Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920

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ABSTRACT

This dissertation describes the evolution of psychiatric practice in the Cape during period 1891-1920, following the appointment of the colony's first Inspector of Asylums. It was a time during which legal reform and social and economic change brought about significant shifts in management of the Cape insane population. The dissertation describes conditions of increasingly strict segregation of patients according to racial categorisation and gender. It argues that this period was pivotal in establishing psychiatric practices closely related to those in Britain. Particular attention is given to the history of Valkenberg Asylum, which opened in 1891, and was the colony's first whites-only asylum.

The dissertation describes those features of colonialism rendered visible through Cape psychiatric practice, and explores their implications for the management of the Cape insane. It argues that Cape psychiatry mirrored and contributed to the racist and sexist attitudes upon which exploitation of the colonised population was predicated, through the production of racist knowledge about the colonised population. The dissertation uses management of the insane in the Cape as an example through which to explore the complex ways in which the 'mother' country was made present in colonial practice through the creation of structures which not only insisted on a hierarchy of knowledge and power flowing from coloniser to colonised but also constructed the indigenous as susceptible to rule.

The dissertation argues that texts have primacy as the medium through which knowledge is formulated, circulated and sustained. Discourse analysis of a wide variety of texts provide a reading of the institutional and discursive practices associated with Cape colonial psychiatry. Doctors, around whose activities psychiatric practice was constellated, are the dominant voice in these texts. However, the subaltern voices of the insane can be distinguished in the contradictions, and silences of the case records, analysis of which is a central focus of the study. Case records are a largely neglected resource in histories of insanity, psychiatry, and asylums. This dissertation formulates and illustrates a method of reading case records which attempts to address the theoretical and methodological problems which have, in the past, contributed to their neglect as a resource.

The dissertation begins with a description of basic historical data necessary to the analyses which follow, and includes a summary of those aspects of the Cape's history pertinent to this study. A brief history of the Cape asylum network forms the context for an outline of Valkenberg Asylum's history, including the social profile of its patients.

Following a discussion of a method and theoretical framework for reading Cape colonial psychiatric activity, the dissertation describes and analyses Cape lunacy legislation, and the certification process through which the insane were identified and detained in asylums. The relationship of the Cape to British laws and certificates foregrounds ways in which imported procedures both silenced and reinterpreted indigenous experience.

The two related activities of diagnosis and identification of aetiologies of insanity are then described. Ways in which psychiatric classification erased patients' connection with their own histories are outlined. It is argued that Cape colonial psychiatric knowledge was related to two central concerns, which mirrored anxieties beyond the boundaries of psychiatry: the importance of separating black from white, and the need to prevent, as far as possible, the increase of insanity in the white population.

The failure of Cape psychiatry to engage with unique features of the context, and consequent erasure of the indigenous, affected the management of the insane in asylums. The dissertation describes the reproduction of race and gender difference within each asylum, and suggests ways in which this reflected broader social and economic contexts.

The dissertation then turns to detailed analysis of case records, beginning with an exploration of the multiple contexts affecting doctors as writers. Systematic analysis of the contents of the case records is used to argue that routine descriptions of the insane were structured more by the combination of psychiatric knowledge with the racist and sexist attitudes of the observing doctors, than by the behaviour and feelings of the alleged insane. Production of uniform descriptions of the insane dovetailed with the structure of legal documentation and psychiatric classification as the means through which persons were stripped of personal identity and became insane bodies, separated from one another by racial classification and gender. Analysis of disruptions and contradictions within generally predictable case record narratives are then used to identify the subaltern voices of patients.

The dissertation ends with comments on the implications of the study both for future research and for current practices in mental institutions.

Chapter One

INTRODUCTION: CAPE PSYCHIATRY AND THE COLONIAL CONTEXT

Introduction

In 1872, the Cape Colony, a British colony, was granted responsible government. The period immediately following was characterised by a flurry of legislative activity in the Cape Parliament, and this included vigorous attention to issues relating to medical practice in the Colony[1]. Between 1879 and 1899 a number of bills were passed, addressing themselves to lunacy, leprosy, rabies, contagious diseases, sale of food and drugs, inebriates, and the control of the medical profession[2]. The new legislation set the scene for widespread reform of the Colony's management of the insane, and included massive increase in the numbers of insane people able to be accommodated in asylums.

Medical legislative reform in the Cape included the creation of a new government position, that of Inspector of Asylums. The incumbent was to be accountable to the government and responsible for the humane and lawful care of the Colony's insane. Duties included monitoring committal procedures, inspections of the day-to-day running of the Cape's asylums, and advising government on all matters pertaining to legislation and the administration of asylums. The man appointed to this post was Dr William Dodds, M.B., C.M., M.D., D.Sc., a Scottish-trained doctor experienced in the treatment of insanity. He took up his post in 1889[3].

From the time of his appointment, Dodds made a series of passionate pleas for improvements and additions to insane asylum accommodation. The colony's insane were frequently incarcerated in gaols, where they 'linger for weeks and months ... waiting for vacancies in Asylums, sometimes dying there before a vacancy is announced'[4].

Commenting on insane asylums in Cape Town, he noted that in the Old Somerset Hospital, which housed 23 'European' and 32 'Coloured' patients, 'the accommodation is most bare and prison-like; it consists of four yards surrounded by cells and high walls, and it is utterly unsuitable for the proper treatment of insane patients'. On Robben Island, where 121 'European' and 132 'Coloured' insane patients were housed, 52 men were sleeping in dormitories suitable for 35. The rooms in which the female insane slept had 'again and again been declared unfit for habitation'[5].

1. R.Kilpin, *The Romance of a Colonial Parliament*, (London, 1930), p.103; E.Burrows, *A History of Medicine in South Africa Up to the End of the Nineteenth Century*, (Cape Town, 1958), pp. 332-3.
2. Burrows, *ibid.*, p.332.
3. CO 1430, 17/6/1889.
4. G.17-'93, p.136.
5. G.17-'93, pp.136-7. This dissertation uses the terms 'white' and 'black' to refer to the racially-based division which structured the colonial experience. Asylum reports are somewhat idiosyncratic in their use of racial terms, as they did not conform to official classifications of the 1891 and 1904 census reports, discussed in detail in Chapter 2. Until after Union, in 1910, only two categories were assigned to patients: 'European' or 'Coloured'. The 'Coloured' label included those labelled 'Native' in case records. The use of the 'European/Coloured' classification changed after Union, when for the first time, 'Native' and 'Indian' are used as categories in reports. When referring directly to racial terms used in case records or reports, and when distinctions were being made

Dodds' concerns about asylum conditions extended beyond a wish to see the insane comfortably housed and humanely treated. Adequate care was for him predicated upon racial segregation. He saw racial mixing in asylums and gaols as detrimental to the process of recovery. He commented with strong disapproval on the fact that the white insane were forced to 'associate with coloured criminals' in gaols[6]. He also noted that overcrowding in asylums meant that there was 'scarcely any mental classification, and not sufficient racial classification.' He added that 'while colour should not be the dividing line in medicine, and every effort should be made to restore or to render happy coloured as well as white, I do not think it right that the two races should mix as they often have to do at present', a comment which summed up the tension between a liberal humanist belief in the necessity to provide medical care for all on an equal basis, regardless of race, and the desire to entrench further the racialised divisions of the colonial social structure[7]. The spectre of racial mixing was a well-chosen means of impressing upon the Colonial Office the urgent need for accommodation. The last decades of the nineteenth century were marked by general concern with the need to maintain racial separation, and Dodds' appeals did not fall on deaf ears[8]. Not only was money spent on reforming the older asylums: in 1891 and 1894 two new asylums were opened. It is significant that these both had exclusionary policies on the grounds of racial classification. One catered for white patients only, and the other for black. Strict racial segregation of facilities continued to be a feature of South Africa's provision for the mentally disturbed until the last decade of the twentieth century.

Dodds was positioned prior to his arrival in the Cape as the catalyst for lunacy reform. The creation of the Inspector of Asylums post signalled the readiness of the Colony to undertake fundamental reform of its provision for the insane. It is with the nature of that provision, its relationship to colonialism, and the effect of colonialism on the production of psychiatric knowledge about the insane that this study is concerned.

Reform of lunacy management in the Cape, the start of which was signalled by the somewhat embryonic Act 20 of 1879, was structured by the Lunacy Acts of 1891 and 1897[9]. After Union in 1910, when the Boer Republics of the Transvaal and Orange Free State, and the British colonies of Natal and the Cape became a single self-governing state, under British sovereignty, two further Acts, those of 1914 and 1916, addressed new requirements created by changes to the

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between different groups of black patients, I have retained the original nomenclature, and have used inverted commas to indicate that the term is being used as it was in the original context.

6. G.17-'93, p.136.
7. G.17-'93, p.136-7.
8. The circumstances fuelling public alarm about racial mixing in residential areas and government institutions are explored in Chapter 2.
9. Details of the lunacy legislation are given in Chapter 4.

governmental structure, and amended and consolidated earlier provisions. This study will focus on the management of the Cape insane during the period 1891-1920, and will describe and discuss psychiatric practice during this time of major restructuring[10]. A particular focus will be Valkenberg Asylum, which opened in 1891 on the outskirts of Cape Town, with Dodds as its superintendent, a post he held in tandem with his duties as Inspector of Asylums. The history of this asylum during the 1891-1920 period foregrounds central features of lunacy reform in the Cape and elucidates the relationship of Cape psychiatric reform to the colonial context.

This chapter will give a brief outline of the contexts within which the study is situated, in terms of both historical background and academic debate. Following this, discussion of the production of Cape psychiatric knowledge and its relationship to colonialism will provide an outline of key points of the argument explored in this dissertation. The final sections will restate the research questions, describe the texts and methods of analysis used to answer them, and give a summary of the development of the argument, chapter by chapter. The conclusion will comment on the contribution of this study to current scholarship.

Contexts

There are three major contexts within which this study is embedded. These are the history of psychiatric knowledge and practice, including the history of insane asylums; the medical, psychiatric and social history of the Cape; and the history of colonialism and the relationship between colonial institutions and their 'home' counterparts.

1. The history of psychiatric knowledge and practice

There are two major strands to the history of psychiatric knowledge and practice. The first of these is concerned centrally with the evolution of understandings of psychiatric illness, traces the development of psychiatric classification, including both diagnosis and aetiology, and changes to psychiatric treatment of those identified as insane. This body of work, often but not invariably undertaken by researchers with psychiatric training and experience, incorporates conceptual histories of major psychiatric syndromes, such as schizophrenia, dementia and manic-depression, and descriptions of changing treatment regimes, from physical restraint and long-term incarceration to 'moral management' during the nineteenth century, and from widespread use of sedatives, dietary treatments and hydrotherapy through to shock therapies, and finally to the chemotherapies which characterise modern psychiatry[11].

10. Choice of the 1891-1920 period is discussed further below, pp.10-11.
11. Excellent conceptual histories can be found in the work of G.Berrios. For example, see 'Stupor: A conceptual history', *Psychological Medicine*, 11, (1981), 677-688; 'Delirium and confusion in the nineteenth century: A

Conceptual histories of psychiatric knowledges tend to be universalist in the sense that they assume the existence of historically unchanging psychiatric syndromes susceptible to identification despite different historical and social contexts. Application of modern diagnostic labels to those described in historical texts confirms the assumption of universally occurring psychiatric disease, and reinforces a medical ideology which links increasingly accurate classificatory activity to progress in treatment[12]. There are however conceptual histories which insist on the possibility that diseases themselves change historically, and others which argue that there are context-specific insanities, or 'culture-bound' syndromes[13].

Regardless of the assumptions underlying particular conceptual psychiatric histories, they all provide a rich source of information on a complex, shifting and specialised semantic field. Awareness of denotative and connotative shifts in the meanings attached to words such as 'melancholia' or 'mania' at different historical periods circumvents simplistic and universalist readings of descriptions of insanity. Given the focus on the specificity of the colonial context and the effects of this on ways in which insanity was described, such contextual information is essential to this study.

Deconstruction of the universalist and realist assumptions of conceptual histories of psychiatric syndromes is a central thread in the work of Sander Gilman on the social construction and changing representations of mental disease. This study will draw on his work in arriving at an understanding of the complex interplay between the biological effects of mental disorder, and their representation in doctors' writing[14].

The second major strand in the history of psychiatry has been located in the discipline of sociology and social history, with a focus on asylum history. Concerned with the social profile of those incarcerated, the economic and social organisation of asylums, careers of asylum doctors and the social and economic imperatives which led to the practice of incarceration during the

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conceptual history', *British Journal of Psychiatry*, **139**, (1981), 439-449; 'Descriptive psychopathology: Conceptual and historical aspects', *Psychological Medicine*, **14**, (1984), 303-313; ' The psychopathology of affectivity: Conceptual and historical aspects', *Psychological Medicine*, **15**, (1985), 745-758; 'Historical aspects of the psychoses: Nineteenth century issues', *British Medical Bulletin*, **43**, (1987), 484-498. See also G.Berrios and H. Freeman, *Alzheimer and the Dementias* (London, 1991) p.23, and E. Hare, 'The two manias: A study of the evolution of the modern concept of mania', *British Journal of Psychiatry*, **138**, (1981), 89-296.

12. An example is Trevor Turner's re-diagnosis of Ticehurst patients in a widely-used modern diagnostic system. T.Turner, 'A diagnostic analysis of the casebooks of Ticehurst House Asylum, 1845-1890', *Psychological Medicine*, Monograph Supplement **2** (1992).
13. See Hare, 'The two manias', and R. Littlewood and M. Lipsedge, *Aliens and Alienists: Ethnic Minorities and Psychiatry*, (Harmondsworth, 1982).
14. S.Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, (Ithaca and London, 1985); *Disease and Representation: Images of Illness from Madness to AIDS*, (Ithaca and London, 1988); *Health and Illness: Images of Difference*, (London, 1995).

nineteenth century and decarceration in the second half of the twentieth century, these histories pay little attention to particular manifestations of psychiatric illnesses and the challenges these pose to those responsible for their management[15]. This has led at times to strident criticism of perceived abuses perpetrated by the psychiatric industry, criticisms which suggest that asylums were primarily a means of controlling deviance, rather than a conduit through which humane care might be delivered[16].

In recent years a number of histories have drawn attention to differences, predicated on social, economic and religious differences, between individual asylums[17]. This body of work is a valuable critique of the tendency in earlier, more general histories to suggest that broad social and economic contexts created uniformity in asylum practice and institutional ideologies, and is able to accommodate more easily description of individual case histories, and the psychiatric knowledge at work in constructing them.

Both the broad and the more narrowly focused asylum histories are an important context for this study. A history of psychiatric practice in colonial asylums requires that they be compared to those in the 'home' context. This involves consideration of asylum networks, and their relationship to changing legislation and asylum medicine across a broad spectrum of institutions. Histories of individual asylums provide a context within which class, race and gender differences affecting individual cases and particular asylum practices can be separated from more general trends common to management of the insane as an undifferentiated group.

2. The medical, psychiatric and social history of the Cape

Making sense of the production of knowledge about insanity in the Cape is inseparable from the histories of class, race and gender as socially and historically constructed categories in the Cape colonial setting[18]. During the late nineteenth and early twentieth period large scale immigration of

15. Andrew Scull's histories of asylums are the most notable and extensive contribution to this literature. Some of the implications of his work, and the work of others in the field are detailed in Ch 2. A. Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England*, (London, 1979); and *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900*, (New Haven, 1993).
16. For discussion of the psychiatric industry as a medium for the control of social deviance, see the collections of essays in W. Gove, (ed.), *Deviance and Mental Illness*, (Beverly Hills, 1982); and S. Cohen, and A. Scull, (eds.), *Social Control and the State*, (Oxford, 1985). See also L. Eisenberg, 'The social construction of mental illness' , *Psychological Medicine*, **18**, (1988), 1-9, for an excellent summary of these issues.
17. Examples include A.Digby, *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914*, (Cambridge, 1985), and C.MacKenzie, *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917*, (London, 1992).
18. There is an extensive literature on the historical construction of race, class and gender categories in the Cape colonial setting. Important resources for this study have been V. Bickford-Smith, 'Commerce, class and ethnicity in Cape Town, 1875-1902', unpublished Ph.D. Thesis, Cambridge University, (Cambridge, 1988); V. Bickford-Smith, *Ethnic Pride and Racial Prejudice in Victorian Cape Town*, (Johannesburg, 1995); S. Dubow, *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*, (London, 1989); S. Marks, and S. Trapido, *The Politics of Race. Class and Nationalism in Twentieth Century South Africa* (London, 1987); C.Walker (ed.),

working class men and women from Europe, increasing poverty among the white population, growth of the mining industry, and contact between racial groups as a result of deployment of large number of black men in industry foregrounded race and class tensions in the colony. While the history of Cape Town itself has much in common with the history of the colony as a whole, its status as a busy port, its cosmopolitan population, its association with small scale manufacturing rather than major industrial growth, and a political tradition of liberal humanism gave it a unique character. As the centre of legislative and social reform of lunacy management, Cape Town's particular history had a major influence on developments in asylums elsewhere. This study will be contextualised in both histories of the colony and of Cape Town[19].

Management of the insane in the colony and the relationship with British practice mirrors broader practices within the medical establishment as a whole. In order to contextualise the emergence of a colonial psychiatry in the Cape, it has been necessary to refer to recent institutionally-based histories of Cape medical practice, and to developments in the field of public health. In both these areas the move towards segregation based on racial classification, increasing legislative sophistication and control, and the influence of the medical profession on the construction of race as a factor in shaping medical care are overriding characteristics of the 1891-1920 period[20].

Changes made to the management of the insane during the 1891-1920 period were closely related to economic, social and political imperatives beyond the confines of the medical establishment. The legal and institutional structures which evolved to address the needs of the colony's insane mirrored a number of concerns permeating Cape politics and social organisation. These include definition of race and gender relationships in public and domestic settings, the social construction of race and gender in relation to divisions of labour, and the impetus towards increasing social, political and economic segregation between those of different racial classifications. The dissertation will situate the institutional and discursive construction of Cape psychiatry within these contexts.

3. The history of colonialism

The history of colonialism in various parts of the world, and the nature of colonial and postcolonial relationships is another context for this study. While exploitation of colonial populations for economic reasons forms the basis on which such relationships have been predicated, recent research has recognised the complexity and lack of uniformity within and

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Women and Gender in Southern Africa to 1945, (Cape Town, 1990); W. James and M.Simons (eds.), *The Angry Divide: Social and Economic History of the Western Cape*, (Cape Town, 1989).

19. Aspects of the historical context are discussed in Chapter 2.
20. The connection between lunacy reform and broader public health developments are discussed in Chapter 2.

between colonial societies. This complexity took the form of ideological contradictions between the 'civilising mission', with its liberal humanist philosophy, and the racist and sexist exploitation of native populations[21]. There were also tensions between colonising governments and their representatives in the colonies. For reasons specific to particular colonial contexts, the evolution of legislative, social and economic practices demonstrated at times the contradictions and confusions of the colonial enterprise. Recent work has also drawn attention to the rich and varied forms of resistance to the process of colonisation in native populations. This 'tensions of Empire' literature is a crucial context for the study of insanity in the colonies[22].

By its nature, insanity is positioned to express the contradictions within any society, by giving voice to the unspeakable, forcing deviance into a public arena, by defining what is to be regarded as 'normal' or 'sane', what requires policing, and what might be ignored. Always fertile ground for public concern, about both the threat of madness to society and the spectre of inhumane incarceration, discourses on insanity provide a forum for the expression of anxiety about any number of social 'evils'. These range from promiscuity to feeblemindedness, alcohol abuse to miscegenation, which are only some of the topics drawn together under the rubric of social control of 'insane' behaviour. The mixture of liberal humanist medical practice, universalising psychiatric knowledge and naturalised racism and sexism in colonial contexts became the web within which colonial tensions were expressed. For these reasons to study the management of the insane in the colonies becomes a history of the tensions of Empire in a more general sense.

Psychiatry in the Cape and the constitution of the colonial

Psychiatric practice in the Cape during the 1891-1920 period was essentially British in character. Cape lunacy legislation was modelled closely on that of Britain, and almost all doctors working in Cape asylums were British-trained. Management strategies and philosophies guiding treatment of the insane had their roots in British experience. This was in keeping with other branches of medicine in the Cape. Although the last quarter of the nineteenth century was a period during which the Cape medical profession was consolidating their legal and professional status, strong links with Britain were maintained. The vast majority had British training, and the British

21. For a discussion of 'civilising' colonialism, see J. Comaroff, 'Images of Empire, Contests of Conscience: Models of Colonial Domination in South Africa', *American Ethnologist*, 16, (1989), 661-685.
22. Major issues facing scholars of colonialism are outlined in F.Cooper and A.Stoler, 'Introduction: Tensions of empire: Colonial control and visions of rule', *American Ethnologist*, 16, (1989), 609-621.

influence on legislation and the professionalisation process came to the Cape not only through colonial authority, but also through doctors' exposure to British medical education[23].

This study is concerned with the relationship between Cape and British psychiatric practices, as an instance of colonialism. It will argue that the essence of the colonial relationship between British and Cape psychiatric practice was to be found in the importation, imposition and marking as 'natural' of 'home' knowledges in the colonised setting.

British psychiatric philosophy in the late nineteenth and early twentieth centuries was universalist to the extent that it assumed the unchanging character of insanity regardless of the class, social or cultural context of the sufferer[24]. It was also marked by biological essentialism, which entailed a number of assumptions. These included a belief in the neurological underpinning of insanity, and a belief that biological difference marked by age, gender and racial classification all had a effect on the form taken by mental disturbance. Universalism allowed doctors working with the insane to assume a basic uniformity between all those suffering from particular mental disorders, despite diversity in social and cultural contexts. Biological essentialism allowed doctors to assume an unquestioned belief in the biological difference between men and women, and between those of different racial classifications. It was a philosophy which posited white maleness as the norm from which women and black peoples deviated, and this made it both racist and sexist[25]. It became possible to talk of 'the female insane' or 'the black insane' as if these groups were invariably and inevitably set apart.

The effect of British psychiatric universalism and biological essentialism on Cape psychiatric practice will be a central concern of this study, which will argue that 'specialised' knowledge of those classified as black reflected a fundamental belief in racial difference, and this was used to justify racist practice within colonial institutions. Further, it will be argued that this 'specialised' knowledge was shaped more by the racism implicit in the colonial enterprise itself, than by intimate knowledge of the colonised peoples. The study will describe the erasure of the indigenous resulting from the use of British legislation, and British models of treatment in the management of the Cape insane population, through the systematic silencing of everything which could not be represented comfortably within imported structures of knowledge. It will be argued

23. E. van Heyningen, 'Public health and society in Cape Town 1880-1910', Ph.D. thesis, University of Cape Town, (Cape Town, 1989), Chapter 2, gives a detailed description of the training background of doctors in the Cape between 1880 and 1910.
24. R.Littlewood and M.Lipsedge, *Aliens and Alienists: Ethnic Minorities and Psychiatry*, (Harmondsworth, 1982), Chapter 1.
25. See J.Oppenheim, *'Shattered Nerves': Doctors, Patients and Depression in Victorian England*, (Oxford, 1991), Chapters 6 and 8.

that Cape colonial psychiatry was, first and foremost, characterised by its failure to represent difference in a locally constructed and context-sensitive knowledge.

Erasure of the indigenous, bound up in the difference in power between coloniser and colonised, is intrinsic to any colonial relationship, and is a necessary part of the social and economic exploitation which structures the colonial enterprise. For example, economic imperatives demanded that the colonised peoples of the Cape became a malleable source of cheap labour. It was this which necessitated the discursive erasure of indigenous peoples as either adult or independent, and cast them as the objects of the colonial 'civilising' mission[26]. The complex role played by Cape psychiatric knowledge in that 'civilising' mission will be an important thread in the argument to follow. The study will suggest that Cape doctors working with the black insane in asylums, used this contact to elaborate and give scientific credibility to the assumption of difference between black and white. This included proliferating knowledge which inscribed those classified as black as 'simple', 'child-like' and 'savage', appropriate subjects for rule and guidance by white colonisers.

Although Cape psychiatry had close links to British psychiatry, its unique economic, social and cultural context shaped its everyday practices in asylums. The study will describe the ways in which male and female, black and white patients in asylums were placed in treatment regimes which reflected the race and gender divisions of Cape society. The need to treat large numbers of black insane people in asylums, and the practices which evolved in relation to this marked Cape psychiatry as different from British psychiatry. It was in the complex tension between universalism, which erased the indigenous as an object of scientific enquiry, and the practice of marking race and gender difference in management practice in Cape asylums, which contributed to the constitution of a uniquely colonial psychiatry.

The choice of 1891-1920 as the period of study

A number of landmark events, both in the Cape and internationally, determined the choice of the 1891-1920 period as appropriate to the exploration of Cape psychiatric knowledge and practice in relation to colonialism.

Firstly, it was important to choose a period during which psychiatric knowledge could be identified as distinct from general medical knowledge. This is important because the study will argue that psychiatry in particular, rather than general medicine, made an significant contribution

26. C.Crais, *The Making of the Colonial Order*, (Johannesburg, 1992).

to the scientific racism feeding colonial forms of exploitation. This contribution rested on psychiatric descriptions of the 'mind', 'mentality', or 'personality' of colonial subjects.

As Roy Porter points out, 'psychiatry' or the practices of ministering to those identified as insane has a history as long as any branch of medicine[27]. However, for the purposes of this study, I am making a distinction between practices associated with the management of the insane, inside or outside of asylums, and psychiatry as a self-consciously medical discipline, which formulated specialised knowledge on the assumption that insanity was caused by identifiable and describable disease processes, amenable to classification, and with the advance of science, alleviation or cure.

A number of factors contributed to the making of such a discipline. In Britain, the establishment of the county asylum system largely managed by doctors in the second half of the nineteenth century created a population of professional men with specialised experience of insanity. *The Asylum Journal* was established in 1853, was renamed *The Journal of Mental Science* in 1858, and was central to the establishment of a professional psychiatric discourse[28].

The Association of Medical Officers of Asylums and Hospitals for the Insane, renamed The Medico-Psychological Association in 1865, was founded in 1863. The MPA statistical tables, which tabulated the demographic data, diagnosis, aetiology, death and recovery rates and causes of death of patients in asylums assumed not only the salience of such information to doctors' work in asylums, but also their competence to undertake such classificatory activity. The tables were therefore crucial to the discursive construction of asylum medicine as a natural science, with observation and classification as the cornerstones of accumulating knowledge. By the time that the work of Emil Kraepelin entered British debates in the first decade of the twentieth century, the intricacies of differential diagnosis of insane states was well-established as an integral part of the professional activity of asylum doctors[29].

Psychiatry as a discipline was institutionally recognised with the establishment of specialised training, a Certificate in Psychological Medicine, in 1885[30]. In 1888, the British Medical

27. Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*, (Harmondsworth, 1987), p.169.
28. *Ibid.*, pp.299-301.
29. Kraepelin's *Lectures on Clinical Psychiatry* appeared in English, translated and edited by T.Johnstone, in 1904. (London, 1904). His work was received into a well-established community in which nosological debate at MPA meetings and in *The Journal of Mental Science* (hereafter *JMS*) was routine. These debates are described in more detail in Chapter 5.
30. For a detailed description of the history of the lunacy profession in Britain, see Richard Russell, 'The lunacy profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum', in W.F.Bynum, R.Porter, and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, v.3*, (London and New York, 1988), 297-315.

Association for the first time offered 'Mental Disease' as a separate section in its annual meeting[31].

There were close links between the Cape and British medical establishments, which ensured almost immediate transfer in skills and knowledge from the one to the other. It therefore is appropriate to identify the second half of the nineteenth century as the period during which a colonial psychiatry was made possible by developments in the field in British medical practice. However, it was only with the advent of widespread changes to the management of the insane in the colony, brought about in the first instance by legislative reform in 1879, 1891 and 1897, that the scene was set for a Cape colonial psychiatry to emerge. In particular, the appointment of the colony's first Inspector of Asylums in 1889, and the drafting and implementation of the 1891 legislation ratified the position of specialised medical knowledge in relation to the management of the insane. Following legislative reform and widespread changes to the day-to-day running of the colony's asylums, a small but growing community of doctors with psychiatric expertise began to contribute to academic debates on psychiatric topics, including observations on insanity in indigenous populations. It is in both psychiatric practice and academic debate in the period following the 1891 legislation that I shall be identifying a Cape colonial psychiatry.

1920 was chosen as an appropriate end-date to the period of study, partly in order to include the 1916 Act within the boundaries of the material to be considered. A further reason lay in the availability of case records. The records of Valkenberg Asylum constitute a unique source of information on the day-to-day management of the insane in Cape asylums. At first a whites-only asylum, it opened to black male patients in 1916, and to black female patients in 1919 and 1920. 1920 was chosen as a cut-off date in order to incorporate the case records of black patients in the primary source material[32].

The choice of Valkenberg Asylum as a focus of study

In the period 1891-1920, there were five asylums accommodating the insane in the Cape. These included the Robben Island and Valkenberg Asylums, which served the western Cape area, and the Grahamstown, Fort Beaufort, and Port Alfred Asylums, all located in the eastern region of the Cape[33].

31. *Ibid.*, p.302.
32. The Valkenberg case series is described in detail in Chapter 2.
33. A brief history of the asylum network is given in Chapter 2.

The opening in 1891 of Valkenberg Asylum, the Cape's first whites-only asylum, set up to be a model of 'modern' and humane treatment for the white insane, marked the beginning of a shift towards increasing racial segregation both in and between asylums. In 1894 Fort Beaufort was opened to accommodate the black insane, and in 1908 Grahamstown Asylum became a whites-only asylum. The history of Cape asylums in the period after the 1891 legislation therefore provides an opportunity to trace the development of an increasingly racialised and gendered psychiatry.

Although it draws on the histories and case material (where available) of all of the Cape's asylums, this study has Valkenberg Asylum as its primary focus. Apart from the availability of case records from the asylum, there are a number of reasons for the use of Valkenberg as a site of exploration. Until 1914, Valkenberg had Dr Dodds as its superintendent, and the pivotal role he played in the history of the Cape's management of the insane makes his institution an important focus for research. His determination to run it as a model of modern treatment and the standard against which other asylums might be judged, positions it as an excellent example of both the intentions and practices of the Cape's newly emerging psychiatric community. As a new asylum, its early history is uncontaminated by institutional practices associated with earlier, less systematically organised, institutional cultures. Being from its inception a whites-only institution makes it ideal as an example of racialised psychiatric practice.

After a period of admitting only the white insane, Valkenberg eventually opened its doors to black patients. Racially segregated accommodation for black men opened in 1916, and for black women in 1919 and 1920. The period of adjustment to the accommodation of black patients in Valkenberg is a window through which attitudes to both black and white patients might be explored.

There is one further reason for the choice of Valkenberg as a focus for this study. Unlike the records of other Cape asylums, a substantial body of clinical notes on patients admitted to Valkenberg during the 1891-1920 period have survived. These make possible the study of psychiatric activity - observation, classification and treatment - in the asylum.

Choice of texts

The texts chosen for analysis in this study are those which shaped and were shaped by Cape psychiatric practice. These include documents relevant to a description of both institutional and discursive practice. Because Cape colonial psychiatry was the focus of study, rather than for example the history of asylums in the Cape, or characteristics of insanity as a condition which

exists outside of the psychiatric relationship, only those texts which shed light on doctors' psychiatric activities were of relevance. This incorporates all those texts which relate to the social and economic organisation of asylums, and the identification, description and treatment of patients. It also includes legal texts and the institutional practices of the law in relation to the insane. The professional identity of doctors, and characteristics of the psychiatric knowledges evolving in the colonial setting are apparent in all these texts, as well as in doctors' academic writing and in asylum annual reports, and correspondence with the Colonial Office.

There are a number of texts which have been excluded from this study. Although broadly relevant to the institutional and discursive constitution of insanity, they are nonetheless tangential to the research question. These include magistrates' court documents pertinent to the committal procedure, which were shaped as much by the imperatives of the legal as the medical profession. Because the interface between the legal and psychiatric professions is complex and deserves lengthy treatment, texts concerned with the insane convicted of serious crimes have largely been excluded. Newspaper reports on the insane and on conditions in asylums reflect the perceptions of the lay public, and although these affected and were affected by changes happening within psychiatry as a discipline, analysis of this was beyond the scope of this study. Similarly, parliamentary reports and debates which impacted upon psychiatric practices but which were concerned with colonial politics more than with psychiatric knowledge and practice were excluded. The observations and concerns of patients' friends and relatives are relevant to psychiatry as an object of study only to the extent that they address perceived expectations of the doctors into whose care patients were committed. The institutional and discursive rules regulating the relationship of nurses and attendants to doctors and to patients are also selectively treated.

Cape colonial psychiatry, texts, and postmodern histories

This study addresses itself to institutional practice of Cape colonial psychiatry and its relationship to colonial social structure. In exploring this relationship, it will assume a distinction, as well as a mutually constitutive relationship, between institutional and discursive practice. Institutional practice incorporates the formal organisation of material resources; discursive practice concerns the mediation of behaviour, perceptions, subjectivities and intersubjective relationships through patterns of encoded meaning[34]. Both are made available for scrutiny through texts. This study will describe psychiatric practice in the Cape Colony through discourse analysis of the texts described above.

34. Further definition and description of the terms used in the analysis and their theoretical relationship are outlined in Chapter 3.

In demonstrating the relationship between text, and institutional and discursive practice, this study will assume that texts are not transparent windows through which a world of events and relationships may be viewed. It will be argued that texts actively construct that world. Texts were the essential medium through which Cape psychiatric knowledge was formulated, circulated and sustained.

In these texts, the dominant voices are those of doctors. As textual analyses of doctors' writing will demonstrate, Cape colonial psychiatric practice was never a unitary enterprise, and the doctors who were involved in the care of the insane had complex and contradictory subject positions[35]. For these reasons, an essential part of the study is to articulate the relationship between doctors' shifting subjectivities and the knowledges to which they contributed and subscribed. The assumption that social institutions and identities are both unstable and contradictory, and the focus on discourse, places this study within the postmodern paradigm[36].

Although this study is of necessity centrally concerned with doctors' writing, analysis of psychiatric practice in the Cape provides an opportunity to make visible experience unencoded in hegemonic structures of meaning. To identify 'dominant' voices automatically invokes 'subaltern' voices, often apparent only in the elisions, silences and contradictions of hegemonic texts[37]. In this study, the subaltern voices are those of the insane themselves, and in particular, the voices of women, and those categorised as black. It is possible to reconstruct aspects of their experience through careful readings of suppressed meaning in doctors' texts. This provides an essential counterpoint to the doctors' perspective. At times the subaltern voices underscore the interdependency of indigenous and colonising, of the exploited and those exploiting; at others they highlight contradiction and conflict of interest. Reading both dominant and subaltern voices allows the possibility of pushing the boundaries of our understanding of the complexity of this colonial relationship.

For a number of reasons, case records have seldom been used as a primary source of data in histories of insanity, psychiatry, and asylums[38]. While they have been used as illustrations of doctors' management regimes, or to undertake retrospective diagnoses of patients' illnesses in the terminology of modern psychiatric classificatory schema, they have not been used as a means of

35. Definitions of terms and methods used in relation to textual analysis are outlined in Chapter 3.
36 For a discussion of the implications for African historiography of postmodernism, see M.Vaughan, 'Colonial discourse theory and African history or has post-modernism passed us by?', *Social Dynamics*, **20**, (1994), 1-23, and D.Bunn, 'The insistence of theory: Three questions for Megan Vaughan', *Social Dynamics*, **20**, (1994), 24-34.
37. G.C.Spivak, 'Can the subaltern speak?', in P.Williams and L.Chrisman, (eds.), *Colonial Discourse and Post-Colonial Theory*, (New York, 1993), 66-111.
38. These problems are outlined in Chapter 3.

tracing the construction and maintenance of psychiatric knowledge through description of encounters between doctors and their patients. Furthermore, systematic analysis of case records as one means of accessing patients' beliefs, feelings and experiences before and after committal have not been undertaken. This study formulates a method of reading case records which addresses the methodological problems that they present as texts.

Summary of the research issues

1. This study describes the evolution of psychiatric practice in the Cape during the period immediately following Dodds' appointment as Inspector of Asylums, a time during which legal reform and social and economic change brought about significant shifts in management of the Cape insane population. It describes conditions of increasingly strict segregation of patients according to racial categorisation and gender. It argues that this period was pivotal in establishing psychiatric practices closely related to those in Britain. Particular attention is given to the history of Valkenberg Asylum. No comprehensive history of Cape psychiatric practice during the 1891-1920 period has yet been undertaken[39].

2. No detailed history of the relationship between colonialism and psychiatry during the late nineteenth and early twentieth centuries has yet been undertaken. This study is concerned with the relationship between Cape and British psychiatric practices, as an instance of colonialism. It will describe those features of colonialism rendered visible through Cape psychiatric practice, and will explore their implications for the management of the Cape insane. It will argue that Cape psychiatry mirrored racist and sexist attitudes upon which exploitation of the colonised population was predicated, and also contributed to that exploitation through the production of racist knowledge about the colonised population. This study will use management of the insane in the Cape as an example through which to explore the complex ways in which the 'mother' country was made present in colonial practice through the creation of structures which not only insisted on a hierarchy of knowledge and power flowing from coloniser to colonised but also constructed the indigenous as susceptible to rule.

3. In describing the relationship between Cape and British psychiatric practice, particular attention will be given to the transformations of British practice linked to Cape colonial

39. Work on psychiatric practice in the Cape has thus far been confined to studies of individual institutions. See H.Deacon, 'A history of the medical institutions on Robben Island, Cape Colony, 1846-1910', unpublished doctoral dissertation, Cambridge University, (Cambridge 1994); D. Moyle, 'Drawing the line: the early history of lunacy in South Africa', unpublished paper, Psychology Department, University of Cape Town, (Cape Town, 1987); R.Warwick, 'Mental health care at Valkenberg Asylum 1891-1909: Aspects of its origins and operation', unpublished History Honours dissertation, Department of History, University of Cape Town, (Cape Town, 1989); F. Swanson, 'Colonial madness: The construction of gender in the Grahamstown Lunatic Asylum, 1875-1905', unpublished History Honours dissertation, University of Cape Town, (Cape Town, 1994).

social, ideological and economic contexts. This will include study of diagnostic and management practices unique to Cape asylums.

4. This study argues that texts have primacy as the medium through which knowledge is formulated, circulated and sustained. Discourse analysis of a wide variety of texts will provide a reading of the institutional and discursive practices associated with Cape colonial psychiatry. Doctors, around whose activities psychiatric practice was constellated, are the dominant voice in these texts. However, the subaltern voices of the insane can be distinguished in the contradictions and silences of the case records, analysis of which is a central focus of the study. Case records are a largely neglected resource in histories of insanity, psychiatry, and asylums. This study formulates and illustrates a method of reading case records which attempts to address the theoretical and methodological problems which have, in the past, contributed to their neglect as a resource.

Summary of chapters

As outlined above, this dissertation draws together two areas of study: a history of psychiatry in the Cape in the 1891-1920 period, with particular attention to the history and case records of Valkenberg Asylum, and the relationship between colonialism and Cape psychiatry. It also presents a method for reading asylum case records. To date little work has been done in the areas in which this study's primary data is situated.

In order to do justice to the inter-disciplinary nature of these topics, and their complexity, this dissertation is of necessity lengthy. It draws on a range of literatures, including those located in historical studies of the Cape and of colonialism, in sociology and the sociology of knowledge, and the history of psychiatry. Relevant literature is referred chapter by chapter, as it becomes pertinent to the argument.

The following section presents an outline of major points in the argument of each chapter as a guide the overall structure of the dissertation.

Chapter Two provides basic historical data necessary to the analyses which follow, and includes a summary of those aspects of the Cape's history pertinent to this study. These include population figures and numbers of insane in the population, racial segregation in Cape institutions and the relationship of this to public health concerns during the second half of the nineteenth century. This leads into discussion of the Cape medical profession as a colonising agency. A brief history of the Cape asylum network forms the context for an outline of Valkenberg Asylum's history, and

comments on Valkenberg's staff. The chapter ends with a description of the social profile of Valkenberg's patients in the 1891-1920 period, a section which includes an introduction to the Valkenberg case series.

Chapter Three summarises important aspects of the theory and methods of analysis used in the dissertation. The chapter provides a method and theoretical framework for reading Cape colonial psychiatric activity, with particular focus on discourse analysis. The chapter is organised around two central issues: the definition and relationship between institutional and discursive activity, and the relationship of both to text. The chapter also offers a method for reading case records.

Chapter Four begins the analysis of Cape psychiatry. It describes the legislative context and its relationship to management of the insane during the 1891-1920 period. This includes analysis of the institutional and discursive implications of the lunacy laws, and in particular, the certification process through which the insane were identified and detained in asylums. Textual analysis of the certificates provides a description of those features of insanity regarded by the medical establishment as salient to committal. The relationship of the Cape to British legislation describes one aspect of the colonial relationship, and foregrounds ways in which imported legislation both silenced and reinterpreted indigenous experience. This chapter outlines the way in psychiatric universalism and standardisation of descriptions of the insane began the process of transforming them from persons to lunatics, a process which led directly to racist practice in their treatment.

Chapter Five elaborates the argument of Chapter Four in relation to psychiatric knowledge as deployed by Cape asylum practitioners. The two related activities of diagnosis and identification of the aetiologies of insanity are described. Ways in which psychiatric classification erased patients' connection with their own histories are outlined. The implications of using British psychiatric knowledge in the Cape are explored, with particular focus on perceptions facilitated or silenced in the process. The chapter argues that Cape colonial psychiatric knowledge was related to two central concerns, which mirrored anxieties beyond the boundaries of psychiatry: the importance of separating black from white, and the need to prevent, as far as possible, the increase of insanity in the white population.

Chapters Four and Five both argue that the failure of Cape psychiatry to engage with unique features of the context, and consequent erasure of the indigenous, combined with the universalist structure of psychiatric knowledge had the effect of focusing attention on the bodies of the insane, rather than their social, cultural or interpersonal context. Chapter Six is concerned with the effects of this on the management of insane bodies in asylums. It describes psychiatric activity as shaping and shaped by institutional structures. This chapter will outline the economic and social

organisation of the Cape asylum network, and the relationships between asylums. The focus of this study of psychiatric asylums will be on the ways in which colonial attitudes to racial classification and gender related to the economic dispensation within each asylum. Discussion of the construction of gender and race difference in asylums will be embedded in an exploration of broader social contexts.

Chapter Seven uses the analyses of the previous chapters as a context for a commentary on the Valkenberg case series. The chapter begins by exploring the multiple contexts affecting doctors as writers. Systematic analysis of the contents of the case records is used to argue that routine descriptions of the insane were structured more by the combination of psychiatric knowledge with the racist and sexist attitudes of the observing doctors, than by the behaviour and feelings of the alleged insane. Production of uniform descriptions of the insane dovetailed with the structure of legal documentation and psychiatric classification as the means through which persons were stripped of personal identity and became insane bodies, separated from one another by racial classification and gender.

Chapter Eight provides an analysis of the largely predictable and universalising narrative structure of the case records. Race and gender attitudes of generations of asylum doctors are described through analysis of a number of patient narratives. In this chapter disruptions and contradictions within generally predictable narratives are used to identify the subaltern voices of patients.

The dissertation ends with comments on the implications of the study both for future research and for current practices in mental institutions.

Chapter Two

CAPE ASYLUMS BEFORE AND AFTER UNION: THE HISTORICAL CONTEXT

Introduction

In 1891, a census estimated that there were 1,921 'lunatic and idiotic' persons in the Cape Colony. Of these 645 were in lunatic asylums. In 1911 the census gave a figure of 4,561 insane, and a further 2,932 imbecile and feebleminded persons in the Union. Of these, 2,442 insane persons and 1,564 imbecile or feebleminded persons lived in the Cape, and 2,150 were in asylums. By 1920, there were 6,225 'mentally disordered and defective' registered persons in South Africa, of whom 2,671 were in five asylums in the Cape[1].

Steady increase in the numbers of institutionalised insane in South Africa in the late nineteenth and early twentieth centuries mimicked the pattern of British and European asylums earlier in the nineteenth century. In Britain, as the network of asylums grew, so did the numbers of the chronically insane living permanently in them. Constant pressure to increase available accommodation, combined with steady growth of numbers of the insane led to alarm that insanity itself was on the increase. There was also despondency about treatment, and the glaringly apparent custodial character of many asylums[2].

There is an extensive literature analysing the reasons for the growth of asylum populations during the nineteenth century, and the role played by medical professionalisation in that growth. Explanations range from the view of asylums as a means of social control, institutions in which the deviant, poor and unwanted of industrialising communities could be incarcerated, through to the view of asylums as a largely humanitarian, if not always humane, response to the plight of the insane[3]. These analyses all address Foucault's 'great confinement' thesis, which not only generated considerable interest in the institutionalisation of insanity but also provoked debate

1. G.36-'92, p.105; U.G.32g.-1912; 1920 Annual Report (unnumbered), p.389.
2. Andrew Scull provides a comprehensive account of the growth of British asylums from a sociological point of view. See Scull, *Museums of Madness* and *The Most Solitary of Afflictions*. Gerald Grob provides an account of American asylums during the nineteenth century. G. Grob, *Mental institutions in America: Social policy to 1875*, (New York, 1973).
3. Scull, *Museums of Madness*, argues that asylums were a means of social control and an important site of professionalisation of medicine. In *Social Order/ Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, (London, 1989), he extends this analysis into twentieth century psychiatric practice in both Britain and America. *The Most Solitary of Afflictions* which gives a rich and detailed account of responses to insanity in eighteenth and nineteenth century Britain maintains earlier arguments, while taking account of the complexity and variation of both social constructions of insanity and familial, legal and medical responses to it. John Crammer, in *Asylum History: Buckinghamshire County Pauper Lunatic Asylum*, (London, 1990), gives an account of an asylum which became large and overcrowded in the second half of the nineteenth century. He argues that the social control thesis fails to take sufficient account of the difficulties mental illness poses for families and communities, and the humanitarian integrity of the men and women who cared for asylum inmates. Grob, while supporting aspects of the social control thesis, also cautions social historians against an oversimplified view of 'the insane' as an undifferentiated group. Insanity takes many forms, and social responses to these are equally varied. G. Grob, 'Reflections on writing the history of American Psychiatry', Triennial European Association for the History of Psychiatry Conference, (London, 1993).

about the historical accuracy and theoretical implications of his argument[4]. A range of asylums are described, from large public institutions through to the small and privately-owned homes housing middle and upper class lunatics[5]. Although these institutional histories address class as a variable affecting patterns of commitment to asylums, consideration of gender and race have been largely neglected[6].

Although asylums of Britain, Europe and America have been a primary focus in the literature, there is a growing body of work on colonial asylums and their differences and similarities to their 'home' counterparts[7]. These studies, with different degrees of emphasis, analyse causes of insanity in the colonies, institutional responses to the colonial insane, relationships between colonisers and the 'native' insane, and treatment of insanity in the colonies. In all these studies race is a focus of interest and also a metaphor for difference, marking the colonial as unique despite its ties to practices in home countries. The effects of gender on experiences of insanity in the colonies is seldom addressed.

Although there was more asylum accommodation *per capita* available for whites, almost equal numbers of white and black insane persons in the Cape found themselves in institutions as a result

4. M. Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason*, (London, 1971). Scull acknowledges the debt of social historians to Foucault in 'Michel Foucault's history of madness', *History of the Human Sciences*, 3, 57-67. For an appraisal of Foucault's contribution, see A. Still, and I. Velody, (eds.), *Rewriting the History of Madness: Studies in Foucault's Histoire de la folie*, (London, 1992). See also Roy Porter, *Mind-Forg'd Manacles*, in which he argues the inaccuracies of the 'great confinement' thesis in eighteenth century England, Robert Castel's investigation of Foucault's central thesis in *The Regulation of Madness: The Origins of Incarceration in France*, (Oxford, 1988), and I. Dowbiggin, *Inheriting Madness: Professionalisation and Psychiatric Knowledge in Nineteenth-Century France*, (Berkeley and Oxford, 1991).
5. For example, Ann Digby describes the history of the York Retreat, a Quaker asylum, in *Madness, Morality and Medicine*, and Charlotte MacKenzie gives a history of a private asylum for the middle and upper classes in *Psychiatry for the Rich*. W.Ll. Parry-Jones describes private madhouses in *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*. (London, 1972).
6. An exception is Y. Ripa, *Women and Madness: The Incarceration of Women in Nineteenth-Century France*. Trans. C. du Peloux Menage, (Cambridge, 1990). Although asylum histories tend not to address gender issues directly, there is a body of feminist literature on women and madness, which examines gender roles and gender socialisation in the social construction of insanity. See E. Showalter, *The Female Malady: Women, Madness, and English Culture, 1830-1980*, (New York, 1985), and J. Ussher, *Women's Madness: Misogyny or Mental Illness?* (New York, 1991). Sander Gilman's analysis of stigma, race and insanity is a reminder of the discursive function of 'race' in the social construction of insanity. See S. Gilman, *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, (Ithaca and London, 1985). G.Grob, *Mental Institutions in America* and 'Class, ethnicity and race in American mental hospitals 1830-1875', *Journal of the History of Medicine and Allied Sciences*, (1973), 207-29, describes segregation of black from white patients in nineteenth century asylums.
7. W.Ernst describes responses to colonisers' insanity in British India in *Mad Tales from the Raj: The European Insane in British India 1800-1858*, (London, 1991). S.E.D. Shortt gives an account of a Canadian asylum in *Victorian Lunacy: Robert M. Bucke and the Practice of Late Nineteenth Century Psychiatry*, (Cambridge, 1986). D. Fox's description of the Californian insane in *So Far Disordered in Mind: Insanity in California 1870-1930*, (London, 1978), has many points of similarity to the insane in Cape Town. M. Vaughan, describes the treatment of insanity in Zambia in the early decades of the twentieth century in *Curing Their Ills: Colonial Power and African Illness*, (Cambridge, 1991). For histories of the treatment of the insane in particular colonial settings see Stephen Garton, *Medicine and Madness: A Social History of Insanity in New South Wales 1880-1940*, (Kensington, New South Wales, 1988), L.E.Fisher, *Colonial Madness: Mental Health in the Barbadian Social Order*, (New Brunswick, 1985), and W. Mitchinson, 'The Toronto and Gladesville asylums: humane alternatives for the insane in Canada and Australia?', *Bulletin of the History of Medicine*, 63 (1989), 52-72.

of their insanity. In 1891, 350 of the insane in Cape asylums were white and 295 black. By 1920, 1,357 of the insane in Cape asylums were white and 1,314 were black. The divisions by gender were not as equal. In 1891, only 249 of the 645 insane in Cape asylums were women. By 1920, the gender difference in rates of admission was still striking. There were 2,236 women and 3,887 men in South African asylums. In the Cape there were 1,056 women and 1,615 men in asylums[8]. This was despite the fact that by 1911 there were more women than men living in the Cape[9]. A number of issues are raised by these figures. Like British, European and American asylums, Cape asylums grew steadily in size. However, the Cape colonial experience of insanity and asylums departed from the pattern of their Euro-American models both in catering for large numbers of the black insane, and in the under-representation of women in their asylums.

The aim of this chapter is to describe the social and historical context within which Cape colonial asylums were established, as the first step towards elucidating the relationship between colonialism and the production of knowledge about insanity in a colonial setting. The chapter will describe the social influences shaping the implementation of strict institutional segregation during the 1890s. The relationship of the Cape medical establishment to British medical practice and to colonial economic and social interests forms the context for a description of the Cape network of asylums and the doctors who managed them. The chapter will argue that the social character of Valkenberg Asylum was largely determined by the history and reputations of older Cape asylums. The establishment of Valkenberg as a model of humane care in turn affected changes made to asylums before Union. The chapter will also discuss the contribution to Cape psychiatry of Dr William Dodds, as first superintendent of Valkenberg and first Inspector of Asylums in the colony; his is the dominant voice throughout the source material of this period. The chapter will end by sketching aspects of the social profile of patients admitted to Valkenberg between 1891 and 1920.

Cape Colony, Cape Town and the evolution of racial segregation

The Cape Colony, granted responsible government by Britain in 1872, had a rapidly increasing population. In 1891 there were 1,527,224 persons living in the Cape. By 1904, the population had increased to 2,409,804, and in 1911, this had risen to a total of 2,563,024[10].

8. G.36-'92, p.389; 1920 Annual Report (unnumbered), p.389.
9. In the 1911 census, it was estimated that the ratio male to female in the Union as a whole was 100:95. In the Cape the ratio was 100:104. When these figures are broken down by racial classification, the ratios for the Cape were: for 'Europeans', 100:93; 'Bantu', 100:111; and 'Mixed'/'Other Coloured', 100:99. U.G.32-'1912. In Cape Town and suburbs, the 1911 census estimated that there were 79,634 men and 81,945 women (all races).
10. G.6-'92, p.386; G.19-'05, p.425; U.G.32-'12, p.x.

Discovery of diamonds in the Cape in 1867, and gold on the Rand in 1886, which transformed the South African economy, led to a massive increase in immigration to the Cape. Between 1891 and 1906, 69,417 white men and 18,819 white women immigrated to the Cape Colony from Europe[11]. Cape Town, an imperial trading town, had a large immigrant population[12]. In Cape Town itself during this period there were approximately 70,000 immigrants, of whom 36,000 were white[13].

Census population figures for the Cape Colony, Cape Town and suburbs, 1875-1911

	Cape Colony	Cape Town	Suburbs
1875	720 984	33 239	12 001
1891	1 527 224	51 251	27 615
1904	2 409 804	77 668	91 973
1911	2 564 965	67 159	94 420

Table 1[14]

Cape Town, the oldest of the Cape's cities, had a history of social and economic domination by an exclusionary white and often English-speaking elite, whom Bickford-Smith has described as a 'grand bourgeoisie'[15]. As the transport system improved, this elite took residence in the suburbs. Those not of the elite remained close to the city centre, in high density housing, often living in slum conditions. Before the 1900s, poorer areas of Cape Town had a racially and ethnically diverse population[16], sometimes suggested to be evidence of a distinctively Capetonian liberal tradition and tolerance for miscegenation[17].

11. C.Simkins and E.van Heyningen, 'Fertility, mortality and migration in the Cape Colony, 1891-1904', *The International Journal of African Historical Studies*, 22, (1989), 79-111.
12. Bickford-Smith, 'Commerce', pp.275-278.
13. Bickford-Smith 'Commerce', pp.275-278.
14. G.13-1876; G.36-'92; G.19-'05, p.12.
15. Bickford-Smith, 'Commerce', pp. 47-91.
16. Racial diversity was marked as biologically determined racial difference in official documents such as census reports, but incorporated ethnic difference. For a discussion of the problematic distinctions frequently made between 'race', 'ethnicity' 'culture' and 'nationality', see Wallerstein, 'The construction of peoplehood: Racism, nationalism, ethnicity', in E. Balibar and I. Wallerstein, *Race, Nation, Class: Ambiguous Identities*, (London, 1991), 71-85, and Bickford-Smith, *Ethnic Pride*, pp. 3-4. Categories used in the 1891 and 1904 census figures were 'European', 'Malay', 'Hottentot', 'Fingo', 'Kafir' and 'Bechuana', and 'Mixed', 'Other Coloured'. Fluidity of definition of various 'racial' groups is reflected in the 1904 and 1911 census reports, which for some tables combine the Malay, Hottentot and Mixed categories into a single 'Mixed and Other, Coloured' group, and the combination of the Fingo, Kafir and Bechuana categories into a single group to be called 'Bantu'. G.19-'05, U.G.32-'12.
17. For example by 1900 District Six had as residents recent British and Yiddish-speaking Russian immigrants, those officially classified as 'Hottentot', 'Fingo', and 'Kafir', 'Malay' and 'Mixed' or 'Coloured', as well as small numbers of Indian, Chinese and Australian immigrants. V. Bickford-Smith, 'The origins and early history of District Six to 1910', in S.Jeppie and C. Soudien (eds.), *The Struggle for District Six Past and Present*, (Cape Town, 1990) 35-43; E.van Heyningen, 'Poverty, self-help and community: The survival of the poor in Cape Town, 1880-1910', *South African History Journal*, 24, (1991), p.134. An example of a study which suggests that Cape Town was unusually tolerant and flexible about segregation can be found in G.Frederickson, *White Supremacy: A Comparative Study in American and South African History*, (Oxford, 1981). Bickford-Smith,

During the 1870s social segregation increasingly became a feature of life in the Cape Colony, culminating in the segregation of public facilities in the late 1870s[18]. Deacon suggests that the granting of responsible government in 1872 'removed official barriers to segregation' in the colony's institutions, including schools, prisons and hospitals[19]. Segregation in institutions between the 1870s and 1890s was often an uneven and inconsistent process, affected by a variable range of socio-political factors. For example, segregation in hospitals before the 1890s was affected by gender, class and possibility of disease transmission as much as by racial classification. Nonetheless, by the 1890s calls for strictly policed segregation was a naturalised feature of public rhetoric, particularly with regard to the colony's institutions, reflecting both already-accomplished racial separation in prisons, schools and hospitals, and anticipating increasing calls for strict residential segregation.

Impetus towards residential segregation came also from the small pox epidemic of 1882 and the bubonic plague of 1901, both of which made slum areas a focus for public concern. The stigmatisation of slum areas linked their sometimes barely habitable conditions with black, rather than white poverty and 'degeneration'. Added to this was the popular image of African people as carriers of disease[20]. Call for sanitary reform and the clearance of slum areas became a rationalisation for a policy of residential segregation. The most dramatic example was the enforced move of Africans to a location in Ndabeni, on the outskirts of the city, in 1901[21].

De facto segregation in Cape Town, both formal and informal, was well established by the late 1890s, somewhat later than developments elsewhere in the Colony[22]. The trend towards segregation was reinforced by the disinvestment of British support for African rights and interests, which began with the peace terms with which the South African War ended, and continued with the segregationist policies of the first Union governments[23].

Ethnic Pride, challenges this view in his analysis of Cape Town economic and social dominance by the solely white elite.

18. V.Bickford-Smith, 'The background to apartheid in Cape Town: the growth of racism and segregation from the mineral revolution to the 1930's'. Paper presented to the University of the Witwatersrand History Workshop, (Johannesburg, 1990). V. Bickford-Smith, 'A "special tradition of multi-racialism"? Segregation in Cape Town in the late nineteenth and early twentieth centuries', in W.James and M.Simons (eds.), *The Angry Divide*, 47-62.
19. Deacon, 'A history', p. 32.
20. At this time African people in Cape Town included those from Hottentot, Fingo, Kafir and Bechuana tribes.
21. van Heyningen, 'Public health and society', pp. 12-13; M. Swanson, 'The sanitation syndrome: Bubonic plague and urban native policy in the Cape Colony, 1900-1909', *Journal of African History*, 18, (1977), 387-410; Bickford-Smith, *Ethnic Pride*, pp.205-209. For a discussion of the stereotyping of African bodies as disease-carriers, see J. Comaroff, 'The diseased heart of Africa: Medicine, colonialism and the black body', in S. Lindenbaum and M. Lock, *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, (Berkeley and London, 1993), Chapter 13.
22. Bickford-Smith, 'The background to apartheid'.
23. J.Omer-Cooper, *History of Southern Africa*, (London, 1987), p.147.

'Agents of empire': the medical profession in the Cape

The Cape Colony had a well-established tradition of using doctors as 'civilising' agents. In 1855, Sir George Grey had specified 'establishing institutions for the education of their children, and the relief of their sick' as a means of gaining influence over the colonised population. An important part of the scheme was to use Western medicine to 'destroy the influence of the Witch Doctors'[24].

Between 1879 and 1899 nineteen bills related to medical concerns were passed by the Colonial Parliament[25]. These included the Medical and Pharmacy Act of 1891 which created the Colonial Medical Council and the Colonial Pharmacy Board. These bodies controlled the licensing of physicians, surgeons and accoucheurs, pharmacists, dentists, midwives and nurses[26]. In 1889 a local branch of the British Medical Association was formed, and its activities, which included regular meetings and the establishment of an extensive library, cemented the professional links between the Cape and Britain[27].

There is an extensive literature on the role of the medical profession in challenging or colluding with the colonial enterprise[28]. This includes examination of the intersection between professional aspirations, the health needs of colonies' indigenous populations and the economic and political aspirations of imperial governments. Imperial needs for cheap able-bodied labour made public health a central concern for colonial governments, and this positioned doctors as 'agents of empire', servicing economic imperatives, and playing a decisive role in shaping public health legislation as diseases imported with colonial regimes decimated local populations[29].

One well known example will illustrate the relationship between members of the Cape's medical establishment and imperial economic concerns. In 1883, despite vigorous attempts to prevent

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24. Quoted in Burrows, *A History of Medicine*, p.180-1.
25. Burrows, *History of Medicine*, Chapter 17, gives details of the legislation passed.
26. Burrows, *ibid.*, p.333.
27. van Heyningen, 'Public health and society', pp.91-2. For a discussion of the economics of medical practice in the Cape, see A.Digby, '"A medical El Dorado?" Colonial medical incomes and practice at the Cape', *Social History of Medicine*, 7, 463-479.
28. See R.MacLeod and M.Lewis (eds.) *Disease, Medicine and Empire*, (London, 1988), and T.Meade and M.Walker (eds.), *Science, Medicine and Cultural Imperialism*, (London, 1991) for collections of essays on these topics. See also M. Vaughan, *Curing Their Ills*. van Heyningen, 'Public health and society', gives a detailed account of the South African medical profession as 'agents of Empire'.
29. Imported diseases included small pox, bubonic plague and tuberculosis. For descriptions of the effects of these on local populations, see E. van Heyningen, (1989), 'Public health and society', Chapter 3, 'The smallpox epidemic of 1882', and Chapter 6, 'The plague epidemic of 1901'. Also see van Heyningen, 'Cape Town and the plague of 1901', in C. Saunders, H. Phillips and E. van Heyningen (eds.), *Studies in the History of Cape Town*, 4, (Cape Town, 1981), 66-107 (hereafter *Studies*); H. Phillips, 'South Africa's worst demographic disaster: The Spanish influenza epidemic of 1918', *South African Historical Journal*, 20, 1988, 57-73; H. Phillips, 'The local state and public health reform in South Africa: Bloemfontein and the consequences of the Spanish 'flu epidemic of 1918', *Journal of Southern African Studies*, 13, (1987), 210-229; R.Packard, 'Tuberculosis and the development of industrial health policies on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, 13, (1987), 187-209; C. de Beer, *The South African Disease: Apartheid, Health and Health Services*, (Johannesburg 1984), Chapter 1, 'Digging their own graves: a social history of tuberculosis'.

spread of the disease from Cape Town to the interior, small pox broke out in Kimberley. A group of doctors, including Dr Wolff, at the time resident surgeon at Kimberley hospital, deliberately misdiagnosed small pox sufferers in case the outbreak interrupted the steady movement of labour into the diamond fields. They persisted in calling the disease 'a bulbous disease allied to pemphigus', and the resulting failure to isolate those with small pox inevitably led to its rapid spread. By the end of 1884, approximately 2,300 cases had occurred, with 700 deaths, of whom 649 were black. Sir Thomas Upington, Prime Minister, noted in Parliament that the doctors involved had acted to protect mining interests[30].

