never reached the Fort Beaufort institution. In addition, the production of knowledge about alcohol abuse generated from Grahamstown asylum should be seen as an attempt by Greenlees to appropriate new medical spheres of interest in order to expand his own professional base. Nevertheless, once committed into Grahamstown asylum patients with alcohol related problems benefitted from enforced abstinence as well as regular meals and most regained some degree of physical and mental health within a

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<sup>87</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 (1907), p.35.

<sup>88</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 (1907), p.35.

relatively short time. The asylum played a useful but limited role as a short term respite service and patients were discharged sober even if they might still be addicted.<sup>89</sup>

Consanguineous or cousin marriages were identified by Greenlees as the third major cause of insanity. This was evident in the decline of the royal families and old aristocracies in Europe who had been weakened through inbreeding and intermarriage and where as a result, insanity was inherent.<sup>90</sup> These ideas were refracted onto Afrikaners and poor whites as he noted that in the colony cousin marriages were extremely common among the Dutch inhabitants who were often motivated by the 'selfish desire to keep property, especially lands within the family circle, regardless of the consequences to the progeny'.<sup>91</sup> In his view, in the colony generally intermarriage between cousins was the most prolific pre-disposing cause of idiocy and imbecility in children of such unions.<sup>92</sup> Quoting from Maudsley and Clouston who were the leading psychiatric experts of the day in Britain he argued that in the delicate question of marriage if there was no hereditary pre-disposition to any disease it was possible for two cousins to marry and produce normal children. But he warned of the inherent risks attached to such unions for it was very rare to find a 'clean bill of health' in any family.<sup>93</sup> Over a period of fifteen years at Grahamstown asylum,

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<sup>89</sup> The same trends occurred in South Australian colonial asylums where the general practice was towards short term care for alcoholics. The temperance movement rather than the medical profession was influential there in establishing separate institutional care for inebriates. See E. Shlomowitz, Chapter Eight, in 'The Treatment of Mental Illness in South Australia, 1852-1884: From Care to Custody', unpublished Ph.D. Thesis (Flinders University of South Australia, 1990), pp.245-279.

<sup>90</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (1905), p.223.

<sup>91</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (January, 1907), p.18.

<sup>92</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (January, 1907), p.17; See for example CA. HGM, Casebook 24, No. 81 and No. 82 for the cases of siblings, thirteen year old William Smith and fifteen year old Ellen Smith who were both admitted in May, 1908 with idiocy, the cause given as inbreeding of parents who were half-brother and sister; CA. HGM, Casebook 24, No. 48, Andrea van Moulen, admitted in October, 1907 with imbecility as a result of her parents being cousins.

<sup>93</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1.

Greenlees produced overwhelming evidence to suggest that mental illness was largely an inherited disease with underlying connections to substance abuse and family intermarriage.

Another important cause of mental disease was located in what was known as 'insanity of the crises'. In line with a biological model of disease, it was generally believed in psychiatric circles that men and women with an existing 'neurotic pre-disposition' or an 'inherent mental instability' were more susceptible to mental illness during the critical life changes brought about during puberty and adolescence, childbirth, menopause and old age.<sup>94</sup> These biological changes in the body influenced mental functioning and according to Greenlees were responsible for a variety of well known psychic symptoms such as the 'changes in mental characteristics of a boy or girl on attaining adolescence' or the 'depressing and vague feelings experienced during the change in women' and even the 'restlessness' of old age, where a person would 'live his life over and over again'.<sup>95</sup>

Within this context of 'insanity of the crises', female physiology and reproduction remained a signpost in locating the causes of mental disease far more than it did in men.<sup>96</sup>

Evolutionary psychiatrists believed that women were particularly susceptible to mental

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No 8 (October, 1903), p.123; T. D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record* Vol. 5, No. 2 (January, 1907), p.17.

<sup>94</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1 No. 8 (October, 1903), p.124.

<sup>95</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No.11 (November, 1905), pp.220-221.

<sup>96</sup> For feminist readings on the relationship between women, psychiatry and mental illness see E. Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London, 1985); Y. Ripa, *Women and Madness: The Incarceration of Women in Nineteenth-Century France* (Cambridge, 1990); J. Ussher, *Women's Madness: Misogyny or Mental Illness* (New York, 1991); P. Chesler, *Women and Madness* (New York, 1997); H. Allen, 'Psychiatry and the Construction of the Feminine', in P. Miller and N. Rose (eds.), *The Power of Psychiatry* (Cambridge, 1986) pp. 85-111.

disease because of their innate biological inferiority due to the instability of their reproductive and nervous systems. Insanity in women was a biologically determined phenomenon, a product of woman's essential nature that interfered with her emotional and rational control.<sup>97</sup> Women were seen to be particularly vulnerable to attacks of insanity during the various stages of childbearing, during and after pregnancy. According to Greenlees over 16% of female cases admitted to Grahamstown Asylum were a result of insanity induced by childbearing- pregnancy, the puerperium (post partum) and lactation. It was his view that the normal mental condition of women during these periods was often one of 'extreme eccentricity amounting to actual irresponsibility'. Matters could be further exacerbated if the mother had a previous history of inherited pre-disposition to insanity or neurosis. Under these circumstances he felt that it was only to be expected that the 'grave physiological changes that are embraced in the various processes concerned in child bearing results in total mental breakdown'.<sup>98</sup>

These clinical judgements were obviously clouded by a particular model of biological gender that understood heightened emotions, nervousness, changeability and passions to be fundamental feminine traits that were common to all women. These stereotypical views about the essential nature of women were used at Grahamstown asylum to account for the high incidence of female pathology that was attributed to hereditary pre-disposition to insanity which was diagnosed in over 43% of white female cases.<sup>99</sup> While women were

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<sup>97</sup> C. Rosenberg, 'The Female Animal: Medical and Biological Views of Women', in C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, 1997), pp. 54-58; C. Smith-Rosenberg, *Disorderly Conduct: Visions of Gender in Victorian America* (Oxford, 1985).

<sup>98</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol.3, No. 11 (November, 1905), p.221.

<sup>99</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol.3, No. 11 (November, 1905), p.220.

defined by their brains and their uterus' as irrational and unstable, as child bearers and mothers they were also carriers of this genetic inheritance to their children.<sup>100</sup> Heredity was regarded as a dynamic process that started when the foetus was exposed to hereditary influences right from the time of conception in the mother's womb. Although mental handicap in children could be caused by birth trauma, according to Greenlees it was also just as likely to occur as a result of the 'highly emotional state' of the mother during any stage of her pregnancy.<sup>101</sup>

Greenlees' views on the connection between women as the carriers of genetic disease also extended to his own conventional ideas about what the 'proper' role of women in colonial society should be.

The unsatisfactory social existence pursued by women in this twentieth century tends to produce children who are insane before their brains could be deranged by their own exertions 'insane by a reflex action of the excitable nervous system of the mother'. The more women unsex themselves the less they are able to bear healthy children and in the interests of future generations, such unsexed creatures should not be allowed to marry until they had passed menopause.<sup>102</sup>

While this discourse reveals much about male fears and anxieties about changing gender roles and the growing presence of women in the workplace, it also reveals the latent gender politics of psychiatry that pathologised female reproduction. At the same time, these rigid and prescriptive views on gender roles were largely indifferent to the social contexts in which these physical crises took place.

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<sup>100</sup> E. Showalter, *The Female Malady* (London, 1985), p. 55.

<sup>101</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (January, 1907), p.19.

<sup>102</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, Vol. 5, No. 2 (January, 1907) p. 18.

Conry at Fort Beaufort asylum did not subscribe to any of these findings. Nevertheless he also held essentialist ideas about what constituted mental illness and its aetiologies in his African patients. It was his belief that a 'consideration of some of the old native customs and modes of life will give a clue to the predisposition to mental deterioration'.<sup>103</sup> He identified the 'ubiquitous and dangerous kaffir' or witch doctor as the source of much mental illness. It was Conry's opinion that the witch doctor caused untold harm with his highly poisonous herbs and potions and sent many of his victims crazy with frequent 'deleterious drugging'. He not only exercised a pervasive influence over people from infancy and later throughout the life of an individual, but was responsible for causing brain instability and mental defects through his witchcraft practices.<sup>104</sup>

For Conry, African customs such as circumcision rituals were another potential source of mental illness in young African men. In his view, the prolonged ordeal of surgical operation, fastings and beatings connected to circumcision could result in complete mental breakdown.<sup>105</sup> Unlike Greenlees who tended to romanticise rural life, Conry noted that drought, starvation and the loss of stock through epidemic disease were all causes of mental breakdown. While he was guilty of pathologising normal African traditions and healing systems as superstitions he did recognise the insidious effects of poverty and squalor caused by the poor living conditions found in the locations of the colony and the underlying mental distress that people suffered as a result of this. However both Conry

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<sup>103</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 (February, 1907), p.35.

<sup>104</sup> J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, Vol. 5, No. 3 ((February, 1907), p.35.

<sup>105</sup> J. Conry, "Insanity among Natives in Cape Colony,' *South African Medical Record*, Vol. 5, No. 3 ((February, 1907). p.35; See A. Mager for a discussion on the importance of circumcision and initiation rituals in African societies. A. Mager, *Gender and the Making of a South African Bantustan: A Social History of the Ciskei, 1945-1959* (Oxford, 1999), p.133.

and Greenlees failed to develop any understanding of the very rich and complex nature of African cosmologies concerned with mental illness.<sup>106</sup>

Beyond the 'physical causes' an additional category of 'moral' causes was used at Grahamstown asylum that today would be more familiar as psychological problems and stress. Moral causes were quite broad ranging and included domestic troubles such as the loss of relatives and friends, adverse circumstances, business worries and pecuniary difficulties, mental anxiety and worry, overwork, religious excitement, love affairs including seduction, fright and nervous shock.<sup>107</sup> The case of Thomas Smith provides an example of a patient whose mental illness was ostensibly caused by business worries but provides useful insights into the ways in which middle class identities were protected, in sharp contrast to the case of the 'poor white' identity of Maria van Loggenburg.

Thomas Smith was thirty two years old when he was admitted to Grahamstown asylum in June 1891. He was diagnosed as suffering from melancholia caused by 'business worries'. Described as a tall, well built young man he had emigrated from Glasgow in Scotland and made a substantial amount of money (10 000 pounds) speculating on the diamond mines in Kimberley. His case aroused considerable interest in the local newspaper and the following extract captures some of the mood of the times.

The case of the unfortunate young man Smith, who was yesterday declared by the High Court to be insane is a sad and peculiar one. He appears to have accumulated a sufficiency of this world's goods to satisfy his requirements and to have been for a long time content with their nature. Six hundred De Beers shares bought at, what even now can be considered to be nominal

<sup>106</sup> See H. Ngubane, *Body and Mind In Zulu Medicine*, (New York, 1977); R. R. Edgar and H. Sapire, *African Apocalypse: The Story Of Nontetha Nkwenke, A Twentieth-Century South African Prophet*, (Johannesburg, 1999), pp.44-52.

<sup>107</sup> Grahamstown Asylum Annual Report, 1903: G55-1904.

prices, presented absolute wealth and so long as his confidence in the security remained unshaken, he was happy. A gradual fall in prices however, unsettled him and a decision was after a mental struggle, taken to sell the shares. He began doing so but the wrench of parting was too great and his mind became deranged.<sup>108</sup>

In the case history notes, he was described by Greenlees as having an 'untidy, dull, depressed look, will not look up and only speaks when questioned several times. His memory is enfeebled'. As a paying patient, Thomas received special treatment and care, but by September of 1893 his mental and physical condition had deteriorated markedly. At this stage, he was described as an extremely difficult patient, 'quite miserably demented, given to fits of childish passion'. His death was recorded in November of the same year, the cause of death given as 'dementia due to business worries'.<sup>109</sup>

My reading of the symptoms recorded in Thomas' case history would seem to suggest that he died of general paralysis as a result of the final stages of tertiary syphilis, a disease which attacked the frontal lobes of the brain. General paralysis manifested itself in quite distinctive symptoms such as an unsteady or 'tottering gait', slurred or 'slip-shod' speech and a quite rapid deterioration of mental and physical capacity, all of which were mentioned in his case history notes. In 1893 the links between syphilis, general paralysis and mental illness, although suspected in some circles, had still to be identified by scientists.<sup>110</sup>

<sup>108</sup> CA. HGM, Casebook 2, No. 799, p.255.

<sup>109</sup> CA. HGM, Casebook 2, No. 799, p. 255.

<sup>110</sup> E. Showalter, *The Female Malady: Women, Madness and English Culture* (London, 1986), p. 111-112. Although links between syphilis and general paralysis of the insane were suspected it was only in 1913 with the discovery of the spirochete bacteria that the connections between syphilitic infections and general paralysis was conclusively established.

Thomas Smith like Maria van Loggenberg had very little chance of recovery. But the crucial difference in the attitudes and attention displayed towards him in stark contrast to the prejudices directed at Maria lay in the contractual nature of his incarceration in that he was able to pay for his treatment and care. Despite conceptual claims that psychiatry was based on sound and objective scientific principles, the search for the causes of mental illness merely underlines the embeddedness of the social in that class, racial and gendered attitudes influenced all aspects of medical diagnosis, classification and treatment in the Eastern Cape asylums. As Stepan reminds us, 'the sciences and the social messages we derive from them are never simply scientific but are complex constructions that always involve struggles over meaning and values'.<sup>111</sup>

Identifying the aetiology of mental illness was an important aspect of the work of colonial psychiatrists such as Greenlees and Conry for they sought to demonstrate that mental illness was not an anomaly but was governed by specific laws that testified to causality. Their work reinforced the view that the complex nature of mental disease was not only understood but that it also offered opportunities to develop appropriate interventions that might prevent mental illness through the promotion of mental welfare and mental hygiene. In 1905 Greenlees defined a new role for himself. Well aware of the poor recovery rates that made insanity such a 'terrible burden of civilisation' he argued that he had a duty to the state to advise government on all matters pertaining to the mental health and welfare of its people. Medical men had 'higher and more sacred duties' to perform than just attempting to cure disease.<sup>112</sup> This political initiative marked an important shift in focus

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<sup>111</sup> N.L. Stepan, *The Hour of Eugenics: Race, Gender and Nation in Latin America* (Ithaca, 1991), p. 201.

<sup>112</sup> T. D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, Vol. 3, No. 11 (November, 1905), p.223.

away from the overstated claims of cure and recovery and introduced a new discourse on preventative strategies that were based on early mental hygiene incorporating eugenic programmes.

Eugenics was a cluster of ideas and activities aimed at improving the quality of the human race, of breeding better people through the manipulation of biological heredity and reproduction.<sup>113</sup> Although these ideas were not new, their modern form originated in Britain in the 1860s with Francis Galton, who was a cousin of Charles Darwin. Influenced by the ideas about biological inheritance and Social Darwinism, Galton's program embraced ideas of improving human stock. Improvement was to be achieved by getting rid of so-called undesirable elements (negative eugenics) in the population and increasing desirable stock

(positive eugenics) in the manner of animal and plant breeding.<sup>114</sup> These ideas gained wide currency from the turn of the twentieth century in Europe, Britain and the United States drawing major support from the middle and upper classes. By 1900 eugenics had emerged in over thirty countries which were all grappling with the social effects of industrialisation.<sup>115</sup>

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<sup>113</sup> See D. Kevles, 'Out of Eugenics: The Historical Politics of the Human Genome', in D. Kevles and L. Hood (eds.), *The Code Of Codes: Scientific and Social Issues in the Human Genome Project* (Cambridge, Massachusetts, 1992), p.5. Eugenics is derived from the Greek root meaning 'good in birth' or 'noble in heredity'; S.E.D. Shortt, *Victorian Lunacy: Richard M. Bucke and the Practice of Late Nineteenth Century Psychiatry* (Cambridge, 1986), p.161; D.B. Paul, *Controlling Human Heredity: 1865 to the Present* (New Jersey, 1995).

<sup>114</sup> R.A. Soloway, *Demography and Degeneration: Eugenics and the Declining Birth Rate in Twentieth-Century Britain* (Chapel Hill, 1990), pp.18-27.

<sup>115</sup> S. Klausen, ' "For the Sake of the Race": Eugenic Discourses of Feeble-mindedness and Motherhood in the South African Medical Record, 1903-1926', *Journal of Southern African Studies*, Vol. 23, No. 1 (March, 1997), pp.29-35.

Eugenic ideas on how to improve human stock were often vague, highly variable and open to a wide range of interpretations that served to underwrite particular interests. In Britain, the movement was strongly influenced by ideas on human heredity and negative eugenics and was closely allied to middle class prejudices caused by fears of working class militancy, urban slums and poverty.<sup>116</sup> In America, eugenics was used to lobby for immigration restrictions against minority groups such as Catholics and Jews from eastern and southern Europe.<sup>117</sup> It was taken to its most extreme and negative form in Nazi Germany in the 1930s when mentally handicapped people were actually exterminated.<sup>118</sup> Vast sums of money were donated to encourage and support research in this area. In America, the Carnegie foundation established a research centre in New York. In Britain, the Galton Laboratory for National Eugenics was established at University College, London in 1907.<sup>119</sup> Eugenics had wide appeal and was regarded not as an aberration but as scientifically liberal. Significantly the most vocal criticism against eugenics in Britain and Europe came from the conservative right in the form of the Catholic church.<sup>120</sup>

Eugenics was both a science and a social movement that was saturated with the racial and class prejudices of Victorian society where standards of fitness were measured against the norms and social standards of white, middle class, protestant men.<sup>121</sup> Its core appeal to

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<sup>116</sup> P. Mazumdar, *Eugenics, Human Genetics and Human Failings: The Eugenic Society, Its Sources and Its Critics in Britain* (London, 1992), p. 2-4.

<sup>117</sup> G. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (Cambridge, Massachusetts, 1994), p. 160.

<sup>118</sup> S.F. Weiss, 'The Race Hygiene Movement in Germany: 1904-1945', in M.B. Adams (ed.), *The Wellborn Science: Eugenics in Germany, France, Brazil and Russia* (Oxford, 1990), pp.46-48.

<sup>119</sup> C. Rosenberg, *No Other Gods: On Science and American Social Thought* (Baltimore, Maryland, 1997), Chapter 4.

<sup>120</sup> N.L. Stepan, *The Hour Of Eugenics: Race, Gender and Nation in Latin America*, (Ithaca 1991), p.112.

<sup>121</sup> N.L. Stepan, *The Idea of Race in Science* (London, 1982), p. 18.; For example Galton's belief that the best genetic material was to be found among the professional educated middle classes was fundamental to the eugenics movement. See R.A. Soloway, *Demography and Degeneration* (Chapel Hill, 1990), p.26.

scientists and social reformers lay in the fact that it appeared to provide practical solutions to the aberrant social problems of urban industrial society such as alcoholism, prostitution, mental illness and criminality.<sup>122</sup> In practice, eugenics was used to manipulate human heredity by controlling reproduction through a range of techniques that included eugenic marriage laws and involuntary sterilisation of the unfit.<sup>123</sup>

Eugenic ideas formulated in the metropole proved to be no less useful in the Cape colony where the maintenance of white racial superiority assumed critical importance. Greenlees was the first medical doctor in the colony to identify eugenic measures as a way of preventing the spread of mental illness, even offering hope that by controlling reproduction through selective breeding the disease could one day be eradicated altogether.<sup>124</sup> In 1903 he proposed that in order to prevent mental degeneration, prohibitions on marriage should be placed on people of a 'neurotic strain' for the 'neurotic has a special affinity for love and marriage' and as a result, the neurotic parent was more likely to produce a 'mentally enfeebled child'. He wrote that it was the duty of all doctors to deal with the question of marriage between people for 'we can't justify the risks of generating a stock of idiots and imbeciles'.<sup>125</sup> Greenlees decried the fact that degenerates 'possessing possibly little more intellect than is required to procreate their own species' were allowed to populate the world with monstrosities that would grow up to be useless members of society ultimately

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<sup>122</sup> G. Stedman Jones, *Outcast London: A Study in the Relationship between Classes in Victorian Society* (Harmondsworth, Middlesex, 1976).

<sup>123</sup> S. Dubow, *Scientific Racism in Modern South Africa* (Cambridge, 1996), pp.120-124.

<sup>124</sup> See S. Klausen, 'For the Sake of the Race': Eugenic Discourses of Feeble-mindedness and Motherhood in the South African Medical Record, 1903-1926', *Journal of Southern African Studies*, Vol. 23, No.1, (March, 1997), pp.36-37.

<sup>125</sup> T.D. Greenlees, 'Medical, Social, and Legal Aspects of Insanity', *South African Medical Record*, 1, 8 (October, 1903), p.123.

becoming burdens on the family or the state and increasing the need for institutionalisation.<sup>126</sup>

Using an analogy between human and animal breeding, he claimed that more care and consideration was devoted to the mating of horses and pigs than to 'our sons and daughters'. 'We are certainly all agreed that love is blind; only it is sad to think how much suffering might be avoided if the bandages were removed from Cupid's eyes and men were to exercise the same care in the selection of their mates as they do when breeding cattle'.<sup>127</sup>

Calling for government to introduce prenuptial legislation to prevent dysgenic (dangerously unhealthy) marriages between neurotic or degenerate people, he argued that while there might be 'fewer geniuses and idiots', the (white) race would certainly be 'happier and healthier' as a result of such measures.<sup>128</sup> He was of the opinion that it was unfortunate that colonial society did not seem ready to accept such drastic measures as sterilisation or the use of the lethal chamber to prevent the breeding of the unfit.<sup>129</sup> In 1906, at a medical congress in Bloemfontein, Greenlees proposed that there should be legislation and government supervision of all marriages in order to decrease the number of consanguineous unions. Government should insist on the good health of both marriage parties and prevent the marriage of one or other party who was an epileptic, an imbecile

<sup>126</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, 5, 2 (January, 1907), p. 21.

<sup>127</sup> T.D. Greenlees, 'Medical Social and Legal Aspects of Insanity', *South African Medical Record*, 1, 8 (October, 1903), p.123.

<sup>128</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, 1, 8 (October, 1903), p.123.

<sup>129</sup> T.D. Greenlees, 'Statistics of Insanity at Grahamstown Asylum', *South African Medical Record*, 3, 11 (November, 1905), p.222; T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, 5, 2 (January, 1907), p. 21. These proposals were never adopted by the colonial state. For a comprehensive discussion on the issues of eugenic sterilisation of the feebleminded after Union see S. Dubow, *Scientific Racism in Modern South Africa* (Cambridge, 1995), pp. 149-154.

or suffering from any form of insanity or transmissible disease.<sup>130</sup> With inheritance playing such a major role in the aetiology of mental disease, restrictions on marriage between people with neurotic tendencies, mental illness in the colony would eventually be eliminated altogether.<sup>131</sup> The significance of this discourse was that it shifted the focus of reproduction out of the traditionally private sphere and into the public realm for the first time. However, the colonial state was too weak to implement any of these proposals and it was only after Union in 1910 that the government began to address some of these issues.

Greenlees also provided expert advice on child rearing practices, particularly the education of neurotic children. In his opinion, neurosis in children where the mind was already unstable from hereditary pre-disposition could be avoided altogether by proper training and management. To prevent faulty habits he advised that children should be taught in pleasant surroundings, eat good, plain wholesome food and spend as much time out of doors in regular physical exercise to strengthen both the physical and nervous systems. He advised that the child should have the simplest schooling possible with no competition or 'cramming of a neurotic child's brain either too much or too early'.<sup>132</sup> Ideally neurotic children should 'throw off the trammels of civilisation and live healthy lives in the open'.<sup>133</sup>

<sup>130</sup> T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, 5, 2 (January, 1907), p. 21; The latter covered a broad range of diseases such as syphilis, alcoholism, drug addiction and contagious diseases. See N.L. Stepan, *The Hour of Eugenics: Race and Gender in Latin America* (Ithaca, 1991), pp. 124-125.

<sup>131</sup> These proposals were not accepted by the colonial legislature, Greenlees arguing somewhat cynically that perhaps too many members found these proposals obnoxious because it affected them on a personal level. See T.D. Greenlees, 'The Etiology, Symptoms and Treatment of Idiocy and Imbecility', *South African Medical Record*, 5, 2 (January, 1907), p.17.

<sup>132</sup> T.D. Greenlees, 'Medical, Social and Legal Aspects of Insanity', *South African Medical Record*, Vol. 1, No. 8 (October, 1903), p.124.

<sup>133</sup> Greenlees was using the overworked comparison between the degenerative effects of urbanisation and industrial life suffered by parents and the idealised view of a supposedly healthier rural population. See R.A. Soloway, *Demography and Degeneration* (Chapel Hill, 1990), p.40.

Alcohol control was considered to be another eugenic issue because it was both a cause and a symptom of heredity. Alcohol abuse in colonial society posed a danger to the internal order of the colony and fueled fears of widespread social and moral decay and anxieties about the future progress and health of colonial society. While Greenlees advocated establishing specialised homes for the compulsory detention of inebriates, these patients were expected to come from the white population as no provisions would be made for the black 'drunkard'.<sup>134</sup> In his opinion the sale of alcohol should be prohibited to all blacks with the sale of 'dop' completely banned.<sup>135</sup> Anxiety about intemperance in black patients was connected to the need to uphold colonial authority. Greenlees directed his anti-alcohol discourse at the state and called on the government to introduce increased taxation on all alcoholic beverages whether local or imported. He considered it to be a shameful fact that one of the chief sources of government revenue was derived from the sale of liquor. The Eastern Province Branch of the British Medical Society felt so strongly about this matter that they passed a unanimous resolution calling on the colonial government in the interests of the 'health both present and future of the people, to so discourage the consumption of alcohol as a beverage by means of increased taxation or such other means as will induce temperance in the hope of reducing crime, poverty and insanity.'<sup>136</sup>

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<sup>134</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, Vol. v, 9 (January, 1898), p.234.

<sup>135</sup> G1-1890: Report of the Liquor Laws Commission, 1889-1890.

<sup>136</sup> T.D. Greenlees, 'Statistics of Insanity in Grahamstown Asylum', *South African Medical Record*, 3, 11 (November, 1905), p.224.

Eugenic and mental hygiene programmes concerned with reproduction, education and the control of alcohol were useful to doctors such as Greenlees as they enabled him to provide both a critique of colonial society and to propose preventive strategies as a basis for safeguarding white prestige in the Cape Colony. At the same time, naively optimistic about his own powers, Greenlees was able to define new fields of medical expertise and opportunities to expand his own psychiatric influence and professional interests beyond the narrow confines of institutional psychiatry.<sup>137</sup> Efforts by Greenlees to medicalise reproduction, education and alcoholism were as much a means of medical empire building in the eastern part of the colony as a search for solutions to problematic behaviours.<sup>138</sup>

This chapter has set out to demonstrate that intellectual ideas taken as psychiatric fact were not innocent but historically contingent, the outcome of the ways in which certain forms of thinking were produced and diffused within Eastern Cape colonial society. The major focus has been to trace the development of scientific methodologies in relation to the aetiology of mental illness. It has sought to locate the emerging colonial discourse of psychiatry in the context of the Eastern Cape mental institutions in the late 1800s. It demonstrates that powerful individuals in the Eastern Cape were influenced by evolutionary psychiatry. The consequence was that hereditary degeneration became the central organising concept in psychiatric practice in the Eastern Cape during this time. This medical model of disease provided a reductive and inadequate framework for interpreting both the medical and social problems of the colonised and the poor and did very little to help patients such as Maria van Loggenburg.

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<sup>137</sup> S.E.D. Shortt, *Victorian Lunacy: Richard Burke and the Practice of Late Nineteenth Century Psychiatry* (Cambridge, 1986), p. 161.

<sup>138</sup> P. Conrad and J. Schneider (eds.), *Deviance and Medicalisation: From Badness to Sickness* (St. Louis, 1980).

The overwhelming emphasis on hereditary pre-disposition to insanity provided useful explanations for the increasing rates of incurable cases. Colonial doctors such as Greenlees were able to gain intellectual legitimacy as scientists and critical thinkers through an identification with the fashionable metropolitan and biological sciences connected to heredity, human genetics and eugenics. Eugenics with its emphasis on racial improvement for whites took on a special meaning in a colonial society that was built on coercion and threats. The production of medical knowledge about the causes of mental illness served the professional interests of doctors as it created the illusion that they not only understood the nature of mental illness but that they had the capacity to cure or even prevent insanity in future generations. The presentation of extensive quantified evidence helped to bring clarity to the basic concepts of psychopathology and helped to consolidate and legitimate the psychiatric system at a time of crisis. In contrast, doctors such as Conry who worked with African people and looked to social practices and environmental issues as causes of mental illness achieved little recognition.

Colonial medical discourse enmeshed its subjects in regimes of power to produce certain types of truth that reflected the preoccupations and prejudices of the era that extended well into the twentieth century.<sup>139</sup> The process began with the increased power of science and intellectual ideas in the shaping of colonial society after 1870. In the decade before union, another strand in the relationship between power, psychiatric knowledge and colonial society was rendered visible as theories about race, class, gender, mental illness and mental handicap were entrenched and formalised.

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<sup>139</sup> L. Swartz, 'The Reproduction of Racism in South African Mental Health Care', *South African Journal of Psychology*, 21, 2 (June, 1991), pp. 240-246.

In sum, psychiatric discourses about the nature and aetiology of mental illness in the colony were more a matter of social construction, embedded in the colonial power relations that both created and policed behavioural norms and furthered the interests of dominant colonial classes. As this chapter has demonstrated, colonial psychiatric theories and practices in the Eastern Cape asylums were shaped and influenced by the European and British scientific and intellectual ideas and beliefs of the day. Mental illness was diagnosed as a biological disease caused by the civilising effects of modern colonial society. Psychiatric discourses were associated with the fashionable biological theories of evolution and degeneration emanating from Social Darwinism, the science of human heredity and eugenics. Within this context, whiteness in relation to mental illness as a degenerative disease was not an unproblematic identity. The social stigma of long term chronic disease such as mental handicap when it was associated with a poor white identity placed new demands for social welfare relief on the colonial state which it was largely unwilling to meet. After 1900 eugenic measures aimed at preventing mental illness permeated psychiatric discourses marking an important shift in thinking from earlier discourses relating to treatment and cure. In the colony, eugenic interventions took on special meaning for the maintenance and protection of a healthy white colonial population. At the same time, the search to establish the underlying causes of mental disease was part of an important internal movement to consolidate the professional interests and reputations of colonial psychiatrists such as Dodds and Greenlees both within the colony itself and overseas.

## CHAPTER FOUR

### THE POLITICS OF MENTAL ILLNESS: COLONIAL LAW, PSYCHIATRY AND THE DANGEROUS MENTAL PATIENT

As the previous chapters have demonstrated, medical knowledge and expertise about insanity and the power invested in this knowledge provided colonial doctors with an official mandate to exercise their authority over the insane. It allowed for the management of the insane to be progressively systematised and consolidated into a structured and coherent framework that formally isolated and segregated them from society in asylums in order for doctors to diagnose, treat, care or control them. Nevertheless, the expansion and consolidation of mental health practices in the colony did not occur in a vacuum but were anchored and secured to the colonial state through a series of legal statutes that definitively established official mental health policies and confirmed the authority of the colonial state. Three lunacy acts were passed by the Cape colonial legislature within a relatively short period of time in 1879, 1891 and 1897 respectively.<sup>1</sup> These acts were important in that for the first time in the history of the colony they established and codified in law a set of formal procedural and administrative rules for certifying and committing the mentally ill into the Cape asylums. These formal commitment procedures set out legal principles of safe custody and care of persons of unsound mind and they brought together a confluence of the professional interests of medical doctors, the criminal justice system, the legal profession and the colonial state. This chapter will examine the ways in which this legislation framed both the discursive and practical moments of colonial psychiatry in the late nineteenth century

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<sup>1</sup> A. Kruger, *Mental Health Law in South Africa* (Durban, 1980), pp.12-16.

Lunacy legislation at the Cape was the most comprehensive and well defined set of civil laws dealing with the administration of the mentally ill before Union in 1910. Natal had passed its own Lunacy Act earlier in 1868, while the Transvaal and Orange Free State Republics were influenced to a large extent by the 1891 Cape Lunacy Act.<sup>2</sup> The 1891 and 1897 Acts in particular were generally well received by the Cape medical fraternity who regarded the changes in the Acts as introducing much needed progressive and innovative humanitarian reforms into the colony. What was of particular importance to medical practitioners was that the Acts seemed to provide substantial safeguards against the illegal detention of the mentally ill and protected doctors against lawsuits for wrongful detention, two aspects which had been lacking in the 1879 Act.<sup>3</sup> Within the colonial psychiatric profession itself, Greenlees who with Dodds was actively involved in drafting both these Acts, referred to the lunacy legislation in somewhat dramatic and overstated terms. 'We have emerged from the darkness and ignorance of the middle ages to the bright sunlight of the *fin de siecle*'.<sup>4</sup> Writing in the *British Journal of Mental Health* in 1910, after his retirement at the age of fifty, Greenlees argued that the colony as a young and developing country had the advantage of drawing on the experiences of lunacy legislation in older countries. As a result, in his opinion, certain aspects of the Cape Lunacy Act of 1897 were well ahead of their times as they were far more innovative and advanced than more conservative European countries.<sup>5</sup>

<sup>2</sup> A. Kruger, *Mental Health Law in South Africa*, pp. 18-19. The Orange Free State Act of 1891 contained similar provisions to the 1879 Cape Act, while the amended Act 4 of 1893 closely followed the 1891 Cape Act. The Transvaal Act of 1894 contained similar provisions to the Cape Act of 1891.