Less dramatic examples of South African doctors' collusion with mining and other industries' economic interests and the resulting failure to provide adequate health care for workers are a persistent thread in South African medical history[31].

Apart from the collusion with colonial authority in neglecting the health of the colony's labour force, the medical establishment played a role in the construction of knowledge about the colonial subject. Close contact between doctors and indigenous populations permitted the growth of a body of supposedly scientific and neutral knowledge about colonised peoples[32]. The discursive construction of medical knowledge as privileged with respect to the bodies, needs and customs of 'the native' was important in mediating the tension between humanitarian and universalist medical philosophy and the sometimes violent assault of colonial economic policies on indigenous populations, especially in industrialised settings[33]. In order for doctors to turn a blind eye to colonial practices which perpetuated unsanitary living conditions, overcrowding and poor nutritional status, all of which led to the spread of preventable disease such as cholera, tuberculosis and enteritis, they had to rationalise such inequalities as tolerable to indigenous populations on the basis of their racial or ethnic difference from their colonisers. In this way,

30. Burrows, *A History of Medicine*, pp.259-62, gives a detailed description of the 'smallpox war'. In *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*, (Johannesburg, 1994), pp. 38-40, Shula Marks discusses the involvement of nurses, particularly Sister Henrietta Stockdale, in the affair.
31. These issues are explored in S. Marks and N.Andersson, 'Issues in the political economy of health in Southern Africa', *Journal of Southern African Studies*, 13, (1987), 177-186. For a discussion of health care under apartheid, see C. de Beer, *The South African Disease*, and A. Seedat, *Crippling a Nation: Health in Apartheid South Africa*, (London 1984).
32. Vaughan, *Curing Their Ills* gives an analysis of biomedical discourses on 'the African'. J.McCulloch describes twentieth century psychiatric discourses in 'The empire's new clothes: ethnopsychiatry in colonial Africa', *History of the Human Sciences*, 6, (1993), 35-52. See also McCulloch, *Colonial Psychiatry and 'The African Mind'*, (Cambridge, 1995).
33. S Marks and N.Andersson, 'Issues in the political economy of health in Southern Africa'. M. Swanson, 'The sanitation syndrome', describes how the racialised medical explanation of the spread the plague was used to justify the necessity for residential segregation. R.Packard, 'Tuberculosis and the development of industrial health policies' describes the ways in which doctors in the first decades of the twentieth century understood susceptibility to TB in the black population in terms of their habits, customs, and even their constitutions.

living conditions which would be intolerable to colonisers were naturalised as either customary or adequate for 'primitive' people[34].

Doctors as 'agents of empire' were therefore amateur anthropologists, describing indigenous populations in ways which constructed the black subject discursively as colonisable. Ironically, part of the colonising process included the importation of Western biomedicine, with its assumption of the universal and culturally impermeable nature of disease and cure, which privileged Western medicine over indigenous health practices. Thus, black subjects were simultaneously constructed as biologically and culturally different to their colonisers and yet treatable within the same medical paradigm.

Megan Vaughan cautions against reading the colonial biomedical enterprise as monolithic. She documents the complexity of the relationship between colonial doctors and the regimes within which they worked. She points out that there were always critics of colonialism in the medical establishment. Moreover, in different countries, and at various times in the course of the nineteenth and twentieth centuries, Western biomedicine had little impact on Africa's 'medical pluralism'. In the period 1891-1920, while Western biomedicine may have had relatively little impact on rural African populations, in Cape Town, the epidemics of 1882, 1901 and 1918 gave impetus to the imposition of Western health measures such as compulsory vaccination. Some of these measures interfered directly with local communities' religious practices[35]. The insanitary and overcrowded conditions of mining compounds and 'native' locations combined with the poor nutritional status of their residents fostered a generally low standard of health while simultaneously undermining connections with indigenous healing systems[36].

The asylum network

By the end of the nineteenth century, Cape asylum practice was firmly located within the framework of Western biomedicine. Asylum doctors, like their counterparts in general practice, played a significant role in servicing imperial interests in the form taken by management of the insane in the colony.

34. A notorious South African example from this century was the provision of an inadequate diet for black psychiatric patients in government-subsidised private facilities on the grounds of 'cultural preference'. Their white counterparts were given a considerably more varied and nourishing diet. A.Stone, C. Pinder-Hughes, J. Spurlock and J. Weinberg, 'Report of the Committee to Visit South Africa', *American Journal of Psychiatry*, **136**, (1979), 1503.
35. A. Davids, 'The revolt of the Malays: A study of the Cape Muslim reaction to the nineteenth century smallpox epidemics', in C.Saunders, H. Phillips, E. van Heyningen (eds.), *Studies*, **4**, pp. 47-49.
36. Unhealthy living conditions in the locations were widely recognised by the medical establishment. The need for cheap labour however, overrode these concerns. For doctors' descriptions of contemporary conditions in locations see R.Packard, 'Tuberculosis and the development of industrial health policies', and M. Swanson, 'The sanitation syndrome'.

The history of Valkenberg Asylum, the institution at the centre of this study, needs to be understood in relation to the history of other asylums in the Cape. Valkenberg's early history was a response to the difficulties and shortcomings of older asylums, and its reputation as a colonial showpiece of modern institutional care for the insane owed much to the stigma and scandal associated with other asylums.

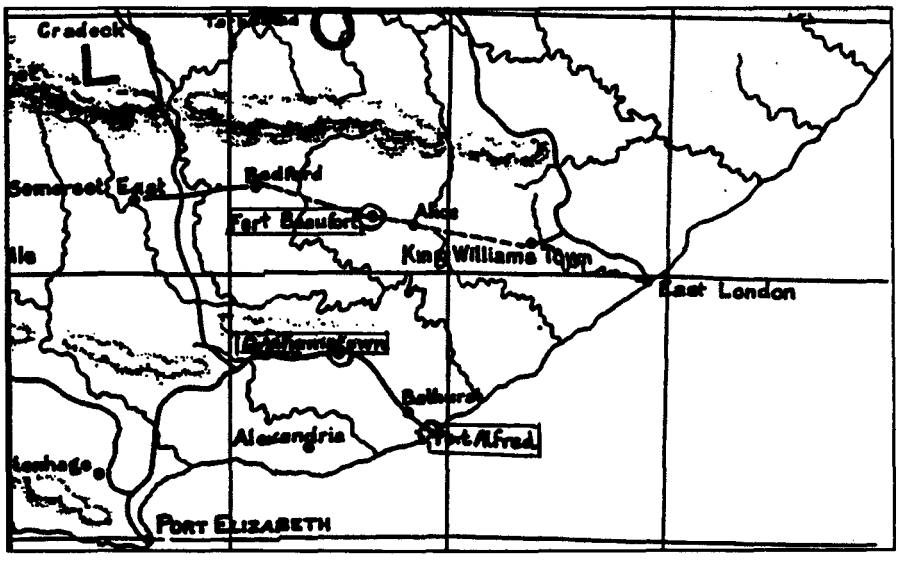
In addition to this, there were close links between the asylums of the Cape. These were maintained partly through regular tours of inspection carried out by Dr Dodds. His lengthy reports on each asylum provided information not only for the Colonial Office, but also for the medical establishment serving Cape asylums. Transfer of patients from one asylum to another in response to patients' and institutional needs resulted in a regular exchange of casenotes and correspondence between asylums. Medical practitioners assisting or deputising for asylum superintendents frequently had experience of working in more than one asylum, and this undoubtedly contributed to the establishment of some degree of shared institutional culture with respect to the management of the insane[37]. Meetings of the British Medical Association gave asylum doctors opportunities to meet each other, and to present papers to medical colleagues on aspects of their work. The superintendents of asylums also met from time to time to discuss policy with regard to the management of the insane[38].

During the period 1891-1920, the Cape was served by a network of five asylums, including Robben Island Asylum and Valkenberg Asylum in Cape Town, and Grahamstown Asylum, Fort Beaufort Asylum and Port Alfred Asylum in the Eastern Cape. In addition to these, Old Somerset Hospital in Cape Town accommodated an increasingly small number of patients between 1891 and 1910. Without exception, all the medical superintendents were British-trained. Some had experience of working in British asylums (see Map 1).

Robben Island was the oldest asylum in the colony[39]. For many years a convict station, it had also been a whaling station and a convalescent hospital for soldiers. The lunatic asylum, and accommodation for the chronic sick and lepers, opened in 1846. Its history as a convict station, its relative inaccessibility to the mainland, and its association with stigmatised groups of people all in need of long term institutional care gave it a reputation for being a bleak place of incarceration, 'a

37. For example, Dr Sinclair Black worked at Robben Island Asylum, Valkenberg and Fort Beaufort. Dr Cassidy served at Emjanyana Leper Colony, as well as at Grahamstown and Valkenberg Asylums. CCP 11/4/26.
38. For example, there was a meeting of superintendents 26/4/1907 to discuss 'the question of dealing with the Coloured insane'. HFB 3.
39. See Deacon, 'A history', for a detailed description of Robben Island's lunatic asylum.

dumping ground' rather than a place of humane care[40]. Inadequate accommodation, poor sanitation, chaotic medical management, pregnancies amongst female lunatics, and corruption and drunkenness amongst the staff led to repeated eruptions of scandal[41]. Despite reforms undertaken by London-trained Dr Edmunds, who did his best to implement a semblance of Connolly's moral management between 1862 and 1872, Robben Island remained a source of disquiet. Scandals continued well into the superintendency of Dr Earnest Moon, British-trained and with experience at Derby Borough Asylum, who was placed at Robben Island between 1904 and 1920[42]. Periodic public unease about conditions on the island fuelled debate about the need to re-house lunatics on the mainland, in accommodation accessible for relatives, and away from the stigmatised leper population of the Island[43].



Map 1

Location of Eastern Cape Asylums

The only other accommodation for the insane in the western region of the Cape was at Old Somerset Hospital, which was built in 1818 by Dr Samuel Bailey, as a civilian resource. Following his bankruptcy, it was taken over by the Burgher Senate, and became a public institution in 1821. Until 1846, it was the only place to house lunatics, apart from gaols. It also accommodated the chronic sick, paupers and lepers. It was never regarded as satisfactory for any of these purposes, and just before the removal of some lunatics to Robben Island in 1846, the

40. Deacon, 'Place of tobacco trees: 19th century institutions', in N.Penn, H. Deacon and N.Alexander, *Robben Island: The Politics of Rock and Sand,* (Cape Town, 1992); Dr Jane Waterston, Visitor's Report on Valkenberg Asylum, CO 7322, 29/12/1899.
41. Deacon, 'A history'; D. Moyle, 'Drawing the line: the early history of lunacy in South Africa'.
42. CO 8053, 15/2/08.
43. A summary of the debate about the location of new asylum accommodation for the insane in the Western region of the Cape can be found in Dodds' Inspector of Asylums report, for 1892, G. 17-'93, pp. 137-140. See also the brief history of Robben Island Asylum included in the Report of the Commissioner in Mental Disorders for the years 1916-18 after Union, U.G. 31-'20, pp. 17-19.

Dean of Cape Town commented that 'anything more wretched and inappropriate for its unfortunate inmates cannot be imagined than the lunatic wards'[44]. It nonetheless continued to be used to accommodate lunatics, with numbers between 1880 and 1891 fluctuating between 100 and 170[45]. There were repeated calls for Old Somerset to cease to function as a lunatic asylum. In 1890, Dr Cox, Surgeon in Charge, wrote at the end of his annual report: 'It is necessary again to call attention to the absolute unsuitability of the Institution for the treatment of lunatics and the urgency for their removal'[46]. Despite the opening of Valkenberg in 1891, and the transfer of many patients there, by 1909, there were still 10 insane patients in Old Somerset Hospital. In June 1905, Dr Jane Waterston, Official Visitor to Valkenberg remarked in her report on the contrast between the 'open sunny courts with their grass and trees' at Valkenberg and 'the terrible lunatic court in the Old Somerset with its very high walls, crowded dark cells, Mixture of races and colours, without a blade of grass or the smallest tree'. She added that '"under observation" in such a den is a screaming farce'[47].

Grahamstown Asylum in the Eastern Cape was first opened in 1875 in the old military barracks at Fort England[48]. These buildings also housed a Chronic Sick Hospital. Dr Robert Hullah, MRCS (1866) LSA. (1867), superintendent from 1875 to 1890, had had experience in English lunatic asylums. Early tours of inspection by Dodds found considerable deficiencies in his management of the insane under his care, including the fact that no case books were kept, and restraint was being used without appropriate authority from the superintendent and Head Nurse. Dodds also mentioned the 'want of order' at meal times, and the 'disgraceful condition' of the latrines[49].

Dr Hullah's successor, Dr Duncan Greenlees, FRS (Edin.), MB, Ch.M. (1882), MD (1901), was superintendent from 1890-1907. Under his management, conditions in the asylum appear to have improved steadily. Like Dodds, he prided himself on his familiarity with the most modern developments in Europe on the treatment of insanity[50]. He also contributed to the flow of knowledge from the colony back to the British medical establishment in a number of journal articles, dealing with lunacy administration in the Cape, and insanity in the native population[51]. As

44. Burrows, *A History of Medicine*, p.122
45. Moyle, 'Drawing the line', p.12.
46. G.37-'91, p.25. See also Dodds report on his inspection of Old Somerset Hospital, 1890, G.37-'91, p.19.
47. CO 7977, June, 1905.
48. A detailed history of Grahamstown Asylum can be found in F. Swanson, 'Colonial madness'.
49. G.37-'91, p.20.
50. For example, Dodds had requested copies of Charles Mercier's work to be circulated to doctors in all the colony's asylums. Greenlees remarked that he 'had already read Mercier's work a copy of which I possess: its main defect, in my opinion, is its want of originality.' CO 7175, 10/12/94.
51. T.D.Greenlees, 'Lunacy legislation in Cape Colony', *JMS*, **56**, 1910, 261-272; 'A statistical contribution to the pathology of insanity', *JMS*, **48**, 1902, 645-666; 'Statistics of insanity in Grahamstown Asylum', *South African Medical Record*, **3**, 1905, 217-24; 'Insanity among the Natives of South Africa', *JMS*, **41**, 1895, 71-78.

these articles and his comments in case notes and correspondence make clear he held strong views on women's inferiority to men, and blacks' inferiority to whites[52]. He also appears to have disliked the white Afrikaans patients admitted to his asylum, a prejudice undoubtedly exacerbated during the Anglo-Boer War[53].

In 1908, it was decided that Grahamstown Asylum should be reserved for white patients only. Greenlees' successor, Dr Cowper, commented that 'this is a very desirable thing', despite its adverse affect on the availability of black patients as asylum labour[54].

Port Alfred was opened in 1889 in old convict barracks, and was under the medical supervision, and later superintendency of Dr Atherstone, MB, Ch.M. (1877). The buildings were always considered to be unsuitable for the accommodation of the insane, and as a result little money was spent on it. It was never regarded as anything other than a means of easing the accommodation shortage in the colony as a whole, and was used primarily to house the chronic insane. It was kept full through transfers from other asylums. In 1913 it was proposed by the Parliamentary Select Committee to use Port Alfred as an industrial and farm colony for the feeble-minded, but this recommendation was not carried out[55].

Fort Beaufort Asylum, from the outset an asylum exclusively for black patients, was opened also in old military barracks in 1894. Run briefly by a lay superintendent, it was taken over by Dr J. Conry, L.K.Q.C.P &S. (1868), MB, Ch.M. (1877), in 1898, following the discovery of irregularities and misappropriation of the asylum's supplies[56]. 'Conry's Annexe', or the 'Hut Annexe', a wattle-and-daub 'location', housing quiet patients, was an experiment in the construction of cheap accommodation for the black insane, and represented a saving to the colony of almost £8,000. The huts were occupied in 1908, and were said to have 'answered their purpose well'[57]. From the start, the asylum had a poor record in terms of patient health, with tuberculosis and scurvy both testimony to the malnutrition of the inmates. Patients were also severely affected by epidemics of influenza and enteritis[58].

52. For a discussion of his views on women, see Swanson, 'Colonial madness'. His views on black patients are discussed in detail in Chapter 5.
53. Swanson, personal communication, 1994.
54. Grahamstown Annual Report, 1908, G. 41-'09, p.30. The full implication of the segregation, and the use of patients as labour are described in Chapter 6.
55. U.G. 31-'20, p.22.
56. CO 7158, 24/4/1895.
57. U.G.31-'20, p.23.
58. Details of the epidemics and the resulting deaths among patients are given in annual reports, 1894-1909. The health record of Fort Beaufort is discussed in Chapter 6.

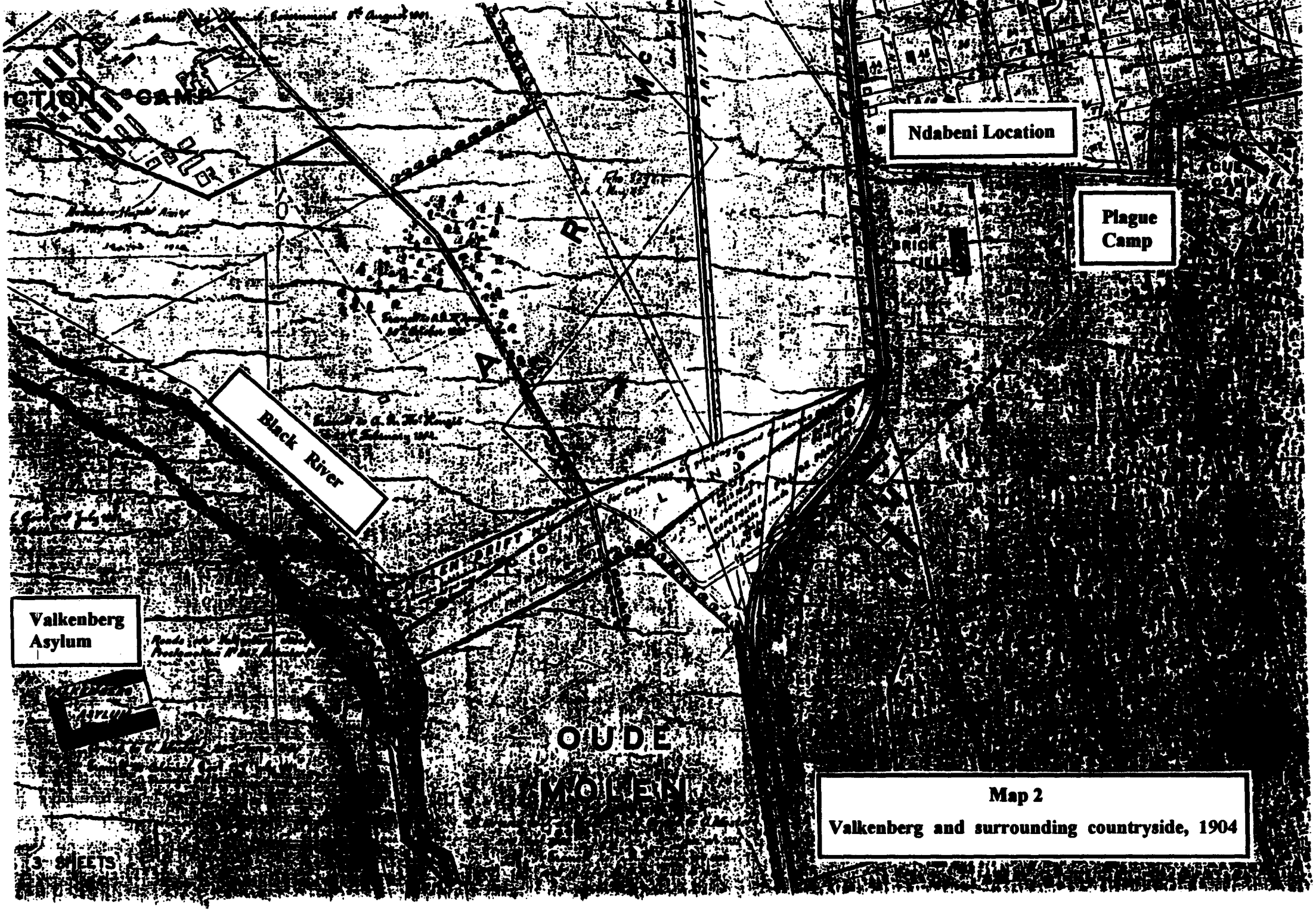
British medical training and close professional connections with British asylum management practices kept the colony well abreast of the latest developments in British and European psychiatric knowledge and practice. Dodds was at pains to cement the ties between the colony and Britain, recruiting staff on his visits there, and circulating annual reports of British asylums and some monographs to asylum superintendents[59]. Even Conry, working in the under-resourced Fort Beaufort Asylum, commented on the 'absolute necessity to obtain Staff from England'[60].

While treatment of patients in the colony was described as comparable to British asylums in its enlightened and humane care of the insane, separation of black from white patients became associated with marked discrepancies in provision, with the black insane having lower recovery rates and higher death rates than their white counterparts. It was in its racial policies that colonial asylum practice took on characteristics muted or absent in British asylums, and it was on the basis of racial difference in the appearance and treatment of insanity that a colonial psychiatry was founded. It was colonial in the sense that it maintained strong links through both ideology and identity with the mother country, but nonetheless was shaped by local constraints, politics and economy.

Union brought together the administration of all asylums in South Africa. By 1910 all Cape asylums had large numbers of chronically insane patients[61]. Less attention was paid to the therapeutic aspect of asylums as they grew in size, and the annual reports post-Union document general trends and policies, rather than detailed accounts of individual asylums. In spite of these changes, principles underlying the management of the insane in the Cape during the period 1909-1920 built on practices established during the period of Dodds' Inspectorship.

One notable exception to this was Dr J. Dunston's interest in feeblemindedness and his determination to provide sufficient institutional 'care and control' for those in this category throughout his term of office as Commissioner of Mentally Disordered or Defective Persons[62]. His concern reflected increasing alarm over the problem of 'poor whiteism' popularly associated with the threat of racial degeneration and feeblemindedness in the white population[63]. The implications of this in terms of institutional resources in South Africa after Union was increasing acceptance of

59. CO 7177 December 1896 contains Dodds' report on a recruiting trip to Britain. CO 1485 14/9/91 and CO 1524 7/7/1892 give lists of asylums in England, Scotland, Ireland and the United States which Dodds wanted to exchange reports with.
60. CO 7919 30/3/1905.
61. U.G.31-'21, pp.15-6.
62. This was the post which replaced that of Inspector of Asylums after Union. Dr Dunston was the first incumbent, appointed as successor to Dodds in 1913.
63. See 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*. This issue is discussed in detail in Chapter 5.



Map 2

Valkenberg and surrounding countryside, 1904

the custodial nature of care for the insane, and a new focus on the identification of the feebleminded, with a view to establishing special education facilities and long-term residential care[64]. It was not until the treatment revolutions which began with convulsive therapies of the late 1930s that the institutionalised insane once again became a focus of attention.

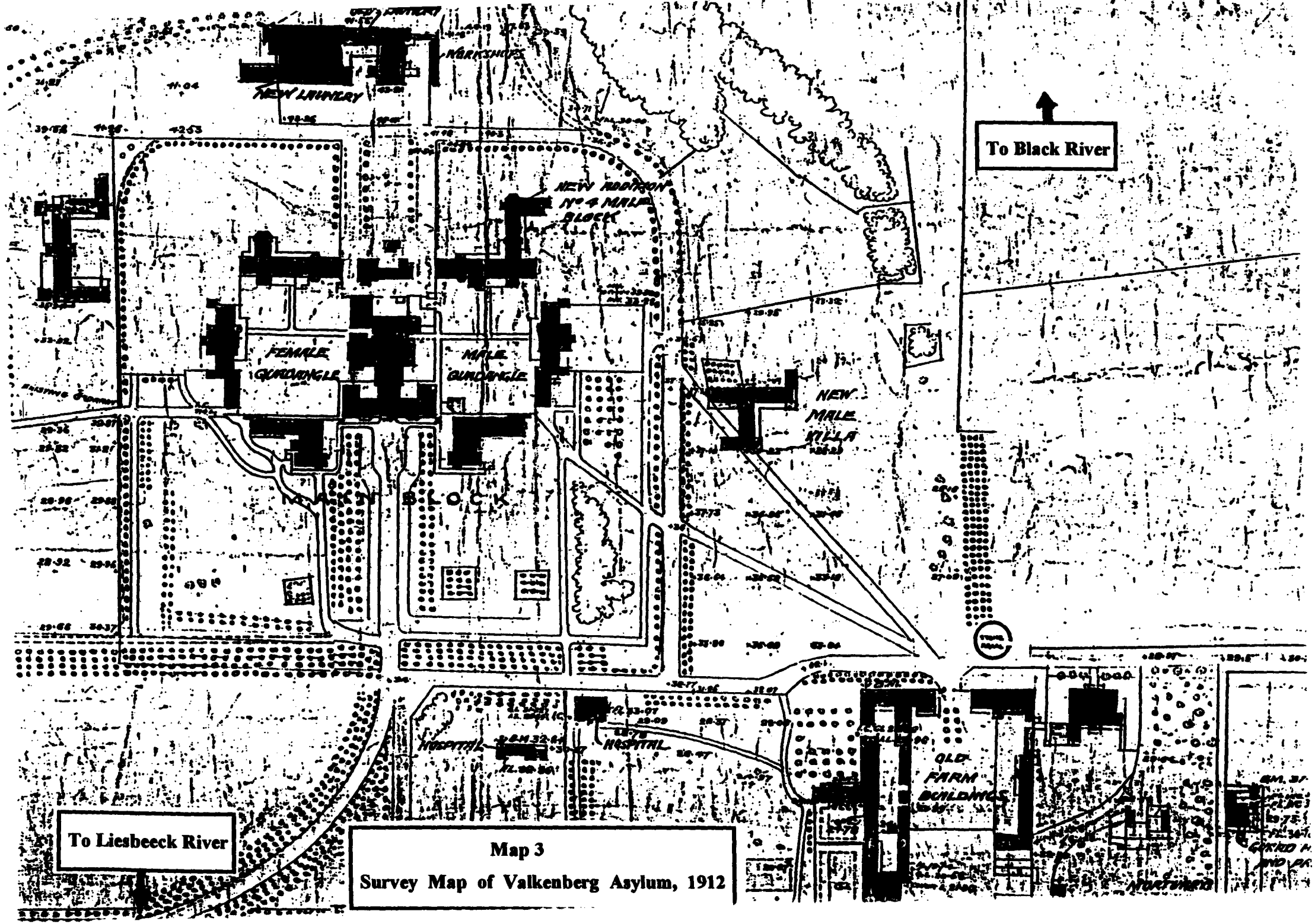
Valkenberg Asylum

Valkenberg, the Cape Colony's first whites-only asylum, and the first also to be designed specifically for the purpose of accommodating the insane, was opened in 1891.

Legislative reform, beginning in 1879, signalled the colonial government's awakening interest in the conditions under which lunatics should be detained and treated. British-trained medical practitioners such as William Edmunds, stationed at Robben Island from 1862 to 1872, and William Ross, on Robben Island from 1884 to 1889, had been keen to institute reforms in the management of lunacy in the colony, along the lines widely believed to have transformed the care of the insane in Britain and Europe[65]. Robben Island was however an inconvenient location for a reformed and enlarged asylum. Building and supplying an institution sufficiently large to meet Cape Town's needs for lunacy accommodation on the island presented logistical problems. Moreover, the barren and isolated environment created difficulty for staff and for patients' relatives who wished to visit. It was the unanimous opinion of the Colonial Medical Committee and Select Committees appointed to inquire into the site for a new asylum between 1855 and 1879 that the institution for the insane on Robben Island should be removed to the mainland[66].

The appointment an Inspector of Asylums in 1889, with the responsibility for guiding lunacy legislation and modernising the colony's asylums played an important part in actualising the decision to create an asylum easily accessible to the public. Quoting at length from suggestions made by English Commissioners in lunacy with respect to the siting of asylums, Dodds stressed the necessity for modern asylums to have easy access to water, gas, and food supplies, as well as recreational facilities from which both staff and patients might benefit. He represented Robben Island as 'of little help to a mind struggling with disease', not only because of its isolation, but also because of its association with convicts and lepers[67].

64. Dunston's first report as Commissioner in Mental Disorders devoted considerable attention to description and discussion of feeblemindedness; this set the tone for his time as Commissioner. For a detailed history of the treatment of the feebleminded in South Africa during this period, see Foster, 'Historical and legal traces, 1800-1900' in S.Lea and D.Foster (eds.), *Perspectives on Mental Handicap in South Africa*, (Durban 1990) 21-70.
65. Deacon, 'A history', Chapters 3 and 5.
66. G.17-'93, p.137.
67. G.17-'93, p.138.



Map 3

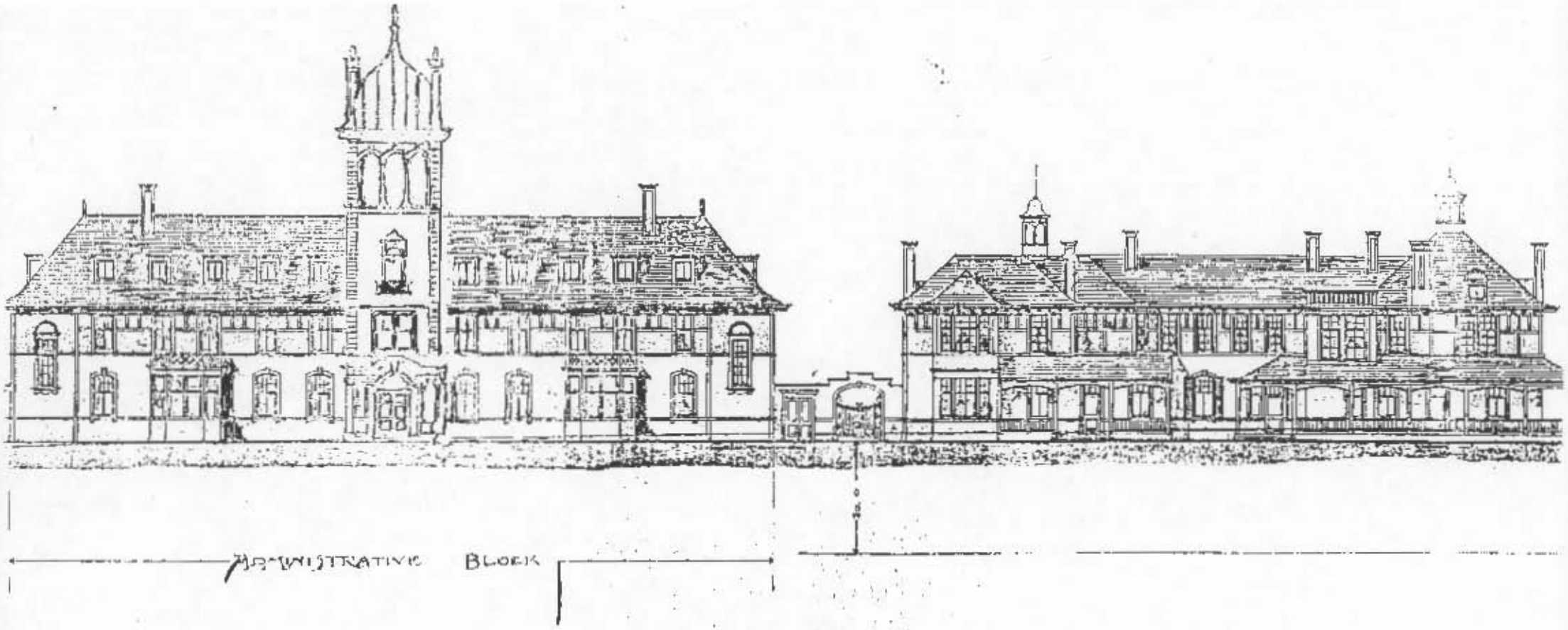
Survey Map of Valkenberg Asylum, 1912

The site eventually settled upon was at one time a farm belonging to Cornelius Valk, and it was from him that the asylum took its name. The land had been purchased by the government of the Cape Colony in 1881, and was used as a reformatory (the Porter Reformatory) for boys, until the site was approved by the Colonial Secretary as suitable for the accommodation of the insane. Strong opposition was expressed by those on neighbouring lands. In 1889, there was a petition from the 'landed proprietors' in the area protesting against the establishment of the asylum on the Reformatory land. The astronomer at the Royal Observatory, which bordered on Valkenberg's grounds, asked 'what steps are to be taken to render our houses and grounds safe from unwelcome and possibly dangerous visits from the patients'[68]. Even after Valkenberg's opening in 1891 Dodds found it necessary to continue to argue in correspondence with the Colonial Office and in his annual reports that asylums should be accessible to the public[69]. In 1894, building began to increase Valkenberg's accommodation by 200 beds, but only after Dodds had had to argue that Valkenberg was a better site than Tokai, which was a considerable distance from populated suburbs.

Dodds also faced opposition when he proposed that black patients be accommodated on the mainland, instead of on Robben Island[70]. It was not until 1916 that the Old Plague Camp Uitvlugt, sited across the Black River from Valkenberg, was opened to accommodate black insane patients, (see Map 2). 106 black men were admitted to Valkenberg up to and including 1919. New accommodation for black patients was occupied in the 1919-1920 period, and number of black admissions immediately doubled, many of them transfers from Robben Island Asylum. By 1920 there were 37 'Native', 3 'Asian' and 187 'Coloured' men on the register. The first black women were admitted in 1919, and on the register in 1920 there were 11 designated 'Native', 1 'Asian' and 167 'Coloured'. Its separation from the white asylum, both geographically and in name, as well as its historical association with the plague, were powerful reminders of its segregated and stigmatised position in relation to Valkenberg. This was not to change until Valkenberg became racially integrated in the early 1990s.

It was against a background of inadequate colony facilities that Valkenberg was opened. The first 36 patients, admitted in February 1891, were housed in the Reformatory buildings, which included the old farm homestead and outbuildings. Minor modifications had been made to 'remove anything that should suggest thoughts of a prison or one of the old prison-like asylums'[71]. Between

68. CO 1470, 17/6/1889.
69. See for example CO 7175, August 1894.
70. CO 7608, 2/10/01.
71. G.36-'92, p.6.



EAST ELEVATION

Map 4

Sketch of proposed plan for Valkenberg asylum

EDINBURGH: JULY: 1892

1894 and 1899, new men's and women's blocks, the administration building, and dining hall were built (see Map 3).

The new asylum was designed by Mr Sydney Mitchell, a Scottish architect, recommended by the Board of Lunacy for Scotland (see Map 4). Although adaptations to the climate of South Africa were discussed by Mitchell and Dodds, the buildings were in the style of European asylums[72]. Provision was made for both male and female private patients, who for a fee were accommodated in small prettily-decorated wards, were given private bedrooms, and were fed a more liberal and varied diet than the majority of patients.

In 1910, *The Cape Town Guide* wrote of Valkenberg's 'picturesque position on the summit of a gentle eminence overlooking a landscape that, except for the mighty mass of Table Mountain overshadowing it, might well be an English one'[73]. The buildings, setting, recreational activities, which included garden parties and cricket matches, and the exclusively white patient population established Valkenberg as a colonial showpiece. It was also an institutional summary of colonial relationship, an obdurate display of colonisers' refusal to adapt institutional culture to foreign conditions[74]. Intrinsic to this was the assumption that in order for white colonials to feel socially at ease, they needed protection from contagion by constant confrontation with difference, regardless of whether this took the form of racial or architectural diversity.

Valkenberg was set up as a model of effective treatment for early and curable cases of insanity. Treatment consisted primarily of regular occupation doing light domestic work and farming or gardening. The asylum had a thriving farm, with a dairy herd, pigs, and extensive vegetable garden. This provided opportunities to employ male patients in labour intended to distract them from their mental affliction. Women did needlework, or helped in the steam laundry or kitchen[75]. Recreational activities included dances, concerts, amateur theatricals, magic lantern entertainments, conjuring, football, cricket, tennis, croquet, avenue teas, drives, and visits to town[76].

Comparisons between Robben Island, Old Somerset and Valkenberg were inevitable, and the inadequate facilities of the former two helped to shape Valkenberg's reputation as a haven for the

72. CO 1488, February, 1892.
73. Quoted in Q. du Toit, 'Valkenberg: 100 years of devoted care', booklet prepared in celebration of Valkenberg's centenary, (1991).
74. It is interesting that there was never a policy in the Cape, as there was in India, of repatriating insane British colonials. In the absence of such a policy, Valkenberg was important as a place in which the British insane could feel 'at home'. For a description of Indian practice, see Waltraud Ernst, *Mad Tales from the Raj*.
75. Patients' labour did not obviate the necessity for employment of a black labour force. The racial dispensation with respect to labour in asylums is discussed fully in Chapter 6.
76. These were the recreations listed in the annual report for 1891, G.36-'92, p.6.

better classes of patient. However Robben Island in particular was a valuable resource for Valkenberg because it housed the black, criminal and violent or dangerous insane. Thus in 1893, John W was admitted to Valkenberg, and diagnosed as having 'mania'. In 1895 he was transferred to Robben Island, and was described by Dodds on the transfer papers as 'a disagreeable patient', impulsive, obscene, and prone to undress himself. John I was a similar case. Admitted to Valkenberg in 1897, and diagnosed as 'melancholic', he was transferred to Robben Island in 1910, because he was often found masturbating, was incoherent, dementing, stuporose, and dirty in his habits. He assaulted other patients, and needed to be secluded[77].

Valkenberg, discursively constructed as a model asylum in the early years of its existence, gradually became indistinguishable from other Cape asylums. The major reason for this was its growth in size, and the accumulation of chronic patients in its wards, which seriously undermined claims that it was able to offer a higher rate of recovery than its sister institutions. In addition to this, the admission of black patients in 1916, even under strictly segregated conditions, challenged its status as a congenial haven for the white insane. It made no pretence to offering black patients a better standard of care, or greater chance of recovery than other asylums. Many of the first black patients admitted in 1916 had been in Robben Island for some years, and were known to be reliable and quiet workers. They were deployed as labour in Valkenberg, and this was not described as 'remedial occupation'[78].

Valkenberg's medical staff

Dr William John Dodds, MB, Ch.M., MD, D.Sc. arrived in Cape Town in November 1889, and was immediately appointed Visitor of All Asylums, an office later called Inspector of Asylums. Apart from being academically highly qualified, he had had experience of asylum work Scotland, where he had been Deputy Superintendent at Montrose Royal Asylum. He combined his duties as Inspector with the onerous job of being Valkenberg's first medical superintendent, from which post he retired in 1913. He was an active campaigner in the field of medical education, and was involved in the founding of a local medical training. He was also concerned with issues of public health, and particularly the control of preventable diseases. He contributed substantially to the Cape branch of the British Medical Association, serving as President in 1898 and again in 1899. He died in Scotland in 1939.

77. In terms of an agreement with Valkenberg Hospital management, the full names of patients in the series may not be published. The records are ordered chronologically according to date of admission to Valkenberg, or transfer to Valkenberg from another asylum. A list of folder numbers, and date of admission to Valkenberg are given in Appendix 1b, and will identify records referred to in this dissertation, for those wishing to consult them.
78. See Chapter 6.

Mental health in the Cape Colony was an area in which inertia, short-sightedness and piecemeal, short-term arrangements characterised medical practice. Before Dodds' arrival, there was no coherent mental health policy and inadequate legislation[79]. The existing asylums were all problematic in various ways, as Dodds' first reports made clear. Although lip service was paid to the principles of moral management, encompassing the ideas of treatment without restraint and therapeutic occupation in cheerful and restful surroundings, the reality of asylum life was far different[80]. The institutions were custodial, prison-like, overcrowded and under-resourced[81].

It is in the context of this dismal situation that Dodds' contribution to the history of mental health care in the Cape needs to be assessed. A major achievement lay in his determination to bring colonial practice in line with practices current in England. This was effected partly through the legislation drawn up under his guidance in 1891 and 1897, and partly through constant pressure brought to bear on the Colonial Office for funding. Dodds' annual Inspector of Asylums reports were influential in this respect[82]. Annual reports from numerous British and American asylums were ordered by Dodds through the Under Colonial Secretary's office, and were circulated to asylum superintendents as a means of keeping them in touch with developments abroad[83]. In 1892, Dodds requested that reports from Cape asylums be sent to asylums superintendents in Britain, America and even the Inspector of Asylums in Melbourne. He said this practice was 'a useful one, furnishing many hints & inducing a healthy rivalry'[84]. He instituted the practice of keeping statistics on asylums as recommended by the Medico-Psychological Association of Great Britain, which played a crucial role in changing insanity from a feared but unknown scourge, into a public health issue around which government planning could take place. He also made regular visits to Britain, and while there he toured asylums, to keep in touch with new developments. He kept up with contemporary academic and theoretical developments: his personal copies of *Journal of Mental Science*, in the University of Cape Town's Medical Library, are annotated in his handwriting[85].

79. The lunacy legislation is discussed in detail in Chapter 4.
80. See J. Conolly 'The treatment of the insane before and after the advent of moral management', 1856, reprinted in V. Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century*, (London, 1975), 146-152, for a description of moral management in nineteenth century British treatment of lunacy.
81. Dodds' Inspector of Asylums reports from 1890 detail the shortcomings of various asylums. See for example G.37-'91. Deacon, 'A history', Chapter 3 gives an account of moral management of lunatics on Robben Island.
82. There was a long-standing tradition in the British medical establishment of using annual reports as a means of bringing pressure to bear on government. For a discussion of this in relation to public health reform, see van Heyningen, 'Public health and society', p.58.
83. CO 1485, 14/9/91.
84. CO 1524, 7/7/1892.
85. Russell discusses the importance of both the statistical tables and *JMS* in establishing asylum doctors' professional status. 'The lunacy profession and its staff'.

Dodds worked actively towards reducing the stigma inflicted upon the mentally ill. This he did by attempting to integrate the insane into local communities. He encouraged patients to spend time with their families on brief visits or on probation. He also encouraged volunteers to become involved with entertainments for patients. He is on record as supporting humane care for all patients, and that this was a value for which he was prepared to fight is evidenced by his numerous outspoken comments on instances of neglectful, abusive or poorly resourced patient care.

However, the standards of care for which Dodds fought were largely directed at the white insane. He was frequently silent on issues of ethnic, racial and social difference, a blindness exacerbated by his lack of experience of having black patients under his care. He failed to rise to the challenge posed by growing numbers of black patients in the colony's asylums, whose 'fit' with the system was sometimes poor. It was left to colleagues running asylums with black patients in them to attempt to make sense of the unique aspects of the colonial situation, including the effects of contact between blacks and white. During Dodds' period as Inspector of Asylums existing discriminatory practices against black patients were extended and formalised, and for this he has been criticised[86].

Dr Cassidy M.B.C.M. (Edin 1887) was appointed as Valkenberg's second superintendent on Dodds' retirement in 1913. He had been Assistant Medical Officer to Lancaster County Lunatic Asylum from July 1889 to July 1895, at which time he immigrated to the Colony. His first appointment in the Cape was to the Cape Government Railways at East London, where he spent 8 months. His next appointment was to Grahamstown Asylum, as Assistant Medical Officer, and he was there for exactly 3 years, until June 1899. He then went to Emjanyana Leper Asylum, as the resident Medical Officer, where in 1904 he became Medical Officer in charge. Apart from these bare details, Dr Cassidy left few traces. Although Valkenberg began to admit black patients during his time as Superintendent, he cannot be said to be responsible for the change, because Dodds not only fought for mainland accommodation for black patients, but also suggested Uitvlugt as a potential site.

From 1903, Dodds was assisted in his duties first by one, and then by two medical officers, one of whom, Dr Swift, was to succeed Dr Cassidy as superintendent of Valkenberg in 1923. He was Assistant Medical Officer in 1902. Dr Cowper, who trained in Scotland, and had had asylum experience in Stirling District Asylum, was Assistant Medical Officer from 1897 to 1902, when he left the Colony briefly to take up a position in the Transvaal. He was later to become

86. Warwick, 'Mental health care at Valkenberg Asylum'.

superintendent of Grahamstown Asylum. Dr R. Sinclair Black MA (Aberdeen); MB, Ch.M., D.P.H. was Assistant Medical Officer at Valkenberg from 1903, and in 1904, he was joined by Dr Watt. Prior to his appointment to Valkenberg, Dr Black had served as a medical officer on Robben Island. He had first come to the Colony as a medical assistant to the Cape Bacteriological Institute. At Robben Island he was demoted from Senior Medical Officer in 1903, because of drunkenness. In 1903, he was to have relieved at Fort Beaufort Asylum during Dr Conry's period of leave, but arrived in an inebriated state, and was sent back to Cape Town. He received considerable support from Dodds, who intervened with the Colonial Secretary on his behalf, stating that during his time of work at Valkenberg, he had not been 'intemperate or taken alcoholic liquors in excess'[87].

The nursing establishment

By 1919, Valkenberg had a nursing staff of 45 white men, 52 white women, and 9 men classified 'Coloured'. With new accommodation completed and occupied during the course of 1919 and 1920, these figures rose to 56 whites men, 66 white women, and 15 men classified 'Coloured' or 'Native'[88].

As with the medical staff, at the top of the nursing hierarchy was staff recruited from Britain. The first Head Nurse, Miss Amelia Fraser, appointed in July 1894, had had experience in both English and Scottish Asylums. She was succeeded by Miss Withers, also British trained and Head Nurse until 1908. She was followed by Miss M.G. Thomson, who was appointed as Head nurse in 1909, and was also British.

Unlike Head Nurses, Head Attendants at Valkenberg were not mentioned by name in the annual reports. This suggests that their status in the nursing hierarchy was lower than that of Head nurses, although the pay scales for male attendants was considerably higher than those for female nurses[89].

In 1894, Dodds instituted the practice of delivering a course of lectures to prepare nurses and attendants to undergo examination for the nursing certificate of the Medico-Psychological Association of Great Britain and Ireland. This professionalisation of Mental Nursing, as was characteristic of the Colony's medical structures, was therefore closely tied to British training and British practice.

87. CO 7978, 6/7/05.
88. U.G.31-'21, p.20; 1920 Annual Report (unnumbered), p.392.
89. *Regulations for the Management of Hospitals for the Treatment of Mental Disease and Defect*, 1914, p.30.

Conduct of nurses and attendants was strictly regulated. In the *Rules for the Management of Asylums*, all asylum employees were required to sign an obligation undertaking to abide by rules which governed every aspect of patient care, and also to a large extent their off-duty life, including their freedom to marry[90]. Women were forced to resign if they married, and only one-third of the male staff at any one time were allowed to be married.

The vigilance with which staff treatment of patients was monitored is difficult to assess, as doctors were not present in the wards for long periods, and nurses and attendants seem to have supported each other in the face of complaints about staff maltreatment of difficult patients[91]. However, when misdemeanours did come to light, they were promptly and strictly dealt with. An example is the dismissal of Nurse Pegel in 1905. She was seen to strike a female patient with a slipper, during a scuffle. Dodds wrote of the incident:

> There are no bruises anywhere and I think I can fairly accept Nurse Pegel's account of the occurrence. But it was wrong of her to use the slipper at all, and she has forfeited my confidence. She has been spoken to before for her sharp way of speaking to patients and I do not think she has the qualities necessary for a good mental nurse.

She was given a month's notice, and Dodds made clear that he regarded her behaviour as too serious to be 'passed over with a censure'[92]. Another scandal erupted in 1906. In 1904, Attendant Andrew McMorrow was assaulted by a patient, who fractured his jaw. He was treated at the asylum by Dr Black, and in 1906 sued the government for #3000, because of permanent damage to the jaw, and negligence, for not have been properly warned about the dangers of his job before he commenced work, or for being properly treated after the injury was sustained.

Although Dodds, in his dual role as Superintendent and Inspector of Asylums, appears to have been strict in his enforcement of the Regulations, he continually brought to the attention of the Colonial Office the difficult circumstances under which all asylum staff worked, and the inadequacy of pension scales, leave arrangements, and pay. He argued that the only way to run asylums properly was to have a stable contingent of trusted staff, and the only way to keep staff was to improve their conditions of service. His campaign was met with a certain amount of success[93].

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90. Government Notice No 267 of 1892.
91. For example, an enquiry after the death in 1929 of John V , an epileptic patient, following an assault on him by male attendants, provides clear evidence that staff collaborated to tamper with the night reports in order to obscure the events leading up to and following the assault.
92. CO 7975, 30/8/1905.
93. CO 7918, January, 1904, April, 1904, 15/12/04. Dodds' interest in upgrading the status of asylum staff at all levels began before his time of office in the Cape. In 1889, with Duncan Greenlees as one co-author, he presented

Valkenberg's patients

Valkenberg's first patients, transferred from Robben Island and the lunatic wards of the Old Somerset Hospital, were carefully chosen. Of the 21 patients transferred from the Old Somerset Hospital, 15 were described as 'quiet', 'harmless' or 'in good health'. One of these quiet patients, had been admitted to Old Somerset in 1889, and was diagnosed as having 'monomania'. At the time of her transfer to Valkenberg the superintendent, Dr Herbert Cox, commented: 'This patient must have improved very much. She is clean and quiet. At times is violent which seldom lasts more than a day.' However, she did not last long in Valkenberg, as she became noisy and violent, required a single room which could not be spared, and she was sent to Robben Island[94]. Of the 6 patients in the batch not described as quiet, 2 were melancholic, 3 were talkative and abusive but not violent, and 1 was epileptic. Of 25 transfers from Robben Island in February 1891, the mental status of the women, 10 in all, can no longer be traced, as the relevant casebooks are lost. Of the 15 men, 7 were described as quiet, and a further 3 were said to be 'dazed', 'stupid' or 'weakminded' and 'childish'. Of the remaining 5 men, 3 were 'restless' or 'excited', and one was almost mute, speaking only in whispers, and refusing to respond to questions. One was described as 'full of delusions'. The overwhelming proportion of the transfers into Valkenberg were therefore said to be quiet. The direct admissions to the hospital were not able to be screened as rigorously as the transfers, and they sometimes proved unsuitable for treatment in the new asylum. As described above, a similar process guided the admission of the first black patients to the asylum in and after 1916.

Between 1891 and 1909, 66% of direct admissions to Valkenberg were made from the Cape Town area. The remaining admissions were largely from the Western Cape region, although some came from other parts of the Cape Colony. There were occasional admissions from other parts of South Africa, and surrounding countries. There were also occasions on which foreigners passing through Cape Town were admitted to the asylum[95]. Every effort was made to return those domiciled outside of the Colony to their home countries.

Figures 1 to 7 give the age, marital status, religious affiliation, occupation and class of attack of all admissions to Valkenberg between 1891 and 1906, the period for which this information is

arguments to the BMA urging the necessity to recognise the contribution of assistant medical officers to the day-to-day running of asylums. The paper, 'Assistant medical officers in asylums: Their status in the specialty', by Drs Dodds, Strahan and Greenlees, was published in *JMS*, 52, 43-50.

94. HOS 60, casebook.

95. The annual reports, 1891 to 1909, detail the areas from which patients were admitted.

tabled in the asylum's annual reports[96]. They also represent, for comparative purposes, the social profile of patients in the Valkenberg series, in the same period.

Both men and women were most likely to be admitted between the ages of 25 and 44: this range accounts for approximately two thirds of all admissions (Figures 1 and 2).

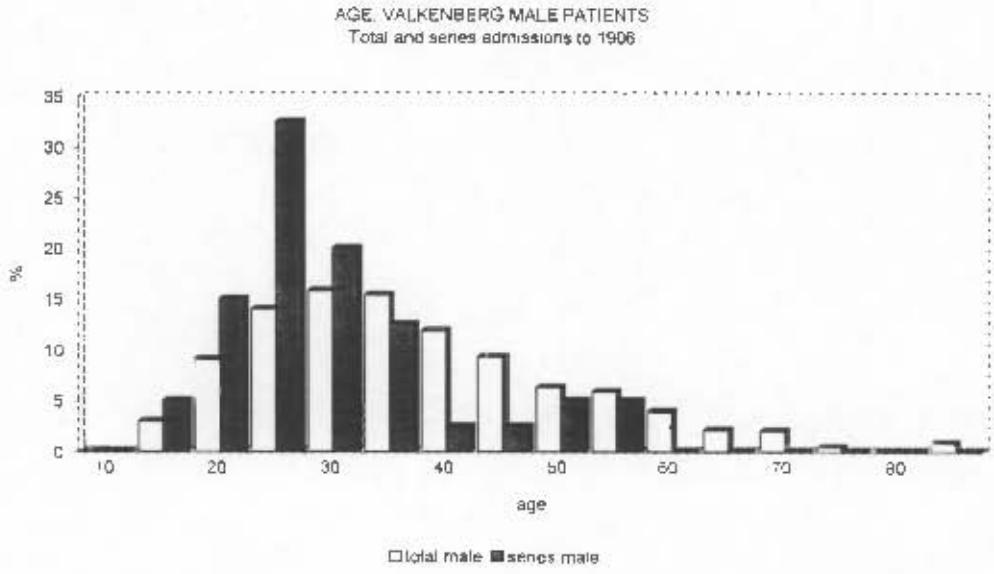


Figure 1

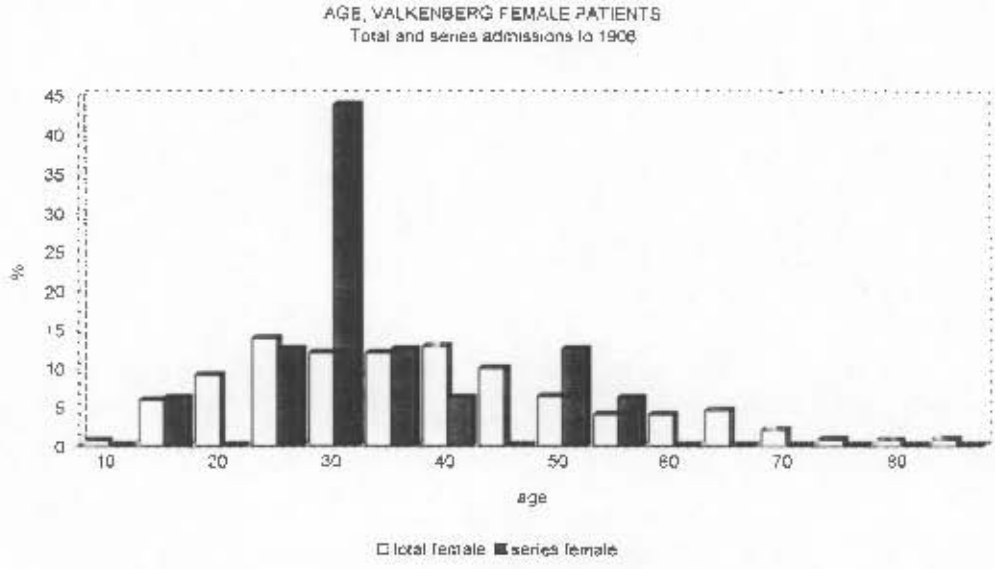


Figure 2

96. Detailed information on patient admissions for each Colony asylum was given in the annual reports up to, and including, 1906. After 1906, figures for all asylums were combined, so that the social profile of Valkenberg patients can be traced only through individual patient's certification documents and casenotes, a task beyond the scope of this study. An exception to this is the religious affiliation of the patients, tabled up to and including 1909. Tables from which these graphs have been drawn can be found in Appendix 2.

Of the male admissions, over half were single. This reflects both the high numbers of single men in the Colony as a whole, and the disproportionate number of single men among those with a mental illness. In the 1891-1906 period, there were more married than single women admitted to Valkenberg. This pattern, which has persisted into the late twentieth century in the population of women suffering from a mental illness, suggests that while marriage significantly improves the likelihood of men avoiding hospitalisation for mental illness, it may increase that likelihood for women[97]. Women were twice as likely to be widowed. This reflects the tendency of women to outlive men, and therefore to experience loss of a spouse and its concomitant stresses (Figure 3).

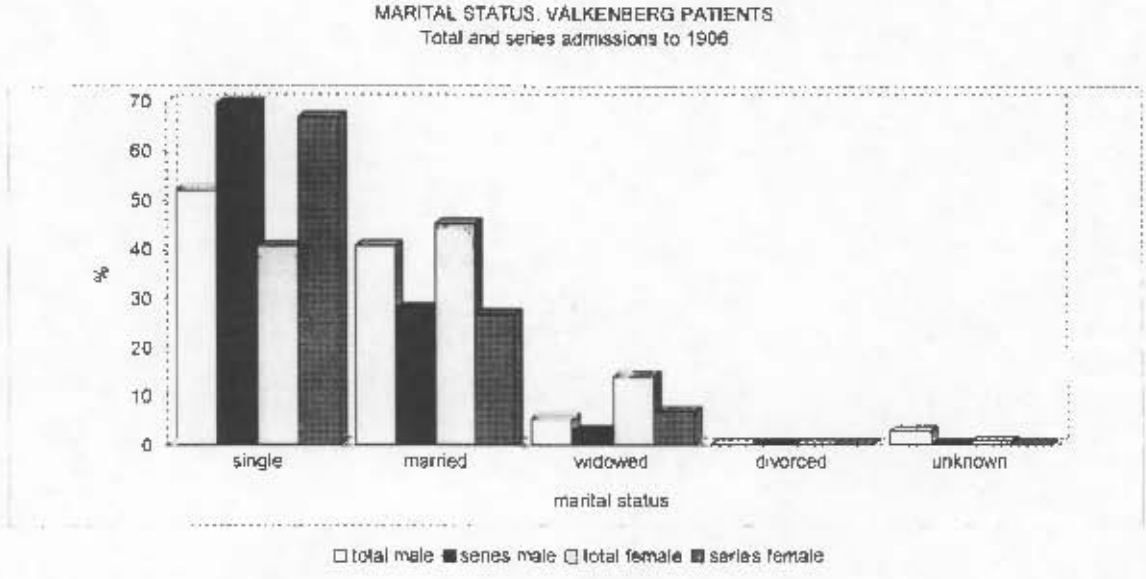


Figure 3

Just over two thirds of the men and three quarters of the women admitted in the 1891-1909 period belonged to the Dutch Reformed, Anglican and Catholic churches. A small but significant minority of patients were Jewish, and many of the remaining group belonged to Protestant religions, including the Presbyterian, Wesleyan and Lutheran churches (Figure 4).

Valkenberg's patients were drawn from a wide range of occupations, ranging from landowners, bankers, and those with professional qualifications, through to unskilled labour and the unemployed. There is considerable ambiguity in the annual report figures on occupation. For example, for female admissions the categories 'domestic duties', 'housewife' and 'unemployed' are used interchangeably in annual reports from different years. For men there are similar ambiguities, with some reports categorising as 'farmer' those working as skilled or semi-skilled farm labour as well as those owning farm land. The reports also did not always distinguish between those who were unemployed, and those for whom information on occupation was

97. This is discussed by Ussher, in *Women's Madness*, pp. 260-65.

unavailable. For this reason the categories shown in Figures 5 and 6 are a rough guide only, and an attempt to use occupation as an indication of social class would be unreliable.