<sup>3</sup> W.M.Bisset Berry, 'Lunacy Legislation from the General Practitioner's Point of View', *South African Medical Journal*, Vol.V, 9 (January, 1898), pp.223-224; A.H. Watkins, 'Lunacy Legislation', *South African Medical Journal*, Vol. V, 9 (January, 1898), pp. 224-225; Editorial, 'Lunacy Legislation in the Cape Colony', *South African Medical Journal*, Vol. V, 10, (February 1898), pp.245-246.

<sup>4</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, Vol.V, 9 (January, 1898), p.229.

<sup>5</sup> T. D. Greenlees, 'Lunacy Administration in the Cape Colony', *Journal of Mental Science*, Vol. 56 (1910), pp. 261- 269.

The tropes of heroic endeavours of 'great' white men, humanitarian reform and progress reoccur in twentieth century writing where there is a general uncritical acceptance of lunacy legislation. These writers locate the Cape Lunacy Acts within the context of the colony being granted representative government in 1872 and as indicative of the colonial state's willingness to take on new responsibilities for the care of the insane as part of its own internal modernisation process.<sup>6</sup> Recent revisionist writers in the field of South African mental medicine such as psychologist Foster and social historians Deacon and Warwick, while highly critical of the role of science and medicine in the treatment of the mentally ill in the Cape colony, see the legal reforms introduced into the Cape colony between 1879 and 1897 as largely unproblematic.<sup>7</sup> Foster in fact argues that while colonial psychiatry both in theory and practice was profoundly racialised, the legal acts were one of the few aspects that were not and notes that this has been a feature of South African law in the twentieth century as well. Deacon adopts a similar position arguing that differential treatment of patients was not dependent on racist legislation because other forces were at work.<sup>8</sup> While both Deacon and Foster put forward strong arguments for social control especially in relation to black patients, they fail to make the political connections to the ways in which the seemingly neutral discourses of the law anchored and legitimated the formidable discretionary power of the emerging colonial state and psychiatrists to confine patients for extended periods of time in such dehumanising institutions as Fort Beaufort.

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<sup>6</sup> E.H. Burrows, *A History Of Medicine in South Africa Up to the End of the Nineteenth Century*, (Cape Town, 1958) pp.344-346; M. Minde, 'History of Mental Health Services in South Africa: Part II. During the British Occupation', *South African Medical Journal*, 48 (August, 1974), p.1632; A. Kruger, *Mental Health Law in South Africa*, pp.12-20.

<sup>7</sup> D. Foster, 'Historical and Legal Traces: 1800-1990', in S Lea and D. Foster (eds.), *Perspectives on Mental Handicap in South Africa* (Durban, 1990) pp.33-34; H. Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910', unpublished Ph.D. Thesis (Cambridge University, 1994), p.168; R. Warwick, 'Mental Health Care at Valkenberg Asylum, 1891-1909: Aspects of its Origins and Operation', unpublished Honours Dissertation (University of Cape Town, 1989), pp. 21-27.

<sup>8</sup> H. Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies*, Vol. 22, No. 2 (June, 1996), pp.299- 302.

In contrast to Foster and Deacon, Swartz has demonstrated that racism was in fact deeply embedded in the legal and medical certificates that were used in involuntary civil commitment procedures, despite the absence of any explicit racist terminology. Through detailed discourse analysis she identifies the certification process for black patients as just one of numerous colonising acts. Swartz argues that in the narrowly defined terminology of the forms which were modelled on British practices, no discursive space was created to engage with any of the unique features of insanity within the colonial population. Within the categories of lunacy administration and the transformation of a person first into a lunatic and then into a 'case' through a compilation of impersonal details, black patients were disconnected from owning any knowledge about themselves or their illness experiences.<sup>9</sup>

As Swartz points out, to argue that lunacy laws in the Cape Colony were not racialised is an oversimplification of the issues surrounding legislation pertaining to the mentally ill. Swartz's work makes a valuable contribution to the genealogy of the history of mental illness by recognising that racism operates at different levels. Her research marks an important first step in recognising that both psychiatry as a human science and the law are socially constructed, each carrying within it, its own ideological baggage. Swartz does not, however, engage to any extent with the politics of mental health in the colony. There remains a gap in the literature which needs to be filled. To this end the central concerns of this chapter will be to demonstrate the 'politics' of mental health care by examining certain aspects of the Cape Lunacy Acts and to map out the interweaving effects of law and

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<sup>9</sup> S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920', unpublished Ph.D. Thesis (University of Cape Town, 1996), p.95.

medicine as they together formed mechanisms or 'circuits of control' that were particularly detrimental to black patients in the Eastern Cape.<sup>10</sup>

The overriding principle that was enshrined in all the Cape legislation dealing with the mentally ill was that of *parens patriae* where the colonial state assumed guardianship over the insane.<sup>11</sup> Legal certification fundamentally altered the rights and freedoms of all the insane in the colony, whether white or black, male or female and reduced all mental patients to the status of a child or a dangerous person.<sup>12</sup> The right of the state to intervene in the lives of the mentally ill was determined on the basis of these two categorisations. As defined by colonial laws with regard to the former, the state in its paternalistic and protective role had a moral obligation and responsibility to uphold the rights of an incapacitated individual to receive treatment and safe custody and to be returned into society as a healthy person. In line with ideas of diminished responsibility associated with mental illness, guardianship in this context implied that these interventions were undertaken for the good of the suffering individual who was incapable of making informed decisions about his/her own welfare or affairs.<sup>13</sup>

The second focus of concern in relationship to the notion of guardianship and the *parens patriae* of the state was located around the issues of the mentally ill as violent and

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<sup>10</sup> For a discussion on the notion of circuits of control see A. M Lovell and N. Scheper-Hughes, 'De-Institutionalisation and Psychiatric Expertise: Reflections on Dangerousness, Deviancy and Madness', *International Journal of Law and Psychiatry*, 9 (1986), pp.361-381; A. M. Lovell and N. Scheper-Hughes, *Psychiatry Inside Out: Selected Writings of Franco Basaglio*, (New York, 1987).

<sup>11</sup> C. Gordon, 'Psychiatry and the Problem of Democracy' in P. Miller and N. Rose (eds.), *The Power of Psychiatry*, (Cambridge, 1986), pp. 228-280.

<sup>12</sup> S. Swartz, 'Colonialism and The Production of Psychiatric Knowledge in the Cape: 1891-1920', unpublished Ph.D Thesis (University of Cape Town, 1996), p. 92.

<sup>13</sup> C. Gordon, 'Psychiatry and the Problem Of Democracy', in P. Miller and N. Rose, *The Power of Psychiatry* (Cambridge, 1886), p. 279.

dangerous and posing a threat to the public order of colonial society. Compulsory civil commitments of the legal category 'danger to others' with regard to the mentally ill were tied to the formidable police powers of the colonial state through authoritarian strategies of government. Here the law was a law of administration and policing that aimed to neutralise the dangerous individual and maintain public safety through preventative detention.<sup>14</sup> Administrative and medical dimensions of the management of mental illness were codified through law to maintain public order and protect society from those individuals who were perceived to be a threat and a risk if left at large.<sup>15</sup> This aspect of guardianship had important implications as security and social defence became the driving force behind mental health policies adopted towards the black insane. It is in this project of social security that the racism of the legal process was embedded.

Psychiatry as a body of knowledge in Western societies has always functioned as a political technology precisely because the specific terms of its mandate received from the state are rooted in this fundamental legal duality, with its competing demands to protect both individual and community rights. These two principles of the law, the one consensual the other coercive, are incompatible and mutually exclusive and expose the whole liberal humanist endeavour of providing services for the mentally ill. The aims of this chapter are to begin to provide a historical perspective on the complex power relationships between the law, medicine and the colonial state as played out in the Eastern Cape asylums. Firstly

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<sup>14</sup> R. Castel, *The Regulation of Madness; The Origins of Incarceration in France* (Berkeley, 1988), p.195.

<sup>15</sup> A. Cohen, 'The Psychiatric Assessment of Dangerousness at Valkenburg', unpublished MA Thesis (University of Cape Town, 19910, p.4. Cohen makes clear that the criteria of 'dangerousness to self and/or others' although yoked together deals with two completely separate issues. 'Danger to self' would describe a patient's behaviour in terms of self-inflicted injuries, suicide being the most extreme form. 'Danger to others' in its broadest sense implies the potential to do harm to others. It is usually associated with violent and aggressive behaviour. Cohen argues that the latter concept is controversial and that the literature reveals a 'morass of contradictory, ambiguous and inconclusive findings. p. 40; See also Chapter Five.

it provides a general background to lunacy legislation and discuss the origins of legal reforms in the Cape. It sets out a brief history of the three Cape Lunacy Acts that were promulgated in the short space of eighteen years between 1879 and 1897 and examines the most important amendments to these laws in the formulation of public policies for administering the insane. A major focus of this chapter is an examination of the discretionary power invested in the psycho-legal principles of involuntary committals. In particular, the chapter explores the inherent tensions in these laws where this interdependence extended beyond their therapeutic aims, to non-therapeutic instances of formidable social power to confine, regulate and control.

This chapter will argue that the liberalising of laws in the colony in fact broadened the net of control around race and black patients, especially with regard to issues of violence and the dangerous insane. Legal reforms served to establish a paralegal jurisdiction over persons who, because of their diminished responsibility, could not be processed through the criminal justice system. It is in this public policy role for neutralising social dangers and maintaining ultimate ends of law and order where lunacy legislation established the power relationships between the colonial state and psychiatry.

Prior to the drafting of the first comprehensive Lunacy Act of 1879 in the Cape colony, lunacy commitment procedures were largely unregulated and informal. Under the rule of the Dutch East India Company of the seventeenth and eighteenth centuries, provisions for the care of the insane came under Roman-Dutch law which stated that the insane, unless they were dangerous, were the responsibility of their own families. Organisations such as

the Dutch Reformed Church as part of its charity work, provided alternative sources for the accommodation and care of lunatics.<sup>16</sup> The right to confine the dangerous insane in places such as the Company slave lodge, the penal colony on Robben island or after the British occupation, in the Old Somerset Hospital which opened in 1818, was granted upon application by a court of law.<sup>17</sup> This was based on principles of common law and informal detention for the purposes of 'restricting, controlling, restraining and confining lunatics'.<sup>18</sup>

The earliest legislation at the Cape dealing with the mentally ill were the Cape Ordinances of 1833 and 1837. These were concerned with the management of the estates and the disposal of property of lunatics and the rights of the courts to appoint curators. They built on the earlier principles of Roman-Dutch common law relating to the mentally ill which remained in place.<sup>19</sup> Pressures to reform the legal system increased after the colony's first mental asylum was opened on Robben Island in 1846 and the numbers of patients steadily increased. Doctors at both the Old Somerset Hospital and the Robben Island asylum influenced by the legal reforms in Britain became increasingly concerned at the lack of medical certification required to justify detention. In 1866, the Colonial Office issued a circular instructing all magistrates in the colony to supply lunacy certificates for each patient as authorisation for the detention of any mentally ill person in an asylum or hospital.<sup>20</sup> Admission procedures were to include a legal certificate from a magistrate

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<sup>16</sup> A. Kruger, *Mental Health Law in South Africa* (Durban, 1980), pp.6-8.

<sup>17</sup> L. A. Hurst and M.B. Lucas, 'South Africa', in J.G. Howells (ed.), *World History of Psychiatry* (London, 1975), p.606.

<sup>18</sup> M. Minde, 'History of Mental Health Services in South Africa: Part II. During the British Occupation' in the *South African Medical Journal*, 48 (1974), p.1629-1631.

<sup>19</sup> E.H. Burrows, *A History of Medicine in South Africa*, p. 334.

<sup>20</sup> Deacon argues that the need to formalise admission procedures was as a result of increasing numbers of white paying patients at Robben Island. See H. Deacon, 'A History of Mental Institutions on Robben Island', unpublished Ph.D. Thesis (University of Cambridge, 1995), p.168.

stating the personal details of each patient as well as two medical certificates supplied by licenced medical practitioners.<sup>21</sup>

At the time Grahamstown Asylum opened in 1875 no explicit legal provisions authorising the detention and confinement of the mentally ill existed and the authority to detain any mentally ill patient was based on the 'highly questionable' powers of the Colonial Secretary.<sup>22</sup> As in the experience of his colleague Dr Edmunds at Robben Island, the medical superintendent at Grahamstown Dr. Hullah, was immediately confronted with numerous difficulties in administering patients at the asylum. In the first place the Eastern District Courts had raised the issue of illegal detention and declared the authority of the Colonial Secretary to detain patients to be legally invalid. It was the court's view that no patient could be legally detained in Grahamstown asylum except by an order issued by the court.<sup>23</sup> Hullah expressed the concern that every lunatic patient in the asylum had good grounds for instituting civil action against the government for illegal detention.<sup>24</sup>

The lack of a legitimate and coherent legal framework tended to undermine the authority of superintendents such as Hullah. An epileptic patient named Dr. W. Eddie had for years been considered the town's eccentric and according to Hullah was an 'object of disgust' within the Grahamstown community. Although seventy three years old and quite frail, he spent his days shambling around Grahamstown scavenging and collecting all kinds of

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<sup>21</sup> A. Kruger, *Mental Health Law in South Africa*, pp. 8-9; H. Deacon, 'A History Of Mental Institutions On Robben Island, 1845-1890', unpublished Ph.D Thesis (University of Cambridge, 1995), p.168.

<sup>22</sup> A. Kruger, *Mental Health Law in South Africa*, p.8.

<sup>23</sup> Grahamstown Asylum Annual Report, 1875: G21- 1876.

<sup>24</sup> For a discussion on court action taken against the colonial state by a Cape Town family for wrongful confinement of a relative in 1873 see E. Bradlow, "'Murder Most Foul": Crime, Impartiality and the Law at the Cape in the Nineteenth-Century', *South African Law Journal*, 110, 2 (1993), pp.241-260.

rubbish. He was admitted to the asylum following a series of debilitating epileptic fits but had periods when he was quite lucid. He was secure financially and insisted on his right to conduct his own financial affairs stating that although he had been admitted into the asylum no judge had legally proclaimed him insane. Hullah in turn did not consider him to be competent to manage his own affairs but was powerless to prevent the local bank from issuing numerous cheques despite the fact that he was a patient in the asylum.<sup>25</sup>

In another more serious instance Hullah had been unable to prevent the discharge of a suicidal patient who had been discharged from the asylum as unrecovered after a successful application by the patient's brother to the Colonial Secretary. Barely a week after he was placed into private care in Uitenhage, he committed suicide by hanging himself. Hullah, against his better judgement, had been forced to comply with the Colonial Secretary's recommendations.<sup>26</sup> The lack of a coherent and workable Lunacy Act resulted in a serious breakdown between certification procedures and the medical and legal systems. Magistrates had difficulty in following correct procedures and regulations and often refused to sign reception orders because only one medical certificate was provided. In some remote districts it was often difficult to obtain a second medical certificate before sending patients to Grahamstown.<sup>27</sup>

These cases not only raised a number of important issues concerned with illegal detention, protective custody and diminished responsibility of the insane but were also indicative of the competing interests between the colonial office, the legal system and the role of asylum

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<sup>25</sup> Grahamstown Asylum Annual Report, 1877: G24-1878; CA CO 1066, 24 January, 1878: Correspondence from Hullah to the Colonial Medical Council.

<sup>26</sup> Grahamstown Asylum Annual Report, 1878: G31-1879.

<sup>27</sup> Grahamstown Asylum Visitors Report, 1878: G.31-1879.

doctors such as Hullah. The system as it stood was unwieldy and Hullah along with the doctors at Robben Island asylum made repeated calls on the colonial state to legislate a formal act. The Cape Lunacy Act No. 20 of 1879 was passed largely as a response to this pressure.