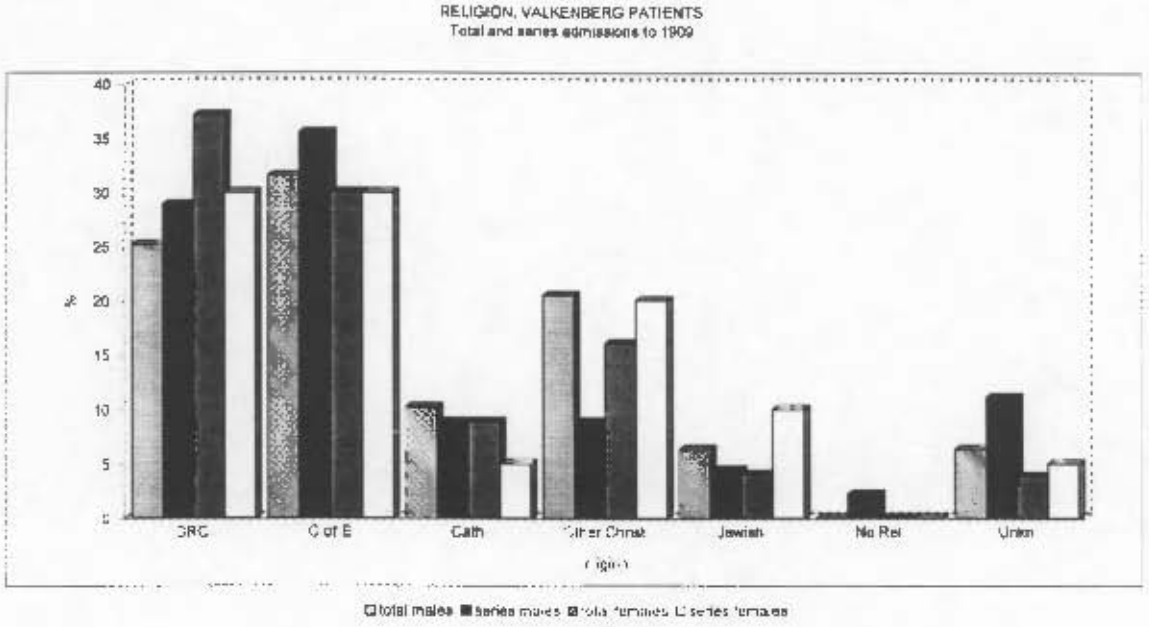
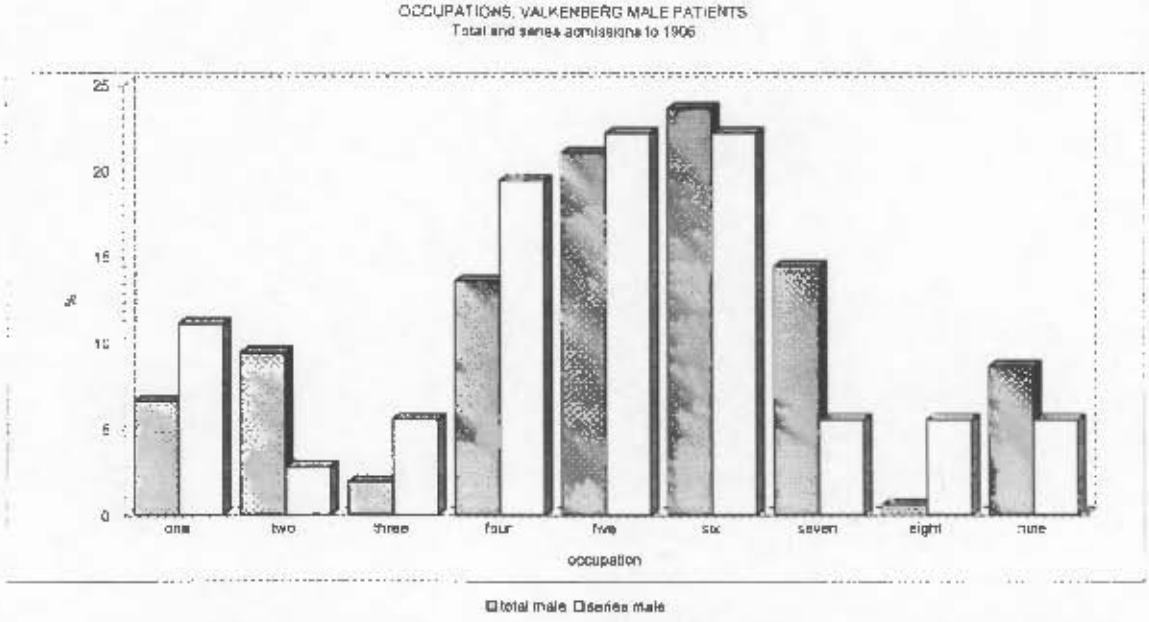


Figure 4

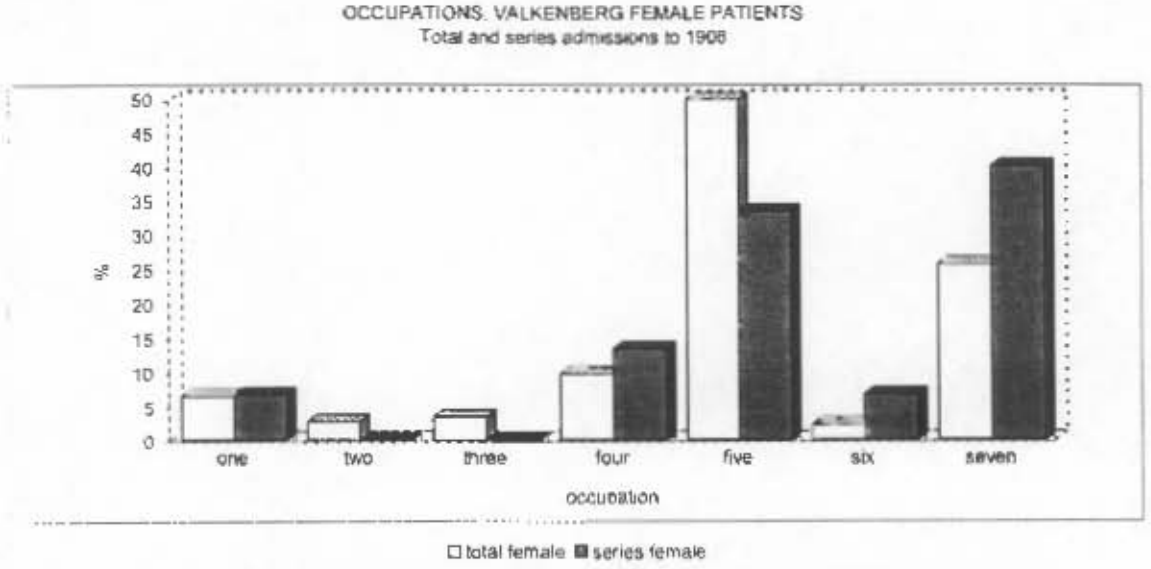
Occupations of male admissions reflect Cape Town's character as a trading centre, surrounded by farming communities and with a busy port (Figure 5).



1: professions; 2: soldiers, sailors, police; 3: miners; 4: farmers; 5: retailers, traders, clerks; 6: artisans, craftsmen, skilled labour; 7: unskilled labour, 8: other; 9: unknown, unemployed

Figure 5

Occupations of female admissions reflect a gendered division of labour, which allowed men a variety of occupations and limited the majority of women to work in domestic settings, either as wives and mothers, or as domestic servants. Less than 10% of women admitted to Valkenberg were employed in occupations beyond the domestic (Figure 6).



1: professions; 2: housekeepers, cooks; 3: dressmakers, shop assistants; 4: domestic service; 5: domestic duties; 6: other; 7: unknown, unemployed

Figure 6

During his time of office Dodds insisted on a policy of early admission to an asylum in an attempt to prevent patients from 'sinking into a state of life long hopeless insanity'[98]. His success in campaigning for sufficient accommodation to carry out this policy is reflected in the statistics given for class of attack on admission to Valkenberg[99]. 41.2% of male admissions and 33.2% of female admissions were suffering from their first attack, and were admitted within three months of the onset of the attack. A further 14.4% of men and 9.5% of women had been insane for under a year[100] (Figure 7).

Figure 8 gives the number of patients resident in Valkenberg between 1891 and 1920. The steady increase in numbers of patients resident in the asylum is a reflection of increase in available

98. CO 1485 22/10/91.
99. Class of attack was defined as follows: First class, first attack and within three months on admission. Second class, first attack above three, and within twelve months on admission. Third class, not first attack, and within twelve months on admission. Fourth class, first attack or not, but of more than twelve months on admission, and Fifth class, congenital. G.16-'95, p 53
100. That women tended to be admitted less promptly than men perhaps reflects the possibility of insane women being contained within domestic settings, and continuing to carry out domestic duties despite their insanity. Such containment was less possible for men, especially if they were expected to work outside of the home. The possibility of dangerous violence from insane men would also have precipitated referral to an asylum. Gender patterns in admission rates are analysed in detail in Chapter 6.

accommodation. Figure 9, summarising the proportion of patients recovered, relieved, not improved and deceased as a percentage of total admissions between 1891 and 1909 gives an indication of long-term outcome. Over a third of patients recovered, and a further 10% were discharged relieved. Just under 10% did not improve and 20% died. It was inevitable that as the population of chronic long-stay patients in the asylum grew older, the death rate, as a percentage of total admissions would rise. The remaining 24.7% remained in the hospital as chronic patients.

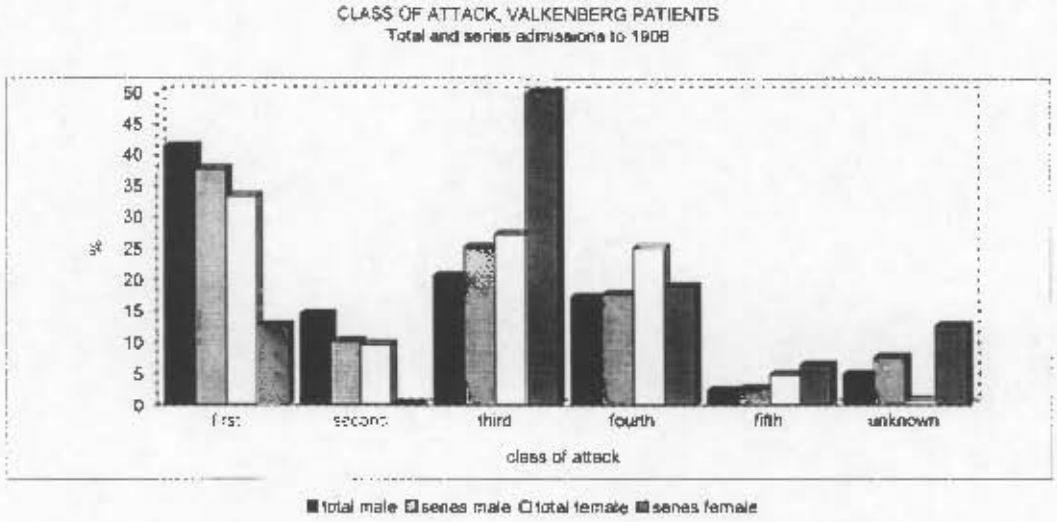


Figure 7

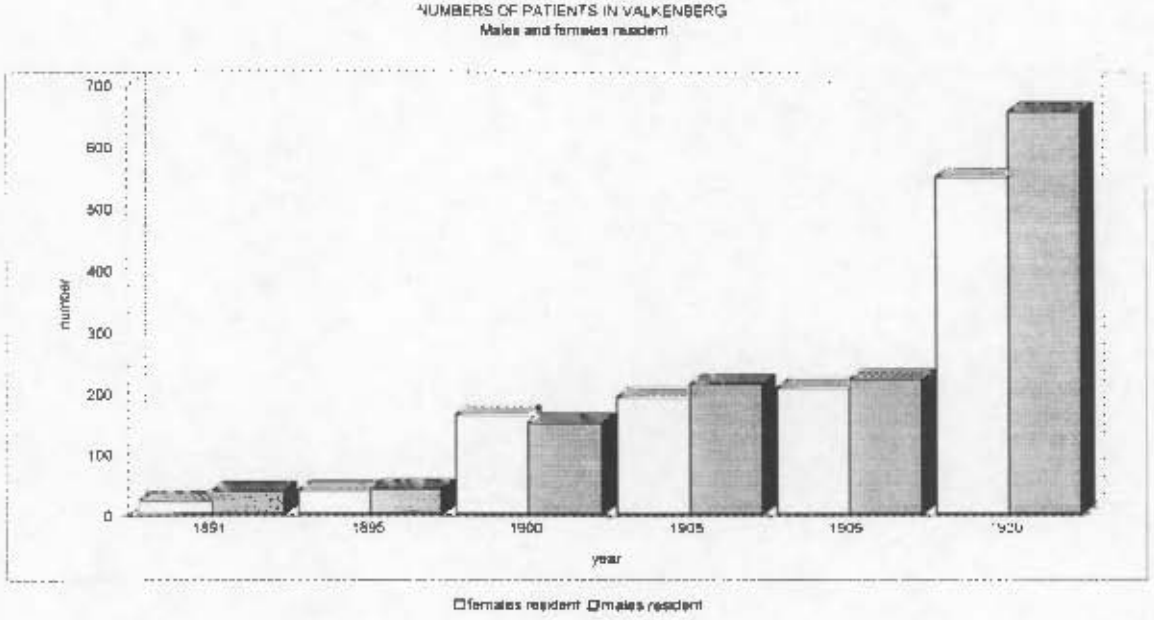


Figure 8

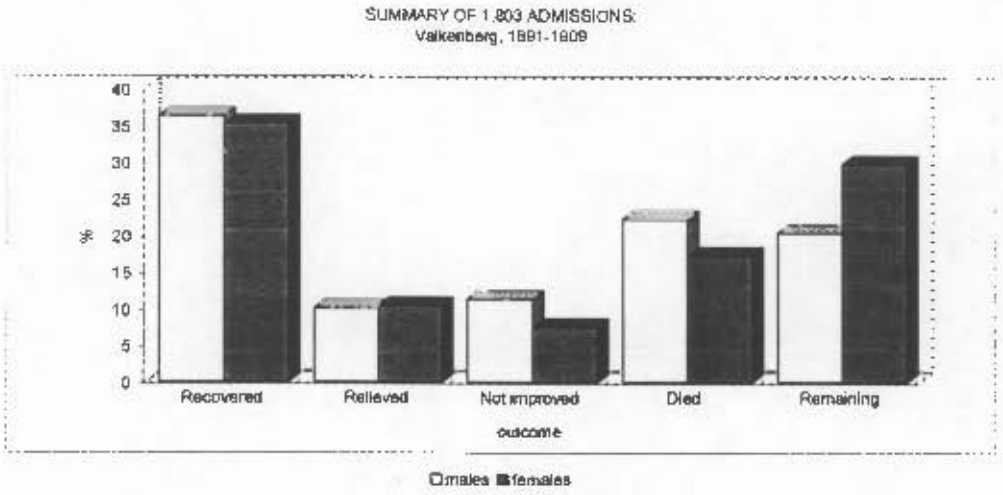


Figure 9

The Valkenberg case series

Apart from the statistics on admissions to Valkenberg in the annual reports, a series of case records surviving from the 1891-1920 period provide a source of detailed clinical information on individual patients. The records, described in detail below, are housed in Archives and Documents, Jagger Library, University of Cape Town.

248 folders from this period have survived, 110 those of 'European' men, 42 'Coloured' men, 4 'Native' men, 76 'European' women, and 16 'Coloured' women[101]. The racial designations are those given on the folders[102]. They contain admission records, and clinical notes documenting the patients' physical and psychiatric state during their stay in Valkenberg. Apart from clinical notes, the folders typically contain copies of all legally required documentation regarding committal, admission forms, Periodical Reports, correspondence with relatives, friends and lawyers about fees or legacies, and lists of patients' property, either on admission, or on their death, irrespective of the institution to which the patient was first admitted[103]. Thus, patients transferred from Robben Island for example, had legal and other documentation, as well as a summary from case-book entries, sent over with them[104]. Some of the case records contain notes from patients' admissions

101. The surviving case records from the 1891-1920 period were discovered in the central archive, among active folders and folders of patients admitted after 1920. Loss of cards from the index system, changes over the years to the numbering systems for folders, and misfiling of folders, inevitable in a large and busy registry, complicated the task of turning up pre-1921 folders. A manual search through the entire collection of patient folders is likely to have turned up the majority of the early records. The records are generally in good condition, although they have been damaged by fish-moth and acidity in the folder covers. Very few of the notes are unreadable.
102. In asylum practice, white patients were during this period segregated from blacks, a division which obscured the heterogeneity of both groups. In terms of accommodation, diet scales and treatment, black patients, including those labelled 'Coloured', 'Native', and 'Indian' were regarded as a single group in asylums, and were set apart as a group from 'European' patients.
103. The legal documentation is described in detail in Chapter 4.
104. Patients transferred from Robben Island include photographs. One folder includes a photograph of a white female patient, transferred from Grahamstown Asylum. There are one or two exceptional case records. John v.N's record

to other asylums, including Robben Island, Grahamstown and Pretoria Asylums, and these are valuable for comparative purposes. Survival of some records of black patients admitted to Valkenberg during the 1916-1920 period makes possible the examination of texts about a wide range of patients of different racial designation, class and gender.

Many of the folders in the Valkenberg series record lengthy admissions to the asylum, with notes stretching on occasion into the 1950's and 1960's. 218 of the patients in the series died in Valkenberg, frequently after lengthy admissions. It is important to stress therefore that the Valkenberg admission date does not constitute the boundary date of the clinical material. However, the certification and admission data, central to the textual analysis, fall within the 1891-1920 period[105]. A summary of admission dates, age, marital status, occupation, diagnoses, length of stay in Valkenberg, and outcome for these patients are given in Appendix 1a[106].

The social and psychiatric profile of the Valkenberg series on admission is set in Figures **10** to **16**[107]. The majority were admitted between the ages of 20 and 40 years, and were single (Figures **10** and **11**).

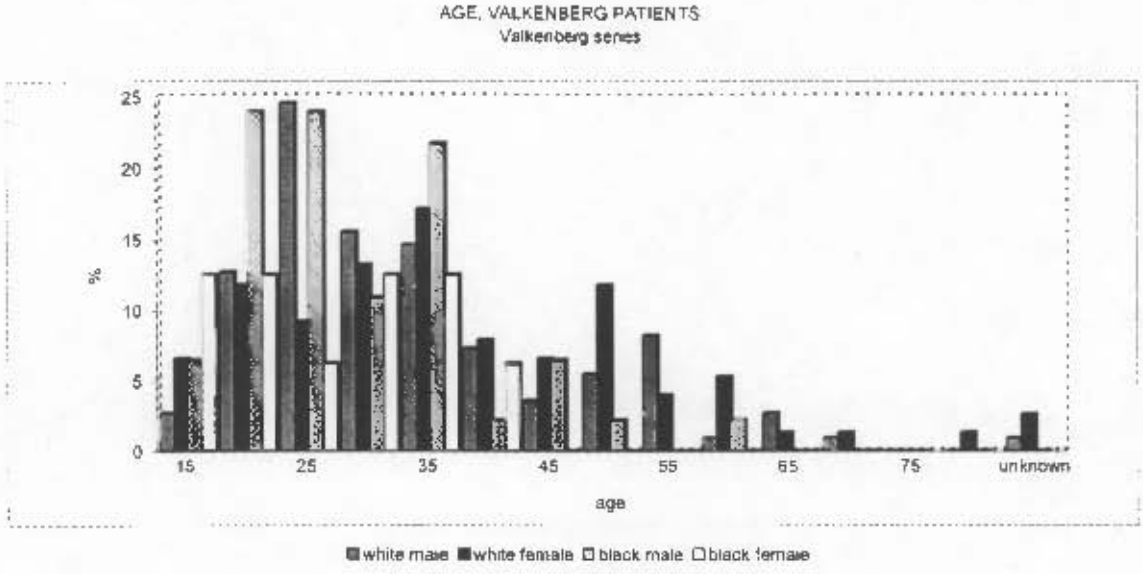


Figure 10

is an example (ME 2087). He was admitted in 1911, and died in 1929, days after what appears to have been an assault on him by attendants. This precipitated a lengthy enquiry at Valkenberg, and the notes include the day and night nursing record for the ward on which he was placed, newspaper clippings, and transcript of the enquiry which took place. A record such as this supplies insight about daily life in the hospital which is often missing from folders belonging to patients whose lives were relatively uneventful.

105. There are six exceptions to this in the series, all patients admitted to an asylum before Valkenberg was opened. The earliest admission in the series was 1876. It seemed unnecessarily constraining to rule these texts out.
106. The implications of diagnoses and actiology are discussed in Chapter 5.
107. The extent to which this profile conforms to the general pattern of admissions between 1891 and 1920 is discussed in detail in the following chapter.

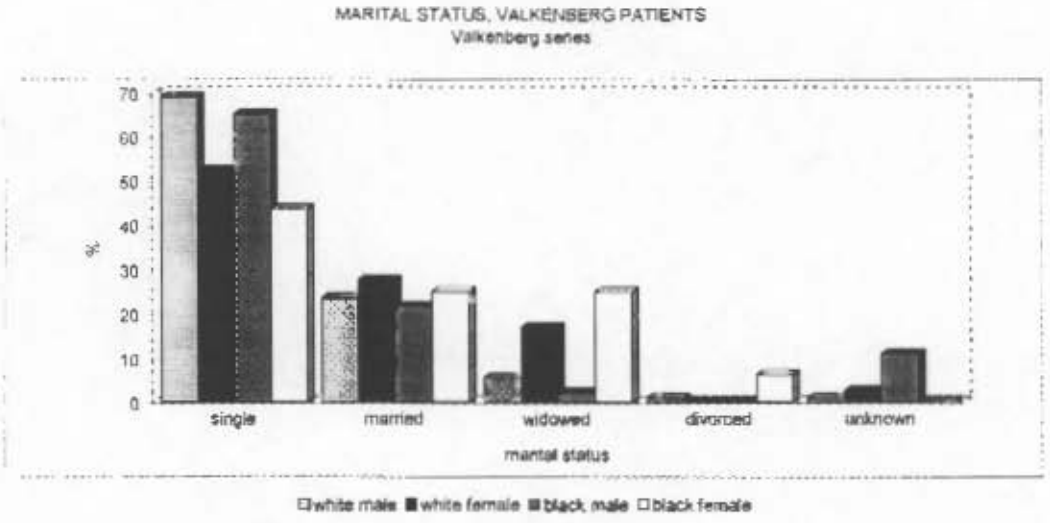


Figure 11

The series also contains patients from a wide range of religious affiliations. More white than black patients belonged to the Dutch Reformed Church, and more black than white patients belonged to Protestant churches such as the Lutheran, Wesleyan, Presbyterian or Baptist churches (Figure 12).

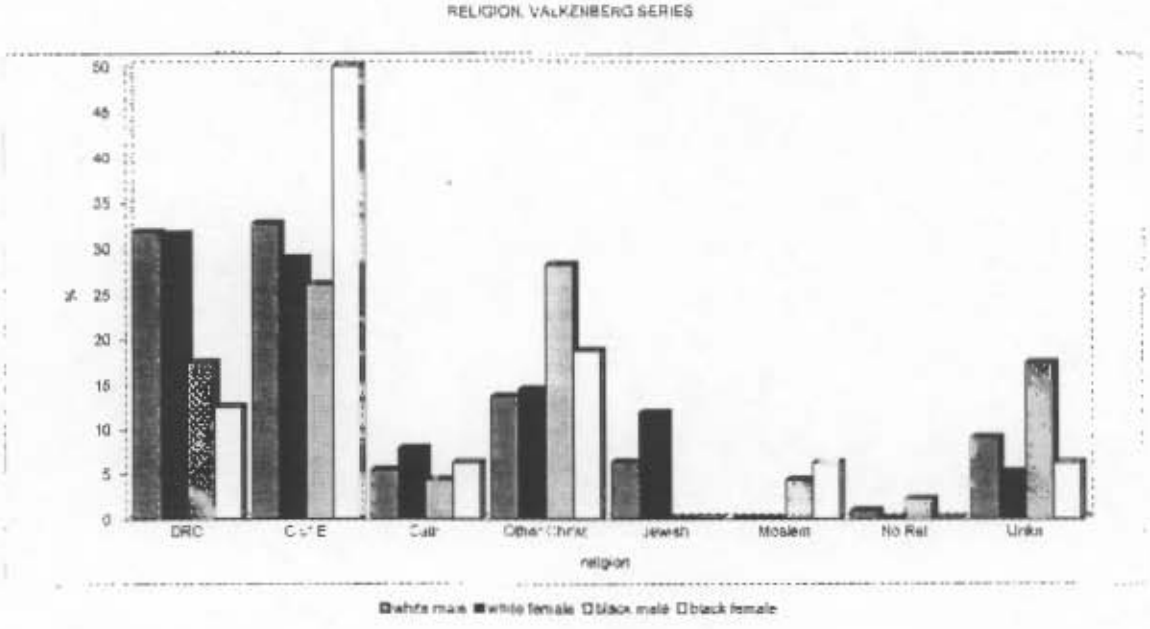
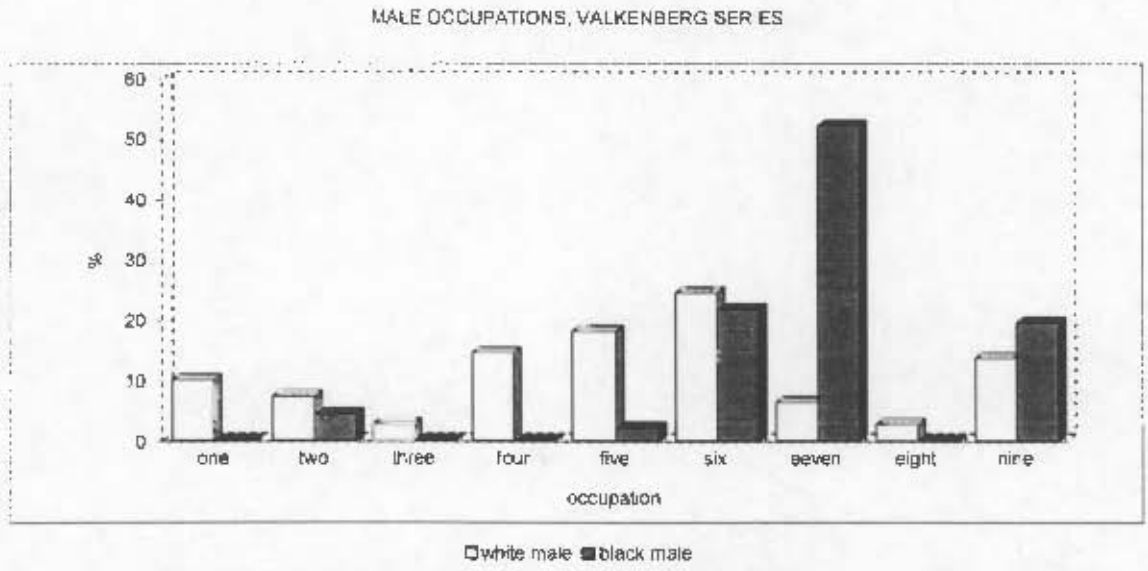


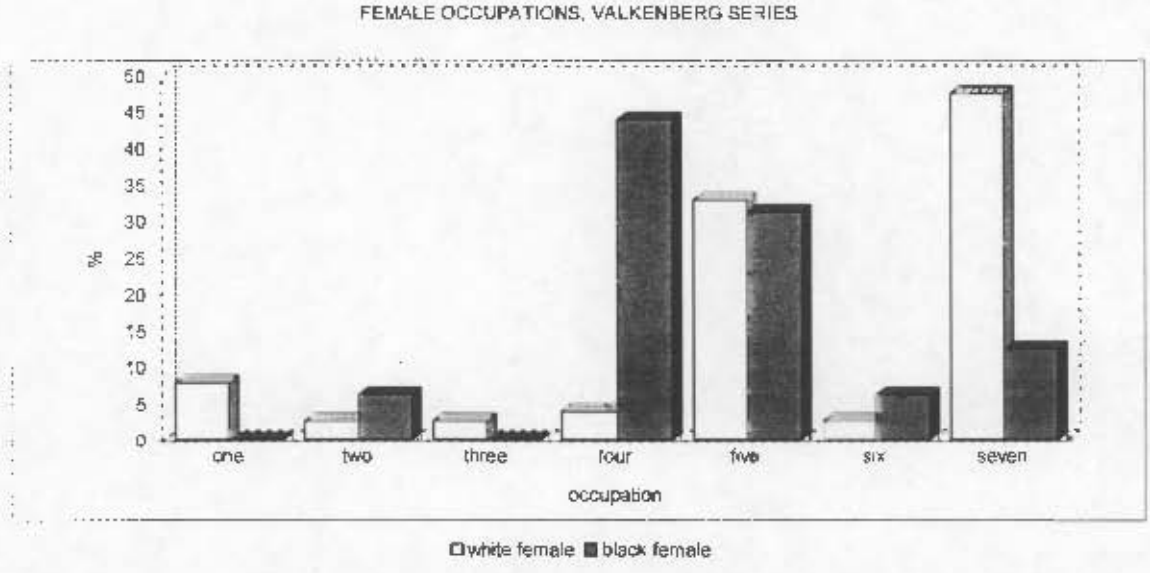
Figure 12

The series contains patients engaged in a wide range of occupations before their admission. Predictably, more black than white men were unskilled labourers, and more black than white women were employed as domestic servants (Figures 13 and 14).



1: professions; 2: soldiers, sailors, police; 3: miners; 4: farmers; 5: retailers, traders, clerks; 6: artisans, craftsmen, skilled labour; 7: unskilled labour, 8: other; 9 unknown, unemployed

Figure 13



1: professions; 2: housekeepers, cooks; 3: dressmakers, shop assistants; 4: domestic service; 5: domestic duties; 6: other; 7: unknown, unemployed

Figure 14

Approximately a third of the patients in the series were said to be suffering from their first attack of insanity on admission (Figure 15).

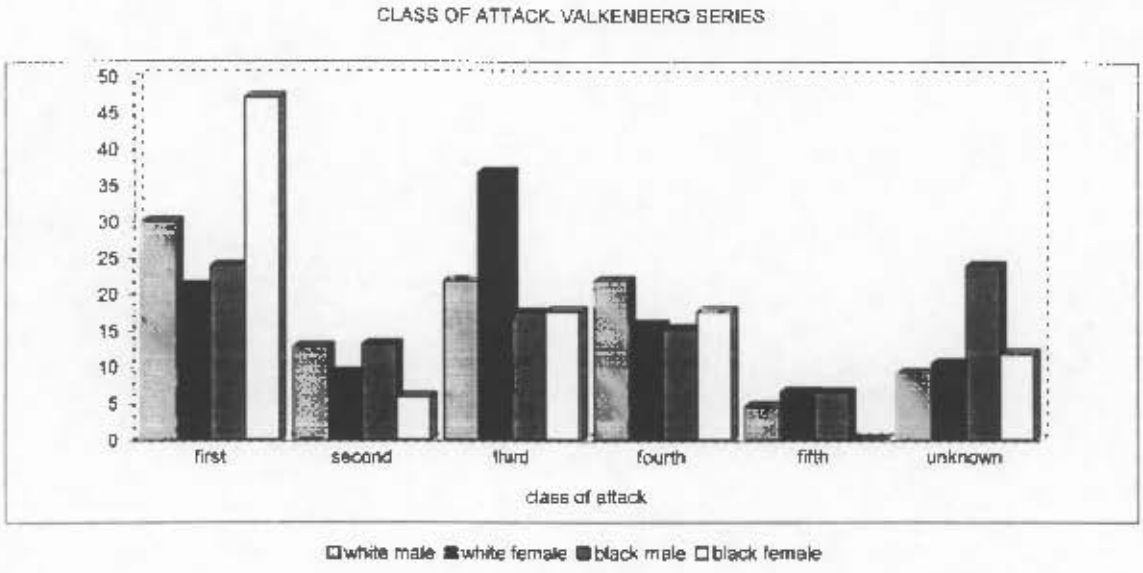


Figure 15

The series also represents patients with a variety of diagnoses, although the majority of patients, both white and black, were said to have a psychotic illness, identified during this period as mania, and later as dementia praecox or manic depression (Figure 16).

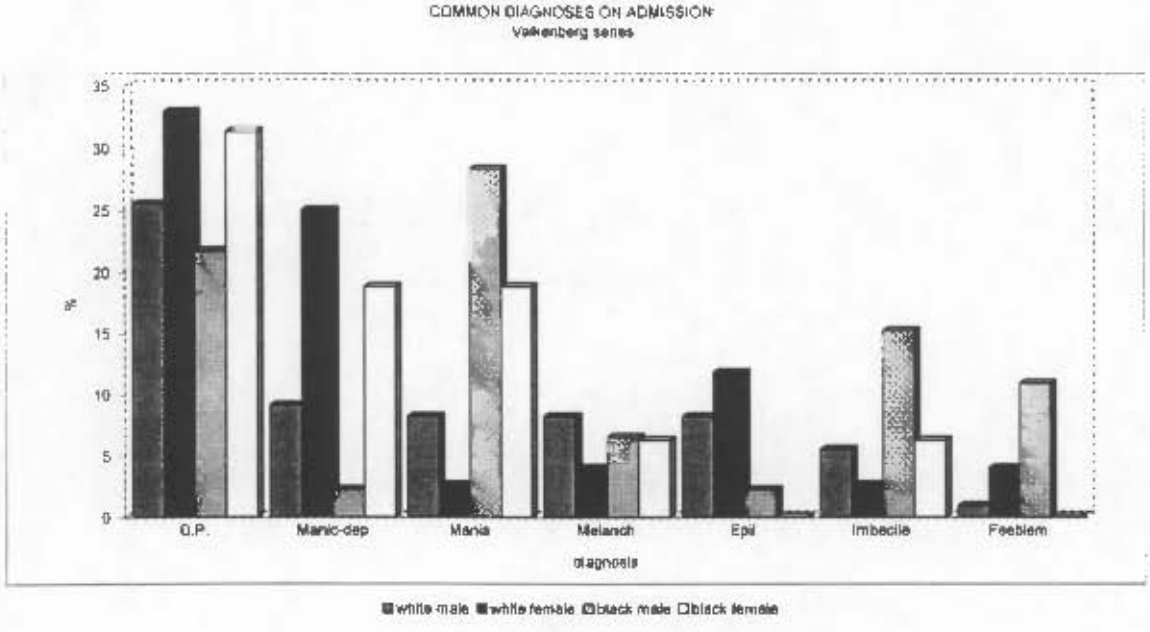


Figure 16

It is difficult to establish with certainty the ways in which patients in the series were similar to the total population of admissions between 1891 and 1920. It is not possible to extract admission data on Valkenberg admissions from annual reports after 1906, the date at which such information

began to be recorded as a single set across all the Cape's asylums. It is however possible to comment on the representativeness of series admissions up to 1906, a total of 60 patients, 4.4% of the total number of new admissions to Valkenberg up to that point. The similarities and differences in social profile between the patients in the Valkenberg series and the total patient population in the 1891-1906 period are represented in Figures 1 to 7.

In terms of religious affiliation and occupation, the two groups are very similar. However, the series over-represents women in the 30 to 34 age group, and men in the 25 to 29 age group. Both men and women in the series were more likely than the total admissions to be single, which has a statistical relationship to chronic and severe mental illness[108]. Those white women in the series admitted up to and including 1906 were more likely than the total population to have had more than one attack of insanity. This, together with the statistics on their age, suggests that the series over-represents those with chronic illness. Only 24 (9.7%) of the 248 patients in the series were discharged recovered. If recovery rate is estimated as a proportion of those resident year by year, the recovery rate in the total patient population is 11.3% for females and 14.5% for males[109].

It is probable that folders of patients who had lengthy admissions to Valkenberg survived better than folders documenting brief admissions, because they would have been in use for longer. Long admissions should not be regarded as indicative of severity of illness however, as patients without social resources may have remained in Valkenberg because they had nowhere else to go.

In addition to the folders, two casebooks, one containing the record of male admissions to Valkenberg up to and including 1894, and one of female admissions from March 1913 to December 1914 have survived[110]. After 1914 the casebook format was abandoned and individual folders were kept on each patient. Those patients in Valkenberg at this date had admission data, and a summary of their progress while in the asylum transcribed from casebooks into the folders. Although the surviving casebooks are an important resource, the folders are a much more complete record, as they include all documentation concerning the patient's time in the asylum, including correspondence, committal papers, and medical records. Because the casebooks constitute a substantially different record to the case folders, patients described in the casebooks

108. 62.5% of the series women were single, as opposed to 40.44 of the total number of women admitted up to and including 1906. 72.5% of the series men were single, compared to 51.66% of the total number of patients. For a discussion of the relationship between being single and chronic mental illness, see J.Wing, *Reasoning about Madness*, (Oxford, 1978), Chapter 3.
109. Recovery rates are discussed in detail in Chapter 5.
110. These casebooks, currently housed in Valkenberg's central administration building, are to be placed in the Medical Museum, Cape Town.

for whom no case folders were discovered have not been included in the data-base constructed from the folder series.

Conclusion

This chapter has argued that there were a number of reasons why, by the end of the nineteenth century, the Cape Colony was ready to pay unprecedented attention to the insane in her population. These included economic growth associated with increase in immigration to the Cape, institutional reform following the granting of responsible government, the professionalisation of the medical establishment, and a new focus on public health and health policy given impetus by epidemic disease. In addition to a general trend towards medical reform, the effects on different sectors of the population of economic change, immigration, growth in the numbers of black people in urban areas, stressful labour and living conditions for black labour, epidemics and wars, all of which were linked to rapid social change, created a climate in which the white ruling elite felt a need to protect their interests. The most direct expression of this was the impulse towards racial segregation, constructed discursively as the cure for social evils of every description.

Valkenberg Asylum was directly a product of this context, inseparable from medical reform, change in the lunacy legislation, and broader institutional change. Set up as a model of humane care for the white insane, it was an institutional performance of the interests of one sector of the Cape's population. This was not only because it offered the white insane the assurance of up-to-date treatment in a congenial setting, strictly removed from contact with the Cape's black insane. It also suggested that cures for mental afflictions provoked by the stress of life in the Colony were possible. The existence of an asylum like Valkenberg reiterated the colonial belief in the propagation of institutional models imported from home as the key to progress. In the Cape, racial segregation was intrinsic to the faithful replication of British asylums on foreign soil. The establishment of Valkenberg as a whites-only institution brought into focus the desire for strict racial segregation in other Cape asylums. The opening of Valkenberg can be read as the first move in a chain of events which shaped the direction of institutional care for the insane for many decades to come.

There was however an important difference between the public rhetoric surrounding lunacy reform, of which Valkenberg's opening was an example, and daily practice. Valkenberg may have offered the white middle-classes the assurance that there was an acceptable place to which their insane might be sent. In reality, as the social profile of its patients demonstrates, it catered for a diverse population, from the poor and unemployed, to those described as 'landowner' or

'gentleman'. Moreover, while some inmates were cured of their insanity, many others were not, and Valkenberg's custodial nature, and its similarity to older, more prison-like asylums soon became clear. Shaped as it grew by the needs of the entire Western Cape region, it gradually lost its status as a model for other institutions in the Cape.

Valkenberg was therefore an institution in which the aspirations and ambitions of newly professionalising asylum doctors can be read. It mirrored too the desires of colonial government. It also stood as an example of colonial ambivalence, performing the wish to be in a colonised territory and yet to stand apart from it, by protecting its inmates from 'native' experience.

Chapter Three

METHODOLOGY

Introduction: Institutional practice and its relationship to discourse

Chapters One and Two set out the central research questions to which this study addresses itself, the major theoretical assumptions underlying those questions and in broad outline, some features of the historical period in which the study is placed. In Chapter One I suggested that texts, necessarily central to any historical study, also have primacy as the medium through which knowledge was formulated, circulated and sustained at the time they were written. The aim of this chapter is to take further the proposition that institutional and discursive practices are in a mutually constitutive relationship. It will also propose that this relationship is always textualised, and that texts present not only the medium through which institutional/discursive practice may be read, but also the means through which those practices were formed and sustained at the time they were written. Thus textual analysis becomes one method through which institutional and discursive practices related to the construction of a colonial psychiatry may be made accessible to study.

'Institutional practice', a form of social practice, describes the formal organisation of members' access to material resources in the service of specified goals. For example, a hospital is one instance of medicine as an institution, organised through distinctive administrative channels to structure patients' access to medical care, and doctors' access to and use of material resources to forward their professional and economic interests. 'Discursive practice', also a form of social practice, is the system 'of rules which make it possible for certain statements but not others to occur at particular times, places and institutional locations'[1]. It constrains the manner in which texts are produced, distributed and decoded[2].

As described in Chapter One, this study is concerned with two instances of institutional practice, colonial asylums, and colonial psychiatry as a discipline. There are two sets of discursive practices to which these are related. The first set is that involved with servicing, maintaining and transforming the economic, social and cultural identity and organisation of asylums in the colony. The second is the set of discursive practices through which psychiatry as a discipline established the parameters of its knowledge and power. This set has connections to the social identity of doctors in the colony, the relationship between various branches of medicine, the nature of the tie between colonial psychiatry and psychiatric practice in Britain, and also the relationship between the medical establishment and colonial authority.

1. N. Fairclough, *Discourse and Social Change*, (Cambridge, 1992), p.40.
2. Fairclough, *ibid.*, p.78.

Despite the connections between institutional and discursive practice, the one is not reducible to the other[3]. Although past social practice is available for scrutiny only through texts and is therefore always discursively filtered, it has nonetheless been useful in this study to insist on two aspects of the material reality within which Cape asylums operated. The first of these concerns the economic structure of asylums, and more broadly, of psychiatry itself. This economic structure, which dictated the ways in which bodies in asylums were housed, fed and treated, was itself shaped by the economic, political and social imperatives of the Cape Colony as a whole. These become apparent in for example, the study of the legislation, buildings, available accommodation, work regimes, diet scales, record of health and disease and death rates of colonial asylums. Although each of these may also be used in analysis of discursive practice, they nonetheless had specific material consequences for the insane, the doctors treating them, and the colonial authorities responsible for their maintenance.

Secondly, insanity itself is not reducible to discursive practice, even though definitions of insanity, and the processes through which the insane were identified, diagnosed and treated were constituted through discursive practice and were therefore socially constructed. To accord a material reality to insanity makes it possible to interrogate asylum case records for evidence of different forms of insanity which may remain constant despite transformation of social and historical contexts[4]. It also opens the possibility of using case records to distinguish between two groups: the insane, and the sane but socially unwanted. Such a theoretical position avoids the reductive process of conflating insanity and social deviance. It also circumvents the temptation to regard asylum populations as homogeneous, regardless of whether they are labelled 'deviant' or 'insane'.

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

This chapter will present the theoretical and methodological framework to be used in the analysis of the texts through which psychiatric practice in the Cape Colony was represented. It will be

3. See Fairclough, *ibid.*, pp. 71-73 for a detailed theoretical exploration of the relationship between discursive and social/institutional practice.
4. There is a long-standing tradition of such work in the history of psychiatry. An excellent example can be found in T. Turner, 'A diagnostic analysis'.

presented in two sections. The first will give a description of textual characteristics of case records, and their discursive position in the representation of psychiatric activity. Case records as a genre of writing will be explored in relation to particular features of the Valkenberg case series. This section will also describe those texts other than case records which will be used in the analysis of Cape colonial psychiatric practice. The second section will outline the methods of discourse and textual analysis employed in the study.

Although the chapter has method as a primary focus, description of method necessarily entails theory. Similarly, the texts used in this study cannot be described without placing them historically. For these reasons, this chapter draws together and restates some of the theoretical and historical material already presented.

Source material

1. Case records as texts

Although there are a large number of asylum histories, an extensive literature on the history of insanity, and the relationship between the identification of insanity and social and economic imperatives, relatively few have case records of insane individuals as a primary source of data[5]. Neglect of this rich source of information extends to studies of general hospitals[6].

There are a number of reasons why this should have been so. The focus has been on institutional as opposed to patient histories and this directs attention to general characteristics of asylum populations, and to the social and economic forces shaping their development, rather than to diversity within any one asylum population. Further, asylum annual reports, lunacy legislation, professional debates and correspondence between institutions and governing bodies are in the public domain and reliably available for study. Case records are less reliably available to historians, often because they are stored in informally organised archives attached to hospital buildings. Moreover, access to these records is at times restricted by laws protecting patient confidentiality.

Perhaps most importantly however is the question of the relationship theorised to exist between individual lives and broader social configurations, fundamental to the choice of research texts.

5. Exceptions can be found in T. Turner, *ibid.*, Digby, *Madness, Morality and Medicine*, and C. McGovern, 'The myths of social control and custodial oppression: patterns of psychiatric medicine in late nineteenth-century institutions', *Journal of Social History*, **20**, (1986), 3-23.
6. B. Craig, 'The role of records and of record-keeping in the development of the modern hospital in London, England, and Ontario, Canada, c. 1890-c.1940', *Bulletin of the History of Medicine*, **65**, (1991), 376-397, and K. Loughlin, 'Reconstructing the individual: the transformation in case history techniques 1900-1930', paper presented to the European Association for the History of Psychiatry, Triennial Conference, London, 1993.

Case histories have frequently been used as illustration of theory, demonstrating for example symptoms of disease, or illustrating the relationship between class and incarceration. In both these cases the record of an individual becomes an example of a wider class of persons, and the case material, no matter how crucial it was in the process of theory formation, becomes an additional source of data, secondary to data which identifies and describes the entire class.

This study will use case records as examples of a wider class of persons or events from time to time, but this is not a primary focus. It will be argued that both the form taken by individual case records and their contents were fundamental to the social representation of men and women as insane patients. Further, these texts defined and described insanity itself. In the process of keeping case records doctors as writers were also positioned as knowledgeable in relation to both emerging definitions of insanity and the everyday management of asylums. Thus, case records mediated institutional and discursive practices on every level. They textualised and influenced relationships between staff, patients and staff, and staff and relatives. They also rehearsed psychiatric knowledge of insanity. For all these reasons, case records will be used as a source of primary data on the social construction of insanity, and the emergence of a colonial psychiatry in the Cape.

2. The Valkenberg case records

Textual analysis of the case records in the following chapters will attempt to arrive at a general description of their distinctive characteristics. One aim of this description is to establish the extent to which they are uniform in their discursive goals and to identify the textual strategies through which those goals are reached, regardless of the race, gender and diagnostic category of the patient. Uniformity in these respects would indicate that the records belong to a single genre of writing, defined here as an institutionally recognised textual arrangement whose conventions are negotiated and formalised by specific interests with specific functions in mind[7]. The analysis will explore the implications of genre-bound representation of professional knowledge and clinical activity. Analysis of common features across all case records will provide the context within which commentary on unique features of selected texts is made possible. It is important to note that the question of the folders being representative of a distinctive genre is separate from the issue of the extent to which the patients in the Valkenberg series are typical of the asylum's total patient population in the 1891-1920 period. The representativeness of the series in this respect was discussed in Chapter Two.

7. J.F.Bennett, 'None so deaf: Stories of the experience of rape in New York, 1990-1991', unpublished Doctoral dissertation, Columbia University, (New York, 1993), p.59.

Analysis of the folders' textual content was facilitated by the use of a computerised data base, which summarised information on the patient's date of first admission to an asylum, date of admission to Valkenberg, gender, diagnoses, aetiology of the illness, treatment, date of death or discharge and cause of death. The data base also included a summary of the Medical Certificates, admission forms and Periodical Reports. These were used to identify descriptors which recurred throughout the 1891-1920 period. The descriptors extracted in this way were used as categories for a content analysis of all folders[8].

*3. **Printed and unprinted source material on the Cape's asylums***

Asylum annual reports, including the annual Inspector of Asylums reports, Official Visitors' reports, and correspondence with the Colonial Office on a wide variety of legal, administrative and professional topics are a primary source of information on institutional and discursive practices in the Cape asylums.

The annual reports include detailed statistical tables, as recommended by the British Medico-Psychological Association, as well as reports on accidents, inquests, illnesses, and recreational events, staffing, expenditure, and building. Accumulative tables allow comparison of patient statistics over the period 1891-1909. Until 1906 there are statistical tables for every Cape Colony asylum. In the 1906-1909 period these tables are combined for all asylums.

After Union, the reports became less informative about individual institutions. The statistical tables continue to be a valuable resource, although it is no longer possible to extract all information about patients from particular asylums[9]. No annual reports appeared between 1910 and 1916. In 1913, tables of admissions to asylums were drawn up, but with no accompanying report. The 1916 report, printed in 1919, the first written by the new Commissioner of Mentally Disordered and Defective Persons, Dr Dunston, covered the years 1916 to 1918 in the statistical tables. There are detailed reports for 1919 and 1920.

The annual report statistics make possible quantitative analysis of demographic, diagnostic and aetiological trends during the 1891-1920 period. This is of particular importance in describing

8. No attempt was made to record the frequency with which each descriptor occurred in every folder. The focus of the analysis was the identification of numbers of patients about whom common descriptors were used. Results of this are discussed in Chapter 7.
9. Although there is no separate demographic information on patients for each asylum, the statistical tables continue to record diagnosis, death and recovery rates for every asylum.

differences between asylums, and between groups of patients divided by racial classification and gender[10].

Also drawn upon in this study are reports written by those who were appointed as Official Visitors to asylums[11]. They record details of accommodation and daily routines in asylums otherwise unavailable. They were intended as a safeguard against ill-treatment or neglect of the insane, and they were available to be used when necessary to allay public fears about what happened behind the closed doors of asylums.

Annual reports and Official Visitors' reports will be analysed as the texts in which the public face of colonial psychiatry was constructed. The annual reports textualised doctors' attitudes to their patients, to insanity and to their asylums. They addressed a wide audience, including members of parliament, the Colonial Office, the medical establishment and interested members of the public. They serviced professional relationships and connections between asylums and the Colonial Office, addressing explicitly the need to change popular perceptions of both the insane and the institutions which took care of them.

Correspondence between superintendents of asylums and the Colonial Office on every aspect of asylum management provides a rich source of data on institutional practices, supplementing printed texts with an informal and less guarded historical record. They are positioned ambiguously between the public and the private. The illusion of addressing a private audience, which erased intermediaries such as secretaries and superiors or colleagues with whom discussions would be held, allowed at times forthright commentary on a range of issues, including one central to this dissertation, the treatment of the black insane[12].

Methods of analysis

1. Discourse analysis

The term 'discourse' shall be used throughout the analyses that follow to refer to the product of 'discursive activity'. Discourse is a mode of representation actualised in texts, but not reducible to them. Following Foucault, Parker defines a 'discourse' as 'a coherent system of meanings'[13]. Using this definition, and Fairclough's definition of discourse as one form of social practice, this

10. For a discussion of the use of quantitative perspectives in historical studies, see A.Digby, 'Quantitative and qualitative perspectives on the asylum', in R.Porter and A.Wear (eds.), *Problems and Methods in the History of Medicine*, (London, New York and Sydney, 1987), 153-174.
11. These reports were not printed. They are available in the Colonial Office Papers, Cape Archives.
12. Correspondence on the treatment of the black insane is described in detail in Chapter 6.
13. M. Foucault, *The Archaeology of Knowledge*, (New York, 1972), p. 107; I. Parker, 'Discourse: Definitions and contradictions', *Philosophical Psychology*, 3, (1990), p.192.

study will assume that discourse constitutes and constructs social reality in three ways: through the formation and symbolic representation of social identities, the actualisation of social relationships between people, and the constitution and representation of systems of knowledge and belief[14].

Discourses both 'systematically form the objects of which they speak' and position the discursive subject, including the voice through which the discourse is articulated[15]. In this way, discourses determine 'what position can and must be occupied by any individual if he is to be the subject of it'[16]. The term 'inscription' will be used to refer to the process through which individuals or groups of people are represented as objects of discourses in texts. Inscription is the process through which lives are turned into 'material traces: written reports, drawings, maps, charts and, pre-eminently, numbers'[17]. 'Textualisation' is a broader term, used to describe the process through which any object is given textual representation. 'Subjectivity' describes experience of self, identity, as it is constituted within discourse.

An example will illustrate these points. During the nineteenth century, the management of the insane fell increasingly into the hands of medical practitioners. Insanity as the object of medical discourse was defined by doctors, the speaking subjects, in terms of nervous disease. This discourse systematically formed the insane as the discursive object in terms susceptible to description within medical knowledge and therefore medical vocabulary. Those to whom the medical discourse on insanity addressed itself - doctors, magistrates, relatives, the insane themselves - positioned them as discursive subjects in ways which constrained observation and perception of insanity largely to sets of bodily signs and symptoms, drew attention to some mental events, textualised in terms of invisible somatic events, and silenced others, and offered a biological understanding of aetiology, and treatment. The medical discourse on insanity defined itself in opposition to historically previous discourses such as those rooted in the institutions of the church or the law. Medical discourse replaced the view of insanity as a symptom of moral weakness for example, or as a threat to social order and therefore a legal problem. In constructing and transforming insanity, medical discourse incorporated activities, vocabulary and discursive strategies drawn from other branches of medicine. These strategies included clinical observation of bodily symptoms and behaviour and insistence on the centrality to treatment of diagnostic classification. Admission forms to asylums for example contained detailed subsections for the

14. Fairclough, *Discourse and Social Change*, p.64.
15. Foucault, *The Archaeology of Knowledge*, p.49.
16. Foucault, *The Archaeology of Knowledge*, pp. 95-6.
17. N.Rose, *Governing the Soul: The Shaping of the Private Self*, (London, 1989), p.6.

recording of physical and mental condition, the latter rendered discursively equivalent to the former in the layout of the document[18]. In a similar way, the statistical tables routinely used in asylums inscribed patients as 'observable, measurable, and quantifiable' through the conversion of lived experience, doctors' observations and idiosyncratic linguistic data into numbers[19].

Medical discourse also absorbed definitions of insanity constituted within the discourses against which it defined itself. For example, the view of masturbation as a cause of insanity, and the vocabulary used to describe masturbation as an activity had their roots in moral attitudes to erotic pleasure. However, the view that insanity was caused in some instances by masturbation was transformed within medical discourse into a biological explanation by positing bodily depletion as an intervening biological mechanism leading eventually to chronic insanity. Insanity resulting from failure of will was systematically silenced, and mental events increasingly came to be represented as invisible neurological activity rather than reflections of the state of the soul[20]. An example from this century is the use of catharsis as a route to psychological healing, a belief which has obvious discursive similarities to religious confession and absolution[21].

Discourse both reproduces and transforms society. Its reproductive effects lie in the naturalisation of the relationship between modes of representation and the objects represented, sustaining particular discursive formations as 'truth'. The ability of discourse to transform social practice is inherent in the dialectical and unstable relationship between social and discursive practice, and also in the contradictions captured within and between discursive practices. Sites of contradiction or shifts in institutional constellations generate new forms of representation and new paradigms of knowledge, which then are naturalised[22].

The ability of discourse to transform as well as construct the objects they represent is also a function of inherently unstable subject positions[23]. Although discourses frequently limit the boundaries of what can be said or understood by the speaking subject or addressee to preferred or dominant meanings, particular historical or discursive contexts make available a range of

18. This is discussed in detail in Chapter 4.
19. N. Rose, 'Calculable minds and manageable individuals', *History of the Human Sciences*, 1, (1988), p.188.
20. This brief description of medical discourse on insanity obviously simplifies, and inevitably distorts the complex set of statements which constituted medical perception/knowledge with regard to the insane. The ambiguities and contradictions contained within it will be explored throughout the analysis offered in the chapters following this one.
21. Foucault's exploration of the secularisation of confession can be found in *The History of Sexuality*, vol.1, (New York, 1978), pp.58-9.
22. For detailed analysis of the role of discursive practice in transforming social practice, see I.Parker, *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*, (London, 1992), Chapter 1.
23. Instability in the subjects and objects of discourse is of course inherent in the arbitrary connection between signifier and signified, which affects all forms of representation. For a full discussion of this, see T.Hawkes, *Structuralism and Semiotics*, (London, 1977), pp.123-150.

decoding positions for their subjects. Shifts in the relationship between institutional and discursive practice, or between discourses themselves, open the possibility for meanings other than the naturalised or taken-for-granted to emerge. In these circumstances negotiated or oppositional decoding of dominant meanings may occur, facilitated by the 'lack of equivalence' between the activities of encoding and decoding[24]. Instability of subject positions implies the unstable and contingent nature of identity itself.

Negotiated decoding legitimises hegemonic definitions while simultaneously incorporating the possibility of exceptions to those definitions in specific situations. Oppositional decoding systematically re-reads hegemonic meanings in terms of an alternative discourse which challenges in a generalised way the naturalised meanings of the dominant discourse[25]. For example, a negotiated reading of the dominant discourse of colonised (black) subjects as children, less highly evolved than (white) colonisers might accept the blacks as children equation, but accord some individuals adult status because they demonstrated 'unusual' ability to make use of educational opportunities. An oppositional decoding would challenge the reading of race as a determinant of intellectual capacity, reading the dominant discourse of blacks as children as serving the economic interests of colonisers, and entrenching existing class positions[26].

Dominant discourses by definition monopolise texts. Sensitivity to negotiated and oppositional subject positions raises the possibility of discovering 'subaltern voices', discourses erased or silenced by dominant meanings[27]. The insane seldom had a voice in the discourses which shaped their management, except as irrational, deluded, incoherent or childish individuals, in need of institutional care[28]. Occasionally case records quote remarks made by the insane as examples of their delusions or incoherence. An oppositional reading of these comments accords these comments representational value beyond the simple illustration of insanity, and insists on the

24. Stuart Hall, 'Encoding/decoding', in S.Hall, D.Hobson, A. Lowe and P.Willis (eds.), *Culture, Media, Language*, (London, 1980), p.131.
25. Parker, *Discourse Dynamics*, p.20. For a detailed description on encoding and decoding positions in discourse, see Stuart Hall, 'Encoding/decoding', 128-138.
26. Note that the dominant reading of black as child was contradicted by those discourses in which colonised black people were expected to take adult responsibility for their actions. In the law for example, blacks were treated as responsible adults, and therefore accountable to the law for crimes they may have committed. Negotiated or oppositional readings would at times draw on these contradictory discourses.
27. For a discussion of ways in which silenced stories may be lifted into representation, see G.C. Spivak, 'Can the subaltern speak?'.
28. The silencing of the voice of madness is a central thesis of Foucault's *Madness and Civilisation.* In 'The order of discourse', he describes 'the madman' as the one whose 'discourse cannot have the same currency as others. His word may be considered null and void, having neither truth nor importance, worthless as evidence in law, inadmissible in the authentification of deeds or contracts, incapable even of bringing about the trans-substantiation of bread into body at Mass.' Inaugural Lecture at the College de France, given 2 December 1970. Reprinted in R. Young (ed.), *Untying the Text: A Post-Structuralist Reader*, (tr. I. MacLeod), (Boston, London and Henley, 1981), p.53.

possibility that at times they offer a view of asylum life from below almost entirely suppressed in doctors' writing. Similarly suppressed are the voices of women and those classified black regardless of whether they were patients or relatives of patients. The identification of their perspectives necessitates a mapping of sites of discursive activity, from which it becomes possible to suggest areas of textual suppression or silence. The fragmentary representation of subaltern voices in official records calls for the construction of those voices as 'a relationship of difference' and a site of absence[29].

2. Texts and textual analysis

In order to describe discourses and their relationship to institutional practices they must be identified in the texts through which they are realised. Thus discourse analysis is inseparable from textual analysis. However, discourse analysis addresses itself to the context and processes of production, distribution and interpretation of a range of texts, all of which can be demonstrated to be instances of a particular discourse. Textual analysis addresses itself to the construction of specific texts, and in this study will include lexical and syntactic analysis, cohesion analysis and description of narrative structure[30].

Lexical analysis is an exploration of word choice in specific linguistic contexts. It will be used in the analyses which follow to include description of the metaphors through which the insane were typically represented. Although lexical analysis informs the description of individual texts in relation to the immediate linguistic context, it also incorporates the description of patterns of lexical choice across texts[31]. Further, analysis of lexical choice across a number of texts also allows the identification of relative lexicalisation within different semantic fields[32]. In this study, repetitive descriptions of the insane, despite multiple changes in authorship over long periods of time, make the case records into a cohesive linguistic corpus. 'Lexical sets' are sets of words which can be demonstrated to co-occur describing closely similar phenomena, or to be used interchangeably within and between texts, creating a high degree of redundancy. For example, in the Valkenberg series the words 'incoherent' and 'rambling' frequently co-occur, and appear to have largely overlapping semantic fields, referring to patients' talk as incomprehensible to the listener.

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29. Jenny Sharpe, *Allegories of Empire: The Figure of Woman in the Colonial Text*, (Minneapolis, 1993), p.17. For a discussion of the relationship between stated and suppressed versions of historical events, see Spivak, 'Can the subaltern speak?'.
30. Fairclough, *Discourse and Social Change*, pp.73-86, identifies vocabulary, grammar, cohesion and text structure as the major components of textual analysis, and these broadly conform, with slight differences in emphasis, to the components of textual analysis used in this study.
31. M.A.K.Halliday, *Language as a Social Semiotic: The Social Interpretation of Language and Meaning*, (London, 1978), Chapter 9.
32. Halliday, *Language as a Social Semiotic*, p.165.

Syntactic analysis is used in this study as a means of locating subject and object positions in particular texts, primarily through analysis of nominalisation and transitivity[33]. The focus of syntactic analysis is therefore the construction of agency in both doctors as writers and the insane.

Cohesion analysis and narrative analysis, both strategies useful for the description of texts longer than one sentence, are of particular interest in the study of a body of multiply-authored texts. They are separate but interlocked analytic strategies. Each case record has numerous entries, and cohesion analysis allows identification of links between sentences within each entry, as well as links between entries. Apart from providing explicit links between sentences or texts, the expectation of cohesion allows the reader to fill in deleted words or phrases even in the absence of syntactic markers of those deletions[34].

In this study narrative, intrinsically cohesive but not reducible to cohesion, is used to describe the textualisation of a story, in which events are implied or said to be connected in a structure given coherence within a particular knowledge framework. Narratives carry within them the elements which allow the reader to predict a limited number of story-lines, or outcomes[35].

The following example will illustrate these points. Cohesion and narrative cohesion can seen in the following sentences. 'She was violent towards her employer. Refused to work. Was found wandering naked in the streets, and taken in by friends. Was violent towards them.' Pronominal deletion links the second, third and fourth sentences to the first, and cohesion established in this way is underscored by repetition of both syntactic structure and lexical choice (repetition of 'violent'). Narrative cohesion is embedded in description of events which are read as cohesive because they are all socially inappropriate. The context of the narrative, the case record of a person identified as insane, provides the knowledge framework ('the insane are violent/ inappropriate/unable to work') within which to predict the events which will complete the narrative: admission to an asylum, treatment for insanity.

33. R.Fowler, 'Power', in T.A.van Dijk, (ed.), *Handbook of Discourse Analysis, vol. 4: Discourse Analysis in Society*, (London, 1985), p.69-71.
34. For a detailed description of cohesion analysis, see M.A.K.Halliday and R.Hasan, *Cohesion in English*, (London, 1976). A summary of important issues in narrative analysis is given in E.Gulich and U.Quasthoff, 'Narrative Analysis', in T.A.van Dijk, (ed.), *Handbook of Discourse Analysis, vol. 2: Dimensions of Discourse*, (London, 1985), 169-197. In the sentences 'Patient is restless. No visitors', 'patient' is readily identifiable as the subject of the second sentence despite the absence of a pronoun, which would be an explicit cohesive tie. Deletions such as the one in the example are frequent in case records. Their effects are discussed in Chapter 8.
35. E.Gulich and U.Quasthoff, 'Narrative Analysis'. See also Fairclough, *Discourse and Social Change*, p.75, on text structure.

Reliance on the ability of the reader to supply deleted words and phrases, and to predict the course of a narrative is a striking feature of case records, which provide brief notes as cohesive and predictable summaries of months or even years of lived experience. Unpredictable events are marked as such by their disruption of the narrative.

Cohesion and narrative analysis also identifies texts which are not cohesive or which contradict narrative predictions. There are many reasons why they occur, including shifts between contrasting narratives made as a result of either doctors' perceptions or changes in patients' behaviour, and shifts in the knowledge framework, which reinterprets behaviour in new ways.

The texts to be analysed in this study are all written, with the exception of statistical data from the annual reports, and a number of photographs of the insane attached to case records. Both statistics and photographs call for analytic strategies in some ways different to the analysis of written text. Textual analysis of statistical data interrogates the construction of the categories against which numbers are recorded. Instead of assuming a transparent or 'factual' arrangement between counted instances and categories in which they are placed, analysis draws attention to the arbitrariness of both categories and categorisation[36]. It also draws attention to authorship, taking into account the discursive position of those doing the counting. A similar process of interrogation is necessary in the analysis of photographs, which are not assumed to have a transparent relationship to 'being there'[37]. Relationship of body to context, dress, posture, and facial expression are subject to authorial intervention. Ways in which photographs are embedded in written texts also interpret them in diverse ways all susceptible to analysis.

Conclusion: Colonial discourse theory and historiography

In this chapter I have argued that texts make institutional practices available for study. Drawing on discourse theory, I have suggested that these practices and the discourses with which they are associated shape the subjectivity of those positioned within them. The aim of the study is to describe colonial psychiatry in the Cape Colony as an institutional practice, and also to describe the subjectivity of the doctors involved in caring for the colonial insane. It is therefore a project which falls within the ambit of colonial discourse theory, an approach which poses some historiographical dilemmas. It is important to raise these, because they bring into focus the limitations, methodological and theoretical, of the analyses which follow.

36. For a detailed exploration of statistical data as discourse see D.Smith, *The Conceptual Practices of Power: A Feminist Sociology of Knowledge*, (Boston, 1990), Chapter 5.
37. J.Berger, *Ways of Seeing*, (Harmondsworth, 1972), Chapter 1.

The first of these is the status accorded to material reality. Discourse theory argues that all experience is discursively constructed. There is no autonomous reality, potentially discoverable by successive historiographical refinements. While it is possible to accord insanity for example, material reality, it cannot be described in ways which escape the receding mirrors of discursive construction. What is possible is a description of the discourses which constituted insanity within particular historical contexts. However layered this description may be, juxtaposing perspectives in ways which interrogate the primacy of any single view, 'reality' remains elusive. To undertake historical description using discourse theory as a theoretical framework places the historian in a self-consciously 'as if' relationship to 'fact', detailing events as though their outlines had a stable identity separable from the historian's gaze. The 'as if' relationship of historian to historical event nonetheless allows the possibility of description.

At the same time this creates another dilemma. Deconstruction of dominant discourses allows a multiplicity of perspectives to be entertained - at least theoretically - in accounts of history. However, discourse analysis rests on the availability of texts to analyse, and texts representing 'subaltern voices' are often hard to come by. Texts performed within dominant discourses carry within them suppressed voices and silences, the unspoken record from which subaltern voices might be reconstructed. In histories of colonialism such reconstruction is at the heart of attempts to avoid reproducing the colonial knowledges through which the colonised were silenced. However, speaking for the silent reproduces the act of colonisation which is the subject of the deconstructive exercise, especially in the light of the tendency of historical description to represent both dominant and silenced discourses as being in some relationship to material reality.

These theoretical dilemmas inevitably result in a methodology which simultaneously reproduces and deconstructs the tension between assuming a material reality and insisting on its discursive construction and hence elusiveness. The focus in the chapters which follow shifts between description of institutional practice and discursive practice. The contradictions generated by these shifts will be addressed within each chapter.

Chapter Four

THE OFFICIAL CERTIFICATES AND FORMS: CATEGORIES OF LUNACY ADMINISTRATION IN THE CAPE

Introduction

In 1896, Emma C was admitted to the Old Somerset Hospital with impetigo of the head and back. She had been living with an aunt, who had recently died of cancer. Her mother was already dead. On her admission, nursing staff found her behaviour to be 'silly and idiotic', and brought her to the attention of the Resident Surgeon of New Somerset, Dr Parson, who examined her and found her to be 'of unsound mind. She is very childish in her ways and dirty in her habits and quite incoherent'. On the same day she was examined by two more doctors, one of whom said her expression was 'fatuous. Plays with a doll in a silly way. Says that her mother is returning from heaven tomorrow to take her home to Cape Town. Says that she has been here three weeks, whereas she has been only one day.' The other said that her expression was that 'of an idiot with foolish and vacant expression. She is very childish in her manner, jerking in bed without any obvious reason, and behaves in an insane way.' The following day, the Resident Magistrate issued a Summary Reception Order, and ordered her to be detained in Valkenberg. Two weeks later, the detention was ratified by a judge's order, and Emma remained in Valkenberg until she died in 1934.

Emma C was not violent, nor dangerous and she had not committed any crime. She was not wandering the streets, nor engaging in publicly offensive behaviour. The forms even name a relative, an aunt, who might have been prevailed upon to offer her a home. It was nonetheless the unanimous opinion of nurses, doctors, and the Resident Magistrate that she was 'a lunatic and proper person to be taken charge of and detained under care and treatment'. Within a twenty-four hour period, Emma 'became' a lunatic, by having her behaviour described in ways which identified her as insane. It was a tautological process, declaring her insane because she behaved in an insane way. The forms justified a decision which had already been formed by the nursing staff, and led to their request that she be examined by the doctor. Therefore they 'knew' her as a lunatic, and presumably had a sense of who appropriately belonged in an asylum, a knowledge corroborated by doctors and Resident Magistrate, the superintendent of Valkenberg, and ultimately a Judge in Chambers.

Everyone involved with the committal of Emma C to Valkenberg was drawing on shared beliefs about what constituted insanity, beliefs which both shaped, and were shaped by, an ongoing interplay of knowledges, legal definitions, medical opinion, and experience of asylums and their inmates. The shared beliefs about insanity, whatever their substance or origins, were structured by the institutions within which they were transformed from experience to knowledge, from spoken opinion to written account. Thus within the institution of the law was written a legal definition of

insanity, a description of a person who would "require" and "match" the care and treatment offered by asylums as institutions. Within the institution of medicine, evolved a way of describing insanity which made it identifiable by doctors, and treatable by doctors in asylums[1].

The circularity of this process, in which asylums are for the insane, and the insane are those who belong in asylums, is illustrated in Emma C's committal papers; it is also pervasively evident in the structure and wording of all the certificates and forms used in the committal process.

In Britain during the nineteenth century, numbers of asylums and numbers of persons identified as insane grew steadily. Lunacy law and administrative procedures, which were then exported largely unchanged to the Cape Colony, became increasingly complex, not only as a response to the expansion, but also as means of sustaining it. These medico-legal documents had both actuarial and contractual functions. Garfinkel argues that 'the contents of clinic folders are assembled with regard for the possibility that the relationship may have to be portrayed as having been in accord with expectations of sanctionable performances by clinicians and patients'[2]. In the same way, committal papers and asylum records were simultaneously a means of accounting for and justifying committals. They recorded reasons for committal, but also used that record to assert that both the decision to commit and the subsequent treatment were appropriate. In this way, they determined and limited what was perceived about insanity, to match institutional constraints.

Dorothy Smith, commenting on the 'interchange between an inexhaustibly messy, different, and indefinite real world and the bureaucratic and professional system that controls and acts upon it' suggests that:

> the controlling schemata of the psychiatric discourse and of the subordinate discourses of social work and psychiatric nursing are built into the categories and concepts used for reporting, sharply restricting what may be incorporated into the textual realities that ground the psychiatric decision-making process[3].

She goes on to say that psychiatric professionals 'learn how to relate to members of their own professions and to those of others, and they learn how to talk *to* patients and how to talk *about* patients and how to talk *to* patients so as to be able to talk *about* patients'[4]. Questions asked on forms and certificates are integral to this process.

1. For discussion of the relationship between knowledge, institutions, and professional subjectivities, see N. Rose, *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939*, (London, 1985) and *Governing the Soul: The Shaping of the Private Self*, (London, 1989).
2. H. Garfinkel, *Studies in Ethnomethodology*, (Englewood Cliffs, 1967), pp.198-9.
3. Smith, *The Conceptual Practices of Power*, p.100 and p.126.
4. *Ibid.*, p.125. An illustration of this is Barrett's demonstration of the disparity between an oral record of a clinical interview with a schizophrenic person, and the written record of this interview. A process of deletion, and the deployment of a specialised vocabulary, transforms the experience from 'person suffering from schizophrenia to schizophrenic' with a case history in important respects interchangeable with that of other schizophrenics. R.

The concern of this chapter is to explore ways in which categories of lunacy administration and certification in the Cape during the 1891-1920 period allowed a common definition of insanity to be formed and shared by institutions involved with its identification and control. This definition staged some information and silenced some, creating a situation in which the legal and medical professions were able to constitute an apparently self-evident, and to outsiders, fair and objective, means of taking individuals out of society, and into asylum care. The chapter will explore ways in which information sought and suppressed in official documentation was shaped by the colonial setting, served imperial goals, and contributed to the production of a colonial psychiatry.

The focus in this chapter will be on formal categories, definitions, and the silences implied by them, and not on the content of the information commonly supplied on official forms. Particular contents will be described in Chapters Six and Seven.

The legislative context

During the 1891-1920 period three major pieces of legislation shaped the formation of Cape colonial psychiatric practice. These were the 1891 and 1897 Lunacy Acts and the Mental Disorders Act of 1916. All three drew on similar legislation passed in Britain, and reflected British attitudes to, and experience of, insanity during the second half of the nineteenth century.

The period 1845-1890 in Britain saw the establishment of a network of County asylums, institutions created to fulfil a legal responsibility to provide care for all lunatics, including paupers. Legislation during this time did more than underwrite the building of large asylums; it also established legal practices in relation to the admission of each patient, including medical examination and certification. Legislation also called for the detailing of particulars such as age, marital status, occupation and religious affiliation, tendency to suicidal or dangerous impulses, and epilepsy. Moreover, the asylums brought into being by the Lunacy Acts were in certain respects public spaces, not only because they were intended to care for pauper and private lunatics alike, but also because they were to be inspected by Visitors drawn from the ranks of the legal, and later from the medical profession. The Lunacy Acts were therefore an important vehicle in the creation of a public discourse which defined the nature of lunacy, appropriate treatment for it, and the architectural spaces within which that care was to take place.

Barrett, 'Clinical writing and the documentary construction of schizophrenia', *Culture, Medicine and Psychiatry*, 12, (1988), 265-99.

The boundary between sanity and insanity was made visible in the practice of legally enforced medical examination, which posited insanity as susceptible to observation and description. Space designed specifically for the insane, and not the criminal or chronic sick or paupers, reinforced the separation of lunacy from other social 'problems', and the spaces themselves made a statement about separation because they were locked and entry, not as a patient, required professional status[5].

The certificates of the British 1845, 1853 and 1890 Lunacy Acts resonate with metaphors invoking both morality and order. Phrases such as 'wandering at large', 'not under proper care and control', and 'of dirty habits', defined both insane behaviour, and by contrast, the substance of sanity. Moreover, the definitions produced a moral order in relation to 'proper care'. This was done by condemning 'cruel treatment', which became a reason for admission to an asylum, and insisting upon its obverse, 'humane care'. However, the legislation, which rendered the insane publicly visible in a particular way, and a public responsibility, paradoxically also hid the insane body from the public eye, by large-scale incarceration.

The definition of insanity in the Cape Colony and early days of Union corresponded closely to that emerging from British legislation during the nineteenth century. However, it had a delayed start. There was little legal or official concern for the colony's insane, at least until the creation of the post of Inspector of Asylums, the arrival of Dr Dodds in the colony in 1889 to fill that post, and the resulting passage through Parliament of the 1891 and 1897 Lunacy Acts. Before that time in general hospitals and on Robben Island the insane, the chronic sick and paupers were in daily contact with each other. Criminals and dangerous lunatics were put together in gaols, and when no hospital accommodation existed, ordinary lunatics were housed in gaols too[6].

Ordinance 105 of 1833 and Ordinance 3 of 1837 were largely concerned with the disposal of lunatics' property, and the appointment of curators for those declared insane. 'Safe custody' of lunatics was legislated for, without elaboration, and confinement of lunatics was provided for by common law only[7]. Ordinance 28 of 1866, addressed from the Colonial Office to Resident Magistrates reproduced certificates modelled closely on those stipulated by the British 1853 Lunacy Act, and put in place the medical examination and documentation of the particulars of each alleged lunatic. However, in the absence of differentiated accommodation for the insane, this

5. J. Louw and S. Swartz, 'Structuring social relationships through discourse and architecture: The case of a colonial asylum', paper presented at European Society for the History of the Social and Behavioural Sciences, (Paris, 1994).
6. From 1846, lunatics, lepers and the chronic sick on Robben Island had separate accommodation, but were often in contact with each other during the day. Deacon, 'A history', p.97.
7. Burrows, *A History of Medicine*, p.344; Warwick, 'Mental health care at Valkenberg Asylum', p.17.

did not materially affect practice with regard to the Colony's insane. Moreover, the 1866 Ordinance was not authorised by any Cape law[8], and was not rigorously applied until Ordinance 31 of 1885, sent by the Under Colonial Secretary to Resident Magistrates insisted that the lunacy certificates be properly completed. Even then, lunatics were held without proper examination and certification, until Dodds set in place a system of thorough inspection of asylum residents.

It is clear therefore that lunatics as a group were not a pressing problem for the Colonial Office, possibly because they were not being identified in large numbers. As Harriet Deacon argues, the banishment of lunatics to Robben Island, until 1875 the Colony's only asylum, suggests the Colonial Office's reluctance to address themselves in any serious way to the presence of lunatics in colonial society, or to take responsibility for their humane care and treatment[9].

Accommodation for lunatics in the Colony until after 1891, was overcrowded and unsanitary, and resort to mechanical restraint, seclusion and abusive treatment of violent or uncontrollable lunatics are well-documented at Robben Island and Old Somerset Hospital Lunatic Wards[10]. This situation led to a succession of scandals, which eventually prompted the Colonial Office to take action on what was becoming a source of embarrassment to colonial authority[11].

The Lunacy Law Amendment Act of 1879 signalled a new interest in medical legislation generally[12]. It dealt with criminal lunatics before, during and after trial, and importantly, with 'persons of unsound mind but not dangerously so'. Dangerous lunatics could be committed to an asylum by a magistrate, on the production of two Medical Certificates. Lunatics not thought to be dangerous could also be confined, but only by order of the Governor. Thus, the crucial differentiation between the criminally insane and ordinary lunatics was written into the law. Unfortunately, the provision did not take into account practical considerations, such as the often urgent need to confine an insane person, without the inevitable delays of the Governor's order. Many ordinary lunatics were criminalised through being accused of petty crime, in order to facilitate their removal to an asylum[13]. The 1879 Act also made provision for Official Visitors to asylums, and for procedures of enquiry in cases where sane persons were incarcerated; the Act also provided for the private care of lunatics by friends.

8. A. Kruger, *Mental Health Law in South Africa*, (Durban, 1980), p.9.
9. Deacon, 'Place of tobacco trees', p.31.
10. Deacon, 'A history', Chapter 3; D. Moyle, 'Laying down the line', p.9.
11. Deacon, 'A history', Chapter 3.
12. The Act was published in *Cape of Good Hope Gazette*, 21 November, 1879. For a discussion of the Act, see Burrows, *A History of Medicine*, p.344, and Kruger, *Mental Health Law*, pp.12-14.
13. Moyle, 'Laying down the line', p.27.

The Act made clear the necessity for humane treatment of lunatics. However, the policing of this was left unspecified, apart from requiring official visits at quarterly intervals, with inspection reports to be sent to the Colonial Secretary. On occasion comments were made about incomplete certification, and recommendations were made about the reclassification of some patients[14].

The Acts of 1891 and 1897 had the effect of bringing the colony closely into line with legal and medical practices in Britain, importing many of its legal structures, and much of its certification and documentation procedure, the only notable exception being the failure to insist on the large-scale provision of accommodation for lunatics[15]. In the 1891 Act distinction was made between dangerous and criminal lunatics, and those who were neither criminal nor dangerous. Certification procedures were laid out in such a way as to obviate the necessity to apply to the Governor for permission before putting insane persons in an asylum. 'Summary Reception Orders', issued by Resident Magistrates on the production of two Medical Certificates, and after examination of the alleged lunatic, allowed the insane person to be detained for one month, at which time further detention had to be ordered by a judge. Safeguards against unfair incarceration were carefully built into the legislation, through certification procedures, and safeguards against the ill-treatment of lunatics in asylums were extended. These included making it an offence for a male person to have custody of female patients; establishing penalties for nurses in cases of proven ill-treatment; and making illegal the use of mechanical restraint without a medical certificate and a record of the incident.

Dodds expressed some dissatisfaction with the 1891 Act, particularly with respect to urgent cases, incipient illness, and the provisions for release of patients temporarily, during respites in their illness. The 1891 legislation was cumbersome, and poorly suited to the realities of treatment. Dodds campaigned for a more flexible and humane system, which would allow patients to spend time with relatives on probation, without having to be discharged and then to go through the laborious process of re-certification. He wrote to the Under Colonial Secretary at length about the case of a Mrs Julia Fischer, a manic-depressive woman who was frequently well enough to be at home with her husband, but who also had a pattern of relapses[16]. He wanted legislation streamlined to allow for immediate treatment in cases which appeared urgent, and he wanted provisions made to allow patients to commit themselves voluntarily to asylum treatment[17].

14. An example is the report of visiting doctors Roux and Abercrombie, writing after an inspection of Robben Island Infirmary in April, 1882, where they found 'one coloured man, removed from the pauper ward, detained without a double certificate'. G.29 -'83, p.27.
15. For a discussion of these Acts, see Kruger, *Mental Health Law*, pp.14-16.
16. CO 1527, 12/5/1892.
17. CO 1485, 22/10/1891.

The Act of 1897 dealt with some of these concerns. 'Urgency Applications' made provision for patients to be admitted to an asylum with one medical certificate only, in urgent cases. This order had to be replaced within seven days by the standard certification. Provision for voluntary boarders was also made. Leave of absence on probation became a possibility only in 1916.

The 1891 and 1897 Acts determined lunacy administration until the Lunacy and Leprosy Laws Amendment Act of 1914 and the Mental Disorders Act of 1916. The latter, shaped by and reflecting the concerns of Dr Dunston, the first Commissioner of Mentally Disordered or Defective Persons following Union, wrote into law classes of mental disorder or defect previously in operation largely in medical discourse only[18]. Doctors were obliged to use these categories in filling out Medical Certificates, and they reflect increasing differentiation between disorders, as well as a recognition of the needs of particular groups, such as the mentally handicapped and the epileptic. Of equal importance was the shift in emphasis away from using dangerousness or criminality as categories for legislation. Although criminal acts were dealt with at length in this Act, the criminally insane were not placed in a separate class from other mentally disturbed or defective persons. The issue of dangerousness was assimilated into the general provisions.

Section 25 of the 1916 Act made provision for reports on the mental condition of patients to the Commissioner annually for the first three years and thereafter in the fifth year, and then every fifth year. These Periodical Reports ensured some medical attention for all patients, in a situation in which increasing numbers made neglect a likelihood. Two obvious dangers were being legislated against here: the sane person being kept in hospital for longer than necessary because he or she received no attention from those in charge, and serious medical conditions being missed because patients were not being examined regularly. These concerns were not new. The general rules and regulations stipulated that asylum case-books make regular entries on each patient. Dodds had repeatedly insisted on asylums casebooks being kept up-to-date, and warned about the dangers of patients not being seen at regular intervals[19].

The Act also extended the legislation on Voluntary Boarders, patients in private dwellings, licensed institutions and the reception of patients in general hospitals and other similar institutions. In this way, the range of persons eligible to be treated was extended, as well as the

18. Classes I and II dealt with functional mental illness, such as schizophrenia or affective disorder, and organic disturbance such as senile dementia, or dementia following illness, accident or substance abuse. Classes III, IV and V set out grades of mental deficiency, in order of severity, idiocy being severe handicap from birth or early age, imbecility a lesser degree of handicap, and feeblemindedness. Class VI concerned moral imbecility, 'a person who from early age displays some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect'. Class VII dealt with epileptics.
19. CO 1524, 7/6/ 1892.

range of institutions in which this could take place. Parallel to this, the 1916 Act specified the functions of the Commissioner of Mentally Disordered or Defective Persons, and hospital boards. Thus the legislation had, in the course of two and a half decades, become both detailed and responsive to the increasing pressure of numbers of insane or defective persons needing care.

The 1916 Act extended the general definition of 'lunatic', which in previous Acts had been simply 'any idiot or person of unsound mind incapable of managing himself or his affairs' to include explicitly suicidal tendency, dangerousness to self or to others, criminal intent or activity, acting 'in a manner offensive to public decency', alcohol or drug abuse, and 'receipt of relief or assistance from public or charitable funds at the time of giving birth to an illegitimate child or when pregnant of such a child'. The latter both reflected, and gave impetus to growing concern, directed largely at white women, in the period after Union with poverty and 'immorality', both of which were commonly regarded as linked to feeblemindedness[20].

As it had in Britain during the second half of the nineteenth century, the lunacy legislation in the Cape defined more than behaviour to be categorised as insane (such as violence, or wandering at large); it also defined the professions which were to control it. Thus the procedures involved in admitting an alleged lunatic to an asylum drew in the police, who were responsible for maintaining order; the medical profession, responsible for distinguishing between 'bad' and 'mad'; and the legal profession, which carried the legal responsibility for the committal, for monitoring the decisions of both police and doctors with regard to individuals alleged to be lunatics, for decisions concerning the disposal of lunatics' property, and for making decisions with regard to payment for upkeep after committal. Shared legal and medical responsibility was never subject to debate in the Cape, as it had been in Britain, where the medicalisation of the treatment of insanity was a gradual process, and involved the replacement of lay asylum managers with doctors[21]. In the Cape, doctors were always assumed to be the appropriate professionals to care for the insane, with one telling exception. At Fort Beaufort, the first asylum for black patients only, had at first no medical superintendent, and this was a marker of its stigmatised status.

That lunacy legislation in the Cape was modelled closely on legislation in Britain had major implications for the definition and management of the insane in the colony. British legislation was formulated through experience and knowledge of insanity in an industrialised, unilinguistic

20. Anxiety about feebleminded white persons in the Cape, thought to be a danger to racial health, is discussed at length in Chapter 5.
21. The occupation of insanity as the territory in which medical doctors were to have authority is discussed in Scull, *Museums of Madness*, Chapters 4 and 5.

context, with large urban populations. This was a context in which there was a history of concern about the problems of managing the insane and a public discourse about the implications of state responsibility for the unwanted[22]. Although there was classist prejudice about both unemployment and poverty, there was also a concerted attempt to provide care for large numbers of people unable to fend for themselves. There was also an already-established and relatively stable social order, which made it potentially possible to differentiate with some accuracy individuals whose distress was clearly the result of intra-psychic or intra-familial disturbance, and those whose difficulties were largely social or economic.

Legislation imported from Britain was fundamentally unsuited to the difficult task of differentiating between social and individual disorder in the Cape. There were two reasons for this. One was the essentialist assumption that insanity had universally identifiable characteristics regardless of class, racial classification and gender. The other was the assumption that there was a single public order.

To ignore the effects of cultural and linguistic diversity on the appearances of insanity, particularly in a population which had been subjected to rapid social change, was one area of blindness[23]. The other concerned the issue of what constituted 'order'[24]. In the Cape there was one order for the white population, and another for the black one, in the sense that black people were expected to conform to the rules of white society, and simultaneously to live in ways unalterably alien to it. In other words, the colonisers had economic interests in maintaining class and cultural difference, and in ascribing that difference to race. In a context of cultural, class and linguistic difference, white 'order' was foregrounded as the norm, with black populations as inevitably deviating from it, being 'disorderly'. This 'natural' disorder was discursively constructed as dangerous unless strictly policed[25]. Rapid growth of urban populations drew attention to the need for public order in cities, but poverty and lack of adequate housing for the black population in cities was naturalised within the racialised colonial order. No provision was made to create a society which would allow black people to aspire to, and gradually achieve, that 'order'. In this situation, insanity was a social problem secondary to those raised by black migrant labour living

22. Scull, *Museums of Madness*, Chapter 7.
23. This universalism had a long history. For example, reforms in Robben Island Asylum were represented within a universalist discourse which assumed that madness is madness wherever it occurs, regardless of race or culture. Deacon, 'A history', p. 165.
24. I am using the term 'order' here to refer to the social, political and moral rules structuring interaction between people, which incorporated and entrenched class and gender difference. The term also invokes the idea of 'orderliness'.
25. The equation between black populations and the danger of disorder can be seen in black residential areas being constructed discursively as dangerous and disease-ridden. Such attributions were located as resulting from race and cultural difference from white 'safety', rather than from unsanitary or slum living conditions, poverty, dislocation or unemployment. These issues are described in more detail in Chapter 2.

in or near cities. No attempt was made to tailor legislation to the difficulties of identifying insanity as a particular instance of the 'disorder' represented by the black population as a whole[26]. Thus, failure to take account of the diversity and complexity of Cape society was a key characteristic of the colonial psychiatry which evolved at the Cape.

The following sections, which describe the implementation of the law through certification, will explore some of the effects of using imported British legislation in a colonial context.

Certificates required by the committal process[27]

The certificates mediating the committal process specified the discursive boundaries within which talk about the insane was to occur, making visible and defining particular forms of 'insanity'. These phenomena, identified initially through both medical and lay experience of insanity, then entered the public discourse of medicine and the law as institutionally-based and professionally validated knowledge.

Close analysis of the questions, categories, examples and layout of the certificates suggests that there were rigid formal constraints on the kind of information they were designed to elicit. They focused on a set of insane behaviours which were used as functional definitions of insanity. Constraints on the description of insanity in the certificates rendered many hypothetically possible insane acts invisible. At the same time, they maintained the fiction that doctors were simply recording their 'observations'. The apparent spontaneity in the interplay between spaces created by the questions and the answers supplied against them was to a large extent an illusion.

The following sections concern the definition of insanity in the Cape, both inside asylums and out, emerging from the most commonly used certificates. For this purpose, the following certificates will be analysed in detail: Medical Certificates which marked the beginning of the committal process; the Statements of personal particulars accompanying those forms; Summary Reception Orders, Reception Orders and Urgency Applications, which marked the entry of the legal profession into the process of committal; the Admission Forms which marked the entry of the patient into the asylum; the Periodical Reports which justified the long-term incarceration of lunatics; certificates recording patient movements, including escape, discharge, death and leave of absence; and finally the Notices of mechanical restraint, seclusion and accidents. It will be argued

26. To achieve a context-sensitive legal definition of insanity which engaged with the complexity of public order in the Cape would have been a formidable task, and it is beyond the scope of this study to suggest ways in which this might have been done.
27. Copies of the certificates described in the following sections are given in Appendix 3.

that the Medical Certificates began the process of person-to-lunatic transformation, defining lunacy as a medical problem, and doctors as appropriate caretakers of lunatics. Summary Reception Orders, Reception Orders and Urgency Applications were central to the definition of the societal order which the legal profession sought to protect. Ways in which the admission forms inscribed lunatics' bodily and mental status in the language of current medical knowledge and the Periodical Reports transformed them into 'cases' will be described. It will also be argued that Notices of mechanical restraint, seclusion and accidents, which inscribed lunatics as dangerous and unmanageable, at the same time inscribed the doctors, attendants and nurses caring for them as humane and considered in their response to insane behaviour[28].

Given major changes in the legislation concerning the insane in the Cape Colony during the period 1891-1916, it is striking that the certificates which mediated admission to asylums by classifying persons as patients changed very little as a result of changes in the law. In fact, the Medical Certificates and accompanying Statement concerning the personal particulars of the alleged lunatic specified in the Ordinance of 1866 are substantively no different from those of later legislation. Forms proliferated as the legal requirements with respect to admission of lunatics to asylums were more closely defined, but the basic processes involved with the admission itself changed very little over the period of fifty years[29]. The fact that legislation in the Cape lagged behind that of Britain does not always permit prediction about which legally mandated forms were in use in the Cape at a particular point, as forms drawn up for use in Britain were sometimes imported and put into use in advance of the passage of Cape laws enforcing their use. However, the legislation eventually passed in the Cape made public, and enforceable by law, the meticulous implementation of official procedures, and made it possible to police formerly haphazard and incomplete certification.

1. The Medical Certificates, 1866-1897

The Medical Certificates of the 1866 Ordinance and 1879, 1891 and 1897 Acts were required to be completed by 'medical gentlemen' 'not assistant one to the other'. Thus, the patient was to be examined separately from any other practitioner, an attempt to ensure independent evaluation. That this was thought to be necessary addressed public fear of wrongful incarceration, and was connected to the spectre of sane men and women being locked up by vindictive or avaricious relatives or friends, or else being put into asylum care on scanty evidence by doctors or managers

28. This dissertation does not discuss specifically the position of criminal lunatics, but rather focuses attention on the emerging definition of 'ordinary' lunatics, who formed the majority of committals. Through this definition, the differentiation of 'order' from 'disorder' in those instances where no crime was suspected or had been proved to have been committed will be discussed.
29. The *Codified Circular Instructions* giving the official forms required by the 1897 Lunacy Act lists a total of 43.

of Private Houses who stood to gain materially from the committal. Fear of committal and therefore the need to be absolutely sure it was necessary, also reflected fear of wrongfully inflicting on a sane person an identity not only deeply stigmatised, but often associated with disappearance from ordinary society for long periods of time, even for life.

The purpose of the Medical Certificates was to declare that the person examined was 'of unsound mind and a proper person to be taken charge of and detained under care and treatment'. To 'take charge' is a phrase invoking a hierarchy of authority, such as exists between adults and children. This is tempered by the carefully chosen phrase 'care and treatment'. 'Care' was a term commonly associated with the word 'humane' in discourses about insanity during the nineteenth century, and coupled with the word 'treatment', emphasised that committal was not simply custodial care.

Following this, the form introduced two sections: (1) 'Facts indicating Insanity or Idiocy observed by myself' and (2) 'Facts indicating Insanity or Idiocy communicated to me by others'. The bracketing together of insanity and idiocy was representative of practice at the time. The two states, while identified as distinct, were not at this time 'treated' in different contexts, with the exception of special provision made for some imbecile children in Grahamstown[30].

The Medical Certificates were placed squarely in the discourse of scientific activity by the instruction to 'observe' 'facts', facticity and observation (rather than interaction for example, or reflection) being the cornerstones of the scientific method. Of course to assume that insanity could be observed from the outside carried with it complex assumptions about its nature: that inward states of disorder were reflected in disordered behaviour, and even in 'stigmata', those bodily marks of defect zealously sought in lunatics of the Victorian period[31]. Observation carried another implication in this context, that of bearing witness, and testifying to the truth. The second of the headings placed doctors in the position of carrying forward the testimony of friends and relatives, and vouching for its authenticity.

Four ruled lines only was allowed for each answer, despite the injunction to the practitioner to 'state the facts upon which their opinion has been formed'. Again the scientific method was the underlying discursive structure, with 'opinion' to be constructed of observable 'facts'. The brevity with which doctors were expected to state their views points to the processes of classification which preceded the construction of the forms, making possible to identify the particular instance as one of a class, all in important respects similar. Thus it was unnecessary to write at length about

30. The Institute for Imbecile Children, Fort England, Grahamstown, was opened in 1894.
31. For a discussion of stigmata identified with insanity during the nineteenth century, see J. Oppenheim, *'Shattered Nerves'*, pp.286-7.

the insanity of every individual as if she or he were unique. A system of classification summarised those arguments, and precisely because it was a summary, consigned many potential observations to silence.

The forms went further than to invoke a classificatory discourse: they offered a set of guidelines, including a request that appearance, conduct and conversation be commented on. A footnote gives the following as examples of 'facts' upon which the doctor's opinion might be based: 'delusions (specifying the nature of the delusions), incoherence, imbecility, fatuity, alteration of conduct and affections, dirty habits, &c.' The '&c.' with which the list ended contains within it an assumption of professional knowledge in the doctor responding to the question, as if she or he (there was one woman doctor involved in making these reponses during this period) would be able to extend the list of disordered behaviours, while retaining the overarching classificatory principle. This assumption of a co-operative and knowledgeable respondent in discourse with the legal profession through the certificate was an example of the way in which the two disciplines shared knowledge and power with respect to the control of the insane.

The list of guidelines to insane behaviours accompanying the Medical Certificates invoked more than disordered, deficient, unruly or incomprehensible behaviour: as with the Lunacy Acts, a moral order is implied. This is contained in the phrase 'dirty habits', a seldom-defined but much-used marker of derangement which appeared again and again in the case records, certificates, statistics and annual reports. It is a portmanteau term, apparently referring to lack of cleanliness, laziness, slovenly dress, bad table manners and bizarre eating habits, incontinence, smearing of faeces, and masturbation. It was a key term, because it crystallised concern about adults who behave like children, and civilised people who behaved like savages. The underlying assumption was not only that hygiene and moral rectitude were simultaneously markers of mental health, but also would protect individuals against invasion by disease. The further implication was that insanity led to brutalisation, summarised in the image of depraved sexuality, and resulting in the degradation of the nervous system, the obverse of evolution[32].

Of necessity, forms guide those who fill them in. Where definitions are given, they often do more than guide answers, they formulate them, and create areas of silence. Thus, drawing attention explicitly to 'dirty habits', for example, directed doctors' attention to a particular set of behaviours believed to be central to the presence of insanity. By contrast, attention was not directed to gender, race, or class difference with respect to the appearance of insanity. This silencing was part of a

32. For a general discussion of the link between depraved sexuality and disease, see S. Gilman, *Difference and Pathology*, Chapter 3.

process whereby 'person' was transformed discursively into 'lunatic', and then 'lunatic' was stripped of race, class and gender embodiment, being left with a small repertoire of disordered, 'dirty', irrational or savage behaviours. Identity-stripping in this way moved the ordinary individual into a homogeneous group, lacking individuality, of stigmatised Other[33].

An example will illustrate this point. It is only in the second half of this century that some women have become less reluctant to discuss their experiences of rape, within or beyond the family setting. In the 1891-1920 period many women would have maintained silence on this subject, particularly with a male doctor, because it was stigmatised and often unsympathetically regarded. For similar reasons, domestic violence tended to be under-reported. The certificates prompted doctors to observe disordered behaviour, without suggesting that they seek causes for that behaviour. Moreover, the person alleged to be insane was assumed to be unable to explain coherently the basis of that disorder. In the context of women's difficulty in discussing violence committed against them by men within their families with male doctors, responses to Medical Certificate questions were likely to be based on inaccurate or inadequate information[34].

It is important here to analyse further the implications of the wording in the Medical Certificates within a colonial context. Racial classification, class and gender would all have affected the nature of the information available to doctors. Three examples will illustrate this[35].

It was almost always a white male British-trained doctor who would 'observe' the person to be declared insane. He may have been in a good position to judge the linguistic coherence, for example, of those white men and women with whom he shared a language, but he would have had little ability to form an opinion about the linguistic or conceptual coherence of those speaking a language with which he was not familiar. The certificates at no point suggest that interpreters be used, despite the linguistic diversity which characterised the Cape.

Racial classification and class affected the extent to which individuals had access to accommodation, baths, toilets and clean clothes. This would have affected reasons for 'wandering at large'. Unkempt appearance, and urination or defecation in public places, all of which would have been implicated in 'dirty habits', may in some instances have been the result of poverty or

33. The creation of Otherness through stereotyping behaviour, in the way that the Medical Certificates stereotype insane behaviour, reducing it to a small set of descriptors, is discussed in Gilman, *Difference and Pathology*, Chapter 1.
34. Cases in the Valkenberg series in which women attempted to convince doctors that they had been assaulted by men in their families are discussed in Chapter 7.
35. Uniformity of content in the certificates is discussed in greater detail in Chapter 6.

poor public facilities. In foregrounding 'dirty habits' as a symptom of mental disorder, socio-economic determinants of these behaviours were likely to be ignored.

Differential access to information affected far more than specific observations however. The Medical Certificates made clear that 'alteration of conduct and affections' was to be taken into account. Furthermore, doctors' observations were to be supplemented with information from others. In the case of those classified black, particularly migrant labourers living away from their families, a history of change in behaviour was often unavailable, and there were no 'others' apart from employers or police to supply additional information. Added to this was doctors' ignorance of culture-bound behavioural disturbance. Taken together with the almost insurmountable difficulty of communicating with black people whose English or Afrikaans was poor gave doctors a tenuous basis on which to form an opinion about the alleged insanity. On top of this, these judgements were being made in a context in which many were attempting to adjust to fundamental 'alteration of conduct' determined by economic and social change.

In summary then, the Medical Certificates were designed to describe generic forms of insanity, divorced from particular social, economic, gender, race and class contexts. They assumed therefore that insanity could be described in terms of behaviours which were universal. These assumptions would have affected doctors' descriptions of behaviour regardless of where they were used. In a colonial context characterised by little understanding of or sympathy for colonised peoples, the Medical Certificates were inevitably an inaccurate portrayal of complex intersubjective situations. Uniformity of description became a substitute for information, rehearsing a belief in insanity as a small set of universally occurring phenomena. The certificates appeared to safeguard against wrongful incarceration for all groups, but could serve this purpose fairly and reliably only for those closest to the doctors themselves in class, racial classification and gender.

2. Changes to the Medical Certificates, 1916 Act

The 1916 Act made several changes to the Medical Certificates. The word 'insanity' was replaced by 'mental disorder', and 'idiocy' by 'mentally defective', probably to soften the pejorative implications of the former terms, although to modern ears they are nonetheless prejudicial[36]. To the words 'care and treatment' was added the word 'control', an accurate description of long-established practice. Provision was made for cases of urgency, and space left for the practitioner

36. V. Sinason, in a discussion of changing nomenclature in the area of mental handicap, argues that stigmatised groups are frequently relabelled during attempts to make them more acceptable, or visible to society. These attempts always fail, because the new names quickly accrue stigmatising connotations. *Mental Handicap and the Human Condition*, (London, 1992).

to comment on contact with the patient prior to the day of the examination. Present bodily health and condition (with special reference to the presence or absence of communicable disease or recent injury) was a new area of enquiry in the 1916 forms, and reflected greater sophistication both in the management of asylum epidemics (learnt through experience of such epidemics, including the plague and small pox, as for example the plague of 1901), and physical management of illness amongst those admitted. A rudimentary diagnostic classification was set out, and included mental disorder, mental infirmity, idiocy, imbecility, feeble-mindedness, moral imbecility and epilepsy. This made provision for the dementias associated with ageing, or alcohol abuse, or infection (such as general paralysis of the insane), and introduced greater accuracy in the classification of the mentally handicapped. The introduction of the term 'moral imbecility' to the form at this juncture is an interesting forerunner of the later categories 'psychopathy' and most recently 'personality disorder', and again signalled concern for a moral order, taking precedence at this point over the variety of diagnoses incorporated into the term 'mental disorder'.

Embedding the process of committal in the universalising language of medical diagnosis reinforced its separation from social and cultural contexts.

3. Reception Orders, Summary Reception Orders, and Urgency Applications

Reception Orders in the 1891 Act, to be signed by the Resident Magistrate, after medical practitioners had seen the person to be committed, declared the person before him (there were no women magistrates at the time) to be a 'dangerous lunatic'. It is brief in comparison to Summary Reception Orders, which dealt with those declared insane, but not dangerously so. Summary Reception Orders were worded in such a way as to anticipate and avoid popular fear of the unjust incarceration of the sane:

> I (the Magistrate) am satisfied that he (*sic*) is a lunatic, and is not under proper care, treatment, or control (or is cruelly treated, or neglected, as the case may be), and that he (*sic*) is a proper person to be taken charge of and detained under care and treatment, ...

Cruel treatment or neglect, here laid at the door of relatives and friends, was in fact closely associated with asylums themselves. The evocation of a particular form of distressing hardship is an indication of its salience in the discourse surrounding the insane, and its appropriation in legal documents maintains it as a possibility, while asserting the obverse, proper care and treatment, as the domain of asylums.

Summary Reception Orders were valid only for one month, whereafter the Resident Magistrate forwarded the Medical Certificates, statements, depositions (if any) and the Summary Reception

Order to the Attorney General. Within the one month period, a Judge in Chambers issued an order for the continued detention of the lunatic in the asylum.

Both Reception Orders and Summary Reception Orders made clear the relationship between the legal and medical professions, doctors having been 'directed...to visit and examine' the alleged lunatic. Although in practice, it was possible for doctors to instigate the process of committal, the documentation assigned responsibility unequivocally to the law.

The 1916 Act dropped the term 'Summary' from Reception Orders, and added as reasons for committal suicidal tendency, dangerousness to self or others, criminal offences, and acts 'offensive to public decency', alcoholism and drug-use, and 'receipt of relief or assistance from public or charitable funds at the time of giving birth to an illegitimate child or when pregnant of such child'. This was an important reworking of the principle underlying committal. In the 1891 and 1897 Acts, persons were removed to asylums if the conditions under which they were living were in some way inadequate, cruel or neglectful. The 1916 Act, by specifying particular mental or physical conditions as reasons in themselves for committal, regardless of the conditions under which the person was living, changed the asylum from a place of refuge when other resources had failed, to a specialised medical institution, providing treatment tailored to defined disorders[37].

Under the 1897 Act, provision was made for urgent committal, expediting the process in that they called for a single Medical Certificate only. They remained in force for seven days, whereafter procedure as for the issue of Summary Reception Orders was used. The language of urgency, behind which lies the idea of a medical emergency, again underlined the construction of the insane as persons to be feared, controlled, and locked up, which ultimately meant being hidden from view.

4. Resident Magistrates' 'Statements', 'Form of Statement to Accompany Medical Certificates,' and 'Further Particulars to be Supplied by Applicant as to Person in Respect of Whom Application is Made'

Prior to 1891, personal particulars of each case were recorded in a certificate labelled simply 'Statement', and signed by the Resident Magistrate issuing the order for a person to be detained in an asylum. The 1891 Lunacy Act relabelled this certificate 'Resident Magistrate's Statement'. The 1897 Act changed the title to 'Form of Statement to Accompany Medical Certificates', but it was

37. Although this process applied primarily to asylums, it also had the effect of defining more sharply the parameters of care in private houses. Section 7 of the Act stipulated that only 'safe and convenient' dwellings could be used for the care of patients in single care, and Section 48, which dealt with licences for private institutions made provision for licences issued to specify classes and sexes and numbers of persons to be committed to them. Conditions under which patients were permitted to be detained in general hospitals were also closely defined, in Section 49.

also signed by the Resident Magistrate. In 1916, the form was again renamed, becoming 'Further Particulars to be Supplied by Applicant as to Person in Respect of Whom Application is Made.'

The Statements were designed to facilitate patient disposal, determining who should be housed with whom, and under what custodial arrangements. The opening questions categorised patients in terms of age, sex, race and class, in the following way. The race of a patient was determined by an enquiry about 'nationality', and 'tribe or race'. The racial classification before 1916 divided potential patients into two groups, 'Europeans' and 'Coloureds', and required, in the case of Europeans, that country of birth, and length of stay in the Colony be specified, thus capturing an important feature of colonial society, its immigrant population and ties to other countries[38]. In the case of 'Coloureds', after the 1891 Act, the form requested information on 'tribe or race', without defining either term. Either or both terms could be applied, but the broad classification of 'Coloured', (and therefore not 'European') was the only one of functional importance for colonial lunacy administration. This determined where the patient would be accommodated, under what treatment regime, and how the costs of maintaining her or him might be expected to be met.

Asylums in Britain and the Cape separated men from women, making information as to the 'sex' of the patient important for disposal[39]. Social class was also marked in the form, through enquiry about 'condition of life and previous occupation'. However, the slippage between race and class in the colony was such that Europeans were automatically 'of better class' than 'Coloureds'; and regardless of class, racial classification determined the line of segregation. There was never enough accommodation for the insane to make separation along the lines of class within each racial group a practical possibility, except insofar as white paying patients were given better bedrooms, more food, and greater recreational variety. There is no record of black paying patients being accommodated in more luxurious facilities than their poorer companions. This was despite the fact that forcing patients to mingle with those of a different class was thought to be deleterious to recovery[40].

38. The 1916 Act retained the division into two groups, but changed the term 'European' to 'white'.
39. Before 1891, attempts to separate men from women in Robben Island Asylum were not always entirely successful. After Dodds' arrival, and the opening of Valkenberg, separation by gender was strictly adhered to. For a discussion of gender mixing on Robben Island, see H. Deacon, 'A history', Chapter 3.
40. 'Class' also referred to the nature of the insane attack. In the 1892 annual report on Valkenberg, Dodds complained that 'instead of having separate wards for the sick, feeble, and dying, for recent cases, for convalescent and quiet cases, for epileptics, for dements and cases of degraded habits, and so on, each of them specifically designed for the class of cases that occupy it, we have but two wards on each side, and these not separated from each other as they should be, and not provided with the special accommodation needed, so that all the different classes are more or less associated with one another.' G.17-'93, p.4-5.

After situating the patient in terms of gender, race, and social class, and thus determining appropriate accommodation, the Statement recorded details of other attacks and treatment for them, and duration of the existing attack. These were used to determine 'class of attack' and concerned the 'hopefulness' of the case, for first attacks of brief duration were considered to have a better prognosis than attacks which had either been preceded by others, or had been of extended duration. Suicidal tendency or dangerousness, and presence of epilepsy had implications for the nature of custodial arrangements required. The cause of insanity was also potentially linked to prognosis. Some alcohol-related mental disturbances, for example, were known to remit quickly with treatment. However, the discursive direction of the question on cause was tied in a single query to inheritance, and was therefore a means of monitoring not only prognosis, but also the spread of insanity through 'unwise marriages'[41]. The certificate's enquiry concerning persons to be informed in the case of the patient's death would have been a blunt reminder to relatives or friends supplying information that insanity was often chronic, and ended only with the patient's death, often after many years of incarceration.

The Statements requested information on the financial status of the patient and family or friends, through the negatively worded instruction to discover, 'Whether friends and relatives are unable to pay for maintenance in an Asylum'. A note at the foot of these statements warned that patients will not be received into an asylum 'without this Statement being properly filled up'[42]. Thus between 1866 and 1915 the Statement had the function of gathering the information which would be the basis of a contract between the patient's relatives and the Colonial government, with respect to payment for asylum care.

In the 1916 Act, the identifying data was followed by enquiry as to the history and nature of the illness, and any history of mental illness in the family. The list of diagnostic possibilities offered to lay people (the patients' friends and relatives) as guidelines was considerably more comprehensive than that given to medical practitioners, including as it does eccentricity, hysteria, neurasthenia, spasmodic asthma, chorea, and alcoholism, as well as epilepsy, idiocy, imbecility, and feeblemindedness. The list for relatives was thus exhaustive, rather than offering a discursive

41. For example, in Dodds' 1893 annual report, he used the year's statistics on causes of insanity to argue that 'every senior boy and girl' be alerted to the danger of propagating inherited insanity through ignorance of the manner of its transmission from one generation to another. G.24- '94, p.35.
42. A general instruction sent from the Colonial Office to all Resident Magistrates after the 1897 Act had been passed sheds some light on this issue: 'A tendency exists among Magistrates, when filling in Lunacy Form 7 (the Statement), to answer the question "Whether there are friends and relatives able to contribute towards the patient's maintenance" in the negative in the case of every *native* lunatic; whereas in many instances careful enquiry would possibly elicit the fact that the patient is not entirely without means, or that there are relatives earning good wages or are in possession of live stock or other property, and who should be in a position to pay something towards the cost of Asylum treatment.' *Codified Circular Instructions: Cape of Good Hope 1904*, (Cape Town, 1905).

space into which the respondent was allowed to project her or his knowledge, as was the case with the guiding list offered to doctors.

The 1916 Act changed earlier procedure by separating enquiry about the financial status of the patient from other personal information. Financial matters were dealt with in a 'Report of Magistrate', and detailed patients' movable or immovable property, and noted the extent to which friends or relatives might pay maintenance.

The Statement of Particulars form was another stage in the transformation of person to 'lunatic'. In them the focus shifted from the sane-insane boundary to categories within the 'insane'. The form therefore gathered the information on racial, gender and class identity which made the differentiation of patient groups possible. The most important division separated those classified as 'European' from the rest of the insane. This classification intimately affected the nature of the experience each person would have once committed.

It is important to note that the problems of identity-stripping implicit in the decontextualised information required on Medical Certificates was not mitigated substantially by the Statement of Particulars. These forms classified the alleged lunatic in terms of gender, racial group, class, diagnosis and history of insane attacks in a hierarchy of categories in terms of their significance for practice. The failure to elicit information about the context in which the disturbed behaviour occurred reduced complex social and cultural identities to little more than inscriptions of what was considered to be self-evident because it was marked on the body.

The interaction between the colonial context and the activity of placing persons into categories regarded as biologically determined had a number of implications. Colonial ideology during this period was premised on the assumption not only of biological difference, but also of the biological superiority of the colonising people. In the Cape, the identity of 'coloniser' was inseparable from 'white male', and this inevitably cast both women and black peoples as biologically inferior. Because insanity was widely regarded as a biological threat to racial health, the insane were also physically inferior to the sane. Colonial psychiatric knowledge was shaped by the interplay between these categories of difference and their implications for the racial health and continued 'superiority' of the colonisers. In the committal process doctors inevitably became monitors of racial purity[43].

43. This theme is developed fully in Chapter 8.

Asylum forms and certificates during committal

1. The admission forms: casebook format[44]

In the nineteenth and first decade of the twentieth centuries, on admission to an asylum, information about every patient was recorded in large, leather-bound casebooks, and in registers, using a format that had been stipulated in the British Lunacy Act of 1853. The case book format was standard, with minor variations, for asylums in the Cape[45]. Although registers of admission recorded all patients, irrespective of race and gender, in the order in which they were admitted, separate casebooks were kept for men and women, and black and white patients, a documentary replica of segregated accommodation.

The first section of the casebook entry on each Valkenberg patient reiterated information from the Medical Certificates and the Statement accompanying them, adding questions about literacy (possibly used to classify 'better class' patients), height and weight, and injuries on admission. Then the information on the Medical Certificates was summarised. The sections following asked for a brief 'history of case', by which was meant a history of the events called the 'attack'. The next section was called 'condition on admission' or 'state on admission' and referred to bodily health and appearance and behaviour. There was a space for diagnosis to be entered, and then a blank page for case notes. In many instances, a photograph was attached, usually head and shoulders only, but occasionally including the rest of the body, fully clothed, and often sitting.

The casebook format thus summarised all the information gathered about the insane person up to the point of committal in such a way that it was immediately available at a glance for use by the asylum superintendent, important because the various forms and certificates containing this information were filed away. Additional information obtained on and after admission had two purposes: questions about weight and injuries, for example was designed to facilitate care of the body. The section on 'condition on admission' and 'form of insanity', or diagnosis, enacted another stage of the transformation of person to lunatic, by creating the discursive space within which specialised knowledge of insanity was to be deployed. That little information on the patient's life and family circumstances was requested extended the identity-stripping of the committal process, substituting a diagnostic for a social identity.

In this identity-stripping process, the use of photographs had a paradoxical place. They failed to personalise the record, precisely because they were not anchored in personal commentary. They

44. An example of the casebook format is given in Appendix 3.
45. For example, see the casebooks of Grahamstown Asylum and the registers of Robben Island. HGM 13; RI 181. The remaining casebooks and registers of Valkenberg are currently being housed on the premises.

maintained a fiction of institutional responsiveness to patients' uniqueness, and were potentially important for the purpose of making those who escaped identifiable to police and members of the public. However, within the asylum, the photographs functioned as ritual markers of entry into 'insane' status, an official record of parts of a lunatic body, retaining only physical "markers" of gender, race, and 'insane expression' to differentiate one body from another[46]. This was the inevitable result of a discursive context in which depersonalising mental and physical measurements made up the surrounding text[47].

Casebooks presupposed a community containable within them. Very little was noted about each inmate, to make it possible to write entries on each over a period of years, sometimes spread throughout the book. As patient populations grew, and as treatment became increasingly complex, so it became impossible to retain this communal record, and casebooks gave way to separate folders for each patient.

2. The admission forms in individual folders

The admission forms which replaced the Valkenberg casebooks in the period 1914-1915, added detail, and called for the use of a more finely calibrated system of knowledge about insanity. However, the impersonality of the record remained unchanged.

The identifying data, and details of this and previous attacks remained almost identical to the corresponding section in the case book, with the addition of a question about children. Next followed a section entitled 'Physical' which begins with outward physical status (weight, face, scars, glands, for example) and moved on through the cardiovascular, respiratory, alimentary, urogenital, and nervous systems to what was called 'Summary Mental Condition'. The information requested on physical status in the admission forms was a major departure from earlier records. Underlying it was an increase in knowledge about physical conditions causing mental disorder, such as infections, tumours or endocrine disorders, and with a general increase in medical knowledge, a growing awareness of the responsibility of medical superintendents in asylums with respect to the bodies of the insane under their care. The numerous questions under the 'Physical' heading would have acted as a reminder to admitting doctors of both their

46. The phrenology/physiognomy debate was still very much current at the turn of the century. J. Oppenheim, *Shattered Nerves*, p.188. Greenlees submitted a set of photograph of lunatic natives, to support his description of their peculiarities in 1895. 'Insanity among the Natives of South Africa', *JMS*, **41**, (1895), p.482. Jane Bennett pointed out to me the importance to the asylum of maintaining an impression, albeit fictional, of respecting individual difference between patients.
47. For a detailed discussion of the function of photographs of psychiatric patients in case records, see S. Gilman, *Health and Illness*, pp. 45-50.

responsibility for the bodily health of the insane, and also the possibility of the connection between mental and physical disorders.

The 'Physical' section had a further discursive effect. By concentrating attention on the body of the lunatic, in every way better known and more manageable than the insane mind, a space for effective action was created, in marked contrast to the inaction engendered by most mental disorder. For the majority of patients admitted to asylums, custodial care aimed at the prevention of physical deterioration or injury was all that was possible. In this regard, it is telling that the section 'Summary Mental Condition', which asked for a detailed account of the insane symptoms, appeared as a subheading under 'Physical'.

The 'Summary Mental Condition' section listed a variety of 'mental' events or capacities for exploration, including for example cognition, attention, memory, hallucinations and delusions. It is important that a competent and thorough response to all the headings, calling for the detailed observation and classification of symptoms of insanity which characterised Kraepelinian psychiatry, would have required specialised knowledge of insanity, beyond the capabilities of doctors in general practice. Emotional tone, for example, can neither be viewed nor measured, and a judgement as to insight depends entirely on the quality of the information the clinician has had the skill to elicit. Memory and orientation are perhaps possible to assess reliably in conversation, but hallucinations and delusions are notoriously difficult to assess in some patients, and suspiciousness or reluctance to respond may be inaccurately 'read' as evidence of paranoia[48]. This section therefore had the discursive function of defining the boundaries of professional knowledge in the asylum setting. 'Summary Mental Condition' however did not summarise previously-given information, and it is difficult to imagine what body of unrecorded information it might have referred to. The term 'summary' therefore pointed to a potential, never realised, pool of information.

After 'Summary Mental Condition' space was given to record diagnosis on admission, diagnosis after discharge or death, and results of post mortems. The diagnosis drew together under a single classificatory term the findings of the mental condition enquiry, and the post mortem results drew to a close a series of acts directed at the care of the body.

The final page had three headings: the first was 'Medical Certificates' with eighteen ruled lines beneath it; the second was 'Family History' with seven lines of space beneath; and the final was

48. S. Swartz, 'Sources of misunderstanding in interviews with psychiatric patients', *Professional Psychology: Research and Practice*, **23**, (1992), 24-29.

'Previous Personal History' with twenty-five lines beneath. Guidelines specified that the family history concerned 'father, father's side, mother, mother's side, brothers, sisters, children, consanguinity of parents, nervous, mental, physical diseases, peculiarities, habits'. These ambiguous prompts directed attention at the mental illness in the nuclear family. The small amount of space given for responses rules out the possibility that this section was ever intended to be used to gather a general history of the family.

The guidelines for the personal history section were 'legitimacy, birth, infancy, childhood, education, character, temperament, habits, adult life, occupation, marriage, children (legit.), accidents, convictions', a list which is a mixture of general enquiry, and specific search for the aetiology of the insanity. It is significant that space left for the personal history is not much longer than that given for the Medical Certificate summaries, suggesting that doctors' observations about current behaviour was still regarded as of equal importance to enquiry about the past.

The explicit addition of sections on family and personal history to the admission documentation marks a turning-point in attitudes to the insane. For the first time, insanity began to be systematically related to broader and broader contexts. Formerly, family and personal histories had been considered of significance only in cases where inherited insanity was demonstrable, or a major event (such as an illness, accident, childbirth, or loss) could be identified as having immediately preceded the attack of insanity.

However, although the enquiry about the patient's context broadened, at the same time it legitimised some kinds of enquiry and silenced others in a systematic way, directed by the generation of a body of knowledge concerning causes of insanity. It would therefore be a mistake to regard the inclusion of enquiry about family and personal history in the patient folders as halting the process of identity-stripping which is clearly apparent in the casebook entries. By translating the histories of every patient into a series of uniform narratives shaped by assumptions about causes of mental disorder, identity-stripping became more, rather than less, comprehensive. This was caused by the circularity of seeking information about causes of insanity which tallied with psychiatric theory.

As with the Medical Certificate enquiry, information available to asylum doctors about their patients was not uniform across all groups, and this affected both diagnosis and management[49].

49. The effects on diagnosis and management of having little information about black patients is described in detail in Chapters 7 and 8.

3. Periodical Reports

Section 25 of the 1916 Act made provision for reports to be written on patients annually for the first three years, and then in the fifth year, and thereafter every five years. This was the first time that regular reports were required by law, although entries in case books on a regular basis were part of the Rules and Regulations for asylums. It is clear that Dodds monitored such entries, because in instances where case books fell behind, Dodds noted the fact in his Inspector's reports. There were two forms for Periodical Reports, the first to be completed after the first year of committal, and a shorter version to be completed after the second and third years, in the fifth year, and thereafter, every five years, until the patient's discharge or death.

The first Periodical Report, after information identifying the case, the institution, and the section of the Mental Disorders Act under which the patient was detained, requested information on whether the patient was homicidal, suicidal, or dangerous. The following sections asked for a history of the course of the 'case' and symptoms previous to admission, a history of the 'case' since admission, with 'special reference' to the 'conduct' of the patient and 'any acts of violence or of tendency to be dangerous to self or others'. The final sections called for the medical superintendent's ratification of further detention 'for the patient's own good or in the public interest', and also asked whether the present institution was the most suitable available for the treatment of the patient. The forms ended with a section for recommendations from the medical superintendent, and instructions from the Commissioner of Mental Disorders. Subsequent Periodical Reports also asked for ratification of continued detention, as well as diagnosis or amended diagnosis, prognosis or amended prognosis, present bodily condition, present mental condition, and a history of the 'case' during the past year.

The Periodical forms used the term 'case' in those places where relatively lengthy commentary was called for. The term 'patient' was used in those discursive spaces mediating the boundary between the asylum and the outside world. Thus a history of the course of a 'case' describes what the person was inside an asylum. The term 'patient' was used to describe what she or he might do in society, if released.

Periodical Reports were therefore a systematic check on the progress of each case, over periods of years, and they ensured that every 'case' was reviewed at regular intervals. It was 'cases' and not 'patients' being reviewed. By the time that Periodical Reports on a patient were due, the person had been living as a 'case' for at least a year, almost always completely severed from the outside world. The men and women in asylums were therefore describable only as cases, not as persons.

The discursive implications of these reports being required by law lay in the time-span and the spectre of neglect and abuse they invoked. The law was a public discourse making explicit that the insane, once committed, spent so long in asylums that Periodical Reports became a necessity. In a situation in which long-term incarceration was a regular occurrence, and that incarceration was frequently accompanied by the deterioration of the patient's mental - and later bodily - health, the Periodicals also formed a legal safeguard for the custodians, justifying continued detention by positing the patient as homicidal, suicidal, dangerous, or so disordered in conduct as to make continued detention essential.

Because the major purpose of Periodical Reports was to justify further detention, they silenced the possibility of a discourse of ameliorating symptoms, or even of stable, and benign although chronic mental disorder. The Periodicals also guarded against patients being forgotten, or else remembered in an abusive way, particularly through physical assault or seclusion. Thus they were implicated in keeping alive an image of asylum life as potentially punitive, a prison and not a hospital[50].

There were large numbers of patients on whom Periodical Reports had to be provided. This, combined with the restrictions imposed by reporting on 'cases' in order to justify further detention, had the effect of producing a striking lack of variation in the reports' contents, despite the obvious diversity in each asylum's patient population. The implications of this for the production of a colonial psychiatry are taken up in Chapters Six and Seven.

4. Transfer, leave of absence, discharge on probation and discharge of patients

Movements of patients from one asylum to another, or out of asylums, when discharged or on leave of absence, were mediated by certificates, which reiterated the Statement information gathered on admission. A Medical Certificate accompanying applications for transfer commented on the patient's mental and bodily condition. The questions on the Medical Certificate asked for both justification of continued committal (to any asylum), and also assurance that there was 'nothing in the Mental or Bodily Condition of the Patient to contra-indicate removal'. The certificates requested from doctors on the transfer of patients after the 1916 Act added a clause about contagious and infectious disease, a major source of anxiety for those running institutions in which the rapid spread of such diseases, once introduced, was inevitable[51]. Certificates

50. The discourse of cruelty was kept alive in other ways as well. For example, The Rules and Orders for the Management of Institutions issued under the 1916 Act urged attendants to 'treat the patients with uniform kindness and impartiality' stating that 'cruelty towards them is of a peculiarly cowardly nature'.
51. This was a particular concern in South Africa for two reasons. Firstly, there was a history of epidemics, including small pox and the plague. Secondly, the spread of disease was facilitated by the labour needs of the mining industry

discharging patients asked the medical superintendent to stipulate whether the patient was 'recovered', 'improved', 'not improved' or 'not mentally disordered or defective on admission', and also to certify whether or not the patient was capable of managing his/her own affairs. It was possible for unrecovered patients to be discharged, but only if 'delivered into the care' of a specified person, a relative, friend or doctor, who then became legally responsible for the patient's 'proper care'. The leave of absence or discharge on probation procedure was designed to simplify re-admission for patients who had periods of relative well-being, but were likely to relapse and need urgent asylum care.

The certificates monitoring patient movements made visible anxiety about identified lunatics/patients being 'lost' either in the system or to the system, and therefore being untraceable and potentially out of control. Like many of the certification procedures, the patient emerging from them was a dangerous or childlike person from whom society needed protection, or whom society needed to protect, two sides of a single process, the parameters of which often became blurred.

It is important to note that the meaning of having their movements monitored differed for white and black patients. Being legally defined as insane fundamentally altered the rights and freedom of the white insane. Black people were in the eyes of the law minors, regardless of whether they were insane, and their movements during the course of the twentieth century were monitored with increasing strictness. There were parallels therefore between being black and being insane, the discursive implications of which will be developed in Chapters 7 and 8.

5. Mechanical restraint, seclusion and accidents

The discourse of cruelty and neglect evident in the committal procedures, and the rules for attendants and nurses, counterpointed by the discourse of violent or dangerous madness, is also evident in the requirement that every asylum complete returns of mechanical restraint and seclusion[52], and also records of accidents. The necessity for such records is an indication both of continuing difficulties in controlling acutely psychotic patients, and also public and professional sensitivity about such methods. Annual reports repeatedly indicated a public commitment to humane moral treatment and mechanical restraint and seclusion was written into the 1891 and

which drew together groups of people from many different regions. The implications of this are discussed in Chapter 2.