The Lunacy Act No 20 of 1879 was the first serious attempt to bring the mentally ill under legal cognisance, although the earlier ordinances were not repealed.<sup>28</sup> The most important features of this legislation were that separate provisions were made for those lunatics who were 'dangerous to society or to themselves' and those 'not dangerously so'.<sup>29</sup> For the dangerous lunatic to be detained in what should have been the local asylum, but was inevitably the jail, a magistrate required the signature of two medical doctors.<sup>30</sup> Additional authorisation from the Colonial Secretary acting on the advice of the Medical Council was required in cases where a person was considered to be insane but not dangerous. One of the main weaknesses in this law was that it was necessary to criminalise anyone who was suspected of insanity before he or she could be legally apprehended and detained. In effect an individual would need to be arrested for a crime which had occurred under 'derangement of mind'.<sup>31</sup> The insane patient could only be released by order of the court, or by warrant of the governor. Another weakness in terms of their practical application was

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<sup>28</sup> E.H. Burrows, *A History of Medicine in South Africa*, p.344. . The Cape Lunacy Act, No 20, 1879 provided for the following: 'To provide for the Safe Custody of Persons Dangerously Insane, and for the Care and Custody of Persons of Unsound Mind. Whereas it is expedient to make provision for the safe custody of, and the prevention of crimes being committed by persons dangerously insane, and also for the care and custody of persons who are insane but not dangerously so'.

<sup>29</sup> Cape of Good Hope Statutes, 1879-1883: Lunacy Act No 20 of 1879, p.42.

<sup>30</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, 9 (January, 1898), p.229.

<sup>31</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, 9 (January, 1898), p.229.

that these laws proved to be cumbersome and resulted in considerable bureaucratic delays especially with regard to patients who required urgent treatment.<sup>32</sup>

It was only after the arrival of Dodds and Greenlees in 1890 that more significant changes pertaining to lunacy legislation took place.<sup>33</sup> They both regarded the 1879 legislation as outmoded by British standards and actively lobbied for government to promulgate new laws. The Lunacy Act No. 35 of 1891, known as the Innes Act was promulgated in March 1892 and repealed the 1879 legislation. This Act made the important distinction between dangerous lunatics, criminal lunatics and ordinary lunatics. At the same time a lunatic was defined as an 'idiot or person of unsound mind incapable of managing himself (sic) or his own affairs'.<sup>34</sup>

Legal safeguards against illegal detention were provided for ordinary lunatics who could only be detained for a period not exceeding one month on the strength of a reception order issued by a magistrate and two medical certificates. A judge's order of the court would have to be obtained if it were found to be necessary to detain a person for longer than one month. In order to accomplish this, two medical certificates, a relative's affidavit, the resident magistrate's report and summary reception orders as well as a report from the asylum superintendent needed to be submitted to the Supreme Court. Without the judge's further authorisation the original reception order would lapse and the patient would be discharged. In practice, the authority of the asylum superintendent was enhanced in the

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<sup>32</sup> CA CO 1123, 20 November, 1880: Correspondence from Hullah to the Colonial Office.

<sup>33</sup> R. Warwick, 'Mental Health Care at Valkenberg Asylum, 1891-1909: Aspects of its Origins and Operation, unpublished Honours Thesis (University of Cape Town, 1989), pp.21-27.

<sup>34</sup> Cape Lunacy Act No. 35, 1891: Cape of Good Hope Statutes, Vol. 3, 1887-1895, p,2926.

certification process.<sup>35</sup> The 1891 Act introduced important new elements into the certification process in that for the first time it was necessary to obtain a judge's decision before a person could be detained for any length of time. The editorial in the February 1898 edition of the *South African Medical Journal* hailed this innovation as a unique feature in lunacy law. 'It is questionable if there is any country where there are such safeguards against the unjust commitment of a person to an asylum as is in this country'.<sup>36</sup>

However, some aspects of the new laws failed to remove the social stigma of certification. There remained a humiliating process whereby the person to be detained and in some instances his/her family were exposed to public scrutiny. In terms of the original reception order the prospective lunatic would have to appear in a public court in order for the magistrate to ascertain whether he/she was a dangerous or ordinary lunatic. In many cases the magistrate would often return a verdict of ordinary lunatic in order to spare the person any further embarrassment.<sup>37</sup>

The main problem with the 1891 legislation was that it failed to secure early treatment in an asylum. This was a matter of priority for all asylum doctors and formed part of their propaganda for treatment. (See Chapter Three.) Greenlees called for the legislation to be amended in order for some provision to be made for some kind of emergency order to avoid delays in the admission procedures. He provided a graphic example of the problem.

The wife of a well-to-do man becomes insane; the husband, in his distress calls in the family practitioner, who advises him to see the magistrate. Perhaps this necessitates a cart journey of many miles, and some delay

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<sup>35</sup> Cape Lunacy Act No. 35, 1891: Cape of Good Hope Statutes, Vol. 3, 1887-1895, pp.2930-2931.

<sup>36</sup> Editorial, *South African Medical Journal*, Vol. V, 10 (February, 1898), p.245.

<sup>37</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, V, 9 (January, 1898), p.230.

occurs before the services of the Magistrate are available. He then has to make a sworn declaration as to the alleged insanity of his wife; if the magistrate is satisfied that the woman is insane he directs two medical men to examine her, and submit a report to him. This again involves the loss of valuable time. On receipt of the doctors' certificates, the magistrate issues a summary reception order, which after duly copied out in triplicate, together with other papers is handed over to the husband, who is then informed that he may remove his wife to the asylum. But before this is done, the magistrate must communicate with the asylum authorities to ascertain whether accommodation can be secured, and only if he answers in the affirmative - and as often as not it is in the negative- can the patient be removed. The delay and worry caused by sending often deficient papers, is often sufficient to make what was a curable form of disease into a hopeless and incurable one; and the poor husband himself becomes well nigh broken down by these harassing delays.<sup>38</sup>

Greenlees advised that the colony should follow the Australian example where a person suspected of insanity could be treated in a 'reception house' where he could receive immediate treatment and then if required could be transferred into an asylum.<sup>39</sup> Scottish law allowed for the admission to a temporary institution on the written authority of one doctor. Greenlees was in effect calling for provisions to be made for voluntary admissions for those people whom he considered to be on the borderline of insanity. None of these features were provided for in the 1891 legislation<sup>40</sup>.

Both Dodds and Greenlees were instrumental in persuading the medical member of the cabinet, the Hon. T.N.J. Te Water to pass a revised law in the 1897 parliamentary session. to address the issue of the emergency order. A doctor was now able to sign an ordinary medical certificate and a certificate of urgency that allowed for the detention of a patient

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<sup>38</sup> T. D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, V, 9 (January, 1898), p.231.

<sup>39</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, V, 9 (January, 1898), p.231.

<sup>40</sup> R. Warwick, 'A History of Valkenberg Asylum, 1890-1909', unpublished Honours thesis (University of Cape Town, 1989), p26-27.

in an asylum for seven days. The asylum superintendent was obliged to report the case to the resident magistrate of the district who would certify the patient in accordance with procedures for an ordinary lunatic. If the magistrate was unable to meet this given time limit the patient would be discharged.<sup>41</sup> Voluntary patients would then be in a position to utilise the rest and seclusion of an asylum.<sup>42</sup> The prospective voluntary patient was expected to contribute financially towards any expenses incurred. Upon application to the superintendent of the asylum and with the consent of the Colonial Secretary the prospective patient could be admitted into an asylum. The voluntary patient was obliged to submit to the rules of the asylum but was allowed to leave having given three days written notice.<sup>43</sup>

The issue of voluntary patients should be seen within the context of Grahamstown asylum as an attempt to move away from the negative associations of a custodial institution in order to create some elements more in keeping with a private sanatorium. It was also an attempt to entrench medical interests in order to gain more direct control over admissions while circumventing the lengthy and time consuming legal process. The most important effects of the Lunacy Acts were to draw together the public policies of the state to the therapeutic activism of psychiatry. This was achieved through what appeared to be universal and neutral legal terms that held that the principles of the right to treatment and safe custody should be applied to all patients in the colony. The 1891 and 1897 Acts

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<sup>41</sup> Cape Lunacy Act, No. 1, 1897: Cape of Good Hope Statutes, p.3686.

<sup>42</sup> The first voluntary admissions to Grahamstown asylum were young unmarried women who were without family support. In the absence of alternative institutions it seems that Grahamstown asylum was drawn into providing social welfare for deserving whites. CA CO 7170, 20 August, 1898: Correspondence from T.D. Greenlees to the Colonial Secretary.

<sup>43</sup> R. Warwick, 'A History of Valkenburg Asylum, 1890-1909', unpublished Honours thesis (University of Cape Town, 1989).

therefore codified clear procedural and administrative rules for civil commitments to facilitate early treatment in properly managed asylums for the insane. It was these aspects of the law that were actively promoted by all the vested interest groups as reform and progress.

While the first part of this chapter dealt with the broad changes in the various Acts this section will look specifically at the law in relation to violence, the dangerous mental patient and the criminal patient which were pivotal concepts in detention and strategies of control. Writers such as Foucault and Castel have repeatedly argued that psychiatry since its inception has been entrusted with a far wider mandate than just medical and therapeutic capabilities.<sup>44</sup> For the special element with regard to the mentally ill remained that of control. Issues of law and order and social control relating to the mentally ill as dangerous and disorderly took on special significance in a society such as the colony that was based on coercion and polarised across racial lines.<sup>45</sup>

The overwhelming feature of the profile of the mentally ill in the Eastern Cape was that black men formed the bulk of admissions into Grahamstown asylum. Black male patients were also the majority of the transfer cases into the other two Eastern Cape asylums. In the Western Cape the same was true for the Robben Island asylum.<sup>46</sup> Valkenberg as the only asylum in the colony reserved exclusively for whites was the exception and in common

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<sup>44</sup> See M. Foucault, 'About the Concept of the "Dangerous Individual" in 19th-Century Legal Psychiatry,' *International Journal of Law and Psychiatry*, 1, 1978, pp.1-18; M. Foucault, *Madness and Civilisation* (London 1991); R. Castel, *The Regulation of Madness: The Origins of Incarceration in France*, (Berkeley 1988), pp. 152-156; R. Castel, 'From Dangerousness to Risk in G. Burchell, C. Gordon and P. Miller (eds.), *The Foucault Effect: Studies in Governmental Rationality* (Chicago, 1991), pp. 281-298.

<sup>45</sup> S.A. Pete, 'The Penal System of Colonial Natal: From British Roots to Racially Defined Punishment', unpublished MA Thesis (University of Cape Town, 1984) p. 52.

<sup>46</sup> M. Minde, 'History of Mental Health Services in South Africa: Part V11, Services Since Union', *South African Medical Journal*, 49 (1975), p. 406.

with British asylums, women were in the majority.<sup>47</sup> In 1901 Dodds raised the issue of race in asylum admissions remarking on the small numbers of white insane in the colonial asylums in comparison to black patients. It was a matter of great concern to him and he criticised what he thought was tardiness on the part of the colonial government to provide sufficient accommodation. He also noted that whites in the colony were prejudiced against using asylums for their sick relatives preferring to find alternative care.<sup>48</sup>

But the correlation between race and high rates of mental illness for black men were tied directly to the reforms in the legal acts and the effects of the operation of the law in colonial society. As a result of the new legislation, civil commitment procedures into the colonial asylums at the Cape generally followed two paths. A person could be certified as insane through co-operation between family members and friends, through doctors such as general practitioners or district surgeons who were usually known to the families concerned and then through the courts as a civil matter. If an urgency order was obtained, admission into an asylum occurred within a matter of days. This circumvented the criminal justice system and tended to favour those patients who had access to family support networks. These tended to be white.

The second path involved the criminal justice system of police, prisons, magistrates and law courts where persons could be arrested or detained for a variety of illegal acts and detained in prison, a jail hospital or a hospital while the legal process took its course.

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<sup>47</sup> S. Swartz, *Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920*, unpublished Ph.D. Thesis (University of Cape Town, 1996), p.30.

<sup>48</sup> Inspector of Asylums Annual Report, G70-1902. Dodds used statistics from English, Scottish and Australian asylums to make this comparison. Both Dodds and Greenlees remained stubbornly blind to the realities of colonial life at the Cape. They were guilty of trying to shape policies based on the metropolitan model instead of addressing the critical needs of black patients.

Finally patients would eventually be admitted into an asylum. According to figures released by Dodds in 1904 over 52% of patients in the colony came through the criminal justice system usually through arrests and increasingly long incarceration in jail due to a lack of available space before transfer into an asylum.<sup>49</sup> With reference to the Eastern Cape, the higher rates of commitment of black men in comparison to white men into Grahamstown asylum was not as a result of higher rates of disorder but because black men were more likely to enter the institution through police involvement.<sup>50</sup>

Police became involved as a result of important changes in the laws of 1891 and 1897 that focused on social control of the dangerous and criminal insane. The most troublesome aspect of these Acts in terms of its control aspects was that it introduced for the first time the broad and vaguely defined principle of 'wandering at large'.<sup>51</sup> This clause provided almost unlimited new powers for policing public safety. Any constable or police officer in the colony was empowered to apprehend and detain in protective custody in prison or a hospital, any person suspected of lunacy who was found 'wandering at large' and whose behaviour posed a threat to public safety. The only proviso was that a magistrate should be informed within forty eight hours of the detention in order to set in motion the formal legal procedures for certification. This clause applied to lunatics not 'under proper care or control, or cruelly treated or neglected' or any persons found in public spaces who were unable to take care of themselves.<sup>52</sup> This effectively gave unlimited powers to the colonial

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<sup>49</sup> Inspector of Asylums Annual Report: G57-1905.

<sup>50</sup> CA. CO 7166, 22 September, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>51</sup> This was a feature of the 1890 English Lunacy Act, See N. Rose, 'Laws, Rights and Psychiatry', in P. Miller and N. Rose, *The Power of Psychiatry* (Cambridge, 1986), pp.202-205.

<sup>52</sup> Cape Lunacy Act 1891: Cape of Good Hope Statutes, Vol. 3, 1887-1895, p.2930. As described in Chapter Three, Maria van Loggenburg was detained for 'wandering at large'.

police to arrest anyone living on the margins of colonial society such as the homeless and vagrants who were posing a public nuisance.

After the 1891 Act was passed, Greenlees predicted that the numbers of applications for admissions into asylums would increase as a result of the 'state assuming its proper role of guardianship of the insane'.<sup>53</sup> What he did not foresee was that at Grahamstown asylum those increased numbers would largely be black patients. The main reason for this was the introduction of a critical new clause in the 1891 Act dealing with the detention of suspected lunatics who were found 'wandering at large'.<sup>54</sup> This was to have unintended consequences in the Eastern Cape as will be discussed below.

The second aspect of these legal 'reforms' that was tied to control were the issues of violence, dangerousness and criminal responsibility that were central concerns in all three of the Cape Lunacy Acts. The law of 1879 was in fact the most explicit and narrowly defined. Lunatics in the Cape Colony before 1891 were simply legally criminal or dangerous persons. But the 1891 Act, influenced by the British legal system, definitively established separate categories of ordinary, criminal and dangerous patients. In an effort to move away from the stigma of defining all mental patients as criminals, the 1891 Act set out important new distinctions between criminal, 'dangerous to self and others' and ordinary lunatics who were neither criminal nor dangerous.<sup>55</sup>

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<sup>53</sup> Grahamstown Asylum Annual Report, 1891: G36-1892.

<sup>54</sup> Cape Lunacy Act, 1891: Cape of Good Hope Statutes, 1652-1895 Vol.111, p.2972930. Clauses 5, 8, 25.

<sup>55</sup> Cape Lunacy Act No. 35, 1891: Cape of Good Hope Statutes 1652-1895, Vol. 111, pp. 2927-2932.

Criminal lunatics referred to three different categories.<sup>56</sup> The first was convicted prisoners who on the grounds of 'guilty but insane' could not be held responsible for their actions and were to be detained under what was known as the 'Governors' Pleasure'. A second category was insane unconvicted criminals and the third was convicted criminals who had become insane while in prison.<sup>57</sup> Dangerousness referred to two separate issues. 'Danger to self' referred to actively suicidal patients, while 'danger to others' referred to the insane with violent intent to commit crimes or offences or harm to others. Patients who were categorised as 'danger to self or others' required special management practices for restraint, safe confinement and custody.<sup>58</sup>

The issues of dangerousness and criminality in relation to the changes made in the Act mainly at the behest of Dodds and Greenlees need to be related back to the Eastern Cape asylums as they interfaced with the legal system and public institutions. Asylum staff had no control over admission policies. Until 1908, when admission into any one of the three asylums became solely dependent on different racial classifications, all patients certified as insane in the Eastern Cape region were first admitted into Grahamstown asylum where they were assessed, treated and managed and then if possible discharged. This process could take anything from a few weeks to a year or more, depending on the specifics of each case. Patients who were not able to be discharged in this manner were transferred into long term care at Port Alfred or Fort Beaufort asylums. These patients, if not discharged directly into the care of their families could remain there indefinitely until their deaths. Only white patients who were able to pay for their care were allowed to remain as

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<sup>56</sup> See K. Herbst and J. Gunn (eds.), *The Mentally Disordered Offender* (Oxford, 1991).