52. Mechanical restraint referred largely to the use of strait jackets, but also to 'stitched trousers', trousers in which the legs were stitched together, to prevent running or climbing, 'canvas combinations', used for a similar purpose, and the strapping of hands or arms to beds, to prevent self-injury and also masturbation. Seclusion referred to the confining of patients alone to locked rooms between the hours of 10.00 a.m. and 5.00 p.m. Patients alone in locked rooms during the night were not regarded as being in seclusion.

1897 Acts as a last resort, and hedged about with precautionary stipulations, including the need in each instance for a medical certificate describing the restraint used and the reason for its use.

It is a measure of the salience of popular fears about lunatics' cruel treatment to asylum superintendents that both the legally-required returns and annual reports in this period tabled instances in which mechanical restraint and seclusion were used. This created the fiction of transparency or accountability for these events. Although mechanical restraint was said to be used for medical or surgical reasons only (for example, if a patient was interfering with surgical stitches, or self-mutilating), there were times when it was used to prevent escape attempts, or masturbation. Seclusion was freely used at night, the euphemistically-named 'private bedrooms' being much in demand for noisy or aggressive patients.

A transforming fiction also operated in the ways in which 'accidents' were described in reports. The idea of 'humane' treatment regimes in asylums, foregrounding compassion as a means through which recovery might be achieved, positioned patients as 'afflicted and suffering'[53]. In order not to disturb this paradigm, the violation of one person by another had to be transformed into what were called 'accidents'. While some of these 'accidents' related to falls associated with epileptic fits, many were assaults of one patient by another, or struggles between patients and attendants, and included instances of attacks resulting in death or serious injury[54].

To disguise assaults as accidents had the effect of removing from public view the day-to-day reality of asylum life, and also of silencing the meaning of violent acts on the part of patients as directed and purposeful expressions of anger, frustration or despair. 'Accidents' are random and purposeless 'mistakes', or the product of confusion caused by insanity. To describe assault by attendants as 'accidents' also disguised their potential for cruelty. The word 'attack' was used to describe the assault of disease on the mind. Such a transformation was necessary to the reproduction of insanity as illness rather than criminality or immorality, and asylums as refuges rather than prisons. Doctors therefore had much to gain from 'humane' treatment as opposed to violent incarceration, in the sense that it achieved for them ownership of a rapidly-growing area of practice.

53. *Rules for the Management of Asylums*, p.9.
54. 'Accidents' detailed in the annual report for 1909 for example, included four instances of fractures caused by falls, one instance of a patient being bitten by another, followed by necrosis of the bone, necessitating amputation of a finger, four instances of fractures caused by fights between patients, three instances of severe self-mutilation, including amputation of a finger, haemorrhage following the severing of the radial artery, and wounds caused by 'hammering on a revolver cartridge', two instances of fractures sustained in unknown circumstances, one possibly being caused by a struggle between patient and nurses, and one instance of a patient dying shortly after a fight with another patient, as a result of injuries sustained.

The fiction of asylums as relatively free from the violence implied in mechanical restraint, seclusion and accidents, was not only for the watchful public but also for those working in the asylums. However, violence in asylums was unavoidable, not only because of the effects of insanity on some patients, but also because stripping persons of their 'outside' identity, and their actions of meaning, brutalised them, making violence - to themselves or others - one of the few means of expression available. Similarly, to nurse people stripped of personal identity was brutalising in the sense that it erased the possibility of interpreting 'insane' acts as intrinsically meaningful. This was particularly the case with the black insane. In this situation the fiction of non-violence and the reality of violence constantly counterpointed each other.

Conclusion: colonialism and institutional violence

Foucault argued that 'no knowledge is formed without a system of communication, of record-keeping and record collection, or without replacing prior knowledge, which is in itself a form of power and is tied in its existence and its functioning to other forms of power'[55]. An analysis of the record-keeping of late nineteenth century and early twentieth-century asylums suggests that knowledge is not always replaced and therefore erased, but incorporated and transformed.

Increasingly complicated record-keeping practices reflected a dialogue between the knowledges of past and present, which enacted transformations in professional activities and identity, and simultaneous transformations in definitions of insanity. Records were forced to become longer as they took account, over long periods of time, not only of contemporary psychiatric practice, but also the past practices embedded within them. This historical embedding revealed itself both as contradiction, and as opposition. Thus the discourse of 'humane care' had embedded within it the contradiction of the insane being subjected to treatment for which they did not volunteer, and over which they had no control which, as Foucault argues, merely substituted one form of coercion for another[56]. At the same time the necessity for a discourse of 'humane care' carried with it the memory of brutality. Discursive continuity with the past kept alive consciousness of past practices and the possibility of their return. It is not surprising therefore to find violence against the insane person a constant feature of the record-keeping of asylums which purported to be humane.

The idea of violence appeared in many ways, all apparent in the categories of lunacy administration. Society was to be protected against violence from the insane; the insane were to be protected against violence from society in general, and asylums in particular; violence, either

55. M. Foucault, 'Resume du cours', College de France, *Annuaire* , (Paris, 1972), p.283, quoted in and translated by B. Cooper, *Michel Foucault: An Introduction to the Study of His Thought*, (New York, 1981), p.79.
56. Foucault, *Madness and Civilisation.*

physical or emotional, between patients was to be avoided through accommodating like with like; and society was to be protected from violence in asylums by translating physical assaults into the language of accidents.

However, another form of violence was unobtrusively committed in the categories of lunacy administration. It was contained in the transformation of person to lunatic to case, and involved the exclusion of the insane from having knowledge of their own insanity, and also of connection and continuity with their past. The exclusion of the insane from this knowledge was effected by the simple expedient of failing to address them directly. Connection with past identities was severed by making the history of the insane attack the only relevant form of knowledge retained in institutional memory.

All the insane were affected by their exclusion from owning knowledge of their insanity. For the black insane an additional barrier to both voice and knowledge was effected in the categories of lunacy administration. In Britain it would have been possible to argue that those involved with committal procedures were aware of far more about the probable life-style and values of most alleged lunatics than was written into the forms. No such awareness could be assumed to exist in the colonies, particularly with respect to black patients. Thus the forms in Britain were in some ways a means of summarising 'common knowledge'; in the colonies they were not a summary, but all the knowledge available.

That certificates were applied to the colonial situation regardless of their 'fit' with the black patients on whom they were used had a number of implications. They reflected a universalist discourse implicated in establishing doctors' credibility within institutions for the insane, by asserting their ability to treat patients of all races. Paradoxically, it was universalism itself which led to racist practice. Failure to match the form to the information which would have been required to make an accurate assessment of the sanity of black subjects, many of whom were unfamiliar with the codes of conduct used to appraise their behaviour, was racist. No discursive space was created within the categories of lunacy management to engage with unique features of insanity in colonial contexts. Instead, the unique history of colonial subjects was replaced by the constriction of a colonising consciousness, which not only silenced black patients' knowledge of their own insanity, but also frequently precluded the possibility of understanding apparently aberrant behaviour by severing it from the family, religious and cultural ties which could have given it meaning. Insanity in black lunatics was as incomprehensible as blackness itself.

The certificates were thus one of numerous colonising acts; they held within them a particular consciousness of insanity, a distillation of knowledge generated in the 'home' country. They channelled power in ways which confirmed colonial authority, by placing the identification of insanity in the hands of the law and medicine.

Chapter Five

RACE AND GENDER IN SOUTH AFRICAN MEDICAL KNOWLEDGE

Introduction: the establishment of professional knowledge about the insane in the Cape, 1891-1920

The period immediately following Dodds' appointment as the first Inspector of Asylums in the Cape saw the rapid growth of a professional discourse about the insane. This discourse was focused on diagnostic and aetiological classifications of insanity. A number of related factors influenced its growth. Dodds' introduction of British Medical Association (BMA) statistical tables into asylum annual reports from 1891 established a professional vocabulary categorising types of insanity and their causes. This specialised vocabulary served as a marker of the difference between asylum doctors' knowledge, and that of general practitioners. It also made explicit the connection between the institutional and discursive practices of Cape asylums and those in Britain.

No longer was the problem of insanity primarily administrative and managerial; it became a matter for academic debate. Regular meetings of the Cape branches of the BMA gave asylum superintendents a public forum in which they were able to address their colleagues on the identification and treatment of the insane. Dodds, Greenlees and Conry published their observations on insanity in *The Journal of Mental Science*, *The South African Medical Record*, and *The South African Medical Journal*, which further established and widely disseminated their professional knowledge, and therefore authority. The professional discourse was also deployed politically. For example, Dodds used professional knowledge in his Inspector of Asylums reports to insist on adequate resourcing of Cape asylums[1].

Institutional development ran hand-in-hand with the growth of professional discourse, and the period 1891-1920 saw the increasing differentiation of insanity from other groups of people such as lepers, the chronic sick, and the mentally handicapped, who also needed long-term institutional care.

Establishment of a professional language of insanity in the Cape was strongly influenced by major shifts in the conceptualisation of knowledge about the insane in Europe, shifts which carried with them a flurry of debate and controversy. The years 1899 to 1909 saw the publication of a number of articles in *The Journal of Mental Science*, the organ of the Medico-Psychological Association, about the issue of classification[2], and later, about Kraepelin's *Lectures on Clinical Psychiatry*,

1. For example, see G.17-'93, p.137.
2. For discussion of the establishment as 'scientific fact' that black South Africans had intellectual ability inferior to that of whites through psychological testing in the 1920's and 1930's, see B. Fleisch, 'Social scientists as policy makers: E. G. Malherbe and the National Bureau for Educational and Social Research, 1929-1943', *Journal of Southern African Studies*, 21, (1995), 349-73; J. Louw, 'Eugenics, Christian-Nationalism and anti-democratic politics in South Africa between the two world wars', paper read at the Psychology and Societal Transformation Conference, University of the Western Cape, (1994), and S. Dubow, *Scientific Racism in Modern South Africa*, (Cambridge, 1995), Chapter 6.

which appeared in English in 1904[3]. Asylum practitioners in the Cape were aware of, and responded to these debates, through the Medico-Psychological Association, articles published in *The Journal of Mental Science*, and distributed to Cape Colony members, and also through changes made to the asylum statistical tables, which necessitated new ways of categorising types of insanity. The results of the debates about classification were reflected in the statistical tables.

The emergence of psychiatry as a discipline in the Cape was marked partly through the use of a specialised vocabulary, taken from British and European psychiatry. It was a universalising discourse, reducing diverse histories and symptoms to small numbers of categories, universally applied. This chapter will argue that muting of diversity in psychiatric description of the Cape insane mirrored the uniformity of description produced by committal and other forms of documentation, as described in Chapter Four. It will explore some consequences of deploying a universalising discourse which silenced social and cultural diversity, but in its insistence upon race and gender as organising principles of classification, asserted and naturalised biological difference. It will argue that a racialized and gendered colonial psychiatry was the inevitable result of failure to address the issue of difference in the appearances and causes of insanity in the Cape insane.

In its combination of biological essentialism on the one hand, and reductive and universalising classificatory categories on the other, psychiatric discourse during the 1891-1920 period allowed Cape doctors to produce descriptions of 'black' insanity. Doctors describing insanity in 'the native' wrote as pioneers, charting unknown territory, with an investment in perceiving their black subjects as anthropologically strange, knowable only in terms of their 'strange' race. The gaze of colonial doctors therefore inscribed the black insane as a group apart, erasing the possibility of perceiving common threads across race and gender divisions[4].

The emergent psychiatry had major implications for patient care. Colonial doctors asserted their knowledge of 'the native' despite unfamiliarity with their languages and social and familial contexts. Erasure of interiority and history for black patients by colonial psychiatry facilitated the development of discriminatory practices within institutions. The chapter will examine ways in which the colonial medical gaze, textualized in the statistical tables, rehearsed the popular perception that the white population came from societies with a history, whereas the native population lived outside history, in child-like, timeless societies. It will conclude with comments

3. E. Kraepelin, *Lectures on Clinical Psychiatry*, (London, 1904).
4. It is significant that the black insane chosen for attention in medical articles were from the 'native' population. 'Coloured' patients were apparently insufficiently different from their white counterparts to warrant such study.

on the sanity/insanity border as a trope for colonial anxiety about both permanence and power as colonisers in Africa[5].

Race and gender in the classification categories

The diagnostic and aetiological categories the Cape inherited from British statistical tables contained a number of gender-specific categories. These included puerperal mania and melancholia, climacteric insanity and lactational insanity as diagnoses, and miscarriage, pregnancy, parturition, lactation, uterine disorders and menopause as causes of insanity. In this way, all women's bodies were marked as fragile and susceptible to insanity at times of physical stress[6]. There was no corresponding marking of diagnoses or causes specific to men or men's bodies. Thus, women were constructed discursively as vulnerable to insanity at those times when their bodies were most visibly different from men's. Moreover, it was women's fertile and procreative bodies which were singled out for attention as sources of stress.

As Oppenheim points out, there was considerable confusion in the way men theorised about women's bodies. Repression of sexuality within a marriage could lead to nervous disorder, but so could sexual expressiveness or 'excess'. Women were regarded as having 'sensitive and highly-strung nerve centres', but they were also thought to be less evolved, refined and capable than men[7]. 'On the one hand, doctors could explain all manner of physical and mental debility by the reproductive burdens that women bore. On the other, when they encountered unmarried or childless women suffering from neurotic illness, medical men could ascribe their condition to the thwarting of biological destiny'[8].

The implications of seeing women as at the mercy of their reproductive organs were far-reaching for those women described as insane. The focus on physical causes led to a practice of indifference about the social, economic, and relational antecedents of the illness, and perpetuated a disregard for common stressors suffered by many women finding themselves in asylums. These pressures included the unacknowledged emotional and physical burden of child-rearing, and the inability to achieve fulfilment in a rewarding career outside of the home.

5. Aspects of the analysis which follows has appeared in S. Swartz, 'Colonising the insane: Causes of insanity in the Cape, 1891-1920', *History of the Human Sciences*, **8**, 39-57.
6. As Oppenheim points out, in the view of nineteenth century medicine, 'at puberty and menopause, during pregnancy, childbirth, and lactation, not to mention her monthly uterine upheavals, a woman was at great risk, for all these biological events demanded heavy payments of nerve force. Any additional exertion at these periods, so the medical theory argued, had to draw on other bodily reserves and could thus bankrupt her nervous resources altogether, consigning her to invalidism'. *Shattered Nerves*, p.188.
7. Crichton-Browne, quoted in Oppenheim, *ibid.*, p.193.
8. Oppenheim, *ibid.*, p.232.

In the colonial context, fear of insane women's unruly, reproducing, bleeding or lactating bodies was closely associated with anxiety about racial borders and racial purity. Insane white women were regarded as likely to produce insane or feebleminded children, endangering the health of the total white population. They were also perceived as having insufficient moral strength to avoid sexual contact across racial borders. Insanity in black women appears not to have been marked as dangerous in the same way. It was black women's sexuality rather than their insanity which was constructed discursively as the source of their danger to white men. The construction of black women as hypersexual and seductive to white men made it possible for colonial psychiatry to erase evidence of the many forms of sexual violence to which colonial life subjected them[9]. This violence included prostitution, assault and rape, concubinage and the widespread practice of white masters demanding sex from women working for them as domestic servants. Considerable evidence of white men abusing their power to coerce black women into having sex with them was put before the 1912 *Commission into Assaults on Women*. The Commission conceded such abuse was widespread, and commented that miscegenation 'both as regards marriage and illicit intercourse' caused 'grave political and social problems, and results at times, in immorality of a most flagrant and revolting nature'. It recommended that legislation forbidding intercourse between white men and black women be passed[10].

The erasure of black women from colonial psychiatric knowledge was also marked by their absence in academic writing. It is striking that neither Greenlees nor Conry made reference to black women in their articles on the black insane of the colony[11].

Colonial asylum doctors all assumed anatomical, physiological and mental differences between blacks and whites[12]. Both Conry and Greenlees felt the insanity found amongst the black inmates of Grahamstown and Fort Beaufort asylums to be distinct enough from that of the white insane to warrant separate description[13]. Despite these assumptions of difference, the bodies of black colonial subjects were not inscribed in the statistical tables as different from those of their colonisers through the creation of race-specific categories. Rather, difference was marked by absence, and this took two forms.

Firstly, as discussed in Chapter Four, all official documentation relating to management of insanity in the Colony, failed to address in any detail race or ethnic difference. This applied to

9. For discussion of the discursive construction of black women as hypersexual, see Gilman, *Difference and Pathology*, pp.76-127.
10. *Report of the Commission appointed to enquire into Assaults on Women*, 1913, U.G. 39-'13, pp.7-9.
11. See J. Conry, 'Insanity among Natives in Cape Colony', *South African Medical Record*, 5, (1907), 33-36, and Greenlees, 'Insanity among the Natives'.
12. Discussion of the relationship assumed to exist between blackness and madness in the late nineteenth and early twentieth-century, can be found in Gilman, *Difference and Pathology*, pp.131-142, and Grob, *Mental Institutions in America*, pp.225-47.
13. See Conry, 'Insanity among Natives', Greenlees, 'Insanity among the Natives'.

psychiatric classification as well. The failure to adapt British nosological systems to the unique social and historical contexts of colonial subjects insisted on a universalising gaze, which denied the possibility of multicultural meanings for insanity.

The second absence took the form of categories deleted from statistical tables because they were under-used or regarded as irrelevant to the black patient population. For example, the Fort Beaufort statistical tables used fewer aetiological categories than other Cape asylums. For example, the 1906 aetiological tables for Valkenberg listed 22 possible causes of insanity. In the same year, Fort Beaufort Asylum listed a mere 8, and those were a simplified and reductive version of the tables used in other asylums (See **Tables 5** and **6**). Thus the tables inscribed the black insane as less complex and less variable than the white insane. The combination of psychiatric universalism and simplification of classificatory systems was simultaneously an assertion of neutrality in the liberal-humanist tradition of Cape medicine and an act of negation.

The tables included in asylum annual reports during the period 1891-1920 provide statistical information on Valkenberg doctors' classificatory choices across diverse groups of patients[14]. The following section will describe general trends, and also patterns of diagnosis and aetiological classification in male and female, black and white patients.

Colonial psychiatry by numbers: race and gender patterns in the diagnosis statistics

Annual reports of Cape Colony asylums during the period 1891-1909 tabled statistical information about diagnoses assigned to new admissions. The reports for 1918 and 1919, but not the 1920 report, give lists of diagnoses for individual asylums[15]. The 1919 and 1920 reports give figures for different racial categories. None of the post-Union reports distinguish between male and female patients. This section will describe statistical trends in diagnosis using available information from both annual reports and case records.

During the period 1891 to 1909, admissions to Valkenberg, and to other Cape asylums, showed a consistent pattern of diagnosis. Acute or recent mania, and acute or recent melancholia were the most frequent diagnoses, followed by general paralysis of the insane (Table **2**)[16]. Acute

14. There are anomalies in the consistency with which diagnoses and causes were tabled in the annual reports. For example, in the years 1907 and 1908, diagnostic information on individual asylums was combined into a single table, and no causes of insanity were given for Fort Beaufort patients for 1894 and 1895. The tables also underwent change during the years 1891-1909. These are reflected in Tables 2 and 5.
15. The statistical tables for 1920 do not list separately information on diagnosis for each asylum in South Africa. The diagnostic patterns for Cape asylums are therefore available for the period 1916-8/1919 only. U.G.31-'20, p.45; U.G.31-'21, p.19.
16. The symptoms covered by the mania diagnosis included a wide range of behavioural, emotional or cognitive disturbances such as running naked, restlessness, excitability, withdrawal, incoherence, delusions and hallucinations. This pattern conforms broadly to that identified by Turner for Ticehurst House Asylum for the period 1880-1889, in 'A diagnostic analysis of the casebooks of Ticehurst House Asylum'. Melancholia at this time referred to irrationality, psychomotor retardation or agitation, obsessions, hypochondriacal complaints, delusions and suicidal behaviour. Sorrow or sadness frequently occurred in melancholic states, but were not a primary

melancholia and mania also accounted for the bulk of those recorded in the annual reports as recovering. White women were more likely to attract an initial diagnosis of melancholia, possibly a less stigmatised condition than mania. In the Valkenberg series, white women were also more likely to retain a diagnosis of mania, melancholia or manic-depression than their male counterparts, many of whom were re-diagnosed as having dementia praecox, once that diagnosis was in regular use. This may reflect the perception that women were emotionally more expressive and labile than men[17]. It is also consistent with the tendency of case records in the Valkenberg series to foreground affective disturbance in both white and black female patients.

White male patients attracted a greater variety of diagnoses than white women, and more often suffered from general paralysis of the insane (GPI) and insanity arising from alcohol abuse. The range of diagnoses given to men is possibly a reflection of lifestyle variety unavailable to women in terms of work, travel, and recreational and sexual activity, all of which may under particular circumstances have led to an insane attack[18].

Black patients were recorded as suffering from 'simpler forms of mania', and were rarely diagnosed as being melancholic[19]. On Robben Island, for the period 1872-1888, Deacon found a differential diagnostic pattern for black and white patients. Of 212 European patients, 20 were diagnosed as having melancholia. Of 114 black patients, not one was diagnosed as having melancholia[20]. A similar pattern was found for black admissions to Fort Beaufort and to Grahamstown asylums. Of black admissions to Grahamstown Asylum between 1875 and 1894 Greenlees gave a figure of 67% with a diagnosis of mania (321 out of 473 cases). By contrast, there were 21 cases of melancholia, a little over 4%. Conry gave a figure of 3.8% of patients diagnosed as melancholic in Fort Beaufort and 62% diagnosed as having mania. Whites were assumed to be more susceptible to melancholia than blacks, because of their superior intellectual development[21]. Both Greenlees and Conry concurred that GPI was rare amongst black patients, Greenlees at the time attributing this to 'a life in the open air, in a perfect climate, with plenty of simple and natural food'[22]. Alcohol-related diagnoses in black patients were also uncommon[23].

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component of the diagnosis. For a conceptual history of melancholia, see G. Berrios, 'The psychopathology of affectivity'.

17. In the Valkenberg series, melancholia was given as an initial diagnosis in 13 out of 110 white male patients, all admitted between 1891 and 1913, and most of these were later diagnosed as dementia praecox patients. This is in contrast to the pattern of white female melancholics, two-thirds of whom were later diagnosed manic-depressive. In 1892, 1902, 1903, and 1904 more melancholic than manic patients were admitted. The last three dates suggest that the Boer War may have had an impact on admissions, with casualties, loss of property and general uncertainty predisposing people to depression.
18. For example, men were more likely than women to have syphilis, following sexual contact with more than one woman, to abuse alcohol, to be exposed to work hazards such as lead poisoning, or injury from industrial accidents.
19. Greenlees, 'Insanity among the Natives', p.72.
20. Deacon, 'A history', p.186.
21. Greenlees had gone to some lengths to prove the inferiority of 'Native' intellectual development, arguing in 1902, from anatomical studies he had undertaken, that 'the brain, taken as a whole, is heavier among European insane than among native insane by an average of about 2 oz. Further, the brain of the European female exceeds that of the native female by over 4 oz'. 'A statistical contribution to the pathology of insanity', *JMS*, **48**, (1902), p.651.
22. 'Insanity among the Natives', p.72.

Diagnoses of patients admitted to Valkenberg, 1891-1909 [1]

DIAGNOSIS	MEN n = 1028	WOMEN n = 622
Congenital mental deficiency		
with epilepsy	1.1	1.1
without epilepsy	1.2	4.0
Epilepsy acquired [2]	2.9	4.2
General paralysis of the insane	8.5	1.1
Mania:		
acute [3]	39.0	32.3
chronic	4.4	7.6
recurrent	2.0	3.1
a potu	5.0	1.6
puerperal	0	3.2
senile	1.4	1.5
Melancholia:		
acute [4]	21.3	23.2
chronic	2.3	3.2
a potu [5]	0.2	0
recurrent	0.4	1.3
puerperal	0	1.5
senile	1.8	2.6
Dementia:		
primary	0	0
secondary	3.2	5.1
senile	2.4	1.1
organic	1.9	1.0
Insanity with gross brain lesion [6]	0.2	0.2
Confusional insanity [6]	0.2	0.3
Stupor [6]	0	0.2
Alternating insanity [6]	0	0.2
Delusional insanity: [6]		
systematised	0.1	0
non-systemised	0.7	0.6
Volitional insanity		
impulse	0.1	0
obsession	0	0
doubt	0	0

1. These figures exclude the years 1907 and 1908, when the annual reports gave combined figures for all Cape Colony asylums. 2. Category same as 'insanity with epilepsy', 1906 onwards. 3. Category added 1897. 4. Added 1896. 5. Added 1903. 6. Added from 1906.

Table 2

Patients remaining in Valkenberg for long periods were often said to have chronic mania or melancholia. Secondary dementia, following acute or chronic mania or melancholia, was a category with accumulating numbers, reflecting the clinical assumption that dementia was an inevitable consequence of mania[24]. Epilepsy and mental deficiency were frequent diagnoses in long-stay patients.

23. Conry, 'Insanity among Natives', p.35.
24. The category 'dementia' at this time included senile dementia, and dementia secondary to attacks of insanity, alcohol abuse, epilepsy, or injury to the brain. For a history of the term see G. Berrios and H. Freeman, 'Dementia before the twentieth century', in G. Berrios and H. Freeman, *Alzheimer and the Dementias*. pp.9-27.

The terms 'hebephrenia', 'katatonia' and 'delusional insanity' were used briefly during the period 1909-1918 to describe psychotic states which later fell into the 'dementia praecox' category, the diagnosis into which by 1918, 22.4% of patients fell[25].

After 1909, dementia praecox and manic depression were the most frequently used diagnoses in Valkenberg, accounting for almost half (44.6%) of the total admissions between 1916 and 1919 (Table 3). Involutional psychoses, epileptic psychoses, intoxication psychoses and defective mental development accounted for 34.8% of assigned diagnoses. The remaining nine diagnostic categories accounted for 20.6% of the admissions only. These patterns conform broadly to those in all the Cape asylums (Table 4)[26].

Diagnosis of patients admitted to Valkenberg, 1918-1919

DIAGNOSES	TOTAL ADMISSIONS n = 504
Infection psychoses	4.2
Exhaustion psychoses	2.4
Intoxication psychoses	7.9
Thyroigenous psychoses	0.2
Dementia praecox	24.2
Dementia paralytica	4.8
Organic dementias	2.4
Involutional psychoses	8.3
Manic-depressive psychoses	20.4
Paranoia	3.0
Epileptic psychoses	8.5
Psychogenic neurosis	0.4
Constitutional psychopathic state	0.6
Psychopathic personalities	0
Defective mental development	10.1
Not classified	0.8
Not mentally disturbed	1.8

Table 3

There is little diagnostic information in the annual reports on admissions of black patients to Valkenberg. However, of the 28 black patients recorded in the 1919 table as indirect admissions to Valkenberg via other asylums, 61% were diagnosed as having dementia praecox, and 46% as having defective mental development. The most frequently used diagnostic category for black admissions to other asylums after Union was dementia praecox, followed by manic-depression, involutional psychosis, epilepsy, and defective mental development[27]. The relatively high numbers of black admissions diagnosed as manic-depressive is unlikely to reflect a shift in the popular

25. Between 1914 and 1918, the terms 'hebephrenia', 'katatonia' and 'delusional insanity' were used to describe psychotic states which later fell into the 'dementia praecox' category. Before 1914, when the Register stops recording diagnoses, the dementia praecox diagnosis had been used only 14 times. There is evidence, from remaining case records, that apart from age of onset, intellectual confusion or deterioration were used by Dr Dodds as criteria when he gave this diagnosis. For example, Ralph H was diagnosed as having dementia praecox on his admission to Valkenberg in 1911, at the age of 26. He was described as having got 'gradually more confused'.
26. See Table 3.
27. See Table 4.

belief that black patients seldom suffered from depression. These figures probably reflect black patients regarded as 'manic' rather than 'depressed'.

Diagnosis of 'White', 'Coloured', 'Native' and 'Asian' Direct Admissions to Cape Asylums, 1916-1919

DIAGNOSIS	WH n = 573	COL n = 252	NAT n = 257	ASI n = 5
Infection psychoses	3.8	3.1	0.8	0
Exhaustion psychoses	2.3	1.2	1.2	0
Intoxication psychoses	8.2	0	0.4	0
Thyroigenous psychoses	0.2	0	0	0
Dementia praecox	22.2	48.6	23.4	0
Dementia paralytica	4.9	0.4	6.7	0
Organic dementias	2.3	0	3.6	0
Involutional psychoses	10.3	4.7	10.3	0
Manic-depressive psychoses	21.5	20.2	27.4	60
Paranoia	2.3	0	0.4	0
Epileptic psychoses	8.6	9.3	9.1	0
Psychogenic neurosis	0.5	0	0.4	0
Constitutional psychopathic state	0.4	0	0	0
Psychopathic personalities	0	0	0	0
Defective mental development	10.5	8.6	14.7	20
Not classified	1.6	3.5	0	20
Not mentally disturbed	1.6	3.5	0	0

Table 4

Race and gender patterns in causes of insanity

The annual report statistical tables give information on causes of insanity up to 1909 only. For the period 1891-1909, there were consistent patterns across Cape asylums in doctors' perceptions of the causes of insanity[28].

Dodds and Greenlees both identified heredity as a prominent cause[29]. It was the leading cause of insanity amongst male and female white patients admitted to Valkenberg up to 1909 (Table 5). Intemperance was second to heredity as a cause of insanity in white patients, and together these formed two major and often intertwined paths to degeneration. Cited as the cause of a wide range of forms of insanity, intemperance was thought to damage the nervous system; this damage was then passed on to the next generation as an inherited trait. Greenlees commented that 'it is a well known fact that ... the drunken father is the most frequent cause of imbecility in his progeny'[30].

28. Literature appearing in *JMS* maps some of the debates which shaped changes to the tables. Examples are S. Strahan, 'The propagation of insanity and allied neuroses', *JMS*, **36**, (1890), 325-47; G. Savage, 'The influence of surroundings on the production of insanity', *JMS*, **37**, (1891), 529-35; W. Lloyd Andriezen, 'On the bases and possibilities of a scientific psychology and classification in mental disease', *JMS*, **45**, (1899), 257-90; C. Mercier, 'The statistical tables', *JMS*, **50**, (1904), 672-79; A. Urquhart, 'The Morison lectures. - On insanity, with special reference to heredity and prognosis', *JMS*, **53**, (1907), 233-321; and S. Coupland, 'The causes of insanity, with especial reference to the correlation of assigned factors: A study of the returns for 1907', *JMS*, **56**, (1910), 1-24. Heredity was identified as a major cause of insanity by all these writers.
29. His discussion of heredity as a cause of mental illness can be found in G.17-'93,p.3, and G.24-'94, p.35.
30. For example, Greenlees, 'Insanity among the Natives', p.220, gave the figures of 22.8 per cent for males and 4.08 per cent for females in England in 1903. Coupland's statistics for alcoholism as a cause of insanity in England in

Aetiology, Valkenberg, 1891-1909: % as proportion of total assigned aetiologies (A) and % as proportion of total admissions (B)

CATEGORY	MALE (A)	MALE (B)	FEMALE (A)	FEMALE (B)
	n = 1260		n = 840	
MORAL				
Domestic trouble	1.0	1.3	6.6	9.3
Adverse circumstances	7.2	9.7	1.4	2.0
Mental anxiety [1]	4.0	5.3	3.6	5.1
Religious excitement	0.8	1.1	1.3	1.9
Love affairs	1.0	1.4	1.1	1.5
Fright & shock	0.6	0.8	2.3	3.2
PHYSICAL				
Intemperance:				
drink	16.2	21.8	4.0	5.6
sexual	0.1	0.1	0	0
Venereal disease [2]	2.8	3.7	0.4	0.5
Self-abuse	0.6	0.8	0	0
Over-exertion	0.3	0.4	0.1	0.2
Sunstroke	1.3	1.7	0.2	0.3
Accident / injury	2.1	2.8	0.4	0.5
Miscarriage [3]	0	0	0.2	0.3
Pregnancy	0	0	0.7	1.1
Parturition	0	0	4.9	6.9
Lactation	0	0	1.6	2.2
Uterine disorders	0	0	0.4	0.5
Change of life	0	0	1.9	2.7
Puberty & adolescence [4]	3.5	4.7	2.9	4.1
Apoplexy [5]	0.1	0.1	0	0
Eccentricity [6]	0.1	0.1	0	0
Sight deprivation [7]	0.2	0.2	0	0
Fevers	1.1	1.5	0.7	1.0
Excessive heat [8]	0.2	0.2	0	0
Epilepsy [9]	2.1	2.8	2.0	2.9
Privation	0	0	0	0
Old age [10]	4.3	5.8	4.5	6.4
Drug abuse [11]	0.2	0.3	0.4	0.5
Cerebral abcess [12]	0.1	0.1	0	0
Cerebella tumour [13]	0.1	0.1	0	0
Other diseases [14]	7.9	10.7	8.6	12.2
Previous attacks	18.0	24.3	21.8	31.0
Hereditary influence	10.9	14.6	16.3	23.2
Congenital defect	1.5	2.0	3.3	4.7
Other	0	0	0	0
Unknown	12.0	16.1	8.7	12.4

Table 5

1. In 1909 this category became mental stress, sudden/prolonged. 2. The 1909 category, 'acquired syphilis' included here. 3. Added 1899. 4. This includes puberty and adolescence, collapsed in some tables and not others. 5. Added 1908. 6. Added 1909. 7. Added 1909. 8. Added 1898. 9. Added 1898. 10. Added 1902. 11. Added 1902. 12. Added 1904. 13. Added 1904. 14. Includes renal failure, cardio-vascular degeneration, heart disease, anaemia.

'Previous attacks' of insanity, causing deterioration in the nervous system, were frequently cited as a cause of current attacks. In Valkenberg women consistently outnumbered men in the

the returns for 1907 gives the figures of 15.8 per cent for males and 6.3 per cent for females. Only heredity was more frequently found to be a cause. S. Coupland, 'The causes of insanity'.

'previous attacks' category during the period 1891-1909. At this time, women were considered to have nervous systems more susceptible to damage than men[31].

It was only in the year 1909 that the 'previous attacks' category was applied to the black patients of Fort Beaufort. Before that time, it was not used, perhaps as a reflection of an institutional will to forget, or at least to render invisible, the history of black patients' illness, which made the category irrelevant.

Under a quarter of Valkenberg patients were thought to have become insane following stressful life events, such as 'adverse circumstances' or 'domestic trouble'. These 'moral' causes were distinguished from the physical, such as heredity, addictions, fevers, accidents, pregnancy, parturition, sunstroke and masturbation. 'Adverse circumstances', which included events such as financial loss, or stress related to active service, were regularly identified as a precipitant of insanity in white men. 'Domestic trouble', a category which would have included marital conflict and widowhood, was the most frequently cited 'moral' cause of insanity in Valkenberg's female admissions. This conforms to the pattern of admissions to Grahamstown. In the black patient population of Fort Beaufort the 'moral' cause categories were so little used that after 1898, they were dropped altogether from the tables (Table 6). The tendency was to find physical, rather than environmental causes to explain insanity in black admissions.

Causes of insanity: Fort Beaufort Asylum 1906

CAUSE OF INSANITY
Injury to head
Hereditary
Ill-health
Attack of convulsions
Child-birth
Religion
Domestic trouble
Unknown

Table 6

In Valkenberg during the period 1891-1909, 16.1% of white male patients and 12.4% of female patients had no identified cause of insanity. In Fort Beaufort in the years 1896-1909, 78.8% of causes listed for male admissions and 84.1% of female admissions had an 'unknown'cause of insanity. Writing off aetiologies as 'unknown' applied equally to the 'Native' and 'Coloured' insane (Table 7). The implications of these statistics are explored in detail below.

31. Oppenheim, *Shattered Nerves*, p.283.

Percentage frequency with which admissions to Fort Beaufort Asylum had an 'unknown' cause for their insanity

YEAR	MALES	FEMALES
	n = 557	n = 408
1894/5[1]		
1896[2]	86	
1897	46.2	53.5
1898	87.5	77.8
1899	86.4	91.7
1900	91.7	66.7
1901	100	73.7
1902	94.7	80
1903	100	66.7
1904	84.9	83.9
1905	71.1	81.4
1906	88.6	85
1907	78.4	78.4
1908	87.5	71.9
1909	59	58.3

Table 7

1. No table of causes was given in the annual reports for 1894 and 1895.
2. There were no female admissions until 1897.

No systematic attempt was made in either the asylum annual reports or in journal articles written by Cape asylum superintendents to relate diagnoses to particular causes of insanity. It was assumed that insane, neurotic or intemperate behaviour in a parent would be passed on to subsequent generations in the form of non-specific nervous degeneration, which could manifest in any number of mental disorders. By the same token, it was assumed that a particular form of mental disorder might have been caused by a wide variety of physical or mental stresses.

Case records in the Valkenberg series confirm the tenuous and non-specific links between diagnoses and causes of insanity. For example, of 29 white men with an initial diagnosis of mania, 6 were said to have inherited the disorder; 5 had 'previous attacks' given as the cause; 3 were said to have become insane as a result of stresses such as worry or overwork; 7 had physical illness or trauma as a cause of the mania; 2 had intemperance given as the cause; and 6 had cause 'unknown'. Similarly, of 21 white men with dementia praecox, 5 were said to have inherited the disorder; 5 were listed as having succumbed to it through stresses; 2 were thought to have become insane as a result of physical illness; and 9 had the cause listed as 'unknown'. A range of causes was also given for diagnoses of melancholia. Epilepsy, senile dementia, GPI, imbecility or feeblemindedness and alcoholic insanity were the only diagnoses for which more consistent patterns of causes were given (Table 8).

Causes of insanity listed for white men in the Valkenberg series with initial diagnoses of 'Mania' and 'Dementia Praecox'

CAUSE	MANIA	DEMENTIA PRAECOX
Heredity	6	5
Previous attacks	5	0
Mental stress / worry	3	5
Physical illness / trauma	7	2
Intemperance	2	0
Unknown	6	9
TOTAL	29	21

Table 8

Professional knowledge and asylum practice

The statistical tables performed discursively the translation of the ambiguous and fluid phenomena of insanity into categories, and then into numbers. Diagnostic classification allowed prediction of outcome, and to some degree guided treatment in the asylum. However, for the largest diagnostic group, the functional psychoses, classification was tenuously linked to both treatment and outcome. For example, there were no treatments specific to dementia praecox or manic-depression, and long-term outcome tended to be uniformly poor across both groups.

Classification had another function apart from guiding patient management. They were a display of knowledge, in which numbers had a central role to play. By erasing ambiguity, they enacted the ability of asylum doctors to identify and count the insane, and also to trace insanity's origin. Classification was the therefore the discursive tool used to construct insanity as knowable, a means through which to control anxiety about a perceived increase in degenerative, savage and poorly understood disease.

The extent to which the apparent clarity provided by classificatory tables was illusory is demonstrated in the Valkenberg series. There was an inexact and even haphazard relationship between categories and the behaviour or events to which they were attached. Over half of the patients were given two or more substantively different diagnoses during the course of their stay in hospital. These changes cannot be accounted for simply as changes in nomenclature. The case notes do not record reasons for using one diagnosis instead of another, resulting in a striking impression of random labelling and re-labelling, irrespective of symptoms. The case records produce narratives of diagnostic uncertainty, contradiction and change at odds with the representation of diagnosis as a privileged truth-telling activity[32].

32. For an analysis of diagnostic changes in the Valkenberg series, see S. Swartz, 'Changing diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: a longitudinal view', *History of Psychiatry*, vi, 1995, 431-451.

Some case records suggest that on occasion, doctors making the diagnoses were not using the same, or even similar criteria, leading to a situation of diagnostic confusion. An example is the case of Maria B, which illustrates not only the struggle to differentiate between functional psychoses, but also the confusion about their prognosis. She was first hospitalised in 1901, in Pretoria, at the age of 30 years. She was discharged 'recovered', in 1910. Her diagnosis at the end of that admission was 'manic depressive insanity on congenital mental deficit'. She was admitted to Valkenberg in 1918. In the Periodical Report of May 1920 Maria was given two diagnoses: manic-depressive psychosis, and terminal dementia. In November 1920, her diagnosis was changed to one of dementia praecox. In 1921, she was said to have secondary dementia following manic-depressive psychosis. In 1923, she was re-diagnosed dementia praecox (paranoid). In 1928, she was once again called manic-depressive, in 1933, dementia praecox (paranoid), and in 1938, manic-depressive. This remained her diagnosis until her death in 1946. At the times when she was being seen as manic-depressive, she was described in reports as 'mildly excited' or 'mildly depressed' in phases. When she was being seen as having dementia praecox, reports foreground hallucinations and delusions, dullness, disorientation and confusion. Twelve different doctors were involved with the writing of Maria's Periodical Reports over a period of eighteen years.

It is important therefore to make a distinction between the textualisation of a psychiatric epistemology in classificatory tables, and ways in which that knowledge was used by doctors recording numbers against them. The reduction of information about people's lives, and symptoms of insanity, into the numbers which appear in the statistical tables was part of a process in which authorship of classification was deleted. The act of one observing clinician making a particular categorisation choice was erased by the statistical tables. It was replaced by a universal clinical gaze, which like the 'perfect disciplinary apparatus', made it possible for a single gaze 'to see everything constantly and to recognise immediately', creating narratives of scientific certainty at odds with the confusions and ambiguity endemic to asylum practice[33]. Deletion of authorship presupposed that all doctors would arrive at the same classification of the psychiatric phenomena they observed. Thus the universalising clinical gaze constructed psychiatric knowledge about mental disease as unvarying regardless of the subjectivity of either the patient or the observing doctor.

Classification is essentially metaphoric in the sense that it compares a single instance to an ideal form, foregrounds similarity and erases difference. However, the metaphoric status of psychiatric classification was disguised within the assumption of a transparent relationship between the activity of naming and the phenomena named, between language and 'reality', observation and 'fact'. The assumption of facticity and the erasure of the intersubjective had important

33. Foucault, *Discipline and Punish: The Birth of the Prison*, tr. A. Sheridan, (London, 1977), p.200.

implications for the construction of doctors' identities. Clinical activity in relation to a rapidly-growing asylum population, made up of patients many of whom were destined for a life-time of institutional care, was little more than observing and naming. Apart from the supervision of custodial care, the identity of asylum doctors during this period was therefore increasingly bound up in classification. It was a clinical gaze taking this form which made possible the elision between diagnosis and identity. For doctors, patients became their diagnosis, as in 'a dirty, dementing dementia praecox', a label which dialectically reproduced 'a doctor'.

Doctors' denial of the intersubjective affected their interpretation of conversations with patients. These interpretations provide a commentary not only on patients' perceptions of their situation, but also on doctors' failure to recognise patients' insight. Doctors 'observed' and recorded the insanity they 'knew' to be there, creating texts which represented patients' gaze and commentary on their surroundings as confirmation of disorder.

When patients described themselves as insane, identifying themselves with the doctors' gaze, they were said to have 'insight'. For example, Margaretha Le R said Valkenberg was 'a place for people that are "bad in the brain". She said she was '"bad in the brain" too. Daniel R went one step further: he confirmed the institutional explanation of the cause of his illness, 'admitting' he was disordered on committal, and that it was due to dagga smoking. The verb 'admit' positioned him as accepting what others would deny, in much the same way as wrong-doing is denied. Patients were frequently said to 'deny' hallucinations or delusions, their denial a refusal of the colonising medical gaze, and an attempt to protect an unspoken and deliberately hidden interior world.

Lack of self scrutiny from doctors' colonising consciousness allowed them to write uncensored and contradictory texts. For example, Marie B was said not to 'appreciate the nature of her surroundings although she thinks this is an asylum' (Oct 1938). This asserted Marie's continuing insanity while inadvertently providing evidence of the accuracy of her insight. Joseph B said Valkenberg was a farm and a place of recreation. The note continued: 'He is very dull, demented and stupid - has difficulty in understanding simple statements addressed to him. His replies are mostly irrelevant' (1921). This was despite the fact that both farming and a wide variety of recreational activities were a routine part of white male patients' daily life in the institution. Ralph H was said to answer questions 'readily but faultily', and to 'look silly and vague'. He knew he was in Valkenberg but the doctor recorded that he was 'unable to say why he was sent here'. Despite this, the note goes on: 'The object of an asylum he says is "to keep people from tragedy. People might murder us or we might get lost."' This simple statement of the asylum's function is recorded as 'faulty' although it is barely different from that implied in the lunacy legislation,

which prescribed 'proper care, treatment, or control' and freedom from 'cruel treatment and neglect' for the insane.

Social Darwinism in the Colony: the dangers of 'going native'

Erasure of causes of insanity in a context which repeatedly marked race as salient constructed the insanity of individual black men and women as impenetrable and therefore beyond the possibility of being known except as 'black' and therefore racially separate. However, despite their lack of knowledge about individual black patients under their care, asylum doctors held strong views about the nature of insanity in black people as a group. These views assumed, and built on, the assumption of biological difference between black and white bodies.

In order to explain why greater numbers of whites than blacks became insane, and the different forms taken by their insanity, both Greenlees and Conry drew on the Social Darwinist notion of an evolutionary scale[34]. Whites were further up the scale than blacks. 'Primitive' races were seen as having less sophisticated nervous systems than Caucasians, a theory 'proved' with recourse to anatomical studies, such as measurement of skull capacity and weight of brain tissue[35]. As Greenlees remarked, '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'[36]. Movement up the scale involved an increase in the complexity and sensitivity of the nervous system. Civilisation was seen as a product of highly developed nervous systems, which were also seen as more vulnerable to stress than nervous systems less highly developed[37]. Thus whites were more likely than blacks to succumb to insanity under stress, and melancholy was the prototypical illness of the sensitive nervous system. Prolonged stress, or repeated attacks of insanity in one individual, or insanity passed form one generation to the next through 'unwise marriages' led to 'degeneration' of the nervous system which could take any number of diverse forms, including mental enfeeblement, moral imbecility or frank insanity[38].

In a colonial society, where 'degeneration' contained within it the possibility of being uncivilised, no better than the subjugated race, prevention of the spread of insanity was an urgent matter, intimately related to the identity of the colonisers as rulers. It was linked with the stigmatised

34. Oppenheim describes the fear amongst late Victorian scientists of 'the terrible possibility of backsliding down the scale of animal life'. *Shattered Nerves*, p.282.
35. For a detailed exploration of the roots of scientific racism in modern South Africa, see Dubow's meticulous analysis of a number of disciplines, including anthropology, anatomy, medicine, psychology and education in *Scientific Racism*.
36. Greenlees, 'Insanity among the Natives', p.75.
37. Oppenheim, *Shattered Nerves*, p.283.
38. For example, in Dodds' 1893 annual report, he used the year's statistics on causes of insanity to argue that 'every senior boy and girl' be alerted to the danger of propagating inherited insanity through ignorance of the manner of its transmission from one generation to another. G.24-'94, p.35.

possibility of 'going native', or losing close connection with the white community, and therefore one's identity as white[39].

Evolutionary theory, capturing and then proliferating the idea of higher and lower life forms, primitive and civilised races, was strongly implicated in the political, economic and social policies of the Cape Colony, because it provided a perfect rationalisation for the assertion that whites were superior to blacks, and would only remain so if the living habits of whites were strictly policed in order to prevent back-sliding[40]. This included asserting the necessity for segregation, control of blacks by whites, and incarceration for those whose degeneration threatened order in society. White women's sexual behaviour in relation to black men became a particular focus for control. Thus degeneracy theory, and the evolutionary ideology it carried explained the cause and perceived spread of mental illness, justified domination of one group by another, and also identified protection of white women as a primary reason for maintaining strict racial segregation.

White insanity, degeneration and the burden of colonial life

The period 1891-1920 saw a shift in the focus of colonial psychiatry from description of insanity in the indigenous population, and concern about the provision of adequate care for the white insane, to anxiety about the growing numbers of whites identified as feebleminded. Feeblemindedness was linked both to poverty, and to inherited degeneration[41].

Both Dodds, Greenlees and later Dunston wrote at some length about the threat of inherited insanity to the white population[42]. Their anxiety was borne out by the asylum statistics, which consistently represented many more whites than blacks as having inherited their predisposition to insanity. This had a complex relationship to concern about the position of whites in colonial society. Greenlees believed that 'inbreeding', regarded as inevitable in a society which had both isolated farm communities and - inland at least - fewer women than men, contributed to an hereditary tendency to insanity[43]. He further identified intemperance, acknowledged to be a common feature of life in the colony, as a contributor to later generations of insane or mentally

39. For a discussion of 'going native' in colonial India, see W. Ernst, *Mad Tales from the Raj*, pp.170-171. For an analysis of Foucault's treatment of race, and its implications for maintaining racial purity in colonial contexts, see A. Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham and London, 1995), Chapters 3 and 4.
40. Dubow, *Scientific Racism*, Chapter 5.
41. Dunston, 'The problem of the feebleminded in South Africa', *JMS*, 67, (1921), 449-458; S. Dubow, *Scientific Racism*, Chapter 5.
42. Dodds, G.24-'94, p.35; Greenlees, 'Statistics of Insanity', p.220; Dunston, 'The problem of the feebleminded', and U.G.25-'29, p.v.
43. Greenlees, 'Statistics of insanity', p.223. For discussion of inherited insanity and perceived links with inbreeding and with the problem of 'poor whiteism', see S. Dubow, *Scientific Racism*, pp.170-80.

enfeebled people[44]. The difficulties of living a colonial life were therefore implicated in the threat to the continued health of the white population.

The apparent prominence of inheritance as a cause of insanity gave impetus to concern about the 'racial health' of the white population, and in particular, control of the feebleminded[45]. Not only were they regarded as 'degenerate types'; they also were seen as susceptible to immoral, criminal and drunken behaviour[46]. In both Britain and South Africa concern about feebleminded women spreading venereal disease, and having defective children strengthened arguments that such women should be segregated from society, or sterilised[47]. It is important to note here that the full force of an ideology which constructed the feebleminded as endangering racial hygiene was directed at women, not men[48]. Slippage between the gender stereotyping of women as childish and irresponsible, and the almost identical stereotyping of the feebleminded, constructed an ideological space in which feebleminded women came to bear the brunt of brutally implemented social policy[49].

There are many examples in the Valkenberg case records of patients whose 'inherited' insanity is described explicitly in terms of anxiety about degeneration and the need to control sexual activity. The case of Francis J, a feebleminded white male patient committed in 1914, is an example. A report written after a year of incarceration gave heredity as the cause of his insanity, and noted that he had 'a history of mentally disordered relations on Paternal and Maternal sides.' His ears were said to be malformed, and 'his general appearance indicates degeneration'. Anxiety about promiscuity seems to have prompted his committal. Having become 'a confirmed masturbator after puberty', he had taken to wandering about half dressed, and 'for public safety' needed to be put in an asylum.

The possibility of promiscuity, and the need to protect the general public from the threat of degeneration is also apparent in the case of Mary E. She was admitted to Pretoria Mental Hospital in 1920, and diagnosed as feebleminded. The Medical Certificates noted her to be living with a

44. In 'Statistics of insanity', p.220, Greenlees called it a 'national vice'.
45. For a history of legislation and debate about the feebleminded in South Africa in the period following the Mental Disorders Act of 1916 Act, see D. Foster, 'Historical and legal traces, 1800-1900'.
46. A popular handbook of the time, written for teachers, social workers and parents identified feeblemindedness as 'an extreme racial peril'. N. Marsh, *Towards Racial Health*, (London,1918), p.196.
47. See J. Saunders, 'Quarantining the weak-minded: psychiatric definitions of degeneracy and the late-Victorian asylum', in W. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, v. 3. (London, 1988), 273-96, and M. Thomson, 'Sterilisation, segregation and community care: Ideology and solutions to the problem of mental deficiency in inter-war Britain', *History of Psychiatry*, 3, (1992), 473; J. Dunston, 'Mental hygiene', *South African Medical Record*, 13/20, (1915), D. Foster, 'Historical and legal traces, 1800-1900'.
48. Oppenheim, *Shattered Nerves*, p.283, discusses ways in which women were constructed as less evolved, more irrational and childish than men.
49. For a detailed description of methods of control of the feebleminded, see M. Potts and R. Fido, *'A Fit Person to be Removed': Personal Accounts of Life in a Mental Deficiency Institution* (Plymouth, 1991).

man, although she was only 16 years old. 'This girl's Errotic (*sic*) tendencies are very much exaggerated, and unless taken under proper care and control she is running obvious risks.' Her appearance was said to suggest congenital mental defect, but this was not elaborated on. Her 'moral sense' was said to be deficient, 'for she admits irregular relations with men, without any sense of shame'. She was transferred to Alexandra Hospital for the mentally defective, and a note on her in 1921 said that 'she would be an easy prey to any unscrupulous person. ...She is emotionally unstable and lacking in self-restraint.' In 1926, during a brief period she spent outside of an institution, an elderly man had wanted to marry her, and this was regarded as sufficient reason to lock her up again.

Black insanity and bodies inside and outside of history

The frequent construction of white patients' insanity as inherited and therefore embedded in a family history, and through that, connected to the health of an entire community, performed an assumption of history which went beyond individual narratives. Not only was there the history of the colony, in which its possible futures could be read; there was also the history of 'home', of Empire. In a society which privileged literacy and regarded oral cultures as ahistorical, white people owned a history; black people did not. Even the willingness of doctors to identify 'moral' causes of insanity in their white patients represented illness narratives as history, by locating the cause of an attack of insanity in earlier events. Black patients were seldom positioned in such narratives[50].

A number of contextual factors contributed to doctors' denial of black patients' history. In comparison to their white patients, asylum doctors knew very little about the lives of the black insane, and this affected identification of causes of insanity, as well as failure to use a full range of diagnostic options. In 1907, Conry noted that 'the history sheets sent with (black) patients to an asylum are particularly meagre in information regarding the previous habits and circumstances of the newly certified lunatic'[51]. He also commented on the fact that 'nurses give little attention to the patients, principally because they cannot understand their language, and so pay no attention to what they say'[52]. He ascribed lack of information partly to reticence on the part of blacks, remarking that 'it is a difficult matter to obtain reliable evidence as to Native customs, Natives being naturally averse to describe what they feel will be repugnant to civilised people'[53]. In this way, blacks were constructed discursively as participating in the failure of doctors to apprehend

50. In the surviving case records, 18.2 per cent of the white male patients, and 11.8 per cent of the white females were given a 'moral' cause by certifying doctors, as opposed to 10.9 per cent of black males and 6.7 per cent of black females. In the Periodical Reports, 9.1 per cent of the white males were given a 'moral' cause, and 10.5 per cent of the white females. Not one of the black patients whose folders survive had a 'moral' cause listed in the Periodicals.
51. 'Insanity among Natives', p.35.
52. CO 7919, 15th September, 1905.
53. 'Insanity among Natives', p.33.

their social and psychological contexts. Lack of knowledge extended beyond the institutionalised black insane. As Greenlees remarked, 'unfortunately the material at our disposal with regard to the normal mental condition of the inhabitants of South Africa is extremely limited'[54].

The case of Antonie M is an example of a black patient who spent 16 years in Cape asylums, 15 of them in Valkenberg, and remained profoundly unknown to those 'treating' him. In 1915 he was arrested in Cape Town, and locked up on a charge of trespassing. On his certification papers, he was said to be a 'Native, tribe not known', a labourer, marital status unknown, religious persuasion unknown, age unknown, cause of insanity unknown. It was also not known whether he had had previous attacks, was epileptic, had movable or immovable property, friends or relatives able to pay for maintenance in an asylum, or to whom notice of death could be sent. Once in the asylum, he had no visitors, and no-one was informed when he died. Thus he was 'known' as labourer and 'known' as insane, but in relation to those with power over him, he was a man with no history, 'unknown'.

Frederick W is a another example of the process through which black patients became 'unknown' to those treating them. He was admitted in 1916, and the cause of his illness was said to be 'financial trouble'. He was a fruiterer in Simonstown, and had become gradually worse after the birth of another child to his wife. The admission form did not repeat 'financial trouble' as the cause of the attack, but simply described its origin as 'unknown'. In this way, having been 'known', a man with a work and family context, he became 'unknown', effaced by the discursive practices of asylum documentation.

Oppenheim has suggested that in Britain the identification of heredity as a major cause of insanity obviated the need to formulate a coherent policy in relation to living conditions as a possible precipitant[55]. In South Africa the search for environmental causes of insanity, at least amongst the black population, would have led inevitably to an examination of the conditions under which they were increasingly being forced to live. Locations with 'houses wretchedly built, always over-crowded, infectious disease frequently existing in them, an utter absence of sanitary arrangements' were identified as a health hazard, and therefore as a threat to the white populations of cities; but the psychological stress of living in locations was not to enter psychiatric debate for many

54. 'Insanity among the Natives', p.71. Anne Digby pointed out to me that in British asylums, little information was recorded about working-class patients on their admission certificates. In the light of this, it is interesting that working-class white patients admitted to Cape asylums, came in with certificates not obviously different from their middle-class counterparts. It suggests that it was race rather than class which affected the quality of information gathered before admission. Digby, personal communication, 31/8/1994. Clearly, in the racialized Cape economy, race and class overlapped to a considerable extent. Moreover, the definition of both race and class were interdependent, the one being used discursively to define the other. For an extensive analysis of this issue, see A. Stoler, *Race and the Education of Desire*.

55. Oppenheim, *Shattered Nerves*, p.285.

decades[56]. The construction of black people as physically different to whites, and therefore able to tolerate appalling living conditions, was central to the failure of doctors to grapple with the damaging effects of racist policies. Blacks were stigmatised as contributing to the wretchedness of locations through their 'uncivilised' habits. Furthermore, tribal customs and healing systems were pathologized as possible causes of insanity, and this provided a convenient alternative to close examination of the effects of segregation and discrimination on mental health. It was in this way that a racialized biological explanation for insanity was privileged, justifying the widespread neglect by psychiatrists of the effects on their patients of stressful environments[57].

Border crossings

Diagnostic and aetiological labels, signifying both what had been and what was to come, and recorded in the transition between life outside and inside the asylum, served as passports into the space of insanity for both men and women, black and white. The labels were used in gendered and racist ways and thus, in addition to border-marking, were the texts in which the progress of differently-marked insane bodies between sanity and insanity, illness and recovery can be read. The idea of border crossings, marked linguistically in the case of insanity by psychiatric labels, also drew together a number of related anxieties which for whites pervaded colonial life.

Contact between white and black communities constituted one form of border crossing. In 1895, Greenlees referred to 'the Kafir' as 'one of the noblest types of mankind'[58]. This idealised image of noble (innocent) savagery underscored the distance between white (civilised), and black (savagery). A distinction was commonly made between the 'true aboriginal', the 'pure unsophisticated savage' or 'raw native' and those whose innocence was spoilt by contact with civilisation[59]. Increase in insanity amongst blacks was attributed to this corruption through contact with European vices, and alcohol abuse was singled out as a particular hazard, despite evidence that few 'Native' admissions were attributable to intemperance[60]. Both Conry and Greenlees attributed the low rates at which black patients presented with GPI to their 'simple life' and freedom from the 'worries of civilised life'[61]. Greenlees claimed that it was only when 'the Native has been long in contact with the white man, learning his bad, rather than his good, characteristics, that general paralysis affects him'[62].

56. Conry, 'Insanity among Natives', p. 36.
57. As McCulloch's history of ethnopsychiatry in Africa makes clear, psychiatric racism was not unique to South Africa. Views remarkably similar to those expressed by South African asylum doctors were expressed by psychiatrists in later decades throughout Africa. *Colonial Psychiatry and 'The African Mind'*. A South African example can be found in the work of B. Laubscher, *Sex, Custom and Psychopathology: A Study of South African Pagan Natives*, (London, 1937).
58. Greenlees, 'Insanity among the Natives', p.71.
59. Greenlees, 'Statistics of insanity', p.219; Conry, 'Insanity among Natives', p.34.
60. Greenlees, 'Insanity among the Natives', p.74; Conry, 'Insanity among Natives', p.35.
61. Greenlees, 'Statistics of insanity'; Conry, 'Insanity among Natives', p.34.
62. Greenlees, 'Statistics of insanity', p.219.

Megan Vaughan suggests that it was the colonial subject who was insufficiently Other, who had '"forgotten" who they were, and had ceased to conform to the notion of the African subject, who most often found themselves behind the walls of the asylum'[63]. This hypothesis, which foregrounds the contact between the known and the alien, the powerful and the colonised, certainly offers a description of the process by which some black men and women were identified as insane and institutionalised. Those in danger were those who challenged the colonial hierarchy, and were stigmatised in the process. If these people were indeed insufficiently Other, then they could be made Other again, by being rendered alien in the discourse of the tables. Being 'unknown' therefore became a discursive equivalent to unknowable, and this lifted from the shoulders of the doctor the responsibility of either intimacy, or negotiation with difference through the identification of similarity. Thus, doctors' apparent lack of knowledge about their black patients suggests the danger of crossing a border of another kind, by allowing intimacy through familiarity. To know too much about colonised subjects implied that they were knowable as people; this in turn implied understanding and sympathising with their aspirations and their humanity. Therefore, in the contact between doctors and the black insane, blacks became unknowable, and nowhere was this more starkly realised than in the failure to find causes for their insanity.

White men and women were perceived as vulnerable to crossing the border between civilisation and savagery through exposure to sun and heat, disease and isolation, all of which were cited in case records and statistical tables as causes of insanity[64]. These characteristics of colonial life represented the cost for colonisers of living away from 'home'. Another cost was formulated in the spectre of whites having sexual relationships with their 'primitive' colonised subjects. Poor and feebleminded whites were considered more likely to have such relationships, and to bear children as a result of them. This was an expression of classist prejudice about the 'reproductive fecundity' of 'vagrants, paupers, mental defectives, drunkards, and criminals', and added to fears of the white population becoming 'primitive' like the 'savage' races of the colony[65]. Belief that miscegenation was taking place on a wide scale, and its conceptual link to degeneracy theory, was fertile ground for contamination fears and served as a justification for keeping the races segregated from each other[66]. The 'Coloured' population became emblematic of the corruption of

63. *Curing Their Ills*, p.125.
64. Dubow describes in detail links made in the early twentieth century between poor whiteism, racial degeneration and climate in *Scientific Racism*, pp.175-180.
65. Oppenheim, *Shattered Nerves*, p.287.
66. Dubow, *Scientific Racism*, Chapter 5; *Commission into Assaults*, p.8.

both black and white, the mixture of black and white blood being seen as the cause of moral and nervous weakness[67].

Ann Stoler points out that for white colonial populations, maintaining racial difference was inseparable from reinforcing class differences between the colonisers and the colonised. Racial categorisation was the means through which class was constantly defined and redefined in the colonies. She points out that colonialism 'was not only about the importation of middle-class sensibilities to the colonies, but about the *making* of them', not only abroad, but at 'home' as well[68]. The connection between class and race were captured in anxiety about poor whites, who were unable to maintain the 'standards' thought to be appropriate to the white population, and were also considered to be in greater danger than their middle-class counterparts of mixing with those of other races[69]

Ethel H illustrates the anxiety of those in authority about sexual activity across racial borders. She was a white woman, first admitted to Valkenberg in 1914, discharged to Single Care, and then re-admitted in 1917, after the woman in charge of her died. On her first admission she was diagnosed as having recent mania, and at that time, she had been 'in and out of prison for the last year for walking the streets and for drunkenness'. On her re-admission, she was diagnosed as being an imbecile. She had been brought back to Valkenberg because she 'frequented the streets as a harlot, and was eventually found living with a coloured man, in very squalid surroundings.' On admission in 1917, she was noted to be depressed, with suicidal thoughts, because she believed herself to be pregnant. A Periodical Report written at this time stated her to be 'an undesirable and dangerous to herself and others'. Her 'undesirability' was felt so strongly that it was recommended that she be 'permanently detained in some Institution'. In 1918, she was given an intelligence test, and said to have the intellect of a child of 11+ years. Between 1917 and 1922 a clear clinical picture of alternating depression and cheerfulness emerged. The symptoms were noted, but her diagnosis of imbecility remained unchanged until 1922, when imbecility was changed to 'moral defectiveness'. At this stage her intelligence was given as 12 years and 10 months. In 1926, she was said to be a psychopathic personality and emotionally unstable[70].

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67. 'Insanity among the Natives', p.72. Marsh for example, *Racial Health*, p.209, wrote of the 'deterioration of those people coming from a mixed British and Asiatic stock' in colonial India: 'their numbers are rapidly increasing, and they soon come to be of a degenerate nature'. For a discussion of miscegenation and fears of degeneration in colonial Southeast Asia, and elsewhere, see A. Stoler, 'Making empire respectable: The politics of race and sexual morality in twentieth-century colonial cultures', *American Ethnologist*, **16**, (1989), 634-660; and A. Stoler, 'Sexual affronts and racial frontiers: European identities and the cultural politics of exclusion in colonial Southeast Asia', *Comparative Studies in Society and History*, **34**, (1992), 514-551.
68. Stoler, *Race and the Education of Desire*, p.99.
69. Stoler, 'Rethinking colonial categories: European communities and the boundaries of rule', *Comparative Studies in Society and History*, **31**, 1989, pp.149-153.
70. Poor whites tended not to do well in tests of intelligence. Dubow, *Scientific Racism*, pp.179-81. Ethel (FE 2076) was no exception. Her scores would have reflected the limitations her educational opportunities, and could not be read as an accurate reflection of her ability.

Ethel's case confirmed the supposition of a close connection between feeblemindedness and poor whites. Her prostitution and sexual relationship with a Coloured man were textualized as evidence of her degeneracy. Not only was she was in danger of propagating her degeneracy by having children; she also seemed likely to add to an already degenerate situation by having children of mixed blood.

Conclusion

The colonial psychiatry which developed during the period 1891-1920 was a complex mixture of the imported and indigenous. Psychiatric classifications used in Cape asylums reproduced the gendered atlas of the insane body used in European psychiatry. To this atlas was added the body of the black insane man, simultaneously 'known' to be childish and simple and 'known' to be unknowable. For white men and women to cross the border of sanity into the savage world of madness and degeneration became the trope for colonial anxiety about their permanence and power as colonisers in Africa. Like dogs in the noonday sun, vulnerable white bodies faced an endless assault from a fierce climate, contamination by the primitive and the alien, and from within their ranks, degeneration into poverty and feeblemindedness. In this setting, the crisis-ridden bodies of white women were particularly in need of shelter and rule from colonial authorities. For these reasons, it is unsurprising that colonial psychiatry constellated itself around two related themes: the separation of black from white, and the determined effort to prevent the spread of insanity in the ranks of the white population.

Early attempts to curb the rising rate of insanity in the white population took the form of attempting to provide treatment of incipient disorder in pleasant racially segregated surroundings. By 1920, the focus was on prevention articulated in the philosophy of the eugenics movement[71]. The separation of black from white within colonial psychiatry took a number of forms, of which segregation was an important part. The behaviour of the black and white insane were placed beyond comparison simply by spatial distance. At the same time, the black insane were produced discursively as alien, through the simple but effective strategy of failing to allow the clinical gaze to penetrate beyond the barrier of racialized anatomical difference. Without either an interior mental life or a set of familial relationships that would guarantee social identity, the black insane were 'unknown', except as 'black'.

The epistemological imperative of establishing separation between white and black insanity also had the effect of distinguishing between black and white mentality. The insanity of white men and

71. Dubow, *Scientific Racism*, pp.144-5.

women took them beyond the borders of the 'natural', but insanity in blacks was no more than a performance of their inherently primitive, childish, unrestrainedly physical and potentially violent 'nature'. At no point was it argued that the black insane were biologically different to black people beyond the institution, presumably sane. In this way, the relation of 'mental disorder' and 'mentality' was elided for people racially constructed as black[72].

Colonial psychiatry thus contributed directly to justifications for the provision of racially differentiated facilities and treatment for those identified as insane, described in detail in the following chapter. It also laid the ground for almost a century of racial discrimination in South African psychiatric institutions.

72. The conflation of 'blackness' and 'madness' in Western culture is discussed by S. Gilman, *Difference and Pathology*, Chapter 5. An example of this conflation is apparent in Greenlees' comment that 'natives' in general were addicted to masturbation, a conclusion he appears to have reached through observation of this 'well-marked symptom of insanity' amongst his black patients. 'Insanity among the Natives', p.74.

Chapter Six

INSTITUTIONAL PRACTICE AND THE LUNATIC BODY: THE EFFECT OF GENDER AND RACE ON THE MANAGEMENT OF THE CAPE INSANE

Introduction: Marking the insane body

In Chapters Four and Five, I argued that the official forms mediating the committal process, and the diagnostic and aetiological categories of the statistical tables, had the effect of stripping insane individuals of a personal identity, and an attachment to a personal past. One consequence of this was the discursive production of homogeneity in the insane men and women in Cape asylums. There was little regard for individual difference, beyond those marked on the body, and labelled in terms of racial and gender classification. The process of categorisation formalised in the official documentation and statistical tables inevitably produced homogenising descriptions of insanity. This was crucial in doctors' self-presentation as liberal humanists, caring for all their insane patients equally and without prejudice.

Asylum practices, which constituted the everyday face of Cape colonial psychiatry, contrasted strikingly with the textual erasure of class, culture and gender difference in the official documentation, and the inevitably homogenising descriptions of the insane emerging from them[1]. In Chapter Five I argued that psychiatric universalism and biologism created the discursive space within which racialised and gendered descriptions of the Cape insane were made possible. Institutional practices in asylums also marked both race and gender difference, and used dominant psychiatric discourses to justify differential treatment. Inevitably, in a society in which both race and gender had a strongly determining effect on the lives people led, psychiatric practice both reproduced and reinforced those divisions.

In relation to asylum practice, race and gender difference was foregrounded when groups of patients were described or discussed. Doctors often maintained a liberal humanist discourse about individual patients, but in dealing with groups of patients, with a view to shaping policy about their treatment, a discourse emerged which asserted and naturalised gender and race differences. Given the colonial setting, a 'man's world'[2], and one in which the colonised races were discursively produced as inferior to their colonisers, difference translated into inequality. Correspondence between asylum superintendents, asylum annual reports and the reports of both the Inspector of Asylums and Official Visitors to asylums, not only differentiated between men and women patients, and blacks and whites, but also produced discourses which justified differential treatment, on the basis of biological difference.

1. Uniformity in the contents of official forms is discussed at length in Chapter 7.
2. For discussion on the gendered construction of colonial societies see H.Callaway, *Gender, Culture and Empire: European Women in Colonial Nigeria*, (Chicago, 1987), Chapter 1; V. Ware, 'Moments of danger: Race, gender, and memories of Empire', *History and Theory*, 31, (1992), 116-137; A. Stoler, 'Making empire respectable'; A. Stoler, 'Sexual affronts and racial frontiers'; and A.McClintock, *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest*, (New York and London, 1995).

Asylums all over the world separated the male and female insane. It was the physical presence of large numbers of insane men and women categorised as racially different from those determining their treatment which was fundamental to the structure of Cape colonial asylums and the evolution of a Cape colonial psychiatry. It affected ways in which the insane were identified and classified, and the availability of accommodation and facilities offered to different groups. Access to both medical and psychiatric treatment also varied according to the race and gender of the patient. Daily routines, including both work and recreation, replicated gendered and racialised divisions of activity in colonial society. This chapter provides an exploration of the ways in which the institutional management of the insane in the Cape was responsive to, and discursively produced and reproduced, markers of race and gender[3].

This chapter draws on a variety of texts, including Valkenberg's case records, correspondence with the Colonial Office, and published documents, which include asylum annual reports, Official Visitors reports, and journal articles.

The 'civilising mission': race and gender in the reform of Cape asylums[4].

In 1894 Dodds, returning from a visit to England during which he had visited several asylums, wrote to the Colonial Office describing the 'enlightened treatment' to be found there.

> The same liberal provision that is seen in England is found on the Continent, in the United States, and in many of the Colonies. I cannot believe that this country will be left behind in this work of mercy and necessity[5].

The term 'liberal provision' had several referents. These included availability of asylum accommodation for all those in need of it, and 'humane treatment of the insane', which was to be achieved by legislative reform, staff education and training, and for patients, remedial employment and entertainment in comfortable surroundings. Dodds' objective during his term of office as Inspector of Asylums was to create 'in a liberal and enlightened spirit' a network of asylums 'creditable to us as a Colony,'[6]. The new dispensation was to apply to all patients regardless of race, class or gender.

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3. Aspects of the analysis which follows appeared in S.Swartz, 'The black insane in the Cape, 1891-1920', *Journal of Southern African Studies*, **21**, (1995), 399-415.
4. Dodds and his colleagues in Cape asylum practice all used the distinction between 'civilised' and 'primitive' to refer both to conditions in asylums, and also to differences between white and black patients. For a discussion of 'civilising' colonialism, see J. Comaroff, 'Images of Empire, Contests of Conscience: Models of Colonial Domination in South Africa', *American Ethnologist*, **16**, (1989), 661-685.
5. G.17-'93, p.140.
6. G.36-'92, p.105; G.37-'91, p.14; G.24-'94, p.39.

The liberal humanist stance implied by 'humane care' for all the colony's insane was represented textually in two related discursive practices. The certification process, indifferent to the racial, cultural and class diversity of the colonial setting constructed the medical gaze as seeing through difference to the essential insanity within. In addition to this, the widespread use of the generic term 'the insane' inscribed insanity as the primary identifying feature separating the population within the asylum as different from the one without.

Repeated reference to 'the insane' in the public domain was not a denial of race and gender difference, which was assumed to be 'natural' in the colonial setting. The erasure of race and gender accomplished in this way proposed 'humane care' *despite* these differences. However, reference to 'the insane' as an undifferentiated group, together with the use of British legislation and asylum structures as models for lunacy reform in the Cape, insisted on the similarities between Cape and British responses to the management of insanity. The unique qualities of the Cape colonial context were consistently downplayed.

Dodds was silent on race and gender divisions when he appealed for resources. When different groups of patients were being described or discussed however, a discourse emerged which asserted race and gender difference, and used these to justify discriminatory practices. This discourse rehearsed the colonial belief that all black people were inferior to white men through the former's distance from the norm of 'civilisation'.

One example will illustrate this process. Greenlees and Dodds had a lengthy debate about the sleeping arrangements of Grahamstown Asylum's black female insane. The discussion summarises the tension between the liberal humanist attempt to provide all the insane, regardless of race, with a 'civilised' standard of care, and the racist impulse to regard black patients as intrinsically primitive, and therefore unable to benefit from such care. During his inspection of June 27th and 28th, 1894, Dodds criticised the superintendent for allowing patients to sleep on the floor, some with and some without mattresses. The initial response to Dodds' report came from Dr Adam, acting superintendent at the time the report was written. On 23rd July, 1894 he wrote to the Under Colonial Secretary's office admitting that 'many of the female natives get out of bed and sleep on the floor in a blanket.' To this admission he added the comment that there were anyway not enough beds in the asylum to accommodate all the black women housed there[7].

On November 19th and 20th, 1894, Dodds carried out another inspection, and on finding black women still sleeping on the floor, said that Grahamstown was the 'only Asylum in the Colony

7. CO 7175, 23rd July, 1894.

where such miserable provision is made for patients at night, and it does not reflect credit on the Institution'[8]. In December, 1894, Greenlees, outspokenly paternalistic in case records about both black and female patients, returned to his post after a period of absence[9]. In a comment which elides 'crude' and 'insane' in the word 'worst', he wrote:

> I am sorry he adverts, in such strong language, to the few of my worst native females sleeping on the floor. My answer to his arguments have been reiterated again and again: and everyone consonant with the habits of the crude native agrees with me. I admit it is not the custom of English Asylums, nor is it the custom of either English Asylums nor Valkenberg to admit raw natives who will not and cannot sleep on bed steads[10].

In January, 1895 Dodds replied that 'crude natives are received into general hospitals, but once within the doors of the hospital, civilisation is the standard, not barbaric habit. And so it should be in Asylums; and so it is, I am glad to say, in every Asylum except Grahamstown.' He went on to suggest that these 'bad habits' would spread to the 'crude' black male patients. He said ascerbically that he expected to see 'before long wattle and daub huts in the female airing court for "crude natives" who object to the provision of civilisation'[11]. As these comments illustrate, Dodds was determined to create and maintain an appearance of 'civilised' standards of care for the insane throughout the Cape. Black women sleeping on asylum floors was at odds with this. However at no point did he argue that the black and white insane should be accommodated together, or given identical facilities. It is significant that he failed to address Adam's request for sufficient beds to accommodate all the black women in Grahamstown Asylum.

Diverse identities, and the stigmatisation of blackness in asylum texts

The first step in the process of justifying differential treatment for groups of patients divided along race and gender lines entailed labelling according to racial characteristics, a practice well established before segregated facilities existed[12]. The 1875 report on Robben Island tabled information on 'European' and 'Coloured' patients separately, and a distinction between patients on racial grounds was made as early as the 1850s[13].

8. CO 7175, November 19th and 20th, 1894.
9. Greenlees' attitudes to women are described in F. Swanson, 'Colonial Madness'.
10. CO 7175, 10 December, 1894.
11. CO 7176, 15th January, 1895. Ironically, wattle and daub huts were indeed resorted to as accommodation for black male patients in Fort Beaufort Asylum, twelve years later.
12. For a detailed discussion of the early development of a racist psychiatry in the Cape, and its relationship to the Otherness of insane patients, prior to 1891, see Deacon, 'A history', Chapter 4. For a discussion of labelling and stigmatisation, see Gilman, *Difference and Pathology*.
13. G.13 -'76; Deacon, 'A History'.

Official asylum documents before 1910 used a simple 'European/Coloured' classification only, a practice which obscured the diversity of both groups. After 1910 official categories expanded to differentiate between 'Native', 'Indian' and 'Coloured' groups. Case records employed a range of other labels, including 'kafir', 'niggar' and 'bastard'[14].

Although all black patients were housed as a single group as segregated facilities became available, distinctions were made between them by doctors responsible for their treatment. Dodds, Greenlees and Conry, superintendent at Fort Beaufort Asylum, all distinguished between 'raw natives' and those living close to 'centres of civilisation'[15]. The former were regarded as leading 'a simple and savage existence', idealised by Greenlees as 'a life in the open air, in a perfect climate, with plenty of simple and natural food'[16]. 'Natives' in locations were assumed to be unable to maintain moderation in the face of unfamiliar and dangerous temptations[17].

There are many examples in the Valkenberg case records of black patients being described in stigmatising ways. Hendrik B, transferred to Valkenberg in 1920, was said to be a 'dangerous degenerate', because he had mixed blood. This was suggested as a reason for his violent behaviour, and his tendency to masturbate. Eliza P, admitted to Valkenberg in 1920, was said to be intellectually 'normal for one of her class', a comment revealing the doctor's assumption of limited intellectual ability in blacks.

Awareness of the stigma carried by racial labels was poignantly expressed by those black patients who had 'delusions' of being white. These reflected not only the desire for acceptance and social status, but also the confusions caused by shifting definitions of what constituted 'white' and 'black'.

Distinctions were made by asylum doctors between different groups within the black insane population. 'Coloured' patients were stigmatised by Greenlees as impure, showing 'all the worst characteristics of both races'[18]. The view that 'Coloured' people were 'dirty, intemperate, shiftless, and dishonest' was common in the white population, and reflected anxiety about

14. HGM 15, pp.13, 14, 19, 35, 43.
15. See for example Dodds' correspondence with Greenlees, CO 7175, November 19th, 20th, and 10 December, 1894 and J.Conry, 'Insanity among Natives' p.36.
16. Greenlees, 'Insanity among the Natives', p.71. Gilman points out that romantic idealisation and stigmatising stereotypes are both a means of refusing intimacy. *'Difference and Pathology'*, p.17. For a discussion of the place of romantic naturalism in the history of South African medicine, see Jean Comaroff, 'The diseased heart of Africa'.
17. 'Insanity among the Natives', p.71.
18. *Ibid.*, p.72.

degeneration through racial mixing[19]. The process of stigmatisation had the social function of preventing further bastardisation of the white race. This was despite the fact that they were also regarded as above the 'Native' people on the evolutionary scale, because of their white blood[20].

Indian patients seem to have been relatively less stigmatised, perhaps reflecting strengths of the Indian community in general, including 'international leverage which could be used in moments of crisis'[21]. By contrast the Muslim population of the Cape, referred during this period as 'Malay', were widely distrusted. This was brought into sharp focus by the Malay riots of 1886, protesting against the closure of burial grounds close to the centre of Cape Town. They were a socially and religiously cohesive group, and it was their assertion of their right to defend this identity which created anxiety about them in the white and 'Coloured' community. At the turn of the century, popular prejudice saw Malay people stigmatised as tricksters, dabblers in magic, untrustworthy and powerful[22]. This prejudice found its way into the delusional systems of a number of patients from different walks of life. It was sometimes expressed in the phrase, apparently current in the decades at the turn of the century, to be 'Malay tricked'. Some examples of the way in which this term was used, taken from cases in the Valkenberg records, will illustrate this.

Adriaan T, a white Afrikaans speaking general dealer, was admitted to Valkenberg in 1910. On admission he 'said he had been Malay tricked etc'. He was a poor white, and probably vulnerable to popular fear of being displaced socially by middle class Malay traders. Once in gaol, he had said that 'certain persons living at Somerset West have performed Malay Tricks on him and others, & nine deaths have occurred as a result of these tricks.' 'Malay tricked etc' suggests a well worn verbal pathway, familiar to the admitting doctor. Maria P was a 'Coloured' domestic servant transferred to Valkenberg in 1920. The Medical Certificates state that she 'says Malays of Cape Town and Mowbray are going to kill her.' On admission, she refused food, saying it was poisoned, and said that 'she has been Malay tricked as chloroform was put outside her window & Malays wanted to convert her to their religion.' This case illustrates that anxiety about the Malay community was confined neither to the white community nor to those struggling to maintain

19. Bickford-Smith, 'Dangerous Cape Town: Middle-class attitudes to poverty in Cape Town in the late nineteenth century', in C.Saunders, H. Phillips, and E. van Heyningen (eds.), *Studies, v.4*, 29-65. The perceived threat to the white population of degeneration through miscegenation is described and discussed at length in Dubow, *Scientific Racism*, Chapter 5.
20. I. Goldin, 'The reconstitution of coloured identity in the Western Cape, in Marks and Trapido (eds.), *The Politics of Race*, 156-181.
21. S. Marks and S. Trapido, 'The politics of race, class and nationalism', in Marks and Trapido, *The Politics of Race*, p.32. Very few Indian patients were admitted to Valkenberg before the mid 1920s, as this was a small community in Cape Town.
22. Bickford-Smith, 'Commerce', p.152. Bickford-Smith discusses the origin of popular prejudice against the Malay population in *Ethnic Pride* , pp.69-76.

middle class status. The association of Malays with poison, trickery and death was linked to a religion poorly understood but stigmatised for not being Christian, and linked through the riots with burials and graveyards[23].

William R was a 'Coloured' fireman admitted to Robben Island in 1917. He believed he had been Malay tricked and that his 'coffee, food and boots had been tampered with'. In 1920, when 'noisy in Garden' he claimed to be 'attacking Malays who are doing him harm'. He also believed that human bones were being ground and put into his drinking water by his next door neighbour, and that a Jew sold him cigarettes with powdered bones in them. The association here, and in the cases described above, of Malays with poison, death, and attacks on the sanctity of human remains is probably attributable to their associations in popular discourse with burials, graveyards, and a religion poorly understood but stigmatised for not being Christian[24].

Black patients were not the only stigmatised group. Because Cape Town was a busy port, both Valkenberg and Robben Island admitted numbers of immigrants, amongst them Russian and Lithuanian Jews. Little attempt appears to have been made to understand the Yiddish spoken by many Jewish patients, and no provision was made for their dietary requirements. Jews 'were considered to have filthy habits and to contribute to the threat of disease'[25]. Despite the association of Jews with ethnic difference, and with disease and dirt, there was never any attempt in the Cape to classify them as 'not white', as was in case in some European countries[26]. However, anti-semitism filtered into the records through voices of patients, as reported by the 'neutral' doctors. John A, admitted to Valkenberg in 1903, and diagnosed as having paranoid dementia, said he 'wanted no bullying master or a Jew'. A letter to the Superintendent from an acquaintance of a Jewish family with a member in Valkenberg gives an idea of public sentiment about Jews. Louisa F was a patient in Valkenberg from 1903, and the writer of the letter claimed to have overheard Harry F, her husband, complaining to a third party about his wife's asylum fees. The writer made the following observation:

> I do not think I would be doing my duty if I were to allow a man like F (and a Jew at that) to get out of his responsibility when he is well able to meet it.

23. A. Davids, '"My Religion is Superior to the Law": The Survival of Islam at the Cape of Good Hope', *Kronos*, 1987, 57-71; V. Bickford-Smith, 'Dangerous Cape Town'.
24. The refusal of Cape Muslims to comply with hospitalisation, quarantine, vaccination and fumigation regulations during small pox epidemics was widely discussed and publicised. They were accused of spreading the disease deliberately, through contaminated linen. The Malay riots of 1886 also fuelled popular prejudice against the Muslim community. For a detailed description see A. Davids, '"My religion is superior to the law"'; V. Bickford-Smith, 'Dangerous Cape Town'.
25. van Heyningen, 'Cape Town and the Plague of 1901'.
26. Gilman discusses the social construction of Jews in European societies as 'black' or of 'mixed race' in *The Jew's Body*, (New York and London, 1991), pp.174-6.

There was overt prejudice against Afrikaners, particularly at Grahamstown Asylum during the Boer Wars[27]. The Afrikaans language was associated with 'the ignorant, the poorer white, and the brown people' and was seldom used by relatives and friends in correspondence with asylum officials[28]. Afrikaans patients from poor families appear to have perceived themselves as threatened at times in their social status by English-speaking whites misidentifying them as black[29]. This anxiety was tellingly summarised by Margaretha G, an impoverished Afrikaans woman admitted to Valkenberg in 1920, who was described as yelling that 'she was a white woman and quite pure'. In this way, the social identity of Afrikaners and Jews was constantly under threat from the overtly racist structure of the Colony, in which groups of people were classified according to a complex amalgam of physical characteristics, parentage, class, language and 'colour', and in which English-speaking whites positioned themselves as the only authority on 'correct' classification[30]. As segregationist policies hardened, these judgements were made on the basis of finer and finer discriminations between 'white' and 'colour'[31].

The 'madam' and the 'loose native': race and gender patterns in the accommodation of the insane

The provision of accommodation for the insane in the Cape can be read as a text in which the attitudes of colonial authorities to their responsibilities for both the care and the control of the insane become apparent. The gendered and racialised structure of those attitudes is immediately apparent in Dodds' choice of images in his appeals for increased accommodation. He wrote for example of a white woman 'for the last five years uninterruptedly locked in her bedroom. It is another case of glaring cruelty to a person of unsound mind inflicted in ignorance.' He also described a white woman 'chained to her bedstead for eighteen months and who is now dead'[32]. He also described a melancholic and suicidal white man, 'a highly educated gentleman', who 'besought (Dodds) piteously to find him a room where he would have a chance of getting quiet sleep, as rest meant life to him in his present state'[33]. Suppressed in these texts were the accommodation needs of the colony's black insane.

27. Greenlees used openly stigmatising language about Akrikaners admitted to Grahamstown Asylum. Felicity Swanson, personal communication, October, 1994.
28. H. Giliomee, 'The Beginnings of Afrikaner Nationalism, 1870-1915', *South African Historical Journal*, **19**, (1987), p.124.
29. E. Brink, 'Man-made women: Gender, class and the ideology of the *Volkmoeder*', in C.Walker (ed.), *Women and Gender*, 273-293.
30. It is important to note here however that regardless of attitudes towards them, Jewish and Afrikaans patients always had access to a better standard of care than those classified as black.
31. The implications of this for asylum care is discussed in the following sections.
32. CO 7175, 16/1/1894.
33. G.16-'95, p.48.

In 1909, the ratio of registered insane to the population was 1 in 1,359. This compared to a rate of 1 in 288 in England and Wales, in 1901, and very similar figures for New Zealand and Australia[34]. Out of the total number of insane, white insane to white population was 1 in 678; and as it is quaintly expressed, 'Other than white insane to Other than white population' 1 in 1,994[35]. These figures probably reflect the extent to which insanity amongst the black population was either hidden from, or ignored by colonial authorities.

By 1919, there were almost 1.5 million whites in South Africa, of whom 4.966 were known to be insane. Only 2,778 could be accommodated in hospitals. There were 4.8 million 'Natives' in the population, of whom 2,135 were known to be insane. 2,893 beds were available to accommodate them[36]. Thus, there were many more beds per capita available for the white population. However, the black insane, once identified as such, appear to have been relatively well-resourced in terms of asylum accommodation.

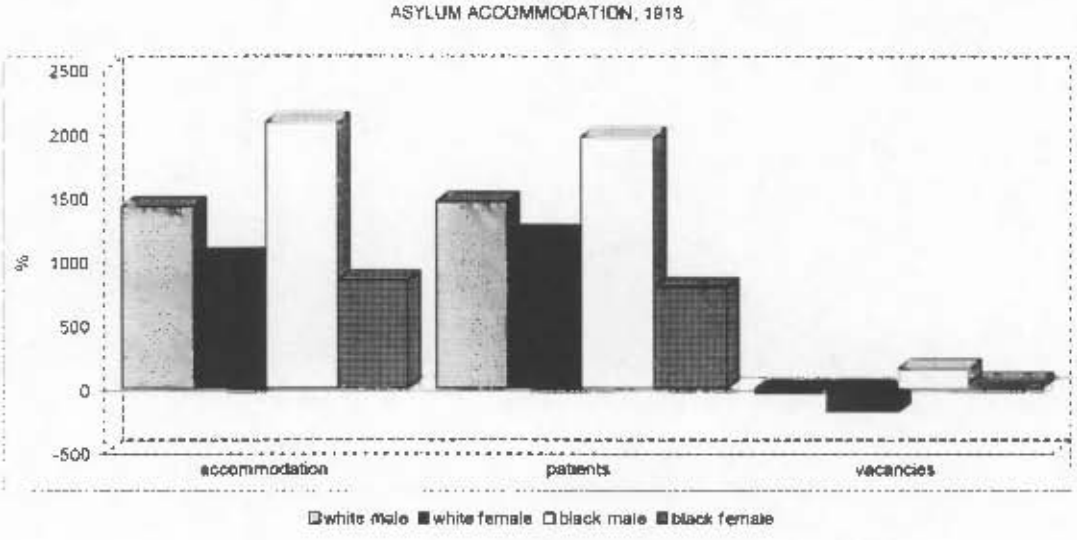

Figure 17[37]

Figure 17 represents accommodation available compared to numbers of patients in the Mental Hospitals of the Union, in 1918. Shortage of accommodation for female European patients was at this stage considerably more acute than for males, suggesting that adjustments were needed in the number of beds made available to each gender. However, even if accommodation had matched requirements exactly, there would still have been more males than females in the asylum. Although there was a surplus of accommodation for both male and female black patients, more

34. G.70-'02, p.55.
35. G.25-'1910, p.9.
36. U.G.31-'21, p.5.
37. These figures were taken from those given in the Inspector of Asylum's Report for the period 1916-1919. U.G.31-'20. pp.4-7.

accommodation was available for men. The 1891 census gave the ratio of women to men in the total population as 99:100[38]. By 1904, the census estimated that the proportion of women to men in the general population was 98:100. By 1911, the proportion was 104:100. For the white population, the ratio was 93:100[39].

In striking contrast to nineteenth and early twentieth century Britain, where there were more women than men in asylums, in the Cape men consistently outnumbered women[40]. This was the pattern all over Africa, and has continued to be the case throughout this century[41]. The Cape made no provision for the accommodation of lunatics on the scale precipitated by the 1845 Lunacy Act in Britain, after which time, large numbers of female paupers swelled the numbers of women amongst the asylum population[42]. In addition to this, statistics on admission rates to asylums from various countries during periods of accommodation shortage suggest that men have tended to be accommodated before women[43]. In the Cape Colony this applied to all men, regardless of race. Ability to continue carrying out domestic duties such as housework and childcare, which although onerous are not in the public gaze, possibly contributed to the containment of insane women within domestic settings.

Deacon has argued in relation to Robben Island that although there was no widespread incarceration of the insane in South Africa, asylums were used as a means to control deviance, which was focused on those groups from whom the greatest threat was perceived, namely criminals and violent lunatics, particularly those drawn from the ranks of the lower classes. In the period 1872-1888, 46% of the admissions were called 'dangerous', 13% 'dangerous and suicidal'

38. G.6-'92, p.xxiii.
39. U.G.32-1912, p.xiv.
40. In 1909 there were 1209 men and 775 women in Cape asylums. By 1920, there were 1615 men and 1056 women. G.25-1910, p.10; 1920 Annual Report (unnumbered), p.389.
41. M.Kisekka, 'Gender and mental health in Africa', in E.D.Rothblum and E.Cole (eds.), *Women's Mental Health in Africa*, (New York, 1990), 1-13. As Dorothy Smith argues in *The Conceptual Practices of Power*, Chapter 5, whether women are disproportionately represented in contemporary mental hospitals and out-patient psychiatric facilities is a contentious issue, partly because conclusions drawn depend upon the way in which statistical information is deployed. In America, women no longer outnumber men in mental hospitals, as they had for much of this century, although they do use out-patient facilities more frequently.
42. Scull argues in *The Most Solitary of Afflictions*, p.160, and p.256, that the discrepancy in numbers between women and men in British asylums in the second half of the nineteenth century is probably attributable to women's longevity, and also the tendency to discharge men after shorter periods of incarceration, because they were more needed as breadwinners. Roughly equal numbers of men and women in the general population were identified as insane. He goes on to argue that the place to look for gender bias is not in numbers of women confined, but in Victorian alienist's gendered descriptions of aetiology, and their characterisation of women as at the mercy of fragile nervous systems. Oppenheim, *Shattered Nerves*, Chapter 6, makes a similar point. It is also important to note that men outnumbered women in private facilities, in which there was a better standard of care. For a discussion of this, see C. MacKenzie, *Psychiatry for the Rich*, p.129.
43. Examples are to be found in Fox's analysis in *So Far Disordered in Mind* of admission rates in late nineteenth and early twentieth century California. Tucker's figures in *Lunacy in Many Lands* (Sydney, 1887) also support this hypothesis.

and 3% 'dangerous at times'. Men consistently outnumbered women[44]. It is possible therefore that 'insane' men were perceived as a greater threat than their female counterparts to the colonial community[45].

The pattern of female admissions to Cape Colony asylums raises the possibility that they were regarded as a last resort for women in need of care. This hypothesis is borne out by the sudden increase in numbers of female admissions to Robben Island once humanitarian reforms had been instituted by Dr Edmunds in the period 1862-1872[46].

Against this pattern of women being underrepresented in the asylum population, Valkenberg stands out as the only Cape asylum which frequently had more women than men resident. It appears not to have been stigmatised to the extent of other asylums in the colony. Given the overtly racist context, being a whites-only institution until 1916 probably made it a more desirable refuge for white insane women than mixed institutions, particularly those with unsuccessful segregation strategies[47]. Moreover, it had excellent facilities for paying patients, and a well-established reputation for humane care of the insane[48].

Another factor influencing Valkenberg's gender ratio was Dodds' determination to reproduce, in South Africa, an asylum which could compete with the best of those in Britain[49]. His insistence on both early treatment, and the possibility of bringing considerable relief to sufferers from mental

44. Deacon, 'A history,' pp.180-185.
45. The threat of insanity to colonial authority is explored in Ernst, who argues in relation to the white insane in India, that 'the desire to maintain social distance between those Europeans who thought they were in possession of their wits and those who were considered to have gone "doolally", was just as strong as the desire to keep people of different social class and racial background apart'. This was achieved not only through racial segregation of asylum accommodation, but also by a policy of repatriating the European insane. *Mad Tales from the Raj*, p.67. Arnold argues that this policy included orphans, the aged and the poor unemployed. 'European orphans and vagrants in India in the nineteenth century', *The Journal of Imperial and Commonwealth History*, 7, 1979, p.113. Under-resourcing of asylums and the fact that no obvious attempt was made to send the insane 'home' suggests that this was not in operation in the Cape.
46. Deacon, 'A history', Chapter 3.
47. The elision of race and class during this period created a situation in which white women of all classes were likely to receive substantially better care than all black patients, regardless of their class. This was despite the fact that in some communities, such as District Six, working-class whites and blacks lived as neighbours, and possibly had more in common with one another than with middle-class communities. See Bickford-Smith, 'The origins and early history of District Six to 1910'.
48. Dr Jane Waterston commented in 1899 that 'it is an intense satisfaction to have such a place as Valkenberg to send mental patients to. One feels that now they have a chance of cure and will be well and tenderly cared for instead of consigning them to some place of which the best that could be said was that they, the patients, would be kept from annoying their relatives and the public generally', (CO 7321, 18/6/99). She also commented, in relation to the rooms for paying patients, that in these 'nothing seems to be wanting for the comfort and well being of the patients', (CO 7324, 4/1/02).
49. Dodds described accommodating 'a highly educated gentleman', a suicidal patient, in his own home during 'the course of 1894, there being no place for him in the asylum' (G.16-'95, p.43). The stress placed on educational status and melancholia in this description suggests Dodds' vigilance in counteracting popular prejudice against the insane, which stigmatised them as wild, dangerous and weak-minded. Dodds' public campaign on behalf of the better class insane undoubtedly affected admission rates to his asylum.

illness, probably encouraged both doctors and relatives to admit white women who would otherwise have been contained within the domestic situation. Although there were many more men than women admitted to Valkenberg in the period under study, there were odd years in which more women than men were actually resident in the hospital[50]. Between 1891 and 1909, 982 men and 616 women had been admitted in total. The often more-or-less equal figures of men and women resident in the asylum year by year can be accounted for by length of stay. Female patients, once admitted, lived longer than male patients[51].

Another piece of the puzzle is the record of those women discharged from various Cape Colony asylums, 'not improved' (See Figure **18**). The fact that there were fewer women in this category, compared to Grahamstown and Fort Beaufort Asylums, suggests that Valkenberg was regarded as an appropriate institution for the long-term care of white women.

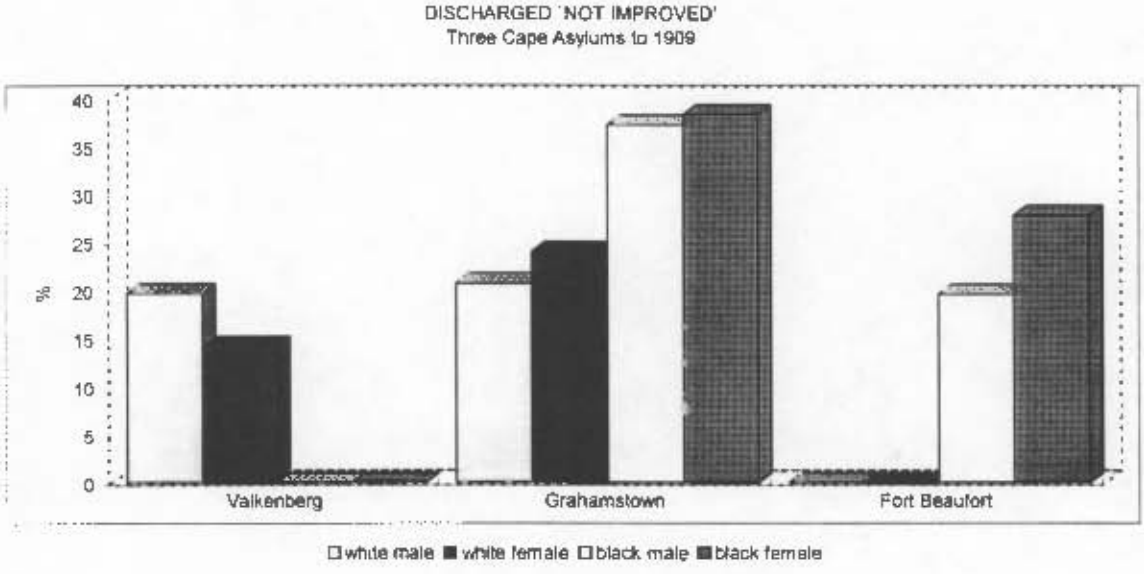

Figure 18 [52]

The complex position of white women in Cape Town needs to be understood against a backdrop of anxieties pervading colonial authorities throughout the Empire. As the census figures demonstrate, there was never a shortage of white women in the Cape comparable to those in other colonial settings, such as Rhodesia or Nigeria. These colonies operated for many years as the domain of men, and women were regarded as intruders, interrupting the social freedom and informality of white men, and restricting their frequent and unchallenged, forced and unforced,

50. This was the case in 1893, 1896, 1899, 1900, and 1901. See Tables 8 and 9.
51. That they lived longer is evident from the lower death rate amongst women. See Tables 8 and 9.
52. G.25-1910, pp.45-6.

sexual liaisons with black women[53]. However, the census numbers give a misleading impression of the way in which the situation was perceived by those in authority. Swaisland gives an account of the efforts made by emigration societies operating from Britain to encourage both middle-class and working-class women to live in South Africa. During the period 1895-1912, 4,821 single women emigrated from Britain to South Africa. Amongst them were domestic servants, children's nurses, governesses and school teachers[54].

Immigration was strongly encouraged, not always successfully, by colonial authorities, for a number of reasons, amongst them a perceived need after the Boer Wars, to prevent English men from marrying Afrikaans women by providing them with marriageable English women[55]. Anxiety about the position of white women in the colony was fuelled by the rape in 1911 of an English governess by an unknown assailant, and the attack in 1912 made on a sleeping housewife by a group of black men, an assault which caused her to take her own life a few days later[56]. These events, which caused a public outcry and a frenzy of anxiety about white women's vulnerability to being attacked sexually by black men led to the Commission into Assaults on Women of 1912. Despite lack of convincing evidence that black 'houseboys' posed a sexual threat to white women, the Commission suggested that 'the employment of male natives to do the work of a lady's maid, chambermaid, laundrymaid or nursemaid be prohibited'[57]. Extensive investigation by the Commission did not uncover evidence that rape was on the increase, nor that white women were in particular danger of assault by black men. This makes all the more interesting their eventual recommendation that black men not be employed in most domestic settings.

Jenny Sharpe argues that the construction of white women as sexually vulnerable in colonial settings served as a reason for repressive and punitive treatment of colonised men by colonisers, also men. It also functioned as a screen preventing the articulation of outrage at white men's assaults on black women, as well as making anyone other than 'white woman' unrapeable[58].

53. Callaway, *Gender, Culture and Empire*, p.4, gives a description of European women's position in colonies which were regarded as 'no place for a white woman'.
54. C. Swaisland, *Servants and Gentlewomen to the Golden Land: The Emigration of Single Women from Britain to Southern Africa, 1820-1939*, (Pietermaritzberg, 1993), p. 41.
55. *Ibid.*, p.42. It is interesting that marriage to Afrikaners was perceived as the threat, rather than concubinage and miscegenation, which was seen as a source of threat in other colonial settings. For a description of white women as protectors of racial purity in the Netherlands, Indies and French Indochina, see A. Stoler, 'Making Empire respectable'. See also C.Knapman, *White Women in Fiji, 1835-1930: The Ruin of Empire?* (Boston, 1986).
56. Swaisland, *Servants and Gentlewomen*, p.95.
57. *Commission into Assaults*, U.G. 39-'18, p.37.
58. Sharpe, *Allegories of Empire*, Chapter 3.

The Commission fuelled the perceived need for employable single white women in the colony. English women of all social classes in the Cape were therefore constituted as an important resource, a bulwark against a growing Afrikaans population, protectors of the safety of English wives and children in domestic situations, and also carriers of English culture and values.

For these reasons, as in many colonial communities, the presence of white women - 'memsahibs' or 'madams' - were regarded as in need of protection, and this would have mitigated against admission to asylums for any mental disturbance except those which were impossible to contain within the home. Their presence in colonial communities summed up the contradictions of Empire throughout the world. Revered for their moral superiority, yet also widely regarded as contributing to racial tension, they represented 'civilised' values, but at the same time, their vulnerability and failure to come to terms with the complexity of colonial society became a metaphor for its fragility[59].

There were also reasons to protect women from white Afrikaans communities against admission to the more stigmatised asylums. Asylums were associated with colonial authority, and the harsh treatment of Afrikaans women in concentration camps during the Boer Wars suggests that English-run asylums would have been regarded as places of last resort. Moreover, the idealisation of Afrikaner women as 'not only the cornerstone of the household but also as a central unifying force within Afrikanerdom' would have mitigated against any but the most disturbed of their number being placed in asylums[60].

The institutionalisation of the black insane of the Cape was subject to very different, but just as complex, constraints. All asylum accommodation available to black patients was of an inferior kind to that made available for whites, and the grim reputation of Robben Island, until 1916 the only facility open to the black insane, undoubtedly discouraged admissions. They were not a homogeneous group, and the fact that their ethnic diversity was disregarded in the provision made for them in asylums probably made some groups reluctant to request that members be accommodated in them. An obvious example is the lack of provision made for the dietary needs of

59. The white woman in South Africa was said to have a 'reprehensible, almost criminal, carelessness and want of thought or of knowledge ... in her conduct towards the native, who is too often regarded and treated as if he were a block of wood without feelings or passion'. *Commission into Assaults*, p.24. Jenny Sharpe points out that perceived racism in the 'memsahib', white women in India, distracted attention from racist practices of white men. *Allegories of Empire*, p.91. Ann Stoler, 'Making Empire respectable', notes a similar pattern in the Netherlands Indies and French Indochina. Also see A.Stoler, 'Rethinking colonial categories', p.139. For a discussion of white men's exploitation of black women throughout the British Empire, see R.Hyam, *Empire and Sexuality: The British Experience*, (Manchester, 1990).

60. For a detailed discussion of the idealisation of Afrikaner women, and its political purpose, see Brink, 'Man-made women'.

Malay patients. Given the racial tension during this period between the 'Malay', 'Coloured' and 'Native' populations, being treated as a single poorly-resourced group must have added to the feared and stigmatised status of asylums.

That provision of accommodation for blacks in asylums more-or-less matched the rate at which the black insane were identified suggests that they were considered a potential threat to the white population if not institutionalised. Colonial labour policy frequently separated 'Native' men from their families, and forced them to live in locations. At times of unemployment or ill-health, whether physical or mental, they had few informal resources upon which to draw. This facilitated their identification, either through the site of their employment or because they became 'loose'. 'Loose natives', those not 'bound' by the contractual and relationship bonds imposed by wage-earning, were a stigmatised category of persons overtly identified as a sexual threat to white women[61]. There is evidence from the Valkenberg series that unemployed 'Coloured' men were regarded with similar suspicion[62]. For example, on admission to Robben Island Nathaniel D was said to 'talk rationally - gives a true account of himself. Admits he was religiously inclined.' The primary reason for his admission appears to have been his tendency to wander off alone onto the mountain, where he fasted and prayed. Carl M who had 'always been queer' was admitted in 1920 when he became dirty and began to run away into the veldt. Jacob Van W was admitted in 1908 when he 'refused to work' and 'wandered aimlessly all over the Country'. Jacobus P said to the examining doctor in 1917 that he 'won't work and doesn't need to'.

The situation for black women living in towns and cities was different. There were only small numbers of 'Native' women living in towns and cities, and those who did were less likely than 'Native' men to have been separated from family. At least potentially they had the possibility of being cared for at home. In rural settings, many 'Native' women lived without their male relatives, and maintained indigenous healing methods. This pattern appears to have persisted in South Africa until very recently[63]. Although in 1904, there were approximately equal numbers of 'Coloured' and white people in the Cape Town area, fewer 'Coloured' women than men were in formal employment. As with 'Native' women this would have contributed to the relative invisibility to colonial authorities of insanity amongst them.

61. The *Commission into Assaults*, p.24, suggested that 'A strong body of evidence supports the view that the classes of natives who commit crimes of sexual assaults upon white females are chiefly loose natives and those engaged in domestic, store and similar service: those, in fact, who are not actually engaged in mine work and have therefore the most opportunities of coming into contact with white women.'
62. See records of Hendrik B, (MC 134), Booi T (MN 45), Jim (MN 5), and John L (MN 17).
63. L.Gillis, R.Elk, O.Ben-Arie, and A.Teggin, 'The Present State Examination: Experiences with Xhosa-speaking patients,' *British Journal of Psychiatry*, **141**, 1982, 143-147.

The reproduction of colonial structures in the asylum system: classification and segregation

Hierarchical classification of patients was the cornerstone of the treatment of insanity in the Cape. The superordinate category separated the sane from the insane. Within the 'insane' group, patients in the colony's asylums were segregated by race and gender. Subordinate to the race and gender classification were categories dividing patients according to diagnosis, duration and severity of illness.

A variety of classification systems, all of which segregated patients by gender, were developed in British asylums in the second half of the nineteenth century[64]. These included classification of patients into groups according to the 'hopefulness' of the case, measured by the length of time they had been insane and the number of attacks they had suffered. The degree to which they were quiet or noisy, violent or tractable, also affected classification. Social class, frequently determined by ability to pay for treatment, was part of the classificatory system. The grouping of patients similar in social class and degree of disturbance was thought to remove 'causes of irritation' which might exacerbate the insanity[65].

Segregation by gender was universal in asylums throughout the world, and extended to segregating male from female nursing staff[66]. The asylum *Regulations* for the Cape, which replicated those in Britain, stipulated that:

> no male nurse, servant, or patient (except in the discharge of a duty with adequate authority and under proper supervision) shall be allowed to enter the female wards, nor shall any female patient enter the male wards. In cases where the physician superintendent shall deem it advisable, he may appoint nurses or female servants to do duty in the male division. Under no circumstances shall a male nurse or male servant be placed in charge of female patients.

The *Regulations* also stipulated that in the case of visitors, 'no male ... shall remain in a room with a female, except in the presence of a nurse or other third person not a patient'[67]. As the Medical Certificates and Periodicals in the Valkenberg series demonstrate, both male and female insane patients were readily identified as behaving in sexually inappropriate ways. This included masturbation, public displays of nudity or sexual desire and liaisons across racial boundaries. Gender segregation in asylums was partly a protection for women who were perceived as actively

64. Grob, *Mental Institutions in America*, p.225.
65. D. Noble, 'The therapeutic environment,' 1853, reprinted in V. Skultans (ed.), *Madness and Morals: Ideas on Insanity in Nineteenth Century*, (London, 1975), p.145.
66. Tucker, *Lunacy in Many Lands*.
67. *Regulations for the Management of Hospitals*, p.12.

encouraging or defenceless against the advances of unscrupulous male staff, visitors or patients. Experience on Robben Island, where a number of women became pregnant during their period of committal before strict gender segregation was enforced, proved to the authorities that such protection was necessary[68]. The scandals erupting about these inescapably visible sexual liaisons reinforced the construction of gender segregation in the Cape's asylums as precluding reproduction rather than sexual activity itself. Although masturbation in both male and female patients was stigmatised as 'dirty', and implicated in mental deterioration, in Valkenberg it was not forcibly prevented[69]. Erasure of female sexual desire beyond the confines of heterosexual marriage not only identified masturbation in women patients as pathological: it also silenced the possibility of lesbian relationships between them, which is a possible explanation for the absence in the remaining case records of reports of sexual contact between women in the asylum. By contrast, there is evidence in the Valkenberg series that staff were aware of occasional sexual contacts between male patients, about which little seems to have been done[70].

Despite policy on gender segregation, there were occasions on which men and women in the asylum did have contact[71]. Women visited insane male relatives, recreational activities such as concerts or dances brought men and women together, and at times women were used to staff male wards. The need to police these contacts with vigilance was reinforced every time they resulted in an overt display of sexual desire. An example is described in the record of James R, about whom it was said: 'Abuses himself and has attempted to have connection with both sexes here. Requires to be kept from female company'.

Segregation by race, linked often to unequal facilities, was also a widespread practice. In 1855, an American asylum attendant, Charles H. Nichols wrote that the 'Coloured' insane 'should be accommodated in special cottages or lodges situated near the main edifice for whites, but so entirely distinct from it that all desirable separation of the races may be maintained'[72]. In India, it was thought to be 'altogether impossible' to mix patients of different race, class or gender[73]. Although both American and Indian colonies purported to see humane treatment for all sufferers

68. Deacon, 'A history', Chapter 3.
69. It was prevented in other asylums and private facilities, by restraining clothes and cuffs. See the case of Hendrik B, (MC 134).
70. See record of Jacob H (ME 997) who was described as being 'on intimate terms with patient F.' There is no record of this liaison being stopped.
71. These contacts were however segregated by race. The only exception would have been black cleaning staff. The records are silent on the possibility of black female domestic workers being sexually harassed or assaulted by patients. Given the colonial context, in which black women were often unprotected from the sexual advances of white men, it is likely that such incidents would not have reached the public domain.
72. Quoted in Grob, *Mental Institutions in America*, p.247.
73. Bombay Asylum Report 1852, quoted by Ernst, *Mad Tales from the Raj*, p.75.

as important, in practice, the poorer and racially stigmatised patients were forced into overcrowded and badly resourced facilities[74].

Classification of patients, with racial classification being a first priority, was a constant theme of Dodds' Inspector of Asylums reports. In 1891, commenting on the necessity for black patients in Old Somerset Hospital to make use of white patients' lavatories, as no others were available, Dodds said, 'These Lunatic wards ... are altogether unfit for the care and treatment of persons of unsound mind'[75]. In 1892, he complained of the failure of Robben Island 'to introduce racial classification on the female side. There are three wards or sections, and in all white and coloured are mixed. I feel sure that this is very undesirable, and that it could be very much lessened, if not entirely obviated; and I hope an earnest attempt to do so will be made'[76].

Concern about racial contact within Cape asylums eased as fully segregated institutions were opened. However, continual policing of the racial boundary performed essential discursive work by rehearsing the need for fine discriminations between 'white' (no colour) and 'colour'. Apart from separating white from 'Native', this process sought to insulate whites from those whose ethnic background was identified in terms of 'mixed' blood. This was despite the impossibility of detecting such difference by physical means. In this way, shadings of 'colour' became a complex summary of judgements which only whites could make, on the basis of class, social standing, language community, and parentage. Thus segregation was increasingly inscribed as the insulation and hence purification of 'white', with those closest to 'white' in 'colour' being the target of intense scrutiny.

The following examples demonstrate the evolution of this discursive policing over time. In 1896, a group of nine black women were admitted to Valkenberg, because there was no other accommodation for them at the time. Their eventual transfer to Robben Island was described by Dodds as 'a relief, for I am more and more convinced that it is a wise thing to separate European and coloured insane patients'[77]. In 1898 the Under Colonial Secretary wrote to Dodds about a child, Matilda Weinand, admitted to the Institute for Imbecile Children in Grahamstown on the understanding that she was white. It turned out that she was a 'half caste child, one of her parents being coloured'[78]. She was referred to elsewhere as an 'off-coloured'. In 1902 Dr Waterston 'noticed one coloured patient' during an official visit. 'It is very difficult to draw the line in this

74. Grob, *Mental Institutions in America*, p.247; Ernst, *Mad Tales from the Raj.*, p.79.
75. CO 1485, 1891.
76. CO 1524, June 7 1892.
77. G.28-'98, p.79.
78. CO 7180, 1898.

country, but I think the one in question was decidedly coloured and therefore not eligible for admission to Valkenberg'[79]. Dodds' reply to Dr Waterston's report on the 'Coloured' patient stated that two 'Coloured' women, said by relatives to be white, had been admitted to Valkenberg. One had been discharged as recovered; the other was too ill to move, but would be transferred to Robben Island when space became available[80]. In 1904, Dodds remarked that 'the colour question has not hitherto given us much trouble', but reported on a woman presumed white during the committal process because she was married to a white man. She was too ill to turn away, once her 'colour' had been detected, necessitating 'the legal fiction' of 'treating her as white' in the statistical tables[81]. The fundamentally fictional nature of her classification as 'Coloured' gives her translation into a white statistic particular irony. In 1911, a 'slightly coloured' woman was admitted to Fort Beaufort Asylum. She was removed to Port Alfred soon after, as she was too 'white' to remain in an institution with a largely 'Native' patient population[82].

The consolidation of segregationist policy on the basis of race was justified solely in terms of white patients' welfare. Being accommodated with black patients was considered to be offensive to the sensibilities of white patients and their relatives[83]. Given a general shortage of accommodation, and the necessity to segregate by race and gender, other forms of classification, such as the separation of noisy from quiet or recovering patients, was seldom achieved.

Foregrounding race and gender as of primary importance in the spatial organisation of patient groups meant deleting class as an appropriate means of patient classification[84]. A meeting between the superintendents of all Cape asylums in 1907 arrived at the decision 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'[85]. The inclusion of 'friends' in this comment makes clear asylum superintendents' sensitivity to the public image of their establishments.

Concern about contact between races was not confined to the insane: there was also anxiety about white staff nursing black patients, in general hospitals and in asylums. During the 1891-1920 period this anxiety came to be focused on the need to protect white female staff from the

79. CO 7324, 6th July, 1902.
80. *Ibid.*
81. G.55-1904, p.51.
82. MOH 1/61, 24/2/1911.
83. HFB 3, 26th April, 1907.
84. However, in the colonial context, the black population was under-resourced in terms of educational and employment opportunities. This linked race and class, so that segregation on the basis of race often, but not always mirrored class divisions.
85. HFB 3, 26/4/1907.

'degradation' of intimate contact with black men. In 1911, Senator Munnik put a question to the Minister of the Interior about 'white nurses (who) were compelled to perform degradingly menial offices towards native men patients, which could well be performed by male native attendants'[86].

The discursive arena of asylum nursing was fertile ground for the expression of anxiety about contamination and corruption of the body, a discourse which readily lent itself to racialisation. In an appeal for more generous retiring allowances for asylum staff, Dodds wrote the following letter, later appended to a petition signed by all the Colony's asylum superintendents, to the Colonial Office:

> An attendant may have to submit to receiving the foulest abuse, to be spat upon, and have urine thrown in his face. He has to attend to patients of insanely dirty habits, who may smear themselves and their rooms with filth, and who, for months, may need to be washed and attended to like napkinned infants[87].

This vivid representation of insanity, a regression to infancy without innocence, and simultaneously malevolently verbal and physically dangerous adulthood, uses the corrupted and corrupting products of body - words, saliva, urine, faeces - to describe corrosion of mind, and links both to mental and physical stress in the attendant.

Also attached to the petition and in sequence with it were comments written by a white nurse at Grahamstown Asylum, on her duties in the black wards. Commissioned by Greenlees, they describe being bitten by black patients, and reiterate the image of corrupting body products, this time racialised and recalling the colonial fear of the rabid bite of wild animals[88].

> In many cases I have known these bites to be very serious; although a Kafir's teeth look very white, clean, and pretty, yet the teeth of the insane must contain some poisonous material, for, at the best, the bite often ends in grave and deep-seated suppuration, with mortification of the tissues...[89].

The discursive context into which these comments were written interlocked race and gender. A white male superintendent ordered a white female nurse to write her remarks in service of an appeal for adjustments to payment which would benefit men more than women, and whites more

86. PAH I/7:16/3/1911.
87. Dodds' letter is dated 1/1903 and the petition 20/12/04, CO 7918.
88. The bite in this text recalls widespread fear in the white population of black violence, often expressed as the danger of black men raping white women. The Attorney General, addressing Parliament in 1902 commented on the dangers of contact between black men and white women, saying 'this was a matter of the gravest importance, for once the barriers were broken down between the European and native races in this country, there was no limit to the terrible dangers to which women could be submitted, particularly in isolated places'. Quoted in R. Hallett, 'Policemen, pimps and prostitutes - Public morality and police corruption in Cape Town, 1902-1904', in C. Saunders (ed.), *Studies, v.1*, (Cape Town, 1979), p. 7.
89. CO 7918, 20/12/1904.

than blacks. This was the gendered and racialised colonial hierarchy, in which white men were positioned as simultaneously protecting and failing to protect white women from the constantly dangerous savage environment.

The nurse also commented on the 'perfect Pandemonium' resulting from 'quarrelsome and noisy' black female patients, acting as a 'ferment' in dormitories. 'I may here state that the number of native women requiring single rooms too often exceeds the number of single rooms available.' Thus the solution to the invasively violent and dangerous task of nursing across racial boundaries was again physical isolation. This construction disabled a reading of asylum life as including violence committed by staff against patients, recalling the erasure of violent attacks made by white men on both black men and women and the violence of the colonising mission itself, which entered the black body, deprived her of adult status and positioned her as a site of infection[90].

In 1916, when Valkenberg began to admit black patients, every attempt was made to maintain its status, acquired in its time as a whites-only asylum, as a refuge for the 'better class' insane. The first batch of black patients were carefully chosen: 56 Native and Coloured working patients were transferred from Robben Island[91]. They were regarded primarily as an unpaid labour force, an institutional practice which neatly silenced both their insanity, and need for care. The black inmates of Uitvlugt were like servants, and in this guise, their occasional contact with white patients reproduced the pattern of contact between white and black in society at large.

The issues raised by the patient classification are illustrated in the case of a black patient, Booi T, transferred to Valkenberg from Robben Island in 1916. It warrants detailed description because it gives an indication of the relationship of state policy concerning classification and segregation to individual welfare, and to the needs and policies of asylums themselves.

Booi T. was admitted to Robben Island in 1906, a married labourer, designated 'Kafir'. He had been brought to Cape Town from Knysna, on the Cape coast. He was diagnosed as having delusional mania, and remained on Robben Island until the 2nd July, 1916, when he was transferred to Uitvlugt, one of the batch of supposedly quiet working patients. The last note about him prior to his transfer was 'Cannot now elicit any delusions as to wealth, powers, & statements as previously given about age[92]. Tidy. Works.' He lasted exactly a month in Valkenberg, before being transferred back to Robben Island. He said he was a white man, and demanded white man's

90. Comaroff, 'The diseased heart of Africa'.
91. U.G.31-'20, p.19.
92. He had claimed to be 2750 years old.

food. He threatened violence, and refused to eat. Valkenberg was considered unsuitable for 'such cases'.

There are a number of issues of interest in this series of events. It confirms records which suggest that Valkenberg admitted black patients only if they were quiet, relatively self-contained, and therefore likely to work well. It suggests the uncertainty of Valkenberg staff in the face of threat from black patients, although they had for years been dealing with acutely violent white patients. With Booi, the threat was not only from physical violence: he also challenged the racial boundary by saying he was white. Moreover, by expecting to eat as white patients did in this elite institution, he was drawing attention to discriminatory practices within the asylum. Complaints about their rations from black patients could have caused Valkenberg's superintendent considerable trouble. Booi's transfer back to Robben Island is therefore unsurprising in this context.

Caring for the lunatic body: institutional economies and differential provision of resources

Thus far, this chapter has argued that the universalising discourse of liberal humanism, represented by Dodds' insistence that humane care be provided for all the insane in the Cape, was in tension with constant awareness of racial and gender difference within the insane population. Racial and gender classification were fundamental to patient classification, and determined the availability of asylum accommodation. The chapter now turns to the effect of classification on treatment.

The hierarchy of status which structured the society outside the asylum was maintained within its walls, with white men tending to fare better than white women, and all the white insane being better cared for than those marked as black.

Within the strictly segregated structures which were consolidated during the period 1891 to 1894, with the opening of Valkenberg as whites-only and Fort Beaufort as blacks-only asylums, a clear pattern of discriminatory treatment emerged. The statistics on dietary scales, recovery rates and death rates, are of particular interest in this respect. It began with allocation of funds, and here the statistics on Fort Beaufort, in comparison with other asylums, are important. Because Fort Beaufort provided for blacks only, discriminatory allocation of funds is possible to detect. In 1909, Fort Beaufort had a nett expenditure of £6,535 per annum, for a daily average of 475 patients. This is in comparison to the nett expenditure of £7,480 for Valkenberg, with its daily

average of 410 patients. The cost per head annually at Valkenberg was £42.6.0, as opposed to £32.1.1 at Fort Beaufort. By 1919, 3.7d were being spent daily on Valkenberg patient maintenance, in comparison to the 2.5d at Fort Beaufort[93].

The cost of diet scales which were appended to the annual report after the appointment of Dunston as Commissioner of Mentally Disordered and Defective Persons in 1916, gives an idea of one area which contributed to these discrepancies. The cost of feeding one white male at Valkenberg per annum was recorded as approximately £25, as opposed to the £6 spent on black females at Pretoria asylum. No comment was made in the report on the discrepancy. A hierarchy was established therefore, in which men were fed more than women, and 'Europeans' more than 'Asians', 'Coloureds' and 'Natives', in that order.

At this historical distance, the relationship of these statistics to the reality of nutrition in asylums cannot be discerned clearly. However, the intent of the Government - that less was to be spent on black patients - is clear. Moreover, it is telling that no justification for this was deemed necessary, presumably because it was thought to be transparently obvious. In 1890 Dodds commented about Grahamstown Asylum that the 'dietary is too liberal, I think, in its allowance of meat, for the native patients at all events'[94]. In this way 'Native' patients were positioned as 'needing' less, because it was argued that they were unaccustomed to eating large quantities of fresh meat. In the same report, Dodds made clear his expectation that black patients tolerate bathing in water used by other patients, although he felt fresh water should be given to whites:

> All the patients have a bath once a week, but complaints arise from more than one being bathed in the same water. Fresh water should at all events be given to the Europeans, though in cold weather and in drought it might be necessary to curtail the quantity for each[95].