<sup>57</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, v, 9 (January, 1898), p.230.

<sup>58</sup> This chapter will not deal with suicidal patients which is a completely different issue.

long term patients at Grahamstown asylum and Greenlees always selected these patients carefully. On the recommendation of Greenlees, Dodds in his capacity as Inspector of Asylums could authorise transfers and discharges.

This situation did not apply to patients categorised as criminal or dangerous, as such cases required specialised nursing and attention. Under the 1891 Act criminal and dangerous patients could not be transferred or discharged without a governor's warrant. Of the three asylums only Grahamstown had the necessary resources in terms of staff/patient ratios and the physical spaces used to confine patients in seclusion when they became psychotic or violent and difficult to manage. With regard to the categories of criminal patients and patients classified as 'danger to others' black men were also in the majority at Grahamstown asylum and it is in this area that issues of social control came closely to the fore.<sup>59</sup>

From the time of his arrival as superintendent Greenlees did not regard Grahamstown asylum as a suitable place for criminal lunatics. His major objection was that the presence of homicidal cases who had been convicted of serious crimes such as assault, attempted murder and rape lowered the tone of the hospital that under his guidance was in the process of transforming itself into a hospital treating acute cases with numbers of private

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<sup>59</sup> Cohen argues in her contemporary work on Valkenburg Hospital that there is a dearth of South African research on the notions of dangerousness in relation to mental illness. Her research has shown that the typical profile of the dangerous patient at Valkenburg is, 'Coloured, male, young, poor, unskilled and unemployed'. See A. Cohen, 'The Psychiatric Assessment of Dangerousness at Valkenburg Hospital', unpublished MA Thesis (University of Cape Town, 1991), p.276; In New Zealand prisons and mental hospitals, Maori men represent a higher proportion of detentions under the label of dangerousness than any other ethnic group. The report states that more than half of people placed by the courts into psychiatric hospitals under the Criminal Justice Act are Maori. It goes on to note that there is a general failure to provide both culturally appropriate and safe community based services for Maoris. See Law Commission, Report No. 30, Community Safety: Mental Health and Criminal Justice Issues, August, 1994, Wellington, New Zealand, pp.27-29.

patients. On a day-to-day treatment and management level, criminal patients needed separate accommodation from ordinary lunatics and careful supervision and surveillance that made unnecessary demands on staff members who were already overworked.<sup>60</sup> Criminal patients posed serious security risks and in his view neither the grounds nor buildings were suitable for confining these dangerous cases. He urgently recommended that all criminal cases should be removed to Robben Island.<sup>61</sup>

Greenlees' real point of objection to the separate categories of criminal and dangerous insane in the Act of 1891 was that in his capacity as superintendent at Grahamstown asylum he had no power to discharge or transfer patients formally certified as dangerous or criminal without an order from the Governor. This required a lengthy legal procedure with final authorisation from the Colonial Governor confirming that a patient was no longer dangerous or criminal and could be 'set at liberty with safety'.<sup>62</sup>

Along with the more serious convicted criminal cases of culpable homicide, assault with intent to murder, assault with intent to stab and assault with intent to rape, the bulk of black cases admitted into Grahamstown asylum were unconvicted criminal cases. These included a range of less serious offences such as 'stock theft, wilful trespass, public indecency, nuisance in public streets, vagrancy, being a brothel keeper' and even obscene language.<sup>63</sup> The steadily increasing numbers of this category of patient entering Grahamstown asylum was a source of constant frustration to Greenlees. In his view, there

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<sup>60</sup> CA CO 1458, 10 November, 1890: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>61</sup> Grahamstown Asylum Annual Report, 1892: A6 -1893.

<sup>62</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, V, 9 (January, 1898), pp.229-230.

<sup>63</sup> Grahamstown Asylum Annual Report, 1891: G36-1892; CA. CO 7166, 26 October, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

was a vast distinction between 'those crimes of a trifling nature such as brawling in the streets or stealing a few apples' and those involved with assault, rape or murder but under the 1891 Act they were all classified as criminal lunatics.<sup>64</sup> He made a number of attempts to transfer these patients but was continually blocked from doing so by the legal provisions of the 1891 Act. In a letter to the Under Colonial Secretary, Dodds too raised the issue of criminal and dangerous cases arguing that as it stood the provisions of the 1891 Act were too restrictive. In his view, the administrative procedures of transfer and discharge were made more difficult, the result of which was to transform the colonial asylums into prisons.<sup>65</sup>

When Fort Beaufort asylum opened in 1894, Greenlees applied to the Colonial office to transfer a number of unconvicted criminal cases where stocktheft and other petty crimes were involved.<sup>66</sup> Dodds supported him in this request with the proviso that no dangerous patients should be included.<sup>67</sup> Permission to transfer some of these quieter patients to Fort Beaufort was finally granted by the Colonial Office. For the most part they were all patients that had been detained under the 1879 Act; their sentences had expired but they still remained insane. For example Baaitjie Plaat had been arrested in Beaufort West for theft in January 1881. He was transferred to Fort Beaufort in 1894 as not 'dangerous at present'. Daniel Kaumas alias Daniel Afrikander was arrested for assault and 'malicious injury to property' at Bredasdorp in March 1888. He was also among the patients selected

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<sup>64</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal*, V, 9 (January, 1898), p. 230.

<sup>65</sup> CA CO 1572, 4 May, 1893: Correspondence from W. Dodds to the Colonial Office.

<sup>66</sup> CA CO 7160, 3 May, 1894: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>67</sup> CA CO 7161, 10 May, 1894, Correspondence from Dodds to the Colonial Office.

for transfer to Fort Beaufort as 'not dangerous at present'. Both men were removed from the criminal list but were still in Fort Beaufort asylum as ordinary lunatics in 1897.<sup>68</sup>

A number of long term unconvicted criminal cases who were not dangerous were also transferred from Robben Island. Amongst others were Cornelius Davids who had been convicted of assault and violent conduct at Cape Town, in September, 1889; Adam Astron, convicted of theft at Ceres in December, 1885; Jan Damara, guilty of indecent exposure of his person at Durbanville, April, 1888; David Deary, convicted of assault in Wynberg, October, 1888; Hendrik Malgas or Malgas Hendriks, guilty of vagrancy at Cape Town, January 1888. These transfers marked an important new shift in the reverse movement of black patients out of the Western Cape back towards the Eastern Cape. Fort Beaufort from its inception was used to warehouse all the unwanted black cases.<sup>69</sup>

But the situation with regard to black patients classified as dangerous remained unresolved as the Colonial Office refused to authorise the transfer of black patients formally classified under the 1891 Act as dangerous.<sup>70</sup> The case of a man named in the records as patient No 941 Plaaitjie provides important insights into the construction of the dangerous insane. Plaaitjie had been arrested and convicted in Kimberly to twelve months hard labour in August 1891 for stock theft. While in prison in July 1892, he was certified as a dangerous insane criminal and admitted into Grahamstown asylum in October of the same year under the warrant of the Colonial Secretary. He was described at various times

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<sup>68</sup> CA CO 7159, 16 October, 1897: Correspondence from J. Conry to the Colonial Office.

<sup>69</sup> CA CO 7159, 16 October, 1897: Correspondence from J. Conry to the Colonial Office.

<sup>70</sup> CA CO 7162, 17 July, 1894; Memo from the Under Colonial Secretary to W. Adams. Permission to transfer dangerous lunatics Arend Solomons and Piet was repeatedly refused. The Under Colonial Secretary acknowledged that the law would have to be revised so that such cases on expiry of sentence could be dealt with either as ordinary lunatics or if deemed necessary as dangerous lunatics. See also CA CO 7162, 25 March, 1892, for a similar discussion.

as 'depressed with fits of passion', a 'good gardener', a 'quiet harmless worker, very silent'. In fact in 1894 he was one of the inmates selected for transfer to Fort Beaufort but his transfer was refused by the Colonial Office.

His situation deteriorated following an attack on a child in the asylum garden in June 1895; he was described as 'greatly excited' and several attendants were required to restrain him. Restrictions were placed on his movements and he was confined to the asylum under close supervision.<sup>71</sup> In March of 1896, Plaaitjie attacked and badly injured Nurse Kenny who was a member of the female nursing staff, in the airing court of the asylum. Her injuries were so serious that she was unable to continue working and the colonial government, notorious for its parsimony, was required to pay a substantial amount as compensation for her injuries.<sup>72</sup> While it is important not to lose sight of such extreme behaviour, the attack on Nurse Kenny by the patient known only as Plaaitjie raises an important issue pertaining to the label of dangerousness, namely that under the Act of 1891 'dangerousness' formed an essential part in legitimating psychiatric social control interventions. Plaaitjie's violent and unpredictable attacks at Grahamstown asylum merely reinforced the view that he posed a serious threat to public safety which not only justified his incarceration but also served to legitimate the social function of the asylum as a place of confinement rather than treatment.<sup>73</sup>

Further, within the context of colonial relations the association of black men such as Plaaitjie with violence and aggression served to nurture a culture of racism inside the asylum. With his identity defined only by his violent actions as a dangerous lunatic or a

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<sup>71</sup> CA CO 7165, 3 March, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>72</sup> CA CO 7165, 3 March, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>73</sup> CA CO 7165, 3 March, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

good worker, Plaaitjie was stripped of any kind of social value as a person needing care and treatment inside the asylum. In addition, staff made no attempt to investigate the circumstances or conditions inside the asylum that may have precipitated Plaaitjie's violent outburst in the first place. This lack of accountability on the part of staff members points to the fact that violence became a self-fulfilling prophecy when conflated with race and male gender. Instead of reflecting negatively on asylum management, this attack by a black man on a white woman proved to be useful to Greenlees. He was able to exploit the inherent racial tensions inside the hospital to make increasingly strident calls to remove all black patients from Grahamstown asylum.<sup>74</sup>

Law and order policies contained in the Lunacy Acts in the Cape colony concerned with criminal and dangerous mental patients need to be located within the context of power relations that entrenched white interests over those of black patients where ideologies of social defence and security were a priority. These ideologies enabled asylum management to ignore the possibility that Plaaitjie's violent outburst was not only an expression of illness but rather demonstrated the effects of institutionalisation and the indifference towards the general welfare of black patients at Grahamstown asylum. Violence was perhaps the only way for him to resist in a situation in which the real issue was one of powerlessness.<sup>75</sup>

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<sup>74</sup> CA CO 7165, 3 March, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>75</sup> For extensive discussions on the dangerous mental patient and the law see M. Foucault, 'About the Concept of the Dangerous Individual in 19th-Century Legal Psychiatry', *International Journal of Law and Psychiatry*, Vol. 1 (1978), pp 1-18; H. J. Steadman, 'Predicting Dangerousness Among the Mentally Ill: Art, Magic and Science', *International Journal of Law and Psychiatry*, Vol. 6 (1983), pp.381-390; A.M. Lovell and N. Scheper-Hughes, 'De-Institutionalisation and Psychiatric Expertise: Reflections on Dangerousness, Deviancy, and Madness', *International Journal of Law and Psychiatry*, Vol. 9 (1986), pp. 361-381; A.M. Lovell and N. Scheper-Hughes (eds.), *Psychiatry Inside Out: Selected Writings of Franco Basaglio* (New York, 1987).

Despite Greenlees' efforts to transfer him to Robben Island, Plaaitjie remained a patient at Grahamstown asylum until 1897 when he was transferred to Fort Beaufort asylum. He was one of a group of patients described by Greenlees as forming a 'dead block' at Grahamstown asylum. These patients could not be discharged as they were unrecovered, nor could they be transferred to Fort Beaufort or Port Alfred asylums as a result of their classification under the 1891 Act as criminal and/or dangerous patients. Their presence at the asylum created a warehouse effect and prevented the admission of urgent and more recent cases from being admitted.<sup>76</sup>

By 1896 the lack of available accommodation at Grahamstown asylum due to the residue of patients classified as criminal and dangerous was causing widespread concern. Grahamstown asylum was under increasing pressure to admit numbers of insane patients detained in jails all over the Eastern Cape. In September, the Inspector of Prisons reported that lunatics who were almost all Africans were detained in nearly every jail he visited. According to him these cases were 'a constant source of annoyance and danger' to staff and other inmates.<sup>77</sup> In October of the same year the Judge President of the Eastern District Courts, Sir Jacob Barry expressed his concerns at the increase in the number of refused applications for admission to Grahamstown asylum. He noted that these were all African cases who were 'left sitting in jail'.<sup>78</sup> Conditions inside these prisons were not suitable for insane patients and in many cases their mental health deteriorated rapidly, leaving little hope of recovery.<sup>79</sup>

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<sup>76</sup> CA CO 7166, 28 October, 1896: Correspondence between T.D. Greenlees to the Colonial Office.

<sup>77</sup> CA CO 7166, 22 September, 1896: Correspondence from T.D. Greenlees to the Colonial Office. Twenty nine cases were in jail pending transfer to Grahamstown Asylum.

<sup>78</sup> CA CO 7166, 22 October, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>79</sup> CA HFB, Vol. 21, 28 December, 1894: Correspondence from J. Conry to the Colonial Office.

As a result of the external pressures caused by the backlog of cases in jails and the internal pressures on asylum accommodation, under the provisions of the Cape Lunacy Act of 1897, the formal category of dangerousness was subsumed into the category for ordinary insane.<sup>80</sup> Greenlees in particular had felt that the separation of lunatics into dangerous and ordinary cases in the 1891 Act was unhelpful as it made the administration of these cases more complex and his job more difficult and time consuming. In his opinion, dangerousness was a symptom common to most forms of insanity and all mental patients at different times displayed tendencies to dangerousness. He recommended that it would be more useful to regard all patients as dangerous as a matter of course and not make separate provisions for this category. In his view, dangerousness had no scientific basis but was rather a legal construct used at the discretion of magistrates in the certification process.<sup>81</sup>

It is important to emphasise that the classification of the insane as dangerous did not disappear from daily asylum practice. The category still continued to appear on medical and legal certificates and case history notes as doctors used the category in a number of flexible and open-ended ways.<sup>82</sup> It was also used as a practical guideline for any special

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<sup>80</sup> S. Swartz, Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920' unpublished Ph. D. Thesis (University of Cape Town, 1996), p72.

<sup>81</sup> T.D. Greenlees, Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal* (January, 1898), p230.

<sup>82</sup> See T.D. Greenlees, 'Remarks on Lunacy Legislation in the Cape Colony', *South African Medical Journal* (January, 1898), p.230. 'Part 1 of the present Act (1891): Any lunatic dealt with under this section, committed to the gaol by a magistrate, cannot be transferred to an asylum without an order of the Governor, and thus the proper treatment of such cases is unnecessarily delayed. Although the medical officer of an asylum can discharge any case under part three, provided he certifies that the person may be set at liberty without danger to himself or others, he cannot of himself, discharge a 'dangerous lunatic without an order of the Governor obtained only after submitting two medical certificates that 'the person is no longer "dangerous" and may be set at liberty with safety'.

arrangements made inside the asylum for these patients. For example, suicidal patients would need increased vigilance while dangerous lunatics with violent tendencies required restraint and would need to be segregated from other quieter patients.

The Act also introduced new provisions for the criminally insane. 'In the interests of justice', unconvicted criminal lunatics charged with petty crimes or offences could have their charges dropped and by order of the Governor revert back to the status of ordinary lunatics.<sup>83</sup> Following the English precedent, a second amendment changed the legal status of convicted criminals back to that of ordinary lunatics once they had served their sentences.<sup>84</sup> The 1897 Act consolidated the legal provisions for dangerous patients and criminal lunatics and in the Eastern Cape, facilitated the movement of patients through Grahamstown asylum to Fort Beaufort and Port Alfred asylums. It gave asylum superintendents such as Greenlees far more direct control over the transfer and discharges of patients and helped to break the deadlock at Grahamstown asylum.

The amendments in the 1897 Act provided some short term gains in that they facilitated the movement of patients through the system and at the same time helped to relieve some of the pressures on Grahamstown asylum. However, these amendments were largely reactive. Their main weakness that they did nothing to address the most pressing issue which was to move the focus of concern away from control towards providing better facilities and treatment for the increasing numbers of black patients. All the 1897 Act achieved in the Eastern Cape was to shift the problems of dealing with the black insane

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<sup>83</sup> Cape Lunacy Act, 1897: Cape of Good Hope Statutes, 1895-1998: Clause 3, p. 3686; Clause 19, p. 3691.

<sup>84</sup> Cape Lunacy Act, Clause 28, p. 3693.

increasingly onto the Fort Beaufort asylum with its limited resources, by effecting through legal means, the quick removal of black patients out of Grahamstown asylum.

In 1901 Conry, the medical superintendent at Fort Beaufort asylum, remarked on the increasing numbers of violent and excited patients who were sent by transfer from Grahamstown asylum despite the fact that the institution was supposed to be a chronic insane asylum.<sup>85</sup> This was evident in the numbers of patients who needed to be placed in seclusion and in the increase in the number of accidents and injuries due to physical assaults on other patients and on staff members. The asylum did not have the staff or the facilities to cope with actively psychotic and violent patients yet they continued to be sent to Fort Beaufort. Conry protested this situation arguing that although patients in the asylum were 'deprived of their liberty for the public good' it was still necessary to provide them with the 'minimum standards of a healthy existence'.<sup>86</sup> By 1907 conditions at Fort Beaufort asylum were so overcrowded that it was little different from any of the colonial prisons that Dodds and Greenlees were constantly criticising, except that the patients were all black.<sup>87</sup>

Although largely unsuccessful, Dodds and Greenlees used the issue of asylum accommodation and the insane in prisons continually to put pressure on the colonial government to release more funds. Unlike the English lunacy laws, the 1891 and 1897 Acts did not make asylum construction mandatory.<sup>88</sup> As the numbers of insane increased,

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<sup>85</sup> CA HFB Vol. 21, 24 November, 1901: Correspondence from J. Conry to the Colonial Office.

<sup>86</sup> CA HFB Vol. 24, 23 December, 1907: Correspondence from J. Conry to the Colonial Office.

<sup>87</sup> Fort Beaufort Annual Report, 1907: G41-1908.

<sup>88</sup> S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920', unpublished Ph.D. Thesis (University of Cape Town, 1996), p.71.

jails and prisons continued to provide alternative accommodation for the colonial insane and by the early 1900s the situation with regard to the lack of asylum accommodation was once again in a state of crisis. Every year Dodds provided graphic descriptions of conditions inside colonial prisons as a way of drawing attention to the 'evil and the risks' involved in detaining lunatics in country jails.<sup>89</sup> Insane prisoners who for the most part were black patients, were restrained in straight jackets, leg irons and handcuffs for hours and even days on end. Dodds protested that the jail was absolutely unfit for such cases and these 'barbaric practices' tended to convert patients into 'wild beasts'.<sup>90</sup> Eight deaths of insane prisoners in jail were recorded in one year alone.<sup>91</sup> In 1908, the Judge President of the Eastern Districts Court and Mr Justice Graham added their voices in expressing their concerns to the colonial government on the long detention of insane patients in jails and refused to grant any further indefinite or unqualified orders for detention in a prison. In the Judge President's opinion, 'such persons clearly cannot be legally detained in gaol longer than is absolutely necessary. A gaol is not the place where they can receive that proper care and treatment which is their due.'<sup>92</sup>

As pointed out in this chapter, the increased number of insane in the colony was also exacerbated by the 'wandering at large' clauses that were contained in both the 1891 and 1897 Acts. The noticeable increases in insane cases in the Eastern Cape were directly related to these broad ranging provisions. Indigent people living on the margins of colonial society were increasingly 'caught' in the widening net of these legal provisions through new police networks that were empowered to monitor colonial public spaces.

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<sup>89</sup> Inspector of Asylums Annual Report, 1904: G57-1905.

<sup>90</sup> Inspector of Asylums Annual Report, 1904: G57-1905.

<sup>91</sup> Inspector of Asylums Annual Report, 1902: G60-1903.

<sup>92</sup> Inspector of Asylums Annual Report: G41-1908.

These were driven by issues of internal policing and security that were indicative of an increasing intolerance for certain kinds of behaviour such as vagrancy and petty crimes that exceeded the limits allowed by white colonial society.<sup>93</sup>

Conry felt the effects of these laws at Fort Beaufort asylum as increasing numbers of patients were admitted under the provisions for 'wandering at large'. Africans were arrested by the police as vagrants and when they were found to be suffering from insanity even in a 'harmless' form were unnecessarily admitted into Fort Beaufort asylum becoming a burden on the state.<sup>94</sup> In his experience farmers too were becoming increasingly intolerant of troublesome insane patients on their properties. A troublesome individual was 'rushed to jail, nobody wants him there and he must still be moved on until provided with room in some asylum'.<sup>95</sup> The asylum also provided accommodation for people who would have been better cared for in nursing homes or old-age homes. In many cases they had been arrested by police for causing an inconvenience to someone and then admitted into the asylum for care over lengthy periods of time.<sup>96</sup> The 'wandering at large provisions' put additional pressure on Fort Beaufort asylum to provide social welfare and public safety services that went beyond its mandate for dealing with the mentally ill.

In Greenlees' opinion the large numbers of 'wandering at large' had come about because of the nature of colonial society. In his view, few asylums in the world had to deal with a population that was so migratory; in one year he had admitted ten cases from Kimberly

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<sup>93</sup> See B.J.F.Laubscher, *Sex, Custom and Psychopathology* (London, 1937), p.226, who argues that the mentally ill African becomes visible when they become a nuisance to white society.

<sup>94</sup> Fort Beaufort Asylum Annual Report: G55-1904.

<sup>95</sup> Fort Beaufort Asylum Annual Report, 1906: G31-1907.

<sup>96</sup> Annual Report Fort Beaufort Asylum: G41-1908.

alone.<sup>97</sup> Although black women were involved in the colonial economy it was largely black men who were drawn into the colony as migrant labour or tenant farmers and the asylum tended to interface with the casualties of this system which separated individuals from their base communities.<sup>98</sup> These observations did not lead Greenlees to deviate from public policy or from his efforts to exclude large numbers of mentally ill black people from the Grahamstown asylum. In the Cape colony the public policy role of psychiatry to maintain social order and protect colonial society was grounded and legitimated in the legal provisions provided by the three Cape Lunacy Acts. While colonial psychiatrists such as Dodds and Greenlees treated mental illness they also contributed to maintaining social order and protecting civil society. Nowhere was this more evident than in the colonial Eastern Cape with regard to the black insane.

This chapter has demonstrated that the lunacy legislation while promoting reforms in the universal language of rights and moral principles was also based on underlying exclusionary practices where security and social defence became the driving forces behind mental health policies. Fort Beaufort asylum was nominally a public control institution treating only black patients who posed a threat to colonial society. Otherwise black patients were generally neglected. Megan Vaughan has demonstrated similar patterns for black patients in Malawi who were only brought under control when they became a nuisance to white society.<sup>99</sup> One of the aims of this thesis is to demonstrate the ways in which psychiatry in theory and practice reproduced broader colonial relations. The Lunacy Acts legitimated the power of psychiatry and anchored it in the colonial state

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<sup>97</sup> CA CO7166, 22 September, 1896: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>98</sup> J. Cock, *Maids and Madams: A Study in the Politics of Exploitation*, (Johannesburg, 1980)pp. 304-306.

<sup>99</sup> M. Vaughan, *Curing their Ills: Colonial Power and African Illness* (1991)pp.100-127.

facilitating government regulation of colonial populations through authoritarian strategies of security and social defence. Under these laws, the psychiatric mandate to confine was formidable and in many cases mentally ill patients had fewer rights than those caught up in the criminal justice system. Psychiatry as a science needs to be seen as a field of power operating in new forms of governmental rationality as the colonial state took on its role of guardian of the colonial order.

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## CHAPTER FIVE

### TOTAL INSTITUTIONS: A COLONIAL LEGACY

Reforms of colonial policies towards the mentally ill in the late 1880s and early 1890s resulted in the expansion and consolidation of the asylum network in the Eastern Cape. This initiative was premised on the need to transform Grahamstown asylum into a medical environment that would be more conducive to creating better standards of care and treatment for recent, acute and convalescent cases of all races. Based on the classification and differentiation of patients according to modern scientific principles, appropriate treatment was designed to take place in pleasant, park-like surroundings. Patients were encouraged to recover and reassert their own powers of self-control and self-respect in order to become, once again, decent and principled human beings. This desired state was to be achieved through humane practices that incorporated the popular philosophies of non-restraint and moral management that were imported from Britain.<sup>1</sup> Mechanical restraints such as straight-jackets and handcuffs were replaced with milder forms of treatment such as seclusion under the close supervision of trained attendants and nursing staff.

However, moral management at Grahamstown asylum proceeded along strict racial, class and gendered lines that mirrored broader colonial relations. Under the management of Greenlees, internal patterns of differential treatment soon emerged at Grahamstown asylum, based on the ability of patients to pay for treatment. For private patients, Grahamstown asylum closely resembled a convalescent home as they were encouraged to

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<sup>1</sup> A. Digby, *Madness, Morality and Medicine: A Study of the York Retreat* (Cambridge, 1985), p.15.

participate in healthy occupations of 'mind and body'. A range of recreational and leisure activities were available to private patients - from visits to a seaside villa in Port Alfred, to country drives and picnics, to visits into town, religious worship and amateur dramatics and dances.<sup>2</sup> Physical activities such as cricket, bowls and tennis were also available. Reforms introduced at Grahamstown asylum established an embryonic private sector based on personalised care for the wealthy in private suites with individualised medical attention that included nursing staff who were employed directly from England and in some circumstances even extended to providing patients with champagne.<sup>3</sup>

In stark contrast to this luxury, the vast majority of patients, men and women, both black and white, who relied on state welfare were locked into a regime of supplying labour for the asylum. All aspects of asylum maintenance were performed by patients themselves undertaken in the guise of occupational therapy. Women, both black and white, were locked into endless routines of domestic drudgery, washing, ironing and cleaning, employed as seamstresses, as cleaners in the wards, as cooks and kitchen staff, as housekeepers and domestic workers for the medical superintendent. White men were employed as carpenters and artisans, while black men took care of the farm and stables. While the ability to work was regarded as a sign of possible recovery, at best this system was exploitative and coercive. Patients were encouraged to work through a system of rewards and punishments where extra favours such as food or tobacco rations were extended for good behaviour or withheld for non-compliant behaviour. Black patients were

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<sup>2</sup> F. Swanson, 'Colonial Madness: The Construction of Gender in the Grahamstown Lunatic Asylum, 1875-1905', unpublished Honours Thesis (University of Cape Town, 1994), pp.68-89.

For a discussion on private care for mental patients in Britain see C. Mackenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917* (London, 1992).

<sup>3</sup> CA CO 7168, 29 July, 1897: Correspondence from T.D. Greenlees to the Colonial Office.

such an integral part of the labour force at Grahamstown asylum that when they were all removed to Fort Beaufort or Port Alfred asylums in 1908 the new medical superintendent bemoaned the loss of his black labour force. This loss was exacerbated by the reluctance of white patients to take over manual work, which they regarded as demeaning.<sup>4</sup> By 1916 accommodation for a small complement of some thirty black male patients was reintroduced at Grahamstown asylum with a view to providing labour.

The presence of white private patients at Grahamstown asylum worked in some measure to protect the rights of poor and black patients as some minimum standards of care were upheld. Although far from ideal, the asylum provided the basic conditions of food, shelter and some measure of safe custody for many poor and black patients. For example, despite discrepancies in diet scales between men and women and between black and white patients, many black patients benefitted from a regular diet.<sup>5</sup> It was the policy at Grahamstown asylum to pursue a 'gospel of fatness' as weight gain was regarded as a measure of recovery in patients.<sup>6</sup> Greenlees made the observation that the increase in weight was most marked in his African patients who were admitted into the asylum 'poor and starved' and in contrast, left 'fat and well cared for'.<sup>7</sup>

However as indigent, chronic patients were transferred to Port Alfred or Fort Beaufort, key features of this care disappeared. In the first instance, a downgrading of medical care

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<sup>4</sup> S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No. 3 (September, 1995), p.411-412.

<sup>5</sup> Grahamstown Asylum Annual Report, 1897: G28-98. For example the average increases in weight for patients discharged as recovered in 1897 were : six pounds for white men; twenty five pounds for black men; nineteen pounds for white women; twenty seven pounds for black women.

<sup>6</sup> CA CO 1458 13 September, 1890: Dietary scales for black patients were adjusted so that mielie meal formed the basis of their diet, while meat was served only twice a week.

<sup>7</sup> Grahamstown Asylum Annual Report, 1897: G28-98.

occurred with the appointments of lay superintendents and part-time medical doctors, usually district surgeons, who were not trained in psychiatry. The district surgeon appointed on a part-time basis at Port Alfred asylum continued to run his own private practice. Although his frequent absences from the asylum were noted to be a cause of concern, no full-time appointment was made.<sup>8</sup> Conry was appointed as the full-time medical superintendent at Fort Beaufort in October 1898, subsequent to the opening of a separate, small female asylum in 1897, but a psychiatrist was never appointed.<sup>9</sup> Fort Beaufort asylum began to admit recent and acute cases from the surrounding local districts from 1897. Until 1908, when Fort Beaufort became an asylum reserved for recent and chronic African patients, these numbers were relatively small.<sup>10</sup> But patients could wait up to six months before being assessed by Dodds on one of his bi-annual visits to the asylum in his capacity as Inspector of Asylums, making a mockery of the discourses surrounding the claims for early treatment under the expert supervision of a psychiatrist. (See Chapter Two.)

Substandard medical care also extended to the provision of nursing care and high staff turnovers were notable features at both asylums. This was due to a number of factors. In the first place, both asylums were situated in small rural towns where it was difficult to find suitable staff. At Fort Beaufort, Conry attributed the difficulties of attracting and retaining good staff to racial factors where white staff were required to care for black

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<sup>8</sup> CA CO 1572, 21 April, 1893: Correspondence from the Inspector of Asylums to the Colonial Office.

<sup>9</sup> Inspector of Asylums Annual Report, 1897: G28-1898.

<sup>10</sup> Fort Beaufort Asylum Annual Report, 1897: G28-1898. Five acute cases from nearby districts were admitted into the asylum for the first time in 1897. This move was justified in that it was seen as too costly to transport these patients all the way to Grahamstown asylum. Although these numbers were always small it put added pressure on the asylum.

patients.<sup>11</sup> In keeping with the poor status of the asylum in providing for indigent and chronic patients, wages at Fort Beaufort asylum were correspondingly low. Nursing staff, both male attendants and female nurses, tended to be untrained with little or no working experience in caring for mental patients. Hospital duties were onerous and at times even dangerous given that so many of the patients suffered from serious forms of illness. Conditions of employment were made more difficult by the lack of adequate facilities and the overcrowded condition of both the male and female asylums.<sup>12</sup> Despite repeated calls by Conry to increase the numbers of staff, patient to staff ratios were never adequate at the Fort Beaufort asylum. These factors tended to make working conditions generally difficult and unpleasant and there was little inducement for members of the nursing staff to remain in employment for any length of time.<sup>13</sup> An example is that during the Boer war there was a mass exodus of male nursing attendants who were attracted into the army by better wages and the opportunities for adventure.<sup>14</sup>

By 1901 the lack of suitable staff combined with the ever increasing numbers of patients was causing concern.<sup>15</sup> Conry was hard pressed just to maintain the most basic standards of care to keep the asylum in any kind of practical working order.<sup>16</sup> In an effort to solve the staffing problems at the asylum Conry was authorised by the Colonial Office to employ black staff from the surrounding areas but this was largely unsuccessful. Applications were

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<sup>11</sup> CA HFB Vol. 24, 2 March, 1900: Correspondence from J. Conry to the Colonial Office.

<sup>12</sup> CA HFB Vol. 24, 11 August, 1900: Correspondence from J. Conry to the Colonial Office

<sup>13</sup> See CA CO 7160, 7 June, 1898: Correspondence from J. Conry to the Colonial Office; CA HFB, Vol. 2, 6 October, 1898: Correspondence from J. Conry to W. Dodds; CA HFB, Vol. 24, 8 May, 1899: Correspondence from J. Conry to the Colonial Office.

<sup>14</sup> Fort Beaufort Asylum Annual Report, 1898: G20-1899.

<sup>15</sup> CA HFB, Vol. 24, 2 March, 1901: By the end of 1900 the inmate population at Fort Beaufort asylum had risen to 257.