The construction of Fort Beaufort's wattle and daub hut annex highlights similar issues. In 1908, at Fort Beaufort Asylum, a wattle and daub hut annex was completed. The 1907 annual report carries this comment on it:

> In July, 1907, the Government decided to erect huts in the form of a location annex to the Male Asylum for the accommodation of 100 patients. This was in place of the proposed New Block for 100 male patients, estimated to cost £9,500. The estimate for the huts was £2,650. This shows a very considerable saving[96].

93. G.25-'10, p.54.
94. *Ibid.*, p.21
95. G.37-'91, p.20.
96. G.41-'08, p.41.

What is interesting about the hut annex is that administrators appropriated the 'barbaric habits' of 'Natives' in a money-saving exercise, and were able to rationalise spending less on Native patients, by arguing that they preferred to maintain their native style of living. The hut annex was thought to be unsuitable to accommodate attendants, and appeal was made for a brick building to accommodate them.

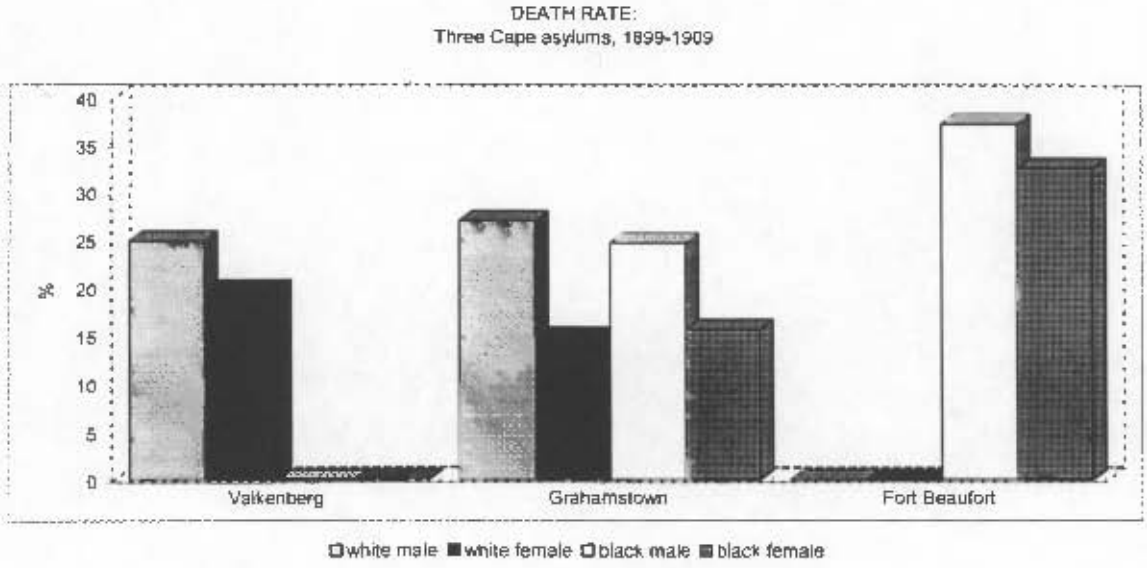

Figure 19

Except at Fort Beaufort, the death rate was generally lower for women throughout the period of study (see Figures **19**[97] and **20**[98]). The impact of influenza, enteritis, and tuberculosis would have affected death rates differentially in the various institutions from year to year, but women were more likely to resist epidemics, and to recover from attacks if they became ill. These statistics reflect mortality rates in the general population[99]. The numbers of women patients succumbing to the influenza epidemic of 1918 are of interest in this respect. In Valkenberg, 135 male patients out of a total of 568 (23.8%), and 57 female patients out of 448 (12.7%) became ill. 17 men and 5 women died.

97. G.25-'10, p.43.
98. U.G.31-'20, p.32 and p.36; U.G.31-'21, p.14 and p.16. By the end of 1919 there were no black female patients in either Valkenberg or Grahamstown. The statistical tables for 1920 do not give information on deaths in each asylum, so 1920 has not been included.
99. van Heyningen, 'Public health and society', p.456. For a discussion of differential death rates amongst different population groups during the 1918 influenza epidemic, see Phillips, 'South Africa's worst demographic disaster'.

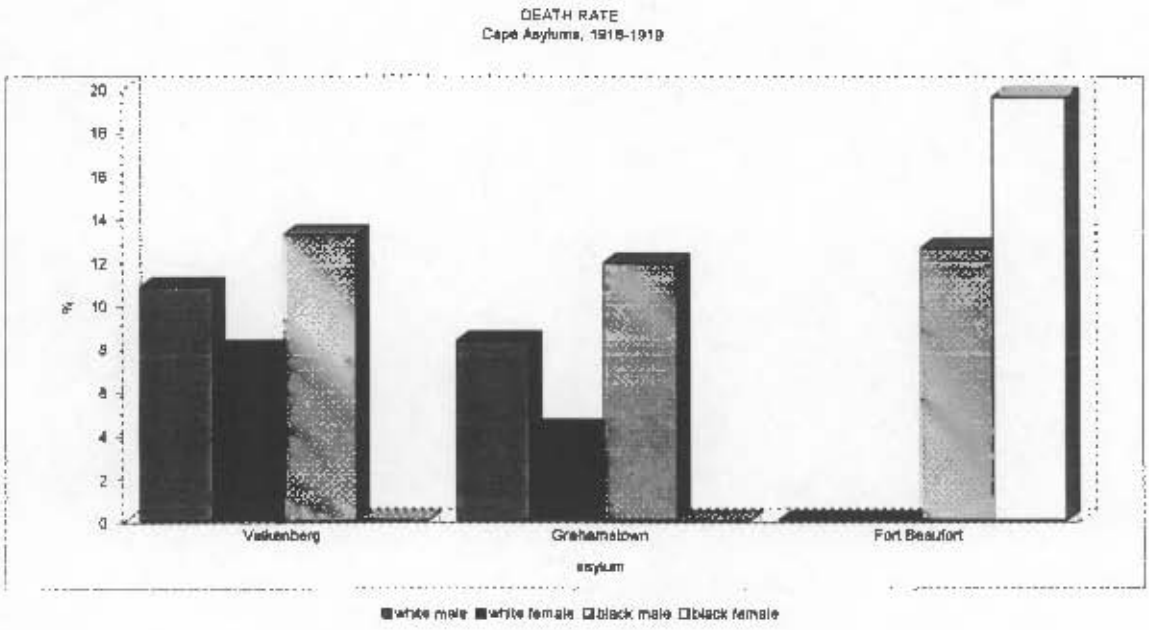

Figure 20 [100]

Death rates amongst black patients were almost invariably higher than the death rate for white patients (Figure **20**). The discrepancy between black and white death rates has continued to be a feature of South African mental hospitals. In 1979, the APA committee inspecting private psychiatric facilities found an 'unduly high death rate' and 'evidence of needless deaths among black patients'. They had a strong suspicion that similar needless deaths were occurring in state institutions[101].

A recurrent feature of the causes of death, listed annually, was the high incidence of tuberculosis amongst black patients. The numbers varied from year to year, but were approximately three or four times higher for black patients[102]. These figures arose directly from poor nutritional status, and overcrowding, and mirror social circumstances outside the asylums, where tuberculosis figures were similarly high for the underprivileged[103].

100. Valkenberg and Grahamstown Asylums had no black female patients on register at the time the statistical tables were drawn up.
101. 'Report of the Committee to Visit South Africa', A. Stone, C. Pinder-Hughes, J. Spurlock and J. Weinberg, Committee to visit South Africa, 'Report of the Committee to Visit South Africa', *American Journal of Psychiatry*, **136**, (1979), 1498-1506.
102. For example, the death rate from tuberculosis amongst European patients in Cape asylums between 1905 and 1909 varied from 4.6% to 9.6% of all deaths, compared to a range of 35.5% to 47.9% for Coloured and Native patients. In 1909, there were 52 deaths from tuberculosis in Cape asylums, 5 were white patients, and 47 black. In 1919, 6 white patients died of tuberculosis, compared to 54 'Native' patients and 26 'Coloured' patients. G.25-'10, p. 15; U.G.31-'21, p.7.
103. van Heyningen, 'Public health and society'.

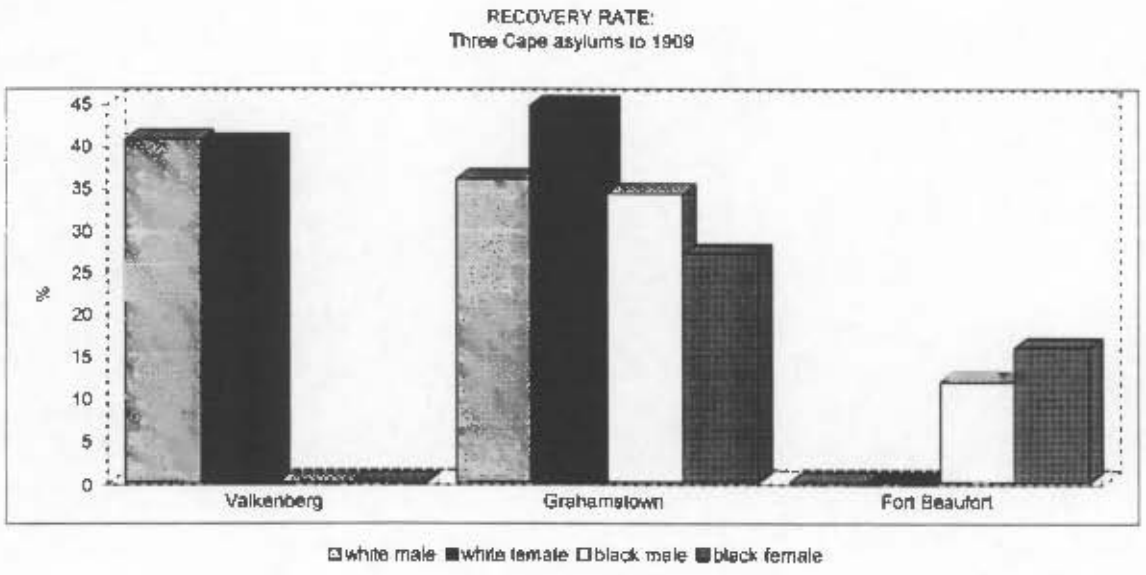

Figure 21

Until 1909, the recovery rates, although similar for men and women, were markedly discrepant for white and black patients. Recovery rates in mental hospitals are notoriously difficult to estimate. A proportion of the population, suffering from congenital illness, or organic disease had no possibility of a cure; others who seemingly 'recovered', relapsed; still others were discharged although they were not fully recovered. 'Recovery' was also linked to a number of other factors, including availability of relatives into the care of whom patients could be discharged, length of stay in the asylum, and the aetiology and prognosis of the disorder for which they had required treatment. White patients were more likely than black patients to be admitted for short periods suffering from disorders with a good prognosis, such as delirium tremens. Their discharge after a brief period of 'drying out' would have inflated recovery rates. Given the relatively low rate at which insanity was identified in the black population, it is likely that only the most incapacitating, disruptive or dangerous conditions resulted in committal. This would affect recovery rates adversely. Moreover, asylum attendants rarely understood the language of their black charges, and knew little about their families or the origin of the insanity. Facilities were overcrowded, and health compromised by poor diet, and insufficient medical coverage. These would have compromised both diagnosis and care[104].

104. The extent to which Native patients in particular were left to look after themselves in asylums was baldly stated by Conry, in correspondence with the Colonial Office about lengthening the working day of nursing staff: 'My opinion is, that considering the Staff here are very seldom in close contact with the Patients indoors, practically only in rainy weather; that the Patients and Staff are during the day almost always out of doors in the large Airing Courts; that when in the Airing Courts the Nurses give little attention to the Patients, principally because they cannot understand their language, and so pay no attention to what they say, ... the leave given here is too much...', CO 7919, 15/9/05.

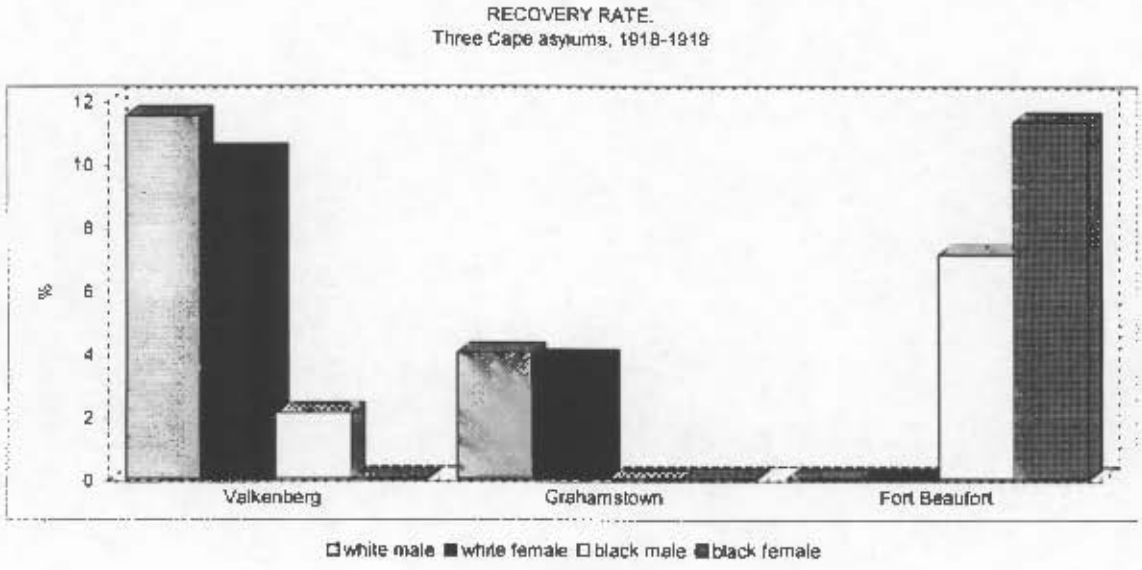

Figure 22

Figures **21**[105] and **22**[106], reflecting recovery rate as a function of cases, as opposed to persons, indicates that black and white patients were discharged 'recovered' at comparable rates. Given that there were no substantive changes to accommodation, diet, and treatment in asylums between 1909 and 1919, the change in the figures is likely to reflect a change is discharge policy, rather than change in recovery rate *per se*. Affecting discharge policy would have been increasing pressure to make space in institutions for acute admissions, which would have forced superintendents to discharge patients regardless of housing and care available to them outside the asylum.

The working body: domesticity and labour

Care for the insane in Cape asylums during the period 1891-1920 was governed by four principles, which together formed the basis of 'moral treatment': 'early' treatment, in 'incipient' stages of the illness[107]; classification of patients according to race, gender, and class of disturbance, separating quiet, 'hopeful' and recovering cases from dangerous or disruptive ones; remedial occupation and recreation; and minimal resort to harsher forms of control such as mechanical restraint and seclusion[108]. Apart from identification and diagnosis of insanity, and assessment of its origins,

105. G.25-'10, p.43.
106. U.G.31-'20, p.32 and p.36; U.G.31-'21, p.14 and p.16.
107. 'Proposal for provision for the insane', Dodds to the Colonial Office, CO 1485, 22/10/1891.
108. G.17-'93, p.137; 'Proposal for provision for the insane', CO 1485, 22/10/1891. Moral treatment did not preclude the use of sedatives and hypnotics which were widely used on disruptive periods throughout this period. The moral treatment outlined by Dodds in his 'Proposal' conformed to contemporary British practice. For detailed descriptions of the changing nature of moral treatment, see V. Skultans, *Madness and Morals*, 146-152. The distinction between 'moral treatment', and 'moral management', which systematically applied rewards and

'moral treatment' was singled out by Dodds as the major component of humane psychiatric practice. Achieving 'moral treatment' in Cape asylums became therefore the focus of reform, and an important identifying feature, in theory at least, of Cape psychiatry.

Lack of accommodation made proper classification of patients impossible, and also affected the availability of early treatment. For this reason, the ideal treatment, given shape by the annual reports during this period, came to consist of regular and routine employment doing asylum work such as farm-work, laundry, sewing, and carpenting, sport, such as cricket and football, indoor games, such as chess, draughts and card-games, plays, dances, and excursions. With this regime, Dodds optimistically hoped 'to cure the curable and to brighten the lives of those that cannot be cured'[109]. There was however considerable difference between the ideal Dodds hoped to achieve, and its practical manifestations. The complexities and tensions of the colonial setting gave moral treatment a unique form, affected by both the race of the patients, and their gender[110].

A gendered regime of occupation was set out for patients in the asylum regulations, including farming and gardening for men, and laundry, kitchen duties and sewing for women. Case records indicate that 'occupation' for both men and women also entailed 'ward work', sweeping, polishing, bed-making and even care of other patients. However, the social position of white women in the colonies affected the extent to which they could be induced to work in asylums. Manual labour of any kind was regarded socially as beneath them, because it was usually carried out by blacks[111]. In 1902, Dr Jane Waterston, in her Official Visitor's report on Valkenberg, remarked:

> In a country where most women have to work from lack of proper service, it is natural to do some housework, even if light, and one cannot help feeling that kitchen and laundry and workroom are healthier places for women patients than even the very pretty sitting rooms and verandahs. Of course a large number are too bad to work but it would be a real kindness to lady patients of the paying class if they had to do something, but then what would friends of patients say?[112]

The structuring of domesticity through both race and class, and concern about public opinion are made transparent in this statement. As Swaisland's work demonstrates, 'proper service' during this period referred not only to training, but also to race, imported British domestic servants being

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punishment to influence patient behaviour, is described by Digby, *Madness, Morality and Medicine*, pp.85-87. Moral management was never formally used in Cape asylums.

109. G.37-'91, p.9.
110. In India for example 'remedial employment' was considered too taxing for white patients unused to tropical climates. Ernst, *Mad Tales from the Raj*, pp. 82-3.
111. E. Bradlow, 'Women at the Cape in the mid-nineteenth century', *South African Historical Journal*, **19**, (1987), p.70.
112. CO 7324, 6/7/02.

describes these narratives.

Chapter Seven

LEXICAL SETS AND THE REPRESENTATION OF ACUTE AND CHRONIC INSANITY IN THE VALKENBERG CASE RECORDS

Introduction: the contents of patients' folders

In Chapter Four, I argued that the official forms and certificates used in the Cape during the period 1891-1920 constrained the way in which insanity could be perceived. At the same time, the forms maintained the fiction that doctors were, as writers, spontaneous and attuned to individual diversity. An examination of doctors' writing in the Valkenberg case records surviving from the period 1891-1920 reveals ways in which the forms elicited uniform patterns of response despite the diversity of the patient population.

The case folders contain the committal certification, admission record and case notes, Periodical Reports, and in some cases, correspondence with relatives or friends, details of maintenance payments, records of physical illnesses, including temperature charts, applications for leave on probation, and transfer and death certificates. Together these documents form temporally and stylistically discontinuous narratives about the course of each patient's asylum career. These records have a striking uniformity across all groups of patients, regardless of racial classification, gender, class, and form of insanity.

A degree of uniformity in the contents of case records across patient populations is the discursive product of their institutional function. Garfinkel, writing about the contractual nature of clinic records, suggests that 'the records consist of procedures and consequences of clinical activities as a medico-legal enterprise'. In this regard, he suggests that 'considerations of medico-legal responsibility exercise an overriding priority of relevance as prevailing structural interests whenever procedures for the maintenance of records and their eligible contents must be decided'[1].

While the contents of case records are shaped by their contractual function within particular institutions, they also reflect other aspects of institutional life. Dorothy Smith argues that texts in institutional settings play an ordering and co-ordinating role across diverse and spatially dispersed organisational activities, and that their interpretation will vary according to their purpose and audience[2]. One of the consequences of this is that the same record may be read in different ways, according to shifts in context. For example, a clinic record may function both as a source of information on a diagnostic problem in a case conference setting, as well as a contract between relatives, legal and medical institutions, justifying a patient's involuntary confinement.

Case records present themselves as factual accounts, but because their audience, discursive goals and therefore their perlocutionary force constantly shift with changes in context, they do not have

1. Garfinkel, *Studies in Ethnomethodology*, pp.198-200.
2. Smith, *The Conceptual Practices of Power*, p.89.

a transparent relationship to the reality they purport to describe[3]. Case records, 'much less than revealing an order of interaction, presuppose an understanding of that order for a correct reading'[4]. The reason for this lies in the assumption of multiple shared, but not inscribed, contexts to which readers within and between institutions are party, and outsiders are not. This calls into question the relationship between textually-mediated 'knowledge' generated in institutional settings, and the 'actualities', or lived experience they describe[5]. Inscribed in 'sanctioned terms and forms', narratives are created, fictively about individual patients, but servicing the contractual and actuarial needs of the institution[6].

Contents of patients' folders therefore, allow patients to be 'known' within a system which determines what counts as knowledge. They repeatedly justify their existence by producing evidence that the institution whose workings they textualise is essential to society. The folders also structure power in institutions by privileging some with the right to inscribe, and not to be inscribed themselves.

The contents of the Valkenberg case records cannot therefore be read as simply 'about' individual patients. Their primary function was the textual mediation of the medical and legal activities of the asylum. Their contents constructed and displayed psychiatric knowledge and professional activity, and biographical notation was subordinated to this primary goal.

Just as the wording on the forms, imported from Britain, erased unique features of the colonial setting, so their contents tended to foreground similarities between insane individuals and to suppress their linguistic, cultural and social diversity. To textualise the Cape insane as homogeneous, and at the same time to develop institutional practices which divided groups according to racial and gender classification, was the central feature of the emerging colonial psychiatry. Its racism was the inevitable consequence of failure to engage with individual diversity, while simultaneously asserting the primacy of biological difference.

There are however some patterns of difference in the case records, which mark the salience for doctors of both racial classification and gender. These patterns of difference are evident as a muted counterpoint to the more readily apparent uniformity of these texts across patient groups. This Textualisation of difference can be read as revealing doctors' gendered and racialised

3. D. Smith, *Texts, Facts and Femininity: Exploring the Relations of Ruling*, (London & New York, 1990), p.218.
4. Garfinkel, *Studies in Ethnomethodology*, p.201.
5. Smith, *The Conceptual Practices of Power*, p.71.
6. D. Smith, 'The social construction of documentary reality', *Sociological Inquiry*, 44, 1974, p.265.

perceptions of groups of patients, rather than as an engagement with individual difference. Ways in which groups of patients were distinguished from each other both reflected, and contributed to , the construction of the psychiatry which emerged in the Cape during the 1891-1920 period.

This chapter will describe the texts in which patients' lives in asylums were recorded. These texts were written primarily by doctors, and reveal a multi-layered, and sometimes contradictory, relationship between doctors, patients, and the medical and legal audiences to which the patient documents were addressed. In the following sections, doctors' position in relation to their record-keeping activities, and the habitual descriptive sets they employed to characterise insanity will be described. The implications of these texts for the construction of Cape colonial psychiatric knowledge and practice will be explored.

Doctors as writers

The contents of patients' folders during the period 1891-1920, were almost entirely written by doctors[7]. The only exceptions to this took the form of legal documents, such as affidavits and resident magistrates' reports, or correspondence from friends or relatives. It is important therefore to consider ways in which the records created by doctors as writers were shaped by their professional training, their responsibilities in asylums, and by the records' intended audience.

1. ***The audience for doctors' writing***: There were major constraints on both the content and the form of doctors' writing in case records. They were accountable to the law for committal and further detention or discharge of patients, for explanation of escapes, assaults or accidents, and for identification of causes of death. This contractual function, and its legal audience, obliged doctors to rehearse discursively the appropriateness of asylums as the institutions in which the insane should be treated, and themselves as appropriate professionals to treat the insane.

Contents of patients' folders addressed a medical as well as a legal audience. Case notes did not belong as possessions to the doctor writing them, but were intended to produce a narrative about each patient for successive generations of doctors. This actuarial function makes it possible to trace doctors' relationship to changing professional knowledge. Awareness of differences between themselves and doctors from earlier decades can be seen for example, in the 1917 Periodical Report on Paul M, a patient committed to Robben Island in 1876, and transferred to Valkenberg in

7. This was the case until the 1970's, when social workers, occupational therapists, clinical psychologists and nurses were allowed to write notes in patients' folders for the first time. The doctors writing in the folders of the Valkenberg series often had not had specialised training in psychiatry; Dr Dodds and Dr Moon, Superintendent of Robben Island, were exceptions. Doctors working in asylums however, clearly had more experience of insanity than those in general practice, who were part of the committal process.

1891, which noted that the cause of his illness on admission had been recorded as 'vanity and crosses in love!' The exclamation makes clear that the writer of the 1917 report regarded this analysis as quaint. Similarly, a 1917 Periodical Report on John C, commenting on the Medical Certificates written in 1902, noted that he was 'said to have an idiotic look!', which immediately constructs 'idiotic look' as archaic terminology.

The use of psychiatric terminology to describe symptoms, and the application of diagnostic labels was a major site of communication between doctors through the case notes. Thus to write of a patient that she was 'predominantly mutistic', had a manner 'suggesting the presence of auditory hallucinations', displayed 'neither resistiveness nor flexibilitas cerea' and was diagnosed 'schizophrenia - catatonic' addressed an audience with specialised knowledge.

However, the relationship of doctors as writers to other members of their profession was in some respects underdeveloped, and this becomes obvious in an examination of the ways in which admission forms were used. Many of the admission forms in the Valkenberg case series are incompletely filled in, because the original admission data was put into case-books, and only demographic data, a summary of Medical Certificate information, and the progress of the case was transcribed for the folder. However, even when case-books were no longer used, it is uncommon to find a fully-completed admission form. While the patient's physical status seems to have been systematically checked, probably because failure to identify physical injuries or illnesses on admission had the potential for serious repercussions later, the section on mental status was usually left blank. Of the 248 records in the series, only 4 had the section on mental condition filled in.

The mental state categories were a site in which asylum doctors' identity as specialists in the diagnosis and treatment of the insane might have been unambiguously established. The mental status examination, framed to explore fully symptomatology along Kraepelinian lines, provided an esoteric language and a theory which would have secured professional territory[8]. It is puzzling therefore that doctors did not take the opportunity offered to them in the admission forms to consolidate their identity as specialists. It seems possible that contradictory forces were at work in this: on the one hand doctors working in asylum settings did not feel their territory to be

8. Scull has argued that control of asylums, combined with an esoteric theory supplied by Freudian ideas secured for psychiatry 'its independence from outside scrutiny and interference in its line of work'. Scull, *Museums of Madness*, p. 258. Cape asylum records suggest that while Freudian theory played a crucial role in establishing professional territory for psychiatrists beyond the reaches of traditional asylum practice because of its association with middle-class 'respectable' clients, it was less salient to asylum practice than the discourses of organic psychiatry associated with Kraepelin.

challenged in any way, and therefore felt no need to textualise an area of specialisation. On the other, doctors appear to have accepted a stigmatised position vis-à-vis the medical profession as a whole, as a result of being associated closely with a stigmatised community[9]. For this reason they were slow to take opportunities provided for them to raise their status.

2. The pressure of numbers: Pressure of patient numbers, and onerous administrative duties precluded doctors from spending much time in the wards. As one patient, asking to be discharged, wrote:

> Doctor, I seldom get the opportunity of speaking to you personally so I must refer the matter to you by means of paper and pen - & I trust you will not think it rude of me. I would like to see you face to face but I can't see my way how to arrange it[10].

Given the large numbers of patients, and the legally-required documentation, for which all asylum doctors were responsible, lengthy and individualised descriptions of patients were an impossibility. Keeping records for doctors had to become a limited and routinised activity, where a small set of descriptors were used over and over[11]. These standard comments were influential in propagating stereotypical ways of describing both acute and chronic insane states. The Periodical Reports in particular are monotonously similar over the entire range of disorders. Apart from containing very brief descriptions of delusional ideas, hallucinations, and disturbed behaviour, they almost invariably comment on 'habits' (to which was attached one of the following adjectives: 'clean', 'faulty', 'dirty' or 'filthy'); ability to work, usually expressed as either 'good worker' or 'unemployable'; and failure to improve, necessitating continued asylum care, most frequently captured in the phrase 'dull and demented'[12].

The use of routine phrases and abbreviations (such as B.H. for 'bodily health', or D.P. Cat for 'dementia praecox, catatonic type') is a common feature of psychiatric practice in large institutions, and apart from providing those writing with a convenient shorthand, has far-reaching consequences for what is perceived about patients. Routine phrases limit observations to what is routinely perceived, at the expense of what might be unique. Reports justified continued stay, in the context of patients' failure to achieve mental health and healthiness was portrayed as a temporary state, inevitably replaced by progressive deterioration.

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9. Stigmatisation took the form of both physical and professional isolation. Kelly Loughlin quotes the superintendent of an Oxford asylum as saying in 1922: 'We have lived for a good many years, a great many of us stuck away outside towns. We have been looked upon as a race apart, and it is only by linking up with other branches of the profession that we shall remove this idea.' 'Reconstructing the individual', p.3.
10. This letter was written by Ethel H, (FE 2076).
11. By 1920 there were over 800 patients in Valkenberg, and at most, 3 doctors to attend to them, and complete the necessary reports.
12. Some of these terms will be analysed in more detail in following sections.

Writing in 1903 Daniel Rambaut wrote of the difficulty in keeping notes on the thousands of patients populating large asylums:

> I have seen case-books in which cases were written up by fifty at a sitting. Who is there who has not seen such notes as 'No change,' 'He continues in the same mental and physical condition,' 'His condition remains unaltered'? I have even seen a case-book which contained a three-monthly record of a patient's mental and physical state for a period of one year after his death![13].

The Valkenberg series contains innumerable examples of patients described at six-monthly intervals as showing 'no change'. 'The above note still applies' is another routine comment; 'there is no change whatever in the condition of this patient' is a longer variant.

Widespread use of 'no change' as a way of describing patients from year to year left doctors vulnerable to the accusation that they had not examined the people they were recording as being unchanged. To elaborate therefore on 'no change', however briefly, had an important pragmatic function for doctors, by protecting them from accusations of neglect. An example is the case of Louis B, admitted to Robben Island in 1918, and transferred to Valkenberg in 1919. He was described in three successive reports in this way: 'no change to note'; 'he remains in his deteriorated state & mumbles unintelligibly when questioned. Habits clean. Appearance slovenly. Unemployable'; and 'there is no change to note whatsoever'. After two slightly fuller descriptions, the following note is given: 'This inarticulate, unemployable, slovenly dement shows no change'. The string of adjectives inscribe him as having been seen, and coupled with the demonstrative pronoun 'this', embodied linguistically the observing presence of the doctor.

***3. Doctors as record-keepers*:** Doctors were positioned as the appropriate professionals to care for the insane, and also as the record-keepers of that treatment. The double role had two implications. It assumed that doctors' knowledge and experience of patients was the only relevant one for the purpose of record-keeping, an assumption which silenced the knowledge of nursing staff, who unlike doctors had intimate contact with patients on a daily basis. In addition to this, positioning doctors as record keepers of their own professional performance assumed that they would not yield to the temptation of inaccurate self-representation.

Doctors' role as record-keepers contributed to their tendency to maintain an observers' 'neutral' stance in relation to the people they were describing. Patients' appeals for help, and the expression of dependent, grateful, angry, amorous or fearful feelings rarely found their way into the records,

13. D. Rambaut, 'Care-taking in large asylums', *JMS*, **49**, 1903, p.46.

except at times when these were described as symptoms of an illness. Stripped in this way of unique subjectivity, patients were textualised as 'cases' typical of a diagnostic category. For example, a note on Hester D described her as 'a demented, dirty, unemployable dementia praecox. Silly and can supply no information.' The only other note from that year commented that 'there is no significant change to report in her mental condition. Physically her health is satisfactory'. Another linguistic marker of patients' absence from their own records can be found in the routine practice of deleting personal pronouns. For example, Hester was described one year as: 'Demented, dull & stupid. Smiles inanely', and the following year as: 'Dull, demented, unoccupied.' This truncated style of writing severed patients from both their names and their gender.

The fiction of doctors' intimate knowledge of the patients under their care was maintained through reporting on intimacy; it was not intimacy itself. Patients' 'private' and often emotionally-charged interior worlds were described, always as symptoms of disease; their 'private' bodily functions were also subject to routine commentary. Coupled with complete lack of privacy in bathrooms, toilets, dormitories and living-rooms, doctors' penetration of patients' thoughts left no space in which intimacy between doctor and patient could be shared, and this protected doctors from uncomfortable closeness with those they were treating. The absence of patients' subjectivities in the records was of necessity matched by an equivalent silence about doctors' subjectivities in their relation to patients. However, doctors' writing did betray some of their attitudes to their insane charges. Patients were described at times using adjectives which suggest doctors' distaste. Examples are 'treacherous', 'untrustworthy', 'greedy', 'gluttonous', and 'slovenly'.

However, the nature of doctors' representation of the insane in their record-keeping was more complex and ambiguous than its routinised and impersonal form initially makes apparent. The purpose of doctors' writing about the insane, the representation of behaviour to both legal and medical audiences as irrational, unnatural, disordered or deranged, interrupted the designated but fictional task of accurate description of 'fact' through 'observation', and subverted the referentiality of the language used. Fundamental to the inscriptive task of representing a person as insane was the textual production of a limited set of behaviours and feelings which were constituted as 'unnatural' and beyond ordinary understanding. This was achieved by severing both behaviour and feeling from the many-layered social, emotional and political contexts which might have explained them.

Constrained partly by the space available to write in on Medical Certificates, but also by the expectation that the person before them must be found to be insane, doctors produced texts that spoke of insanity by radical decontextualisation[14]. For example, William M was described as 'laughing in an imbecile kind of way' on one of his Medical Certificates. Edward F was described as 'extremely stupid - quite an idiot'. To certify someone as insane because he behaved in an 'imbecile kind of way' labelled that person an imbecile without defining imbecility. In the context of a Medical Certificate intended to record observations of insanity, 'imbecile' connotes that insanity, in a fundamentally ambiguous way. The word functions as an empty signifier, lacking the context which would give it meaning[15]. Linguistic carriers like these are available to convey whatever referential contents their readers wished to supply in the reading. Disguised as closely-observed 'facts', the words conveyed different meanings to legal and medical audiences, each of which would bring very different experiences and knowledges to bear on the reading of them. The language used by doctors to represent the insane was thus richly and ambiguously connotative, but denotatively empty, labelling not describing. In this way, the language of all the documents doctors produced about their insane charges did not rehearse their knowledge so much as reproduce assertions that some people were insane and others were not.

***4. Doctors as writers in the Cape colonial setting*:** The failure to provide contexts in describing insanity took its place in a series of such failures which were intrinsic to the colonial setting in which doctors worked. When doctors certified or submitted Periodical Reports on patients, particularly those classified as black, they frequently had no access to contexts which might have made sense of 'symptoms'. One of the effects of this evident in the Valkenberg series was the lack of commentary on social and cultural context, on the effects of migrant labour, or even on major social disruptions during the 1891-1920 period, including the Boer War, Union and the First World War, the stresses of which must have had an impact on the incidence of mental disturbance[16].

The reproduction of colonial structures in doctors' writing is apparent for example in the identification of black men and women as 'boys' or 'girls'. Thus, a 45 year-old man admitted to Grahamstown Asylum was described as a 'tall lanky looking boy', a 39 year-old man an 'adult

14. Nancy Tomes points out that it was relatives rather than doctors who first identified insanity in a family member, and that the decision to certify followed from the family's inability to cope, rather than on a medical judgement made by the certifying doctor. Doctors were under pressure from families to secure asylum accommodation. N. Tomes, 'The Anglo-American asylum in historical perspective', in J. Giggs and C. Smith (eds.), *Location and stigma*, (London, 1988), p.14.
15. For a discussion of 'empty' signification, see R. Barthes, 'Myth today', *Mythologies*, (St Albans, 1973), 109-158.
16. This issue is explored at length below.

native boy', and a thirty year-old woman as 'apparently a Malay (bastard) girl'[17]. A black man admitted to Robben Island in 1911 and transferred to Valkenberg in 1916, was known as 'Jim', 'a quiet tidy boy'. In this case, the failure to provide a full name simultaneously severed Jim from his family and from adult status.

The discursive reproduction of the colonial relationship can be seen in the record of Phillip D, who was described by the examining doctor as 'unlike himself and instead of the respectful boy I know him to be, he refuses to do what I tell him and says he is my "baas" and becomes excited without cause'[18]. The record of Adam M, transferred to Valkenberg in 1917, is another example. He had his left arm raised by the doctor examining him, he held it up for a considerable time. On being asked why he had done this, he replied 'that the boss put it there.' For the doctor, Adam's fixed posture was a symptom of insanity. For Adam, it constituted both obedience and servility, because he did not question the order he had been given, despite its apparent lack of purpose and his own discomfort. In this moment, unselfconsciously described by the observing doctor, Adam's subjectivity and the colonial order were one: all white men were the 'boss', and all blacks accountable to them.

Concern to police racial divisions is also evident in doctors' writing. For example, Maria L was said to be 'so dirty and neglected looking that it is difficult saying whether she is a pure white or bastard.' In this case, social class was also an issue. A doctor wrote about her: 'I can hardly imagine this patient anything else than the "poor white" she really is'[19].

Doctors also reproduced colonial attitudes to women. Isabella G, a white woman admitted to Valkenberg in 1917, had 'jealousy of her husband' given as the cause of her illness. Her husband had complained that she 'neglects her housework and children. She curses and swears, throws stones on the neighbours' houses. She breaks the crockery & furniture of my house.' In this example, the expectation that women should provide labour for households regarded as the sole property of their husbands was not questioned by the certifying doctor.

17. HGM 15, p.99 and p.10; HGM 20, p.29.
18. 'Baas', the Afrikaans word for 'boss', is a rare example of Afrikaans appearing in the case records of Valkenberg. It suggests that the interview was conducted in Afrikaans and translated into English for the written account. Given the class differences between asylum doctors, all of whom were English-speaking, and black Afrikaans-speaking labourers, it follows that the code-switch here is a linguistic marker of that class difference.
19. HGM 19, p.3.

The representation of patients in doctors' writing

In order for any person to be committed to an asylum for treatment during the 1891-1920 period covered by the Valkenberg series, she/he needed to be described in ways which would not be considered sane, both by the writer and by prospective readers. The Medical Certificates, written in the decontextualising and tautological style described in the previous section, were the texts which achieved the transformation of person to insane patient, using a small set of descriptors to connote acute states of insanity. These descriptors recurred over the entire 1891-1920 period, and were used in ways which gave primacy to commonalities amongst the insane, and to a large extent, played down differences created by both gender and racial classification.

After patients' admission to asylums, doctors continued to use small decontextualised descriptive sets in constructing texts which justified continuing asylum care. Within this textual frame, degeneration resulting from mental disease was presented in case-notes and Periodical Reports as inevitable. Changing patterns of symptoms in individual patients signalled the continuing presence of underlying disorder. Documents after committal collapsed the discursive categories of 'deranged mind' and 'deranged bodies' into one, and patients became cases in need of physical care. The asylum, the context in which both degeneration and the production and reproduction of symptoms took place, did not enter texts about patients except as a benign and necessary institution, a place within which insane bodies could be managed.

The texts in which doctors describe patients' insanity can be divided broadly into two groups. The first group textualises states of acute insanity, before or during committal, or during periods of relapse after committal. It includes long-standing, often congenital, conditions requiring institutional care[20]. The second describes both chronic insanity, often following long periods of incarceration, and the behaviour of the insane within the institutional setting of the asylum. The following sections describe lexical sets commonly used to represent acute, chronic insanity and doctors' perceptions of behaviour during confinement, in the case records of Valkenberg series.

Table 9 gives a list of the lexical sets commonly occurring in the Medical Certificates, the texts in which acute states of insanity, or long-standing conditions needing institutional care were described. **Table 10** gives a list of lexical sets commonly used in Periodical Reports. These capture descriptions of chronic insane states, behaviour during confinement, and descriptions of

20. These conditions include patients with mental handicap, whose symptoms were in many respects akin to those of the chronically insane. I have included them in the 'acute' group because committal to an institution was often justified in the certificates through descriptions of recent changes to behaviour which made institutional care a matter of urgent necessity. They are described below.

acute episodes of insanity within the asylum. There is considerable overlap in the two sets of descriptors[21].

As described in Chapter Three, the lexical sets listed in **Tables 9** and **10** were arrived at through the following procedure. Summaries of the Medical Certificates and Periodical Reports of all the folders in the Valkenberg series were used as the means of identifying common descriptive words or phrases. From the summaries a list of descriptors was derived, and this was used in a second survey of the contents of every folder, in order to arrive at an estimate of the frequency with which they occurred. The lists are not exhaustive, and the estimates of the frequency with which they occurred are intended as a rough guide to their differential use across groups of patients divided by racial classification and gender. It is important to note that many of the folders contain reports stretching over decades of institutional care, and a summary is inevitably no more than a partial representation of their contents.

Numbers in each lexical set, Medical Certificates

Descriptor	White male	White female	Black male	Black female
	n = 110	n = 76	n = 46	n = 16
Violent	44	26	19	4
Excited	24	21	6	5
Incoherent	40	28	19	9
Deluded	67	40	19	11
Restless	19	14	6	4
Talkative	9	11	4	3
Nakedness	2	1	3	2
Masturbation	7	0	13	0
Stupid/simple	20	14	17	1
Stupor/muteness	3	3	0	0
Depressed	31	13	4	1
Hallucinations	10	6	5	4
Silly/childish	16	14	17	3
Refusal to talk	0	4	3	2
Abusive/obscene	6	6	0	1
Dirty habits	7	3	2	0

Table 9

21. The method by which lexical sets were isolated is described in Chapter 3.

Numbers in each lexical set, Periodical Reports

Descriptor	White male	White female	Black male	Black female
	n = 110	n = 76	n = 46	n = 16
Violent	15	19	2	3
Excited	32	32	13	10
Incoherent	42	33	23	6
Deluded	51	39	23	9
Restless	16	24	6	6
Talkative	5	7	3	7
Nakedness	0	1	0	0
Masturbation	13	1	0	0
Dull/demented	79	48	41	13
Stupid/simple	33	15	18	7
Stupor/muteness	10	8	3	0
Depressed	10	13	5	2
Hallucinations	27	30	15	5
Silly/childish	0	4	3	2
Refusal to talk	0	1	0	0
Abusive/obscene	3	6	0	1
Dirty habits	32	25	7	0

Table 10

The descriptors of acute insanity:

1. Delusions and the discursive construction of 'reality': An analysis of the contents of the Valkenberg folders suggests that 'derangement of mind' was often achieved discursively by characterising the alleged lunatic as 'deluded'. 'Delusions' may be defined as fixed and unshakeable beliefs about oneself, others, or the experiential world that do not conform to the beliefs of most people in the same social, economic or cultural context[22]. Talk perceived as delusional attacks the foundation of shared meanings which mediate perceptions about 'reality', including assumptions about relationships, causality, and the referentiality of language. This is despite the fact that delusions often reflect common cultural anxieties or societal changes, and also encode, however cryptically, personal experience[23].

22. It is important to separate here the prominence of delusional thinking in psychotic illness from the use to which reports of delusions were put in doctors' certificates and Periodical Reports. Psychotic illness is often characterised by delusional thinking, but it is impossible to judge from the Medical Certificates whether the persons described were deluded or not, because of the failure to offer a context in which this judgement could be made. The significance of the label 'delusional' in the certificates is that it was used to justify incarceration.
23. An example of a common anxiety appearing in 'delusional' ideas is the belief of some patients in the Valkenberg series that they had been 'Malay tricked', a belief which tapped into prejudice against the Malay community. This is discussed fully in Chapter 6. There were other beliefs which reflected contemporary concerns. Examples are those about rulers (Queen Victoria, Lord Kitchen), and about the coming of gas lighting and electricity. These are evidence of the extent to which delusions were in fact referential of a shared, not idiosyncratic, reality. The encoding of personal experience in delusions also seems likely to be implicated in memory of those experiences. Writing them off as 'out of touch with reality' undercuts their effectiveness as carriers of both meaning and memory, and also their salience in the story-telling within relationships, which is often the way experiences are transformed into memories.

For example, Johanna W. insisted that she was 'fastened by chains', and that parts of her body were 'found in different places'; that someone cut her open and had 'taken her womb away'; that she was 'constantly in a coffin and they move her from coffin to coffin'; and that the man who cut her open was a 'Lord'. She was using these descriptions to represent events which most people would agree could not have taken place. She was also insisting that her words corresponded to reality for her - that she was 'telling the truth'. Although readers of these delusions may understand them as metaphors for experiences of physical or emotional abuse akin to being disembowelled, Johanna herself 'believed' her delusions to be true.

The Medical Certificates of 137 (55.2%) of the Valkenberg series contained descriptions of delusions, or references to delusional thinking. 122 (49.2%) of the series were described as deluded in the Periodical Reports (Figure 23). Delusions were sometimes the only symptom of insanity described given in Medical Certificates. To be described as delusional appears therefore to have been sufficient reason to recommend committal, regardless of other aspects of the person's behaviour.

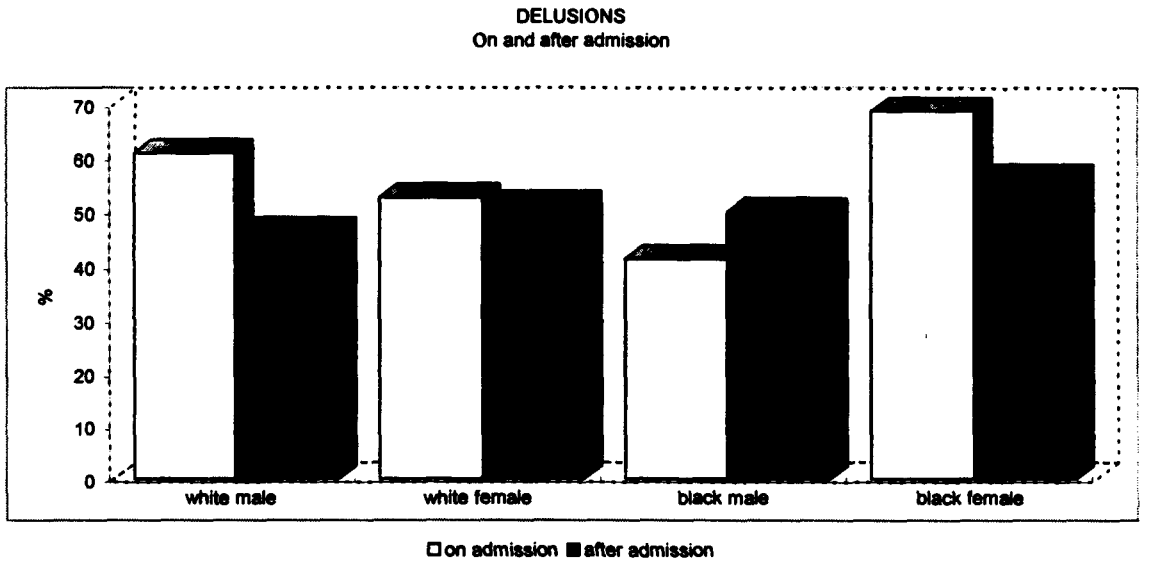

Figure 23

Doctors seldom had direct access to patients' delusional ideas, and relied on relatives' or friends' representations of those ideas. These may at times have been self-interested accounts. There are black and white women in the Valkenberg series for example, who reported sexual abuse at the hands of brother, uncles, fathers or employers, and these were referred to as delusional, on the grounds firstly that such abuse was assumed by many to be uncommon, and secondly that the men involved denied such abuse.

There is also evidence that little attempt was made to understand the contexts in which 'delusional' ideas of black patients may have arisen. For example, Christina C, a Malay woman admitted to Valkenberg in 1920, was said to have the 'delusion' of being followed by Christian children. Given popular prejudice about the Cape Malay population, it is not beyond the bounds of possibility that she was indeed subject to scrutiny and harassment by neighbourhood children. Jim, a 'Basutu' man, said he was 'not ill, but bewitched', and this was also regarded as delusional, despite the fact that this may have been a rational belief in terms of his cultural background.

To report one idea as being delusional cast doubt on everything the patient said, as thereafter, words were no longer assumed to refer to a shared experience of the world. For example, Mary W., who was reported to be dull, stupid, depressed and deluded on the Medical Certificates, had her 'delusions' described by one doctor in this way: 'Says she is old in years but young in sense - she has delusions about being under the treatment of some nurse for Hysteria and that she has been very wicked and that the nurse won't come to see her now'. There was no recorded attempt to explore the basis of this story. Jacobus A, admitted to Valkenberg in 1917, was said to be incoherent and delusional. One doctor, went on to note: 'Says he plays marbles to pass the time', a statement neither delusional in content, nor incoherent.

*2. **Incoherence in the multilingual Cape context:*** 'Incoherence' was another means by which alleged lunatics were perceived to place themselves outside of socially-shared meaning. As with beliefs which were called delusions, it is often impossible to judge whether those labelled coherent were impossible to understand. This is not only because Medical Certificates did not contextualise what was said; they also did not often give examples of utterances which were claimed to be incoherent. 'Incoherence', or the inability to make oneself understood, addresses directly accession to common meanings, the ability to relate to others, and the construction of convincing representations of the experience of self in the world. Like delusions therefore, incoherence was centrally implicated in the process of signifying irrationality on the basis of disordered relationship to reality, which is always linguistically mediated.

Being 'incoherent' or 'talking nonsense' , 'talking disconnectedly', 'babbling' or 'rambling' was used to describe 96 (38.7%) of the patients in the Valkenberg series. It continued to be central as a descriptor after committal, with 104 (41.9%) of the Valkenberg series being said to have incoherence as a symptom (Figure 24). It was seldom illustrated, but apart from disjointed or illogical speech, which is difficult for the listener to follow, it seems to have referred to delusional, nonsensical or socially-unacceptable content of speech. William M was reported as

saying that 'Church was the world - and England and America High Rome'; this was described as incoherent. He was also described as 'laughing at things which were going on in the workings of nature', which was not labelled incoherent, but was nonetheless given as a symptom of his insanity, presumably because it seemed nonsensical to the doctor examining him. Similarly, Annie B was described as speaking 'much religious nonsense'. Thomas B, whose speech was said to be 'voluble and incoherent at times', was noted to use 'disgusting language. - Also writes filthy letters full of delusions'. Eliza P was described in the Medical Certificate as 'continually talking nonsense, making weird sounds, shouting, swearing & cursing'.

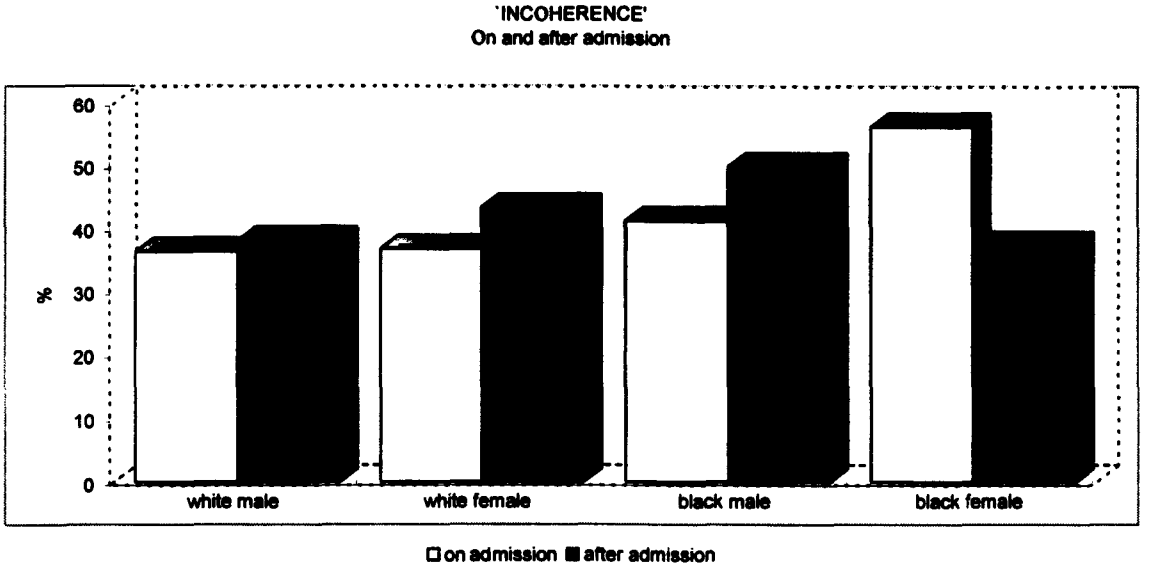

Figure 24

Incoherence also appears to have been used to describe the conversation of patients using a language or dialect difficult for the interviewer to understand. This applied to many black patients, as well as to white patients who did not speak English[24]. The case of Amelia O, a Jewish woman admitted to Valkenberg in 1912, illustrates this. She had immigrated from England in 1910 to be with relatives after having been abandoned by her husband, and was described on the Medical Certificates as talking 'incessantly' and 'incoherently'. As much of her 'chatter', consistently remarked on throughout her twenty-one years in Valkenberg, was in Yiddish and therefore not understood by anyone, it is clear that little effort was made to make sense of what she was saying.

24. 9 out of 16 black women, and 19 out of 46 black men in the Valkenberg series were called incoherent on the doctors' certificates. 6 out of 16 of the women and 23 out of 46 of the men were identified as incoherent in Periodical Reports. Yiddish-speaking patients were also labelled incoherent. Amelia O, a Jewish patient, was described as making 'noisy & foolish conversation'. The Periodical Reports repeatedly mention her 'chattering unintelligibly in Yiddish'; 'speech a mixture of Yiddish and English, irrelevant, incoherent.'

In the small sample of black women whose records from the 1891-1920 period have survived, 9 out of 16 were described as incoherent on the Medical Certificates. Compared to 19 out of 46 of the black men, and an even lower proportion of the white patients, both male and female, this statistic suggests that black women may have been prejudiced in interviews with certifying doctors by failure to master a standard dialect. A higher proportion of black men than women were in formal employment, and mastery of colonial English was important to the process of finding and retaining work in colonial employment structures. Popular prejudice would have fuelled doctors' expectation of black women being difficult to understand. An 1887 newspaper article carried the following description of Cape Town 'Coloured' women:

> Coloured women-folk, who appear to spend all their time basking their raggedness and filth in the sun and wind on the stoeps of their dwellings, yell and shout to one another with violent windmill-like waving of the arms and a vigorous use of the tongue, tipped with a vernacular unknown except to the Philosopher learned in barbaric tongues[25].

*3. **Naming violence:*** Violence, including wild, threatening, assaultive, suicidal or homicidal behaviour was given as a description of 93 (37.5%) of the series patients in the committal documentation (Figure 25). As with delusions and incoherence, violence, or the threat of violence, qualified as insane when it interrupted social assumptions about rationality. It included parents' assaults of children for example, but excluded relatives' attempts to control the behaviour of their 'insane' kin[26]. Thus, Sarah S, who tied the hands and legs of her children and kept a chopper under her pillow was 'violent', but the fact that Thomas F was manacled to his bed by relatives because he wanted 'to go out' was not.

As with the descriptors explored above, the Medical Certificates frequently label supposedly insane persons as violent, without saying how this manifested itself. The threat of violence was therefore invoked as a signifier of derangement, without further explication being thought necessary. Hendrik B for example was described as 'violent and wild looking; suspected of masturbation'. In this way a text is created of a violent and sexually disinhibited person without any indication of what constituted the violent behaviour.

25. *Lantern*, 5 October, 1887, quoted in Bickford-Smith, *Ethnic Pride and Racial Prejudice*, p.116.
26. Again, it is important to separate violent behaviour as a symptom of insanity from the uses to which the threat of violence was put in the Medical Certificates. Actual violence resulting in the death or injury of others would have been processed, in the first instance, through the law, and the Valkenberg series under-represents these cases. Nonetheless, violence was frequently used as a descriptor, and often referred to future danger rather than past injury. Any threat of violence was useful to doctors because it justified asylum accommodation being made available as a matter of urgency. This was important because asylum accommodation was scarce.

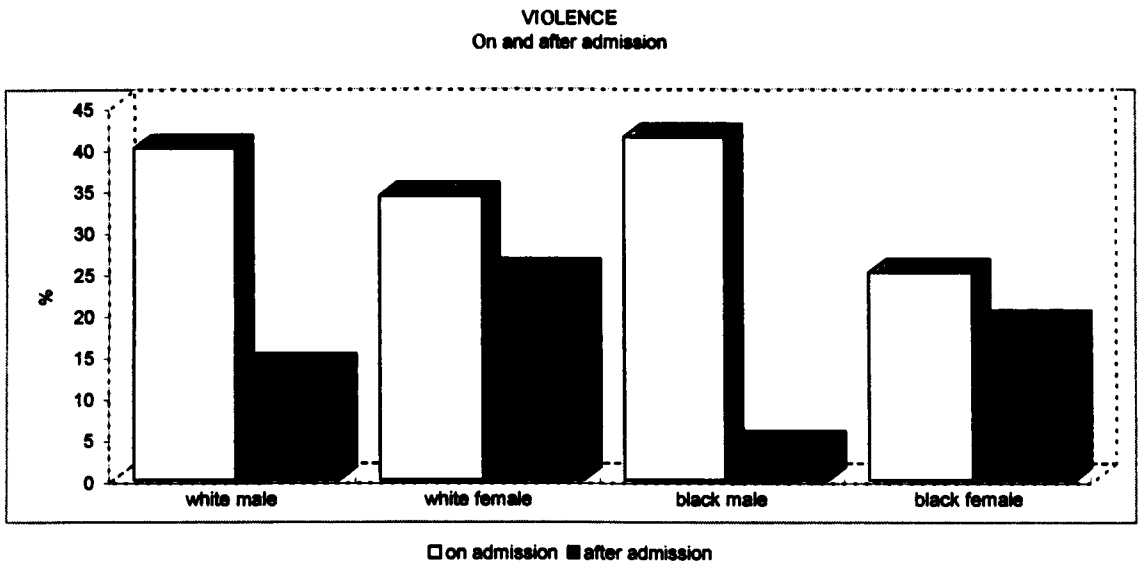

Figure 25

Once in the asylum, there were few opportunities for patients to be violent, and as they became institutionalised they were less likely to engage in any impulsive or destructive behaviour. Violence was mentioned in relation to only 39 (15.7%) of the series in the Periodical Reports, suggesting that it did not play a major role in justifying continued asylum care. In keeping with their textualisation as foolish children, black male patients were less likely than their white counterparts to be seen as violent. This was despite the approximately equal proportion of white and black patients said to be violent on admission.

In issuing Periodical Reports, doctors were reporting on their own effectiveness as providers of care, as well as the state of their patients; and high levels of violence in asylums would have suggested insufficient vigilance and control. It is possible that other descriptors such as 'excited' or 'impulsive' or 'destructive' replaced 'violent' in order to present the asylum as an effective environment for the control of the insane. An example of this mitigating translation can be found in the case of Hendrik B, described as violent and dangerous before admission, and as 'untidy and destructive' after admission, although his behaviour was so difficult to control that he had to be restrained by being placed in canvas combinations.

When violence did occur, it was described in terms which related it solely to mental disorder, and not to the ward context. Thus Hester D was said to be 'violently impulsive at times - never to be trusted.' Maisie L made 'violent efforts at self-destruction and mutilation'. Ralph H had hallucinations, 'and frequently becomes aggressive saying that other inmates say insulting things about him.' Violent behaviour was also used in Periodical Reports to justify aspects of treatment,

such as the use of mechanical restraint or seclusion. Alfred N 'became extremely maniacal and *had* to be placed in the padded room.' Hendrik B '*required to be kept* in a suit of canvas combinations' because he was 'untidy and destructive'.

4. Excitement, restlessness, talkativeness, and the issue of feminine passivity: 'Excitement' was a term used about 56 (22.6%) of the series in the Medical Certificates (Figure **26**). For example, Maria A's Medical Certificate described her as having a 'fierce look, excitable, shrieks and sings.' The admission form gives a clue to the way in which this word was being used: 'Patient is in a state of acute excitement. Very marked psycho-motor activity - roars and shouts continuously.' Of Eliza P the Medical Certificate said 'She is excited and gesticulates. She raves, sings and babbles incoherently.' About Thomas B it was said: 'This man is wild and excitable. He is untidy in his appearance - gesticulates in a loud declamatory style'. Jan K was 'sometimes quiet, but suddenly gets excited, and makes threatening gestures with his hands and looks suspiciously about, shaking his head.' From these examples, it is apparent that 'excitement' referred in this context to emotional and physical arousal considered inappropriate to the context.

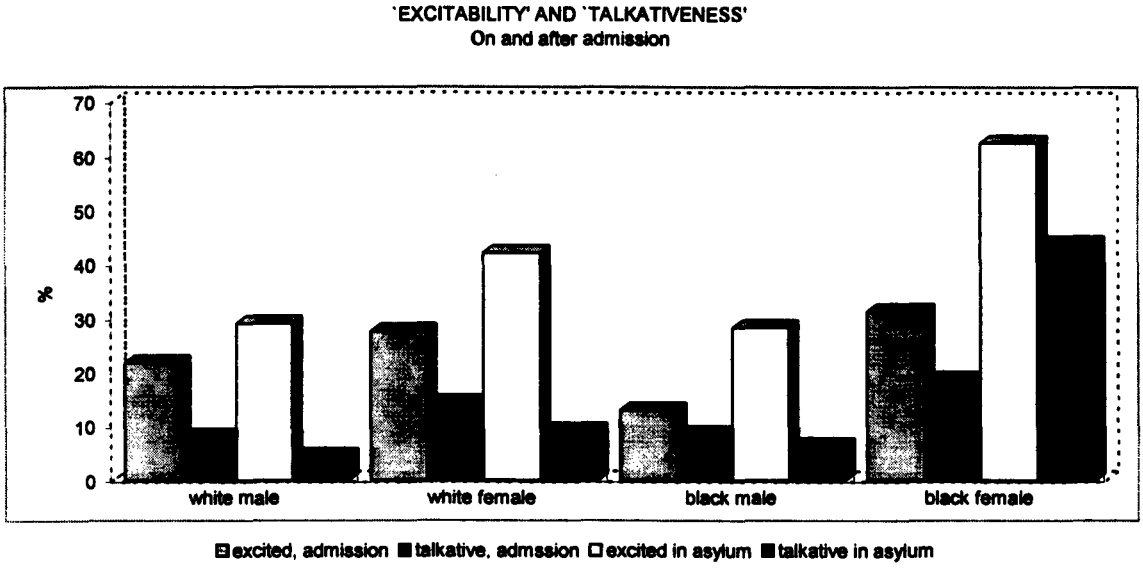

Figure 26

Restlessness, including both propensity to wander, and inability to sit or stand still was a feature of the committal state of 43 (17.3%) of the series and frequently occurred in the same context as the descriptor 'excited'. Talkativeness was also perceived as a symptom of insanity in some cases, particularly when it was experienced as incoherent, or accompanied restless or excitable behaviour. It appeared in relation to 27 (10.9%) of the series as a descriptor of insanity. An example is the case of Francis J, said on a Medical Certificate to have 'life long instability -

restlessness - never could follow any employment - lived at home - sitting quiet for hours - now talks incessantly - often incoherent.' Louis B was said to talk 'incessantly. He often wanders about aimlessly and hides in the bush.' Daniel R was 'very talkative and restless at nights.' Amelia O was said to be 'erratic' in conduct and 'noisy and foolish. Conversation: she talks incessantly.' Julia P 'maintains a ceaseless chattering of nonsense, accompanied by senseless laughter.'