<sup>16</sup> CA HFB, Vol. 24, 2 March, 1901: Correspondence from J. Conry to the Colonial Office.

few in number and those men who were hired proved to be unsuitable. Conry complained that African staff were unreliable, often rough with patients and non-compliant when it came to discipline, refusing to do some aspects of their work which they regarded as demeaning.<sup>17</sup> A mixed work force of black and white nursing attendants created internal tensions. African staff were paid a meagre wage of one shilling per day, with board and lodging, but were required to do the same work as European staff.<sup>18</sup> Wage discrimination was exacerbated by the superior education of black staff. In many cases, African staff were better educated than some of their white colleagues who were illiterate.<sup>19</sup> If African staff were to be an effective means of solving the critical staff shortages at the asylum, Conry proposed that nursing attendants should all be African, working under the supervision of senior white charge attendants. He made the point that as good men were hard to find, wages needed to be substantially increased. There was little incentive for black staff to remain in employment at the asylum under the existing conditions when other options were open to them. Africans retained a measure of independence with regard to work choices in that high prices were being paid in the district for maize harvests and cattle.<sup>20</sup>

Conry's suggestions were not adopted and staff shortages continued to plague the asylum. The decision to segregate the three Eastern Cape asylums solely along racial lines in 1907 resulted in a substantial increase in the numbers of recent and acute patients who needed specialised care, but no attempt was made to upgrade the nursing staff at Fort Beaufort

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<sup>17</sup> CA HFB, Vol. 24, 4 June, 1901: Correspondence from J. Conry to the Colonial Office.

<sup>18</sup> In comparison, cash wages for mine workers at Kimberley during the same period varied between twenty to thirty shillings per week. See P. Harries, *Work, Culture and Identity: Migrant Labourers in Mozambique and South Africa, c1860-1910*, (Johannesburg, 1994), p.52.

<sup>19</sup> CA HFB, Vol. 24, 4 June, 1901: Correspondence from J. Conry to the Colonial Office.

<sup>20</sup> CA HFB, Vol. 24, 11 June, 1901: Correspondence from J. Conry to the Colonial Office.

asylum. Instead, in the interests of economy, a new category of lower ranking 'native helps' was introduced, creating clear and unequal racial hierarchies within the nursing staff. Wages for African staff were pegged between one and two shillings per day and rations were set at fifteen pounds a year as opposed to twenty five pounds for white staff. In the 'interests of cleanliness', African staff were provided with uniforms, but these were distinct from the uniforms of white staff and cheaper in quality.<sup>21</sup>

At no time did medical or nursing complements at Fort Beaufort or Port Alfred asylums compare favourably with those of Grahamstown asylum. These discrepancies were always justified on financial grounds, in that indigent patients with little hope of recovery did not need expensive care. In addition to this downgrading of medical and nursing attention Fort Beaufort and Port Alfred asylums never provided sufficient or suitable accommodation for the special needs of mental patients. Classification and differentiation of mental patients that were such a fundamental element of medical treatment were virtually non-existent at Fort Beaufort asylum. In both the male and female asylums, patients were herded together in large dormitories and if they became violent and difficult to manage they were secluded and locked up in single rooms. But given the haphazard and piecemeal arrangements at the asylum, there were insufficient single rooms to cope with the needs of patients during periods when they were actively psychotic or agitated. At times patients were even left to sleep in the corridors.<sup>22</sup> By 1908, facilities at the asylum were completely over extended. Conry reported that both male and female asylums were overcrowded with 'excited and dangerous' patients who required single room accommodation. He warned

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<sup>21</sup> CA HFB, Vol. 3, 26 April, 1907: Correspondence from Medical Superintendents to the Colonial Office.

<sup>22</sup> Fort Beaufort Asylum Annual Report, 1900: G28-1901.

that, 'it is a saddening and trying state of affairs to face each night with the knowledge that death may occur from violence among the excited cases who cannot be separated owing to the lack of single rooms'.<sup>23</sup>

However, the tendency remained to locate the endemic violence at Fort Beaufort in the experiences of mental illness and to ignore the social context in which this violence occurred. Facilities at Fort Beaufort were at best rudimentary and far from ideal. Furniture was kept to a bare minimum and the dormitories were bleak and austere places, a far cry from the proposed ideal of the asylum as a home from home. At the male asylum, patients who were unable to work spent most of their days outside in the enclosed airing court where there was little shelter from the elements. When it rained patients were all herded together in one day room, a scene which Conry reported needed to be witnessed to be believed. Staff battled to keep conditions clean and sanitary when patients were confined to the day room for any length of time due to inclement weather.<sup>24</sup>

As could be expected, the overcrowded and unsanitary conditions led to frequent outbreaks of infectious diseases in both the male and female asylums and enteric fever, typhoid and tuberculosis were endemic.<sup>25</sup> Conry attributed the high rates of tuberculosis in Africans in the Fort Beaufort area to the unsanitary living conditions contained in their 'mud huts'. In his view, overcrowded huts were responsible for a lack of personal cleanliness and an unhealthy food supply. In his experience African children were susceptible to chest diseases because of their unclothed states which made them

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<sup>23</sup> Fort Beaufort Asylum, Annual Report, 1908: G41-1909.

<sup>24</sup> Fort Beaufort Asylum, Annual Report, 1906: G31-1907.

<sup>25</sup> CA HFB, Vol. 24, October, 1901: Correspondence from J. Conry to the Colonial Office.

vulnerable to tuberculosis as adults.<sup>26</sup> The overcrowded conditions at the asylum facilitated the rapid spread of tuberculosis which was not yet recognised as an infectious disease. In 1906, thirty seven deaths occurred at the asylum among staff and patients as a result of an outbreak of typhoid. The local water supply was identified as the source of contamination, but Conry also pointed to the African locations surrounding Fort Beaufort as other sources of contamination.<sup>27</sup> An outbreak of scurvy occurred in 1909, the unintended results of cost cutting exercises where diet scales at the asylum had been reduced to an absolute minimum.<sup>28</sup> Life as a mental patient at Fort Beaufort asylum was really no better than being confined in one of the colonial jails as in many cases, mental illness was exacerbated by the pathological conditions inside the asylum.

Although it was a much smaller asylum accommodating one hundred patients, conditions at Port Alfred asylum were no better. Port Alfred asylum was distinctive in that its patient population was made up of low prestige cases, the senile elderly and the mentally handicapped of all races.<sup>29</sup> While Dodds urged asylum staff to 'exercise ingenuity and perseverance' when dealing with patients of the 'most unfavourable kind', this did not extend to providing any kind of quality care.<sup>30</sup> Employment at the asylum was marked by low wages and long working hours as the small complement of only eight full-time nursing staff were locked into endless regimes of cleaning and washing patients.<sup>31</sup> Nursing staff were required to undertake additional duties that at Grahamstown and Fort Beaufort asylums involved patient labour. Staff turnovers were high, due to voluntary resignations

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<sup>26</sup> CA HFB Vol. 24, October, 1901: Correspondence from J. Conry to the Colonial Office.

<sup>27</sup> Fort Beaufort Asylum, Annual Report, 1906: G31-1907.

<sup>28</sup> Fort Beaufort Asylum, Annual Report, 1909: G25-1910.

<sup>29</sup> CA CO1572, 12, 13 April, 1893: Correspondence from W. Dodds to the Colonial Office.

<sup>30</sup> Ca CO 1531, 25 April, 1892: Correspondence from W. Dodds to the Colonial Office.

<sup>31</sup> CA CO1572, 14, 15 June, 1892: Correspondence from W. Dodds to the Colonial Office.

or dismissals as a result of negligence and drunkenness.<sup>32</sup> Coloured nursing staff were employed at the asylum in an effort to create a more stable and reliable work force. More than anything else, patients at Port Alfred were vulnerable to neglect and disinterest as many of them remained in helpless and dependent states. This was reflected in the high rates of accidents reported at the asylum. Thirty six accidents were recorded in a period of six months. One patient was badly burned, others were injured in falls where limbs were broken and another found drowned in the river.<sup>33</sup> Death rates at Port Alfred asylum were the highest for all three asylums but this was never questioned as it was considered a result of the numbers of elderly patients resident.<sup>34</sup> Policies of non-restraint did not apply at Port Alfred and patients who were destructive of their clothing were placed in straight jackets with their hands tied and locked behind their back for extended periods.<sup>35</sup> The saving grace at Port Alfred asylum was that a few of the less disabled patients were taken on regular trips down to the beach. For the most part however, senile and mentally disabled patients at Port Alfred were contained and isolated in a 'twilight zone', while at the same time being neglected.<sup>36</sup>

In the Eastern Cape, chronic mental disease and social welfare issues were embedded in colonial relations that undoubtedly shaped administrative practices that partitioned off spaces and segregated the mentally ill from society in what were to become virtual ghettos. But the heart of the problems at both Port Alfred and Fort Beaufort asylums were related to matters of finance and the reluctance of the colonial state to allocate resources to the

<sup>32</sup> CA CO1572, 14, 15 June, 1892: Correspondence from W. Dodds to the Colonial Office.

<sup>33</sup> CA CO 1572, 12, 13 April, 1893: Correspondence from W. Dodds to the Colonial Office.

<sup>34</sup> CA CO 1572, 12, 13 April, 1893: Correspondence from W. Dodds to the Colonial Office.

<sup>35</sup> CA CO 1490, 5 August, 1891: Correspondence from W. Atherstone to the Colonial Office.

<sup>36</sup> A. Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700-1900* (New Haven, 1993), p.161.

most marginal members of colonial society. Under the direction of Dodds and Greenlees, Valkenburg and Grahamstown asylums had always been allocated the greatest sums of money, leaving the low status asylums constantly battling for resources<sup>37</sup>. At Grahamstown asylum Greenlees had been successful in expanding the base of private patients. Income derived from this source increased over the years and was used to contribute to the escalating running costs of the asylum.<sup>38</sup> Crucially, this income was also used to subsidise the welfare costs of deserving white patients. At the same time, Greenlees augmented his own salary by drawing commission on the income generated from these paying patients, whose presence in the asylum served to raise both its stature and reputation.

The aversion of Greenlees to the presence of black patients at Grahamstown asylum was not only based on ideological grounds and his innate racism, but lay also in his recognition that black patients were economic liabilities in that they were unable to contribute financially to their maintenance.<sup>39</sup> At the same time there was a corresponding reluctance on the part of the colonial government to continue to subsidise the black insane who had previously always been classified as pauper patients.<sup>40</sup> Following the decision to segregate the three asylums solely on racial lines in 1907 and with the Cape colony in the midst of an economic recession, the government began to search for new solutions to their ongoing financial problems regarding the black insane. At the instigation of Dodds in the late

<sup>37</sup> Port Alfred Asylum, Annual Report, 1904: Correspondence from W. Atherstone to the Colonial Office. In the twelve years of Port Alfred's existence only 8 000 pounds had been allocated for improvements. Atherstone remarked about the demoralising effect on the staff.

<sup>38</sup> For example in 1898 the income received from paying patients at Grahamstown asylum for the year was over 3 000 pounds. See CA CO 7169, 28 May, 1898: Correspondence from T.D. Greenlees to the Colonial Office.

<sup>39</sup> T.D. Greenlees, 'Remarks on Lunacy Legislation', *South African Medical Record* (January, 1898), p.223; See A. Digby, '“A Medical Eldorado”? Colonial Medical Incomes and Practice at the Cape', *Social History of Medicine*, 7, 3 (1995), pp. 475-476, for a discussion on medical practitioners' attitudes to black patients and their perceived lack of economic potential.

<sup>40</sup> CA HFB Vol. 4, 6 July, 1908: Correspondence from the Colonial Office to J. Conry.

1890s, Conry had made several unsuccessful attempts to board out quiet patients with the local Fort Beaufort farmers, both black and white in order to alleviate the burden of the chronic insane. These farmers proved to be generally unwilling to take on these responsibilities.<sup>41</sup>

In his annual report of 1906 Dodds first emphasised the need for black families to take some kind of financial responsibility for their insane relatives.<sup>42</sup> In 1908 the colonial office instigated an aggressive plan by authorising resident magistrates in the Eastern Cape to obtain some kind of minimum contribution from black families towards the cost of maintenance of their relatives in government institutions.<sup>43</sup> It was hoped by this means to foster a habit of making regular contributions. But these moves on the part of government were naive and proved to be generally unsuccessful. Magistrates were either unable to locate family members or if the search was successful, most families were not in any financial position to make any kind of contribution.<sup>44</sup> Suggestions were even made to impose a 'hut tax' to assist in keeping costs down.<sup>45</sup> At Fort Beaufort, the illegal practice of confiscating patients' money on admission as a casual contribution towards their maintenance was instigated, despite the fact that the lunacy laws laid down quite specific guidelines against this.<sup>46</sup>

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<sup>41</sup> Fort Beaufort Asylum Annual Report, 1897: G28-98; Fort Beaufort Asylum Annual Report, 1898: G21-99.

<sup>42</sup> Inspector of Asylums Annual Report, 1906: G31-1907.

<sup>43</sup> CA HFB, Vol. 4, 6 July, 1908: Correspondence from the Colonial Office to J. Conry.

<sup>44</sup> See CA HFB Vol. 10, 17 October 1910: Correspondence from the Resident Magistrate, Butterworth to the Colonial Office; CA HFB Vol. 8, 16 June, 1910: Correspondence from the Resident Magistrate, Lady Frere to the Colonial Office.

<sup>45</sup> CA HFB, Vol. 3, 26 April, 1907: Conference of Medical Superintendents, Grahamstown Asylum.

<sup>46</sup> CA HFB, Vol 24, 21 February, 1901: Correspondence from the Colonial Office to J. Conry ; This was justified by interpreting Clause 31 of the 1897 Lunacy Act to refer only to paying patients. See CA HFB Vol. 7, 24 January, 1910: Correspondence from the Colonial Office to J. Conry.

The problem of maintaining large numbers of dependent black patients at Fort Beaufort was exacerbated when racial segregation of mental institutions in 1908 meant that Fort Beaufort asylum was the only institution in the Eastern Cape treating the African insane. The asylum was not equipped to cope with these new demands on its services. Instead of instituting a much needed upgrade to provide for the increased numbers of recent and acute cases, a 'hut location' was built on the premises to accommodate up to one hundred quiet, chronic male patients. At the instigation of Dodds, twenty five wattle and daub huts were erected to accommodate 'quiet and weak-minded male native patients needing but little care and attention and able to live in condition approximate to their homes'.<sup>47</sup> Each hut accommodated five male patients. To save expenses, no bedsteads were provided and patients slept on the floor on rugs and mattresses. The hut annexe or 'Conry's annexe' as it later became known, was justified as an attempt to provide accommodation that was less confining for those patients who would spend the rest of their lives living in the institution. But in effect it was really just a cost saving exercise that saved the government almost 7 000 pounds.<sup>48</sup> The original idea had been conceived by Conry, but it was revised at the meeting of the five medical superintendents held at Grahamstown in April 1907.<sup>49</sup> Following his unsuccessful attempts to place black patients with local farmers, Conry devised a plan to create some kind of community based farm colony where patients under supervision could work and live in less restrictive surroundings. This proposed project was modelled on other successful community based projects such as the ones in Gheel in

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<sup>47</sup> Inspector of Asylums Annual Report, 1905: G32-1906.

<sup>48</sup> S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, Vol. 21, No. 3 (September, 1995), p.410.

<sup>49</sup> CA HFB, Vol. 3, 26 April, 1907: Correspondence from the Conference of Medical Superintendents to the Colonial Office.

Belgium and in Scotland where farming communities were created for the mentally handicapped.<sup>50</sup>

Twenty five thatched huts fenced off in a bare corner of the asylum grounds as an extension of a traditional rural world was a far cry from Conry's original concept. The entire project indicates the extent to which colonial policies adopted towards the black insane both by the government and colonial doctors were driven by financial concerns rather than by any attempts to grapple with the very real and serious nature of mental illness in the black population of the colony. By 1910, with no corresponding upgrading of their facilities neither Fort Beaufort nor Port Alfred asylums was equipped to provide any kind of medical care for recent and acute cases. Colonial psychiatrists such as Dodds and Greenlees created a two-tiered system of treatment in the Eastern Cape that privileged individualised care for those who could afford it at the expense of the vast majority who were poor. The most common feature of care was that patients were merely shut away in isolated and remote corners of the colony. This period, which was hailed as one of progress and reform was in fact distinguished by the disappearance at Port Alfred and Fort Beaufort asylums of any of the features that were considered necessary for treating the mentally ill. Despite the advocacy of Dodds and Greenlees that their vocation was a 'noble and 'philanthropic' one, they had in fact created a system where for the most part care was no better than in the prison system which they had both been at such pains to criticise. The history of internment and control in the Eastern Cape during the colonial period forms an integral part of the genealogy of psychiatric practice in South Africa that

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<sup>50</sup> See P. Sedgwick, *Psychopolitics* (Oxford, 1980), p.241-256; R. Castel, *The Regulation of Madness* (Berkeley, 1988), p.224.

was directly shaped by the racial, class and gendered character of the patient body. In the present post apartheid era, the racial foundations of these institutional arrangements are in the process of being dismantled.<sup>51</sup>

More than thirty years after union, the legacy of colonial psychiatric practice in the Eastern Cape led to an outbreak of violence that serves as a final illustration of the impact of colonial psychiatry on black mental patients. On the evening of 7 January 1943, two hundred and fifty male patients at Fort Beaufort Mental Hospital went on the rampage. Using garden tools such as spades, rakes and picks looted from a storeroom, patients smashed through the locked doors and barred windows separating the wards and dormitories. Baton-wielding nursing attendants were unable to contain the violence, as the riot spread throughout the hospital block. In the ensuing chaos and confusion, staff members and other patients were indiscriminately assaulted, hospital property destroyed and blankets and bedding set alight. Twenty-one patients and seven African nursing staff were injured. Timely intervention by the police and the local army volunteer regiment restored order and prevented the perceived threat of a frenzied mob of armed and dangerous mental patients running amok within the Fort Beaufort community.<sup>52</sup>

Officially, it was reported that the violence had started in the wards and dormitories accommodating all the hospital's epileptic patients.<sup>53</sup> Epilepsy was a serious and irreversible organic brain disorder leading to dependency needs that persisted over a

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<sup>51</sup> See G 68 E2, 9/96: Government White Paper, Human Rights Violations and Alleged Malpractices in Psychiatric Institutions, January, 1996.

<sup>52</sup> State Archives, Pretoria (SAB), NTS 7682 R170/332, Internal memo, Dr. P.C. Uys, Office of the Mental Hospital, Fort Beaufort, 17 January 1943.

<sup>53</sup> SAB, NTS 7682 R170/332, Correspondence to the Commissioner of Mental Health, Pretoria from Dr. I.R. Vermooten, Physician Superintendent, Office of the Mental Hospital, Fort Beaufort, 21 January, 1943.

lifetime. In 1943, no effective treatment was available and epileptic patients at Fort Beaufort formed a substantial proportion of the chronic, long-stay hospital population, placing a considerable burden on hospital resources.<sup>54</sup> In the report it was stressed that, by the very nature of the disease, epileptics were difficult patients to nurse; they lacked self control, were often confused and agitated and were predisposed to irrational outbursts of violent behaviour.<sup>55</sup> According to the report, the arson, vandalism and assault committed by inmates were the outward and visible signs of this underlying pathological condition. As these inmates were sick, they could not be held responsible for their actions.<sup>56</sup> The report concluded that given these circumstances, no member of staff could have anticipated or prevented the outbreak of violence which was sudden and unprovoked. Faced with this difficult situation, staff had in fact acted in a restrained and sensible manner.<sup>57</sup>

According to the report, the situation was aggravated by a small group of inmates who were 'intent on fomenting trouble' inside the hospital. These men were identified as being frequently hostile towards authority, aggressive, confrontational and non-compliant. They

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<sup>54</sup> Under the 1916 South African Mental Disorders Act, which was still in force in 1943, epilepsy was classified as a mental illness and defined as 'a person suffering from any condition which brings about lapses in consciousness, which may or may not be accompanied by seizures which may become chronic'. A. Kruger, *Mental Health Law in South Africa* (Durban, 1980), p.48.

<sup>55</sup> Epilepsy is a neurobiological disorder with underlying psychiatric complications. Symptoms range from seizures, disorders of movement and awareness, disorientation and cognitive impairment. Major advances in drug related therapies for epilepsy only took place after the Second World War in the 1950s and 1960s and facilitated treatment in non-institutionalised settings. Today most epileptics are able to lead normal and productive lives. See O. Temkin, *The Falling Sickness: A History of Epilepsy from the Greeks to the Beginnings of Modern Neurology* (Baltimore, 1971), pp.386-387; R. Porter, 'Epilepsy: Social Section' in G.E. Berrios and R. Porter (eds.), *A History of Clinical Psychiatry: The Origins and History of Psychiatric Disorders* (London, 1995), pp.164-172. For a discussion on epilepsy within the South African context see M. Blackbeard, 'Epilepsy: Legal Problems in South Africa', unpublished Ph.D. Thesis, University of South Africa, June, 1994.

<sup>56</sup> See S. Sontag, *Illness as Metaphor* (New York, 1978); *AIDS as Metaphor* (Harmondsworth, 1989). Epilepsy was a highly stigmatised disease, commonly viewed by outsiders with fear and deep-rooted prejudices.

<sup>57</sup> SAB, NTS 7682 R170/332. Dr. P.C. Uys, Office of the Mental Hospital Fort Beaufort, 17 January, 1943.

threatened the safety and security of other helpless inmates who were coerced into participating in the riot, as well as that of the broader Fort Beaufort community. One inmate, No. MN 2436, Sam Makleni was identified as the 'ringleader and troublemonger'. The report stated that when he was not incapacitated by fits, he possessed 'organising abilities of no mean order' and found that he was responsible for instigating the violence.<sup>58</sup>

Punitive interventions were made to break up this network of patient alliances and Sam Makleni became a convenient scapegoat. He was isolated from the other inmates and locked up in seclusion for several weeks on the grounds that his continued anti-social and threatening behaviour posed a 'danger to others and himself'.<sup>59</sup> He was eventually transferred to another unspecified institution and so offloaded into a system where the restraint and control of the dangerously mentally ill was regarded as a legitimate part of the medical regime.<sup>60</sup> Possessing fewer rights than a person in the criminal justice system, Sam Makleni was condemned to endless confinement within the catch-all psychiatric category 'danger to others' that contradictorily defined him as both mad and sane. Five other 'troublemakers' were separated and moved to alternative wards where they were kept under increased surveillance.<sup>61</sup>

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<sup>58</sup> SAB, NTS 7682 R170/332. Dr. P.C. Uys, 17 January, 1943.

<sup>59</sup> 'Danger to self and/or others' is a key legal principle for involuntary civil commitment to a mental institution. It concerns issues of risk and harm embodied in the mentally ill person who might become violent. The two categories although linked together, deal with two separate issues. 'Danger to self' describes behaviour ranging from self neglect to suicide as its most extreme form. 'Danger to others' in its broadest sense implies violent and aggressive behaviour that poses a threat to the safety of others. See A. Cohen, 'The Psychiatric Assessment of Dangerousness at Valkenberg Hospital', unpublished MA Thesis, (University of Cape Town), June, 1994. p.4.

<sup>60</sup> P. Chesler, *Women and Madness*, (New York, 1997), p.8.

<sup>61</sup> SAB NTS 7682 R170/332. Dr. P. C. Uys, 17 January, 1943.

Strategies of blaming a few patients for the violence and absolving the rest as innocent victims merely served to deflect attention away from the real issues at hand.<sup>62</sup> What the report revealed was that the incident at Fort Beaufort was very much part of a general protest against the desperate conditions inside the hospital, a response to a situation that for many patients had become unbearable. Riddled with internal tensions and conflicts, the records reveal a closed, isolated and confined world of locked wards, barred windows, enclosed yards and armed nursing staff. Patients expressed their frustration and anger at the lack of personal privacy caused by the overcrowded living conditions in the wards and dormitories. Personal belongings haphazardly stored under beds were searched on a regular basis by staff looking for illegal contraband such as razor blades and bits of wire. Meagre possessions were arbitrarily confiscated in this process. Patients objected to the fact that they were required to perform menial labour as gardeners and cleaners under the guise of occupational therapy without financial compensation.<sup>63</sup>

Diet and food were used as disciplinary strategies that were both demeaning and degrading. A system of rewards and punishment operated whereby privileges such as extra meat rations were given as a reward to patients for good behaviour, or withheld as a way of controlling difficult and unco-operative patients.<sup>64</sup> The authoritative structures within the hospital created an atmosphere of mistrust and tension, not only between patients and staff, but between patients themselves as they competed for private space. When Sam Makleni

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<sup>62</sup> See J. Sims, *Medical Power in Prisons: The Prison Medical Service in England, 1774-1989* (Milton Keynes, 1990), for a discussion on the handling of prison riots.

<sup>63</sup> SAB NTS 7682 R 170/332. Dr. P. C. Uys, 17 January, 1943.

<sup>64</sup> This was a well established principle in all mental hospitals in the Cape Colony during the nineteenth century and proved to be particularly durable. It was still in use in some South African mental hospitals in the 1980s. See H.J. Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies*, 22, 2 (June, 1996), pp. 297-298; S. Swartz, 'The Black Insane in the Cape, 1891-1920', *Journal of Southern African Studies*, 21, 3, (September, 1995), pp. 409-410.

openly contested a decision by staff to deprive him of food, which was always in short supply, all these pent up frustrations and shared grievances boiled over into a full scale riot.<sup>65</sup>

Clearly, if the outbreak of violence was an expression of mental illness, it was even more a collective response to the pathological conditions and deprivations produced within the 'total' institution itself.<sup>66</sup> But significantly, doctors dismissed these grievances and concerns as 'trivial, merely irritating factors', glossing over the many shortcomings inside the institution. By refusing to accept any responsibility for the poor conditions inside the hospital, doctors were able to deflect criticism away from their own flawed administrative practices.<sup>67</sup> In order to maintain an appearance of professional competence in the face of this breakdown of internal order, hospital authorities deliberately played down the incident in public. A short press statement was released in which the extent of the violence was muted. The riot was reduced to a disturbance, the number of injuries limited to two people and the minor problems settled to the satisfaction of the 'natives'. *The Star* newspaper reported the story in its back pages, far more concerned with the global struggle of the Second World War than the small local struggle of a group of men attempting to claim

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<sup>65</sup> The overcrowded conditions inside the hospital created serious health problems for inmates throughout the war years. Dysentery and diseases of malnutrition such as pellagra, scurvy and beriberi were endemic to the institution. The hospital also suffered from critical staff shortages. See M. Minde, 'History of Mental Health Services in South Africa, Part III: The Cape Province', *South African Medical Journal*, (2 November, 1974), p. 2232.

<sup>66</sup> See E. Goffman, *Asylums: Essays on the Social Situations of Mental Patients and Other Inmates* (Harmondsworth, 1961), for an account of the encompassing effects of 'total' institutions that strip away the identity of inmates, controlling all aspects of their lives through bureaucratic organisation. For a discussion on South African total institutions such as prisons and mine compounds, see C. van Onselen, 'Crime and Total Institutions in the Making of Modern South Africa: The Life of "Nongoloza" Mathebula, 1867-1948', *History Workshop Journal*, 19, (Spring, 1985), pp. 62-81; R. Turrell, 'Kimberley's Closed Compounds: A Model for Southern African Compounds', African Studies Seminar Paper, African Studies Institute (University of the Witwatersrand, September, 1982).

<sup>67</sup> SAB NTS 7682 R170/332, Correspondence to the Commissioner of Mental Health, Pretoria from Dr. I.R. Vermooten, Physician Superintendent, Office of the Mental Hospital, Fort Beaufort, 21 January, 1943.

their human rights.<sup>68</sup> The final ironic twist to the story was provided by the Department of Native Affairs who expressed interest in the possible responsibility of the hospital's African employees in the riot. The department was investigating a number of recent disturbances in similar institutions where 'native' staff were involved.<sup>69</sup>

By 1943, despite repeated calls over the years to shut it down, Fort Beaufort Mental Hospital also known by this time as Tower Hospital, remained a large, isolated and mainly custodial institution. The hospital was one of twelve government funded institutions in the Union of South Africa providing care for the mentally ill under the centralised authority of the Department of Internal Affairs. Although these institutions were all racially segregated providing separate and generally unequal facilities for black and white patients, the Fort Beaufort institution remained, as in the colonial period, an institution reserved exclusively for black patients with rigid separation enforced between male and female patients.<sup>70</sup> Patients involved in the riot were all black men, involuntary civil commitment cases drawn largely from communities marginalised by years of rural underdevelopment and the racialised low wage urban economy.<sup>71</sup> Their poor social status within the institution itself was conditioned by the chronic and incurable nature of their disease and by their dependence on state welfare for their treatment.<sup>72</sup> Confined to the overcrowded wards of a

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<sup>68</sup> *The Star*, 10 January, 1943.

<sup>69</sup> SAB NTS 7682 R170/332 Secretary for Native Affairs, 13 January, 1943.

<sup>70</sup> M. Minde, 'History of Mental Health Services in South Africa, Part III: The Cape Province', *South African Medical Journal*, 2 (November, 1974), p. 2232.

<sup>71</sup> S. Marks and N. Andersson, 'Industrialisation, Rural Health and the 1944 National Health Services Commission in South Africa' in S. Feiermann and J. M. Janzen (eds.), *The Social Basis of Health and Healing in Africa* (Berkeley, 1992), pp. 137-140.

<sup>72</sup> Services for black patients after Union generally did not improve to any great extent. See R. Edgar (ed.), *An African American in South Africa: The Travel Notes of R. J. Bunche* (Athens, 1992), pp. 188-189, for a discussion of Weskoppies Mental Hospital in Pretoria in the 1930s: See R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, A Twentieth-Century South African Prophet* (Johannesburg, 1999).

public institution, stigmatised by a disease such as epilepsy and exposed to the daily degradation's of what Foucault describes as 'complete and austere' institutions, these men experienced a continual reinforcement of their devalued and diminished status.<sup>73</sup>

The events at Fort Beaufort Mental Hospital in 1943 bring into sharp focus the pervasive and enduring legacy of colonial policies adopted towards the black insane. They highlight the resilient and durable character of the underlying practices and structures that were laid down in the late nineteenth century and early twentieth century. The riot draws attention to the 'hard' end of psychiatric care, to the quite blatant non-therapeutic social functions of confinement, discipline, regulation and control of the mentally ill. As an administratively driven institution with an emphasis on control and cost effectiveness, patients were transformed into inmates and guarded rather than treated, reducing the capacity of the hospital to function as a medical institution providing a patient-centred environment. At best, the institution functioned as auxiliary and subordinate police cells. Just as in the colonial era, the main function of the hospital was to protect the community from the dangerously insane and the outbreak of violence at the hospital merely served to legitimate and reinforce the power invested in this medical model to confine and control. At the same time it served to insulate medical staff from any kind of public scrutiny or accountability.

The riot in 1943 also demonstrates the high stakes involved for the people who were caught up in the injustices and inhumanity of institutional life where overcrowding and the absence of therapeutic activities were the norm. The pessimistic and negative discourses

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<sup>73</sup> M. Foucault, *Discipline and Punish: The Birth of the Prison* (London, 1991), p. 235.

about the essential hopelessness of mental illness combined with the threat of violent behaviour formed part of a legitimising narrative that linked psychiatric medicine to a 'cult of incarceration'.<sup>74</sup> In South Africa for much of the twentieth century black patients were only drawn into this system when they posed a danger to society. Otherwise they were generally left outside the system.<sup>75</sup> The distancing effects afforded through the medical model left black patients at Fort Beaufort hospital with few opportunities to negotiate better conditions. Not only were patients deprived of their liberty, but they were forced to endure the psychological and physical distress of living in these dehumanising conditions.

On another level, the riot at Fort Beaufort hospital demonstrates that despite all the restrictions and encompassing effects of a 'total institution', patients were able to create networks and alliances amongst themselves. Human beings, even in the most restrictive of circumstances, have a remarkable capacity for innovation, survival and resistance.<sup>76</sup> Although this resistance was only partial and temporary, the violence that surfaced at Fort Beaufort was a response to a whole range of frustrations that were caused by the pathological effects of institutionalisation. The riot at Fort Beaufort serves as a powerful reminder that the philosophy of incarceration and control after 1910 remained intimately connected to the ongoing exercise of the power relations invested in medical and psychiatric practice in the Eastern Cape and elsewhere in South Africa.<sup>77</sup>

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<sup>74</sup> M Terre Blanche, ' "The Knowledge that One Seeks to Disinter": Psychiatry and The Discourse of Discourse Analysis,' in A. Levett, A Kottler, E Burman, and I. Parker (eds.), *Discourse Analysis in South Africa* (Cape Town, 1997), p. 140.

<sup>75</sup> D. Foster, ' Introduction', in S. Lea and D. Foster (eds.), *Perspectives on Mental Handicap in South Africa* (Durban , 1990).

<sup>76</sup> See C. van Onselen, ' Crime and Total Institutions in the Making of Modern South Africa: The Life of "Nongoloza" Mathebula, 1867-1948', *History Workshop Journal* , 19 (Spring, 1985), p. 63.

<sup>77</sup> M. Foucault in C. Gordon (ed.), *Michel Foucault: Power/ Knowledge Selected Interviews and Other Writings, 1972-1977* (New York, 1980), p. 131; See also M. Foucault, *The Birth of the Clinic* (New York, 1970); *Madness and Civilisation: A History of Insanity in the Age of Reason* (London, 1991).

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CO 7163	Letters received by Colonial Office, 1895
CO 7163	Letters received by Colonial Office, 1895
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