In the committal texts black and white women were described as talkative and excitable more often than men. Both talkativeness and excitability can be read as reflecting popular perceptions about women's tendency to gossip or chatter, and doctors' tendency to label any behaviour not in keeping with quiet and deferential conduct in the presence of men as deviant[27].

After their committal, the women in the Valkenberg series continued to be seen as more 'excited', 'restless', and 'talkative' than the male insane. They were also more likely to be seen as 'violent', and 'abusive' than their male counterparts. As discussed in Chapter Five the data from both the statistical tables and correspondence suggests that women had to be violently deranged in order to be admitted to an asylum. The Valkenberg case records confirm this hypothesis. Showalter, noting that commissioners to Colney Hatch Asylum in Britain described 'the female department, as is usually the case in all Asylums,' as 'the most noisy', suggests that reports such as these 'reflect the expectations and wishes of male observers that women should be quiet, virtuous, and immobile'[28].

5. Stupidity, simple-mindedness, childishness, and silliness as racial markers: The descriptors described so far all relate to the textual production of insanity as violent disturbance, foregrounding overactivity and therefore loss of control as a reason for confinement. There was a group of patients however who did not present as violently deranged. In the Valkenberg series, 52 (21%) of all patients were described on their Medical Certificates as 'stupid' or 'simple' (Figure **27**). These descriptors were often accompanied by descriptions suggesting childish, foolish or silly behaviour. For example Rosina S, who was described on one Medical Certificate as having an 'imbecile unconcerned demented appearance', was also said to engage in 'strange, purposeless and foolish conduct, constantly walking round and catching imaginary objects.' The other Certificate said she had a 'silly and demented look, looking into vacancy.'

27. E. Showalter, 'Victorian women and insanity', in A.Scull (ed.), *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, (London, 1981), p.320.
28. *Ibid.*, p.320.

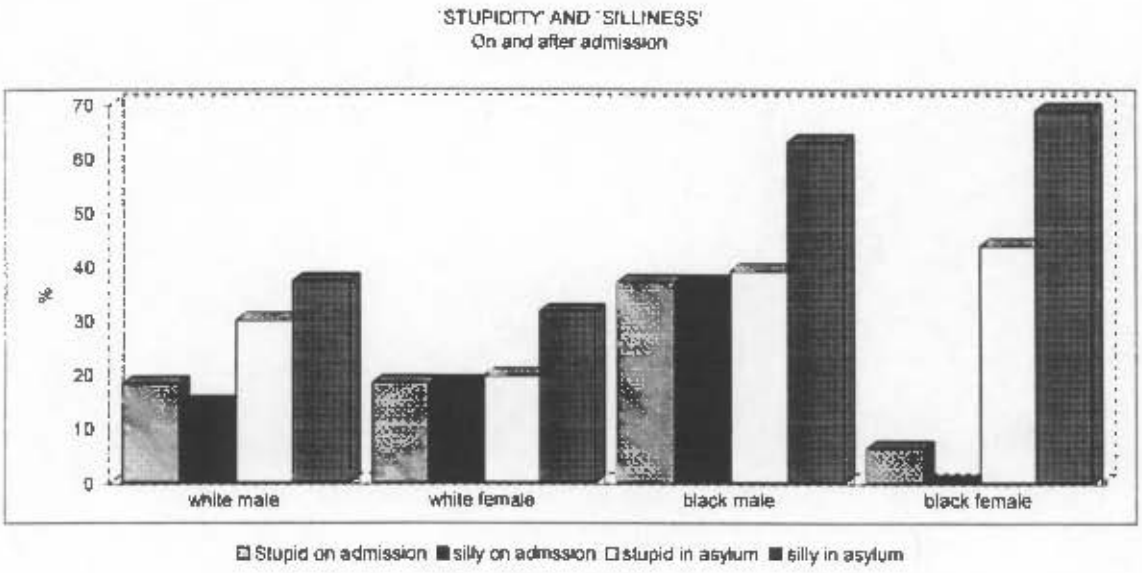

Figure 27

These descriptors were used more often than the diagnostic pattern would predict. Overall, 8.9% of patients were given an initial diagnosis of congenital mental defect, imbecility, feeblemindedness, or idiocy. To seem stupid to an examiner was not therefore simply a matter of limited intellectual capacity, and could have been a misinterpretation of depression, suspiciousness, or the bewilderment or fear caused by the committal procedure. The record of Ferdinand H is an illustration of this. He was said to refuse to 'answer questions put to him, in fact is dumb and in addition behaves like an idiot'. He was given a diagnosis of dementia praecox. Adam M was said to have 'a sulky appearance, will not answer questions', 'generally sullen'. On admission he was said to be 'stupid and sullen' in spite of the fact that he was given a diagnosis of depression, not imbecility.

The group of patients identified as either stupid or childish or both was being confined for reasons fundamentally different to the violently insane. These were people who seldom posed a threat to order, and who were of concern because they were seen as child-adults, not productive members of society. Nonetheless, the Medical Certificates needed to frame their behaviour in such a way that confinement in an asylum would be an appropriate form of management for them. For Rosina S, described above, this was done by emphasising strange behaviour. The confinement of Margaret M, described as looking 'very foolish' was justified on the grounds that she 'just shakes her head, sucks her wrist all the time one is speaking then laughs. Sleeps out at night under bushes, seen putting her hand in stercus pail and put solid stercus into sack and carry it off.' Margaret was from German South West Africa, and may not have understood what was being said

to her, which would account for her inability to answer questions. The other reason for her confinement lay in her handling of faeces, a taboo activity.

Black men were described as 'stupid' or 'simple', and as 'silly', 'foolish' and 'childish' by certifying doctors almost twice as often as their white counterparts. Jacobus P for example was described on one Medical Certificate as 'dull, stupid, grinning expression - no power of conversation, no memory of past events etc.' Jacobus A was said to 'look silly. Quiet. Incoherent.'

The monolingualism of many white doctors during this period is likely to have had an effect on the number of black patients characterised as 'stupid'. For example, of Jimmy S, a Malay tailor first admitted to Robben Island in 1904, it was said, 'when asked questions shows no signs of understanding them, often giving his name in reply', and 'says "I don't know" to everything he is asked'. Read by the doctor as a symptom of insanity, Jimmy's lack of understanding could well have had a basis in language difficulty. Being bereft of access to a particular linguistic community was in Jimmy's case linked to being an animal. He was described as 'generally foolish' and 'stupid', eating his food 'like an animal'.

The perception of allegedly insane black men as both stupid and childish invoked the need for benign parental care, conveniently offered in the form of 'humanitarian' (although involuntary) asylum care. By characterising black men as 'stupid', white male doctors had at hand the means of discounting their 'insane' unhappiness, and their reactions to stress as colonised subjects. To regard an insane patient as intelligent is to address the possibility of an interior life, which would raise the possibility of rational explanation for 'insane' behaviour, as well as the danger of colonial authority, here invested in the person of the examining doctor, being scrutinised, and asked to account for his actions. In this way, 'stupidity' in black men is inseparable textually from 'intelligence' in the examiner; irresponsible 'foolishness' or 'childishness' in black men positions the examiner both as adult and as responsible, in a way that obviates the need for textual demonstration of that adult responsibility.

'Disobedience', being 'stubborn', 'sullen' and 'sulky', all words which appear frequently in the records of the male black insane, also inscribed them as children, rather than as adults[29]. These terms assumed cheerful willingness and obedience in an unequal power relationship as the norm, and rebellion against it as deviant[30]. For example, Phillip D was described as 'dull and stubborn'; Jim as 'inclined to be sulky'; Booi T as 'surly'; and Gilbert G as 'sulky, cunning and determined'.

29. This lexical set does not appear in the tables, which reflect only those lexical sets occurring most commonly.
30. Nandy describes the relationship between British colonisers in India and the 'childish Indian' who is perceived as 'ignorant but unwilling to learn, ungrateful, sinful, savage, unpredictably violent, disloyal and, thus,

The discursive profile of the black insane as stupid and childish systematically erased their adulthood. It contrasted with the way in which insane white men retained adult status and adult sexuality in the case records. The record of Ralph H, a white man admitted to Valkenberg in 1911 illustrates this. The period before his admission was described in this way:

> Was an upholsterer and thoroughly understands the trade. He saved a little money and bought ground and this seemed to worry him. He used to stand about for hours and refuse to work. This was about six months previous to admission. He gradually got more confused - became dirty in his habits and made an indecent assault on a woman in the house - this event he put down as an 'ineffectual circumstance'.

In this text, Ralph maintained his status as a competent upholsterer through the present tense of 'understands'. His 'insanity' was given a rational basis by describing his worry over the ground he had bought. He was given voice in the record about the assault he made, using vocabulary suggestive of adult and educated speech. The hint at impotence in the word 'ineffectual', which resonates in the context as both excuse and a slightly pompous absurdity, presented him as endearing but not childish.

6. Depression, withdrawal, inactivity, muteness and the question of black interiority: Apart from the violently deranged and stupid or childish groups of patients, there were those who were described on committal as either depressed, or withdrawn, even stuporose. In the Valkenberg series, 49 (19.8%) of all patients were described as depressed on doctors' Certificates (Figure **28**). Depressive affect as an isolated symptom therefore played a relatively minor role in both the committal procedure, and the perception of patients' mental states once they were in the asylum. Patients admitted with depression as a symptom always had other symptoms which necessitated asylum care. These ranged from stuporose behaviour, often accompanied by refusal to eat, severe weight loss, and incontinence, to restlessness and agitation, delusions, incoherence, and threats of violence against self or others. The threat of suicide was an undisputed reason for admission to an asylum as a matter of urgency. This group can be differentiated from the violently insane group on the basis of the melancholic colouring of their delusions and violent behaviour, and their experiences of themselves as sad, miserable, worthless or sinful. Magdalena C is an example. She was described by one Medical Certificate as 'in bed lying with her mouth open and I could not get any reply to my questions.' The other Certificate described her as never resting: 'She cries day and night. She is very depressed. She won't eat unless when fed. She says her friends with whom

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"incorrigible"'. These children needed to be repressed by 'controlling rebellion, ensuring internal peace and providing tough administration and rule of law'. *The Intimate Enemy: Loss and Recovery of Self under Colonialism.* (Bombay and Calcutta, 1983), p.16.

she lives wish to kill her.' On admission she was said to be 'very depressed and miserable, self-absorbed, disinterested in her surroundings, very retarded. Extremely difficult to get her to speak. She is evidently subject to depressing delusions. Said her children were being murdered.'

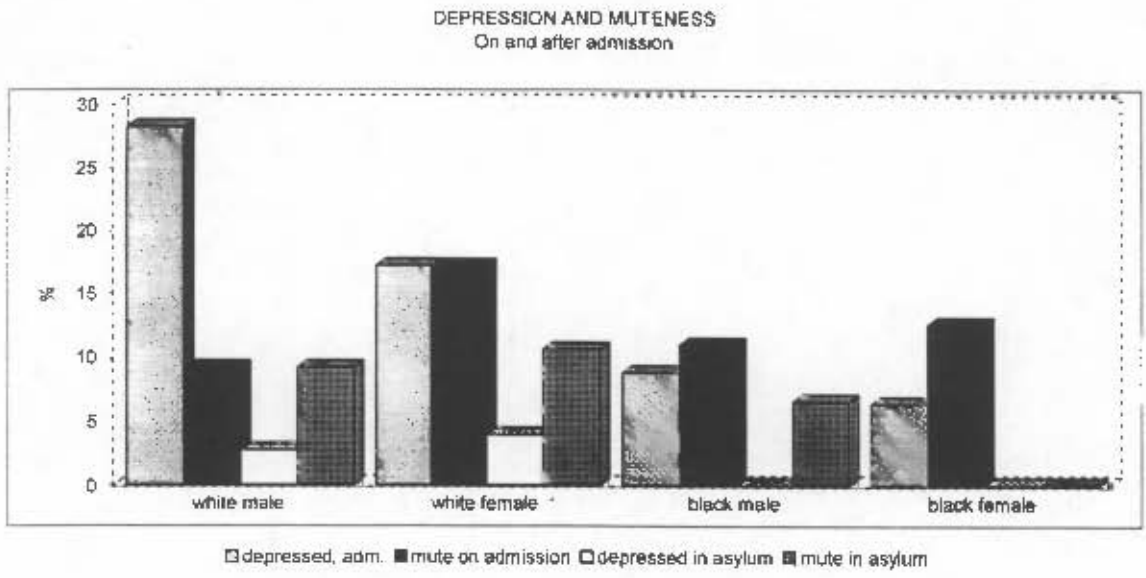

Figure 28

In comparison to white committals, relatively few black patients were described on Medical Certificates as depressed, despite their having similar symptoms. This is related to the erasure of interiority described above. For example, Alfred H, a white man admitted to Valkenberg in 1916, was described as 'very melancholy. Began to weep while I was talking to him.' In contrast to Alfred's melancholy, related textually to the act of weeping, Antonie M, a black patient admitted to Robben Island in 1915, was said to cry, and say he was dying. The doctor added the comment: 'Cannot get any coherent statement from him. ...is quite out of his mind.' Another doctor described him as having a 'silly demented appearance'. Neither Certificate linked his obvious distress to depression. In a similar way, John L, a black patient, had terrifying delusions that people wanted to kill him. The doctor wrote that John had 'begged me to save him'. Despite his distress, the doctor described him as simply as 'stupid looking'.

Only 30 (12.1%) of the Valkenberg series were described as depressed in the Periodical Reports, which suggests that depression as a symptom was not perceived as sufficient reason for continued confinement. Depression was a condition likely to remit with time more often than dementia praecox, and it is probable that patients with uncomplicated depressions are under-represented in the Valkenberg series, which favours chronic, long-stay patients. Patients with depression as part

of a psychotic illness were described much as all other psychotic patients, in terms of degeneration; this will be described in following sections.

Only 6 patients in the series presented with a clinical picture of underactivity, silence, and withdrawal. After committal 21 (8.5 %) of the series presented in this way. All these patients except one, diagnosed manic-depressive, were later diagnosed as having dementia praecox, catatonic type. For example, on the Medical Certificates, Frank R was described as 'lying in a stuporose condition, refuses food passes no urine & is constipated.' After admission he was reported to 'stand or sit in one place all day long. Does not speak or occupy himself in any way. He takes no apparent interest in anything.' He was given a diagnosis of dementia praecox, catatonic type.

7. 'Faulty' habits, public nakedness, masturbation and sexual activity as a threat to public order: As discussed in the previous chapter, the word 'habits' was written into the medical certification procedure, and 12 (4.8%) of the Valkenberg series had 'faulty' habits given as a symptom of their alleged insanity. This figure rose to 64 (25.8%) after committal. Faulty habits were a signifier of 'body' corrupted by 'mind'. The contexts in which it was used situates it in the semantic field of clean/dirty. Frequently used synonyms for 'faulty' are 'filthy', and 'dirty'. However, the referents for dirt were ambiguous. The term was often used to include unkempt appearance, being incontinent of faeces or urine, eating or drinking in socially inappropriate ways, and even being idle. Many certificates used the term in conjunction with comments on patients' sexual or social behaviour, including using foul or obscene language, making any kind of public sexual display such as masturbating, exposing oneself, running about naked, or being erotically suggestive, and indulging in masturbation privately. Because 'faulty habits' were seldom sharply defined, and were sometimes described as one of the group of behaviours listed above, all of these behaviours became indissolubly linked. They acted as a summary of stereotypical images of madness, and suggested its cause lay in sinfulness. In this sense, to have 'faulty' habits could be seen as quintessentially Other[31] (Figure 29).

Some examples of patients described as having faulty habits illustrates the range of behaviours with which they were associated. Philip S during the committal process was 'very excited, restless, talkative & using foul language, destructive, very dirty habits, required private bedroom, collecting rubbish. Since remained in same state for about 3 months. Collected rubbish & masturbated.' Edward F was said to be 'very dirty' and to run after 'girls in the street and has been

31. Gilman, *Disease and Representation*, pp.1-6.

in gaol 3 times for indecent exposure'. Ralph H was said to have 'dirty habits, passes motions in bed.' Attilio R. was said to have dirty habits, passing urine in his shoes, and trying to drink it. Martha D. was 'lived in a dirty fashion', 'living in a one-roomed hut surrounded by Coloured labourers'. Hester D was given a clitoridectomy for 'faulty habits' (masturbation) in a private sanatorium before her admission to Valkenberg.

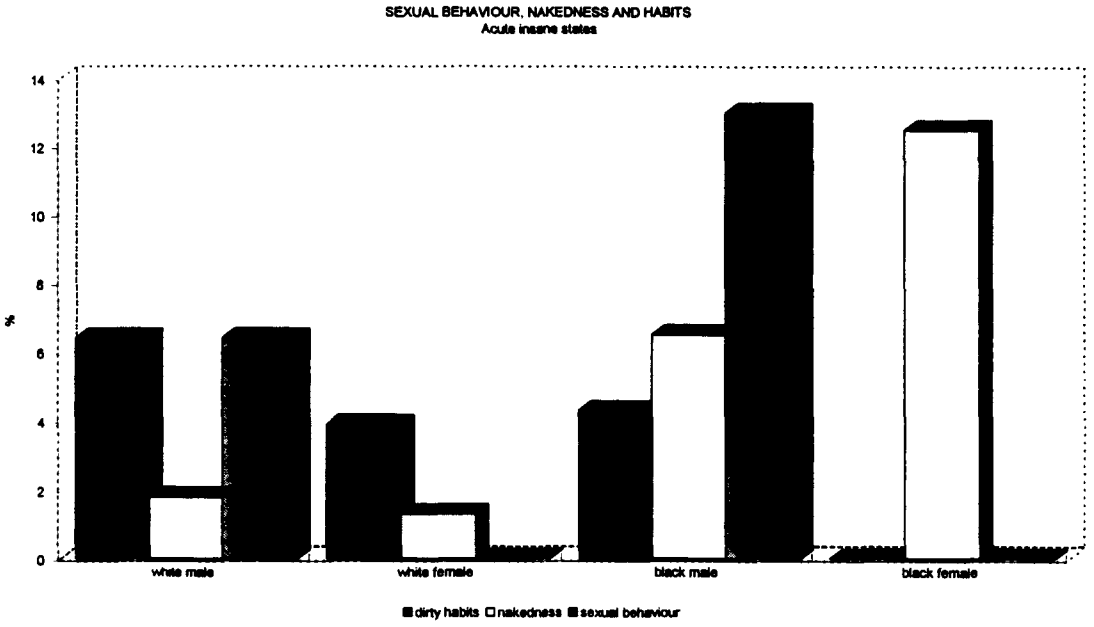

Figure 29

Black men and women were twice as likely as white men to have nakedness commented on as part of their alleged insanity. For example, Julia P, a 'Coloured' woman, was found naked in a church, 'nursing her clothes like a doll'. This, and 'talking nonsense' brought about her admission. Carl M, a 'Coloured' man, 'stripped himself naked in the presence of two neighbours' and this led to his committal via the police. Jacobus P walked in the street in 'indecent attire'.

Sexual activity (sexual assault or masturbation) was also more likely to be identified as part of the insane behaviour in black, rather than white men. This was in keeping with the stereotypic public view of black men as sexually uninhibited and dangerous[32]. Jacob v W for example, in addition to taking off his clothes, attempted to masturbate during the interview with the examining doctor. Phillip D was tied up while temporarily detained in gaol to prevent him from masturbating. Christopher L, while detained in gaol, took off his clothes, and threw his boots out of the window. He had been brought in because he had tried to 'commit indecent assaults on little girls,' and 'is very foolish'.

32. The *Commission on Assaults on Women* for example describes 'the raw native' as being 'brought up in an atmosphere of immorality and lust, his thoughts and speech are lewd', p.13.

The threat of uninhibited sexuality perceived in black patients was however transformed discursively into harmlessness in the Certificates. The masturbation and nakedness of Jacobus A for example was made harmless by adding the fact that he played football with his hat. In the case of Jacobus P, one doctor wrote: 'Boy stands in a half crouching condition and laughs continuously. ...Only laughs when asked why he assaults his mother.' The characterisation of an adult male as 'boy' together with the indignity of the half-crouching posture and seemingly irrational laughter transforms dangerous violence into the defiance of child pitted against parent. Similarly, Jacob v. W was described as 'vacant' while attempting to masturbate during his interview with the doctor and this removed his sexuality from an object of desire and from conscious agency. One doctor said Jacob's 'answers are fairly rational but he has absolutely no reasoning powers and is not responsible for his actions'. This divorced his replies to questions from conscious agency, making 'rationality' in the interview a lucky accident.

The descriptors of chronic insanity:

The 'facts' indicating insanity in the Medical Certificates can be grouped into those which addressed 'mind', such as delusions and incoherence, and those which referred to disordered behaviour, such as violence, restlessness or faulty habits, and therefore began to construct narratives which represented insanity as disorder of 'body'. The fundamental transformation of person to insane patient had of necessity however, to begin with mind, as 'diseased mind' was the reason for committal. Descriptions of chronic insanity in the Valkenberg case records textualised disorder of mind as first and foremost leading to gross degeneration of body.

1. Dullness and dementia: The Periodical Reports use the words 'dull' and 'dementing' about 181 (73%) of the 248 patients in the Valkenberg series. Many of those described in this way were undoubtedly suffering the effects of living in a 'total institution'[33]. It is clear that a socially impoverished environment, combined with low staff expectations, and a restrictive ward regime, produces behaviour which Wing and Brown termed a 'clinical poverty syndrome', characterised by social withdrawal, flat affect and poverty of speech[34]. There is however, an additional dimension to the 'dull and demented' narrative strand in the descriptions of chronic insanity.

33. R.Barton, *Institutional Neurosis*, (Bristol, 1966); E.Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth, 1961); J.Wing and G.Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals, 1960-1968*, (Cambridge, 1970).
34. *Ibid.*, p.178

During the time that the majority of Periodical Reports on the Valkenberg series were being written, dementia was considered to be the most likely outcome of psychotic illness. In line with Kraepelin's view of dementia praecox as a degenerative disease, doctors reporting on patients described what they perceived as progressive deterioration[35]. This was despite Bleuler's influence on ways in which schizophrenia was conceptualised. He felt that not all those suffering schizophrenic illnesses progressed to a state of terminal dementia, and this was partly why he preferred the term 'schizophrenia' to that of 'dementia praecox', with its inevitable association with somatic destruction[36].

The lingering effect of popular and professional belief in life force being drained away by chronic, untreatable conditions can therefore be seen in descriptions of the majority of patients in the Valkenberg series as 'dull and demented'. Regardless of the academic debates current at the turn of the century, those working in asylums believed in, and therefore saw, progressive dementias in their psychotic patients. Writing to the Under Colonial Secretary in 1891, Dodds argued for the importance of providing accommodation for the insane to be treated 'in early and hopeful stages, and to unstintingly use, at this stage, every possible means of treatment, that shall prevent the sufferer sinking into a state of life long hopeless insanity'[37].

Examples of patients described as 'dull and demented' will give an indication of some of the behaviour to which the phrase was attached. Rosina M was described as having a 'vacant and stupid' expression. 'She is dull and demented and can give no information about herself. She is hostile to examination and refuses to answer more than the first few questions. She is profoundly disorientated for time and place, cannot even say if it is morning or afternoon.' Magdalena C was described as 'noisy, restless and demented; never answers or appears to understand a question.' Joseph B was said to be 'dull and mentally deteriorated. He cannot give any account of himself, is disorientated in all respects. ... Emotionally he is indifferent and is content to carry on with a mechanical existence.' About Francis J it was said that 'he is becoming progressively dull, more demented and indifferent. His appearance is stupid and bovine. He just stands and lolls about. Does not play the piano. Does not converse. Does nothing.'

As these examples make clear, patients perceived as 'dull and demented' were regarded as unable to enter into conversation of even the simplest kind. What was lost was the ability to make and sustain contact with others, to act as a social being. This made animals or machines of what were

35. Kraepelin, *Dementia Praecox and Paraphrenia*, trans. R.M.Barclay, (Edinburgh, 1919).
36. Berrios, G. and H Freeman, *Alzheimer and the Dementias*, p.23.
37. CO 1485, 22/10/1891.

once people. The degeneration implied here was of 'mind', leaving only 'body' as accessible for contact and observation.

2. Childishness, foolishness, silliness, stupidity and the institutional erasure of knowledge: 50 of the Valkenberg series patients were characterised as 'silly', 'childish' or 'foolish' on the committal documentation. This figure doubles in the case-notes and Periodical Reports: 105 (42.3%) of the series are described in this way (Figure **30**). These descriptors are therefore implicated in the representation of chronic insanity, and also describe the effects of prolonged asylum care. That they were positioned discursively as irresponsible children is not surprising: the insane were minors both in law and in terms of the asylum structure, with the doctor representing patriarchal authority[38]. This also explains why black patients, both men and women, were much more likely than white patients to be described as 'silly', 'childish' or 'foolish'. They were also more likely to be regarded as 'stupid' or 'simple'[39].

The descriptors 'silly' and 'foolish', often used with the word 'childish', referred to immaturity and irrationality, and to affect or behaviour inappropriate to the context. Thus, Nathaniel D was described as having a 'silly, foolish expression. Grins inanely.' Stephen D's answers to questions were said to be 'very silly', because 'irrational' and 'irrelevant'. Hester D was described as giving 'unintelligible replies in a silly high-pitched voice'; and talking 'like a small child, whining for "mammie"'. she was also said to be 'facile, silly - absolutely lacking in comprehension', and to grin in a 'silly, facile fashion.'

In some contexts, 'childish' was the descriptor used to characterise immature interests and behaviour. Thus Stephen D, a white patient, was said to be 'profoundly childish in his interests' because he played with reels of cotton. The descriptor 'childish' was also used at times to represent limited intellectual ability, and was linked to patients' confusion about where they were, and how long they had been confined, to their general knowledge, and their ability to 'give a good account' of themselves. What constituted 'giving a good account' of oneself is not spelled out explicitly in the records, but appears to include being able to converse coherently, and to orient oneself, in conversation, in terms of identity and ward life. The profoundly disorientating nature of the asylum context was never considered when doctors expected patients to know dates, or

38. Foucault, *Madness and Civilisation*, p.252.
39. The first batches of black patients admitted to Valkenberg were chosen because they were quiet and good workers. 20% were diagnosed at some stage during their committal as feebleminded, which would have been reflected in Periodicals' descriptions of them as 'simple' or 'stupid'. However, there are many more instances of black patients being described as stupid than the numbers amongst them diagnosed as feebleminded.

length of time they had been confined. Many did not read newspapers, receive visitors, have birthdays acknowledged, or leave the grounds, and so had almost no way of keeping track of time.

Disorientation would have affected black patients more profoundly than white ones. Coherence, general knowledge and lack of confusion about nature of the institution would all have been affected by fluency in English, educational standard, and ultimately therefore by racial classification. Thus Margaret M, a black woman who knew little English, was described as 'silly and childish, gives a poor account of herself' in one report and in another: 'She is very simple and childish and grins continuously when interviewed. She gives her name and knows her domicile but apart from this she cannot give any account of herself.'

The 'childish, silly, foolish' lexical set had much the same discursive effect as representing patients as 'dull and demented': it justified continuing asylum care in terms of disorder which was more physical than mental, for a number of reasons. On the one hand dementia, caused by mental disease, was thought to lead to childishness; on the other, never to have developed age-appropriate intellectual ability was a nervous system defect. Foolishness was linked with deteriorating intellectual ability, and silliness often described outward and observable characteristics, such as facial expression and manner.

*3. **Identifying hallucinations***: Hallucinations were explicitly identified as part of mental disturbance in only 25 (10.1%) of the series patients in the Medical Certificates, although at times behaviour which possibly related to hallucinations was often described (Figure **30**). Persons said to talk to themselves, laughing or calling out for no apparent reason, gesticulating, or staring may have been hearing voices. Hallucinations were more difficult than delusions to uncover during a single examination, and often only asking questions specifically intended to elicit information about hallucinations would have been effective in differentiating between delusions (beliefs about relationships) and hallucinations (delusional beliefs enacted in conversations, bodily sensations or visions).

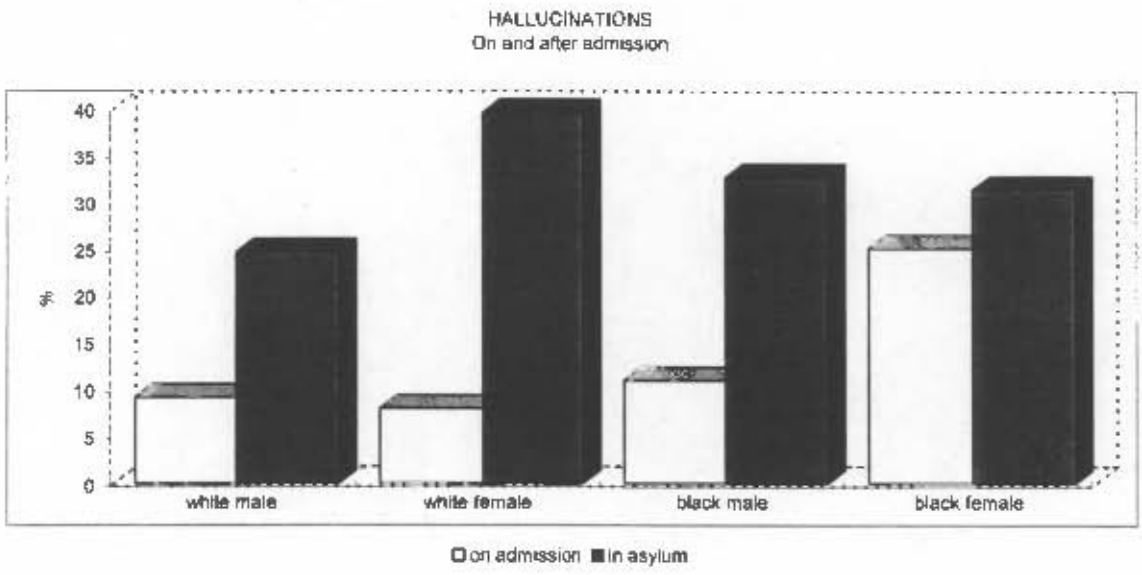

Figure 30

In comparison to this, 77 patients (31%) in the Valkenberg series were identified as having hallucinations in the Periodical Reports and case-notes. Describing hallucinations had usefulness for doctors as a discursive site in which specialised observation and terminology could be employed: in conjunction with opportunities afforded by the ward context for patients to be seen engaging in behaviour suggestive of hallucinations, this offers an explanation for the difference in identification of hallucinations before and after committal.

*4. **Faulty habits and degeneration of the body:*** Commentary on 'body', as opposed to 'mind', is most apparent in representations of patients' 'habits'. With striking regularity, comments on the 'habits' of patients were noted in the Periodical Reports and case notes. 64 patients (25.8%) were described as having faulty habits at some point in their confinement, 'faulty' referring to the wide range of behaviours described above. However, there were seldom notes or reports which did not mention 'habits': if they were not 'faulty' or 'dirty' then they were 'clean'. The following examples illustrate some of the managerial and custodial concerns reflected in representations of 'habits', the discursive space in which 'body' was captured.

Pieter D, admitted with clean habits, became 'wet and dirty'. 'His habits are filthy.' 'His intimate habits are filthy & he does no work.' Here it seems that habits referred to incontinence of urine and faeces. Rachel K was described as being 'in a condition of deep dementia. All mental attributes are lost. Wet in habits and destructive.' Here habits referred unambiguously to incontinence. The degeneration of the body is here linked to disordered mind. There were times when 'faulty' habits were said to lead to degeneration of the mind. An example is Herman L,

described in 1922 as 'becoming much more demented as the result of frequent masturbation', and 'given to frequent masturbation which enfeebles him, mentally and physically.'

There is a curious dysjunction between the unexplicit 'faulty habits' and the colloquially explicit 'wet' or 'wet and dirty' with which it was sometimes replaced. The attitude suggested by the rather coy expression 'intimate habits faulty', is that such things cannot be spoken about freely, whereas the bald 'wet and dirty', which in effect objectifies the behaviour, strips the patient of privacy. The contrast perhaps reflects the ambivalence attendants and doctors felt about their charges, on the one hand regarding them as children without rights or responsibility or even consciousness, as objects, but on the other as adults who *should* be responsible and clean. There is a sense of moral outrage about filthy habits inappropriate to the seriousness of the sufferers' plight.

The complexity of this discourse is perceptible in connections made between paired opposites: good worker/ clean in habits; idle, lazy/dirty habits. There were those who were active and took responsibility, and others who were passive, like babies, and did nothing, not even take care of their excreta. An example of the way in which the paired opposites worked can be found in the case of Stephen D, who was described as adorning himself with bits of rag, and plants, and who 'played with his penis'. He was said to do 'nothing to occupy himself', to be 'very untidy and careless in appearance'. 'His habits, manners are very bad indeed - won't busy himself in any useful way.' In this case, over a period of years, a commentary is created on Stephen as a sexual body, untidily adorned with 'rubbish', and not working.

A further dimension to the issue can be traced through the records of patients described as dirty, who then become clean, and vice versa. The *General Asylum Regulations* of 1892 state the following: 'Patients often entail on the attendants most unpleasant duties, but by regular and persevering attention, very great improvement can be effected in their habits, just as in the case of children; so much so that it is in the interest of the attendants, as well as their duty, to bestow the utmost pains on such cases'[40]. Dodds makes it clear in his Inspector's reports that wet and dirty patients reflect badly on the habits of attendants. He gave instructions that patients to be toiletted frequently, if they tended to soil themselves, and also to be raised at night. He commented with approval on those wards which showed improvement in the numbers of patients dry at night[41].

40. *General Asylum Regulations*, p.4.
41. An example is the comments made on Old Somerset Hospital's management of incontinent lunatics in May 1890 (CO 1524).

Close reading of the records makes clear that patients 'habits' change, irrespective of the course of their illness, and this must have to do with ways in which they were being managed[42].

Black patients were less likely to be textualised as having 'dirty habits' than white patients, particularly white women, who were said to have 'dirty' or 'faulty' habits more often than any other group of patients. This is of particular interest because the 'dirty habits' of black patients had a place in scientific discourse, and yet the Valkenberg series characterises fewer black than white patients in this way[43]. More men than women were noted explicitly to engage in masturbation or sexual display, and it is possible that the euphemism 'dirty habits' was used as a substitute in the records of female patients. If this was the case, it performed the function textually of erasing women's sexual desire and behaviour. At the same time, expectations of cleanliness for black patients may have been so low, that when dirty habits appeared, they were not regarded as worthy of comment.

The textualisation of black male patients in the case records as docile and clean was appropriate to their essential function as unpaid labour for asylum. Given its early history as an elite whites-only institution, Valkenberg had a particular interest in its black inmates being orderly, obedient and clean. It is likely that Valkenberg's preference for quiet and hardworking black patients, and Valkenberg's doctors' tendency to perceive them in this way, combined to mute or erase the violent, disorderly and dirty from the case records of black patients. However, striking gender differences in descriptions of patients after committal add complexity to this picture.

42. The toilet facilities available to patients had a role to play in the extent to which they were clean or otherwise. The earlier records contain comments on chamber pots, and night pails (sometimes hurled by violent patients at each other and at staff). Asylum reports frequently mention unhygienic conditions in some wards and hospitals, for example the central channel in the concrete floor, leading to a receiver, in certain Old Somerset wards (CO 1524, 1/6/1892). Presumably, these arrangements did not facilitate hygienic practices. Even in the 80's Valkenberg had wards under-equipped with toilets (WHO report, 1977). There was little privacy for patients, as many toilets were not in separate cubicles, and had no doors, as a precaution against escapes and suicides. The smearing of faeces and incontinence was not uncommon, and this may have acted as a model for patients already placed in a situation in which continence, cleanliness and hygiene was difficult to achieve.

43. Greenlees, 'Insanity among the Natives', p.74, remarked that 'in confinement and while insane, the natives are extremely filthy in habits, and are accustomed to eat all manner of injurious articles'.

Conclusion: institutional functions of patient folders

Doctors writing about patients admitted to Valkenberg between 1891 and 1920, constrained by context and their role as agents of colonial government, created accounts of insanity which asserted the fundamental homogeneity of all insane patients. This is apparent in the repetitive use of a limited number of lexical sets to describe diverse patients experiencing a wide range of behavioural and emotional disturbances.

The patients themselves were allowed to speak only to voice delusions or to be incoherent. Absence of voice was compounded by the representation of an interior world of meaning as 'untrue', 'unreal' and 'incoherent'. The textual erasure of relational intimacy and acknowledgement of a meaningful interior life, allowed the discursive transformation of persons into bodies, sometimes clean and working well, sometimes faulty, uncontrollable and doing no work. Patients were represented as out-of-control child-adults, condemned for not behaving appropriately, yet characterised as incapable of adult thought or adult temperance. These records are therefore a graphic and at times jarring illustration of the process characterised by Foucault as the silencing of the 'stammered dialogue' between reason and madness[44]. Failure to maintain a discourse of intersubjectivity had a number of consequences for both institutional practices and attitudes to the insane.

The discursive practice of commenting on the daily functioning of insane bodies placed outside the possibility of dialogue erased the possibility of doctors entering into and understanding patients' subjective experience. It also prevented a negotiated decoding of asylum experience. This provided the discursive context within which descriptive uniformity across all groups of patients was produced. In this way, absence of dialogue maintained the psychiatric construction of insanity as a universal phenomenon, and fed directly into doctors' failure to grapple with the cultural, class and gender diversity of their patients.

Repetitive accounts of insanity written entirely from the doctors' perspective contributed to the creation of a discontinuous and ahistorical record of patients' experience. Doctors left notes on series of brief interviews with patients. The purpose of each set of notes interview was to give a synchronic account of present behaviour. Thus although notes were made over periods of years, and present in some respects as cohesive narratives about insane individuals, recording events over many years, there was seldom a diachronic perspective on patients' lives in the asylum[45].

44. Foucault, *Madness and Civilisation*, p.274.
45. Chapter 8 examines the complete case records of a number of individual patients and will illustrate the extent to which they were both discontinuous and ahistorical.

This lack of historical continuity was mirrored in the perception that patients inevitably degenerated into disorientation and loss of memory. Patients' 'loss of memory' was matched by the failure of asylum records to keep alive their past, their individual identity, and their history of relationships in the asylum. Memories of the past are intersubjectively and discursively created, often through recounting and recording stories. The failure of asylums to accord significance to these activities undoubtedly had consequences for patients' own ability to preserve their memory.

Gradual failure of memory, and the textual emphasis on insane symptoms and bodily functioning had the effect of foregrounding the biological, in descriptions of patients, rather than the psychological or social. For example, descriptions of the black insane as having a dangerous combination of sexually disinhibition and intellect inferior to that of white people formulated psychiatric disturbance as being rooted in predetermined biological potential or vulnerability. In the context of a colonial asylum, biologism underscored the difference between groups on the basis of racial classification and gender. Discriminatory institutional practices were therefore reflected in and supported by discursive practice. Both paved the way for the production of psychiatric knowledge which was distinctively colonial, and served the interests of Empire.

The striking absence in the case records of an esoteric vocabulary reflecting specialised psychiatric knowledge, in combination with a focus on bodily function, is an indication of what was to characterise that colonial psychiatry. It also suggests that the fact that doctors were the gate-keepers of information about the insane was more fundamental than specialised knowledge to their power in asylums. This will be explored further in the following chapter.

Chapter Eight

NARRATIVE CONSTRUCTION OF RACE AND GENDER IN PATIENT RECORDS

Introduction

Annie B, aged 19 years, an Irish Catholic schoolgirl, born in Cape Town, and living with her mother, step-father, brother and two step-brothers, was committed to Valkenberg, on January 16th, 1892, after having been examined on that day by two doctors. She died in Valkenberg in December 1961, and a bulky folder of more than 150 pages records aspects of her seven decades spent in the institution.

The narrative begins with certifying doctors' descriptions of Annie's insanity. The first, responding to the request for 'facts indicating insanity or idiocy observed by myself', described Annie as having 'excited appearance, strange conduct'. He noted she was 'afraid of people, wants to run away'. Her conversation was 'incoherent and rambling, cannot converse rationally', and she had delusions of having 'living things in her body which are eating her, & put there by devils etc etc'. The second certificate contained very similar information.

Annie's aunt and step-father told the doctors that she had to be watched because she wanted to run away from home, was 'occasionally violent', and threatened to take her own life.

On admission to Valkenberg, a brief history was recorded. She was described as 'backward at school and rather stupid'. Her 'temper and disposition' had changed a year before her admission, and gradually worsened. She had delusions that she was full of worms and was being poisoned. She altered the meaning of what she read, perceiving it as referring to herself. She 'threatened to drown herself'. She had been in love with 'a youth, who did not respond'[1].

On admission Annie was described as 'maniacal, singing, imploring protection, saying she was being poisoned and talking much religious nonsense'[2]. Acute symptoms were replaced by 'silly, childish, mischievous' behaviour and incontinence at night. She also refused to keep on her clothes. At times she was 'bad tempered and struck nurses and patients'. She became 'more and more abusive', but also 'more and more demented and remains so'.

Over a period of forty-four years, the narrative of Annie's insanity centred more and more on confusion, disorientation, vacancy, dullness and dementia. Thus in 1921, she was said to be

1. Unfortunately, the casebook in which Annie's admission record would have appeared is missing, and the loose-leaf admission form records only her name, age, the fact that she was suicidal but not dangerous or epileptic, her diagnosis ('hebephrenia'), and death from broncho-pneumonia in 1961. The history given here is taken from the first Periodical Report, written in 1917.
2. This information is contained in the summary of her behaviour after admission, first Periodical Report, 1917.

'confused and disorientated'; in 1925 she was described as 'extremely demented'; 1929 she was said to be 'dull and vacant; is confused, answers in an incomprehensible and irrelevant manner, is disorientated', and in 1930 she was said to be 'extremely demented. Does not know her name and cannot answer any questions rationally.' The Periodical Report for 1937 stated her to be 'profoundly demented': 'In appearance she is dull and stupid and in manner she is foolish'. In 1942, she was said to have impaired memory, and to be 'disorientated in all spheres'; in 1952 she was described as 'unable to grasp simple questions'. Case-notes, written at regular six-monthly intervals, differed from the Periodicals in wording, but not in substance.

Many years after her admission Annie was reported to have developed a new symptom, that of self-mutilation. This was not related to the contexts in which it appeared, which makes it impossible to decipher its origin, or significance. Equally enigmatic were the reports on Annie's 'habits'. At times she was reported to have 'clean intimate habits', while at others her habits were said to be 'faulty'. Sometimes she was said to be a good worker on the ward, polishing and scrubbing; sometimes she was described as 'unemployable', 'a poor worker'.

Annie died senile, after having had epileptiform seizures over a period of nine years, as a result of cerebral arteriosclerosis. The regularity of the reports, coupled with commentary on her symptoms and bodily functions, suggested intimacy, and supported the fiction that the records paid attention to individual difference. It was however a univocal narrative of a confinement, fictively Annie's, but similar in all but the name on the cover to dozens of others[3].

The narrative emerging from the case record of Annie's confinement is a good illustration of accounts typically given of patients' histories, insanity and behaviour. In some respects it is a coherent narrative, following a predictable course: acute symptoms of insanity became chronic, and were accompanied by physical deterioration, leading eventually to death. In other respects it does not achieve coherence. For example, no attempt was made to account for changes in symptoms and behaviour between one report and the next. These contradictory sequences occur frequently in the Valkenberg case series. New symptoms, and often new diagnoses erupted into the narratives unexplained, and occasionally patients described as 'hopelessly demented' were discharged recovered[4]. 'Idle' patients became 'good workers' and 'idle' again. Clean habits became faulty seemingly without reason. The only reliably stable strands were the patients' name,

3. Univocal because although written by a number of doctors, their writing was constrained in ways which disallowed their subjectivities to emerge in the documents they produced. They do therefore 'speak with one voice'.
4. The implications of this are explored in Chapter 5.

racial classification and gender. The tension between predictability in the narrative structure, and the discontinuity and narrative disruption implied in juxtaposed unexplained and contradictory reports will be the focus of this chapter.

In Chapter Seven, two separate but interdependent discursive strategies were identified as central to the textual construction of insanity in the Valkenberg case series. The first of these is the production of uniform descriptions of insanity despite the diversity of the patient population. The second is the discursive marking of race and gender difference which such descriptions facilitated.

This chapter will argue that predictable narratives are linked to uniformity of description across diverse patient groups, and that marking of race and gender was embedded in these narrative structures. It will also argue that contradiction and disruption to narrative structure was used partly to textualise doctors' perceptions of the irrational, inexplicable nature of insanity itself.

Using the general characteristics of the Valkenberg case series as a context for the analysis, this chapter will describe the narrative structure of patient records. The purpose of this narrative analysis is to demonstrate in relation to specific patients the ways in which institutional and discursive practices in the asylum dovetailed to construct insanity as appropriately managed through asylum care. It will illustrate doctors' racialised and gendered perception of the illnesses of these patients, and will argue that this was intrinsic to the development of a colonial psychiatry. The chapter will argue that it is only in the unfolding stories of individual patients that the full impact of that psychiatry can be understood.

The case records contain a jigsaw of documents, including certification papers, admission forms and Periodical Reports, case notes, letters to and from relatives and friends, accounts and details of income and estates, temperature charts and even lists of clothes. Narrative structure will be read primarily from the contents of Medical Certificates and Periodical Reports, the major sites of patient description in the records. Other documents will be used as secondary sources of material for analysis[5].

5. Documents such as the sworn statements of relatives seldom add to information in the Medical Certificates, which usually incorporated relatives' comments in their descriptions of patients. Similarly, admission forms and case notes seldom added substantively to comments in Periodical Reports. Correspondence between the medical superintendent and relatives or friends sometimes concerned financial arrangements, and did not contribute to the ongoing description of the patient's insanity. When asked for a report on a patient's progress, the superintendent's letters were usually brief (no more than a sentence or two), general and euphemistic.

The structure of psychiatric narratives

In Chapter Three, 'narrative' was defined as the textualisation of a story, in which events are implied or said to be connected in a structure given coherence within a particular knowledge framework. Narratives place events in layered or linear sequences, imply a necessary temporal relationship between them, and allow the reader to predict a limited number of story-lines, or outcomes.

Predictability however was only one aspect of the patient narratives. In Chapter Seven it was argued that the case records were discontinuous in two ways: they were written by many different doctors over long periods of time, and they were an incomplete account of those periods, selecting some events to record, and ignoring others. Partly for these reasons they were also ahistorical, producing a fragmentary record of a patient's life in the asylum. In addition to this, they were ahistorical in the sense that they frequently deleted significant aspects of patients' past lives, cultural and social identity, and relationships within the asylum context. Readers' expectation that individual case records be a predictable and biographical account of the lives of the patients whose names they bear is therefore in tension with their fragmentary, synchronic structure.

This chapter will also use narrative structure to attempt to reconstruct some aspects of patients' subjective experience in the asylum. Their 'subaltern voices', indistinctly heard through records which largely silenced them, can be found in their delusional systems, hallucinations, behaviour, and commentary on their surroundings[6]. Filtered through the organising consciousness of doctors' writing, these voices are an important counterpoint to the discursive construction of the insane as objects of the doctors' gaze. At times it is possible to find in patients' comments on their situation an oppositional decoding of dominant discourses, a rejection of stereotyped gender roles, and a rebellion against stigmatised status. In attempting to identify the 'silent' narratives which may be used to interrupt the surfaces of doctors' writing, requires that each text be interrogated for an understanding of what it *enables* and what it *disables* for the uncritical reader[7].

6. Spivak, 'Can the Subaltern Speak?', 66-111.
7. An example of textual interrogation which outlines silenced narratives can be found in Jenny Sharpe's description of reports and fictions surrounding the 1857 Indian Mutiny. She points out that horrifying tales of English women being raped and mutilated 'displaces attention away from the image of English men dying at the hands of the insurgents'. The image of white women as victims of savage attacks also silences the narrative possibility of British soldiers raping Indian women. *Allegories of Empire*, p.67.

Race, gender and colonisation in narrative

This chapter will describe the limited number of racialised and gendered narratives through which doctors constantly reproduced their understanding of insanity in ways which linked individual to generic identities. This reading of the patient folders, taken together with the contradictions inherent in doctors' 'humanitarian' and yet fundamentally racist and sexist position vis-à-vis their insane charges, adds to a growing literature on the tensions of Empire, and the ideological inconsistencies of the 'civilising mission'[8]. Important in this regard are the records of those patients who challenged racial boundaries and gender roles. In Valkenberg, these were black patients and women with ideas 'above' or 'below' their station[9]. This chapter will use the records of patients at race and gender 'frontiers' to highlight the conflict between the discourse of inclusion and equality of liberal humanism, and the exclusionary tactics of a colonial authority becoming increasingly preoccupied with respectability and its relationship to racial purity.

The term 'racial frontiers' is taken from Ann Stoler, who makes the point that although the 'colonial politics of exclusion' was predicated on the assumption that racial boundaries were self-evident, judgements about who belonged to 'coloniser' (European) and 'colonised' (native) groups were constantly challenged by sexual relationships at the frontiers of cultural, class and national borders[10]. She also points out that in colonial contexts, middle-class 'respectability' 'prescribed the personal and public boundaries of race' through 'gender specific sexual sanctions'[11]. In other contexts which demanded daily contact with colonised populations, 'respectability', particularly for women, became a strategy through which racial boundaries could be policed. An example is given by Shula Marks, who describes the perceived need to maintain the 'status and self-respect' of white nurses in the 'confused and ambiguous world of the colonial hospital', in which there were black patients and black domestic labour[12].

The outlines of race and gender variation in case record narratives can be discerned in lexical sets described in Chapter Seven. These variations include for example black men, displaying sexual or violent behaviour in public, found to be 'deluded' or 'incoherent', committed to asylum care, then becoming increasingly 'childish' and 'stupid' although working as labour for the institution, and eventually becoming chronically incapacitated. Similarly, there is the narrative outline of white

8. These tensions were described in Chapter 6.
9. There does not appear to have been the same anxiety about white men having relationships with black women: women were identified as the guardians of racial purity. This of course was a means of men policing their sexuality. *Commission into Assaults on Women*, U.G. 39-'18.
10. 'Sexual affronts and racial frontiers'.
11. 'Making empire respectable', p.635.
12. *Divided Sisterhood*, p.33.

women committed for 'excited', talkative and sexual behaviour, and failure in household duty, continuing to be 'excited' and 'dirty' after committal, and deteriorating into 'dementia' after years in the asylum. The analysis of patient narratives will illustrate some of the ways in which constructions of race and gender identity served institutional, and broader colonial purposes.

Although this discussion of narrative is primarily concerned with Cape colonial psychiatric practice, it relates to two wider contexts. The first is the racialised and gendered structure of psychiatric knowledge wherever it was practised, and the second is the relationship between that knowledge and patients' experience of themselves.

The biologism underlying psychiatric theory in the late nineteenth and early twentieth centuries led inevitably to a focus on those differences in psychiatric illnesses which could be accounted for in terms of bodily difference, including racial classification, gender, and body defect such as inherited or congenital mental handicap[13]. The unquestioned assumption that bodies perceived as different would have different needs, experiences and illnesses was a general one, and fed into racialised and gendered social organisation at every level. Thus patients and doctors shared expectations with respect to race and gender.

There were ways however in which doctors' expectations of their patients acted powerfully to construct situations in which behaviour fulfilled those expectations. There is an extensive literature on the social construction of mental illness, focusing mainly on twentieth century psychiatric theory and practice[14]. This literature suggests that there is a complex interplay between social and cultural identity, gender, class and illness experience, and that doctors' explanatory models influence diagnosis, treatment and ultimately the course of the illness itself.

13. It is beyond the scope of this study to detail the development of psychiatric knowledge and its relationship to the physical sciences. The biological strand of psychiatric theory is discussed in relation to both gender and race in Oppenheim, *Shattered Nerves*. See Chapter 7, for a discussion of its implications in relation to general trends in the case records. Chapter 5 amplifies on the theme of biological assumptions about insanity in relation to theories about insanity in the black population of the Cape Colony.

14. See for example the discussion of 'symptoms' in relation to institutional life in Barton, *Institutional Neurosis*, and W.Caudill, *The Psychiatric Hospital as a Small Society*, (Cambridge, 1958). S. Cohen, and A. Scull, (eds.), *Social Control and the State*, (Oxford, 1985); W.Gove, (ed.), *Deviance and Mental Illness*, (Beverly Hills, 1982); and T.Scheff, (ed.), *Labelling Madness*, (Englewood Cliffs, 1975), contain a wide range of papers debating the extent to which psychiatric illness is socially constructed. D.Ingleby, 'The social construction of mental illness', in P.Wright and A.Treacher (eds.), *The Problem of Medical Knowledge: An Examination of the Social Construction of Medicine*, (Edinburgh, 1982), 123-143, and L.Eisenberg, 'The social construction of mental illness' *Psychological Medicine*, 1988, 13, 1-9, are both seminal papers. L.Johnstone discusses the effects of expectations about gender roles on psychiatric decision making in *Users and Abusers of Psychiatry: A Critical Look at Traditional Psychiatric Practice*, (London, 1989). In *Making it Crazy: An Ethnography of Psychiatric Clients in an American Community*, (Berkeley 1985), Sue Estroff discusses patients' experiences of severe mental illness. B.Luske gives a valuable description of the discursive construction of patient experience in a hospital setting in *Mirrors of Madness: Patrolling the Psychic Border*, (New York, 1990).

One example will illustrate these points. The following text was written in 1883 by Dr Alice Bennett. She was in the unusual position of being a woman physician in charge of the female wards of an American state asylum during the final decades of the nineteenth century. In a strongly-worded appeal for an end to the practice of using physical restraint in asylums, she described the effect on one of her patients of eventual release from seclusion and restraint. The patient was:

> an immensely powerful, muscular German woman, one of the first admissions to this Hospital; (she) brought with her a reputation for ferocity calculated to strike terror to the soul of the uninitiated. For months she had been chained in a dungeon, the limited space of which scarcely permitted her to lie at full length on her heap of straw. Through the grating of the heavy door was thrust the food, which she must eat as best she could, with hands confined. Here also the curious were privileged to gaze upon this monster in human form, who with her hair, long ago torn out by her own hands, and her expression of savage distrust and defiance might well see, something less than human. A year ago I introduced a gentleman interested in public charities to this same woman, standing in the door of her neat little room, which she invited us to enter and inspect. Her thick grey curls surrounded a face strongly marked and resolute, yet not unpleasant to look upon, and her general appearance was such as to attract a stranger at once. She was led to speak of her former experience; 'And *why* were you locked up in a dungeon,' asked my friend, 'Because' - but I cannot repeat her language. At the mere recollection, a tithe of her old fury was aroused, and her mien hinted at the total annihilation of anybody in her path. 'But why did you have those feelings there and not here?' persisted the visitor *'Because they locked me up.* Would *you* like to be locked up like a beast?' came the answer, with an emphasis which was a whole sermon in itself[15].

Like the woman described by Dodds as having been chained to her bedstead for eighteen months, this patient embodied and engendered raving madness[16]. Once 'savage' and 'less than human' this woman, racially marked through her foreign identity, was domesticated by humane care. In being recreated as the object of male gaze, in this text represented in the figure of 'a gentleman interested in public charities', she was textualised as 'not unpleasant to look upon' in her 'neat little room'. Not only was she able to converse rationally, she was also restored to essential femininity, her body able to 'attract a stranger at once' and her room a display of domestic pride and skill. She was an example of successful treatment because she was not a challenge to the gendered hierarchy which allowed her to be displayed by a woman doctor to a male visitor. Just as much an exhibit for the 'curious' as she had been in the past, she even gave a brief performance of her old madness; this in combination with her 'immensely powerful, muscular' body and her 'strongly marked and resolute' face, both of which suggest masculinity, were reminders of the necessity for continued incarceration.

15. Reprinted in Tucker, *Lunacy in Many Lands*, p.46.
16. CO 7175, 16/1/1894.

In this encounter, the patient's understanding of her transformation from beast to domestic femininity matched seamlessly that of her visitors. The same mesh of subjectivities can be seen in the ways in which patients in the Valkenberg series enacted the racist and gendered gaze of the doctors describing them. This is clearly reflected in black men referring to themselves as 'boys', and calling the doctor 'boss'. The patient calling herself 'a white woman and quite pure' positioned herself in a hierarchy of race, highly salient to her hospital accommodation and treatment, linking 'white' with 'pure'. The woman who told the doctor certifying her that she was 'old in years but young in sense' not only identified herself as childish: under the gaze of a male adult, she enacted the child status of women in relation to men.

Without access to extensive accounts of patients' experiences in Cape asylums it is difficult to determine the extent to which the illnesses described were socially constructed. However, it is possible to use narrative structure, and particularly the contradictions emerging from them to suggest ways in which theories about insanity in the 1891-1920 period influenced patients' subjectivity. There is an important conceptual link between the social construction of illness experience in the asylum and the numerous ways in which the colonial context shaped subjectivity. It is possible to conceptualise doctors' construction of patient subjectivities as in itself a colonising act. This widens the field of enquiry to include the relationship between psychiatric practice as a colonising agent and other forms of colonial exploitation not necessarily unique to the asylum setting.

One example, taken from the record of Annie B, will illustrate these points. Approximately one quarter only of all the documents in the folder relate to her mental and physical condition. The remaining documents, with the exception of a few letters from relatives, concerned financial arrangements. Annie became one beneficiary of an aunt's estate in 1915, and the administration of this inheritance necessitated regular correspondence with lawyers and the South African Association for the Administration and Settlement of Estates, who handled the estate until Annie died. Annie's money contributed substantially towards the costs of her confinement, but was not used to add to her comfort by providing her for example with extra food or clothing.

The folder contains one letter from Annie's mother, dated 1916, in which she discussed at length her sister's estate, and detailed expenses which would reduce the amount finally to be inherited by Annie. She died in 1928, and there is no record surviving of her having visited Annie in Valkenberg. After 1928, there was some correspondence between Annie's brother and two step-brothers and Valkenberg's superintendent, most of which were concerned with financial matters.

A note appended by a step-brother to one letter commented that Annie's brother 'dreads, for some reason or another to go to Valkenberg'. Without family to visit and to act as signifiers of a personal past, Annie's story shrank, inevitably, to her history as a patient. In this way, the identity 'Annie B' was emptied of its past and present connections outside of hospital life, and was available to be colonised by a patient identity.

There were several levels of colonisation. Patient Annie was represented in forms and documents of British origin, and arising out of British-based experience and knowledge of insanity. Insofar as she could work, she was colonised as labour. Her financial resources were colonised by the hospital. Perhaps the most profound act of colonisation took the form of robbing Annie of her own agency. Will and desire were replaced by 'impulsiveness', 'faulty habits' and 'bad temper', all represented as being caused by her insanity, not stemming from a rebelling self. Hospital practices and accounts of her life within those practices deprived her of voice and motivation, of private space within which a self free from domination could have been created, and rendered her finally 'dull and demented'.

Patient narratives I: domesticating white male madness

William M, a 27 year old, single unemployed man from a middle-class Cape Town family was admitted to Valkenberg in 1900. He was reported to 'break out into laughter for no reason at all', and to stand still 'in one position without saying a word to anyone but muttering to himself'. When asked, he said he was laughing at 'the workings of nature'. One doctor said 'he leads an entirely purposeless life'. He spent several months in Valkenberg and was discharged. For a time he was able to work, the records do not state in what capacity. In 1908 he was re-admitted, this time following noisy, abusive and violent behaviour. He remained in Valkenberg until he died of T.B. in 1927. The years of his residence in the asylum seem to have been uneventful. He was described as behaving 'more or less like a machine', but also as 'scowling, hissing, smacking his lips,' all suggestive of an animal-like quality in his body-language. He was consistently said to be 'well behaved', and a 'good worker'. Although he was said to be in a 'terminal state of weak-mindedness after simple dementia praecox', he showed remarkable insight into his situation. Asked in 1920 by a doctor why he was in Valkenberg, he said 'to keep quiet'. He also identified the asylum's purpose accurately: he said its function was 'to keep us here'. 'Keeping quiet' and 'being kept' summarise the asylum's containment of his previously noisy and disruptive behaviour, the permanent status of his committal, and also his domestication. He expressed 'no desires and made no complaints'.

His taming went further than simply turning him into a quiet and undemanding patient: he was put to work, and through the nature of the work was feminised. He bathed and dressed other patients, made beds, and cut bread, and in the evenings helped to put patients to bed. In this way the narrative presents the process through which violent man became passive (feminised) body.

There are many examples of this process in the records of the white male patients in the Valkenberg series. Stephen D, described as displaying 'many monkey-like antics' was also said to 'coo like a dove'. Said by one doctor to be 'decorative', he was depicted as 'kissing visitors on the cheeks', and 'decorating himself with all manner of trinkets and cloth'. Alfred H, admitted in 1916, was said to 'weep like a woman' during his bouts of depression, and to have no desire to leave Valkenberg because he lacked confidence in himself. John C, admitted in 1902, was said to 'suck his fingers like a little girl'. 'Unctuous emotionalism' was said to characterise John v. N.'s conversation, a feminising description because emotions were stereotypically seen as a woman's domain. Thomas B was described as 'very vain especially on dance nights when he spends a long while in front of the looking glass'. Paul M worked in the pantry and tended the ward's garden, becoming agitated whenever anyone approached newly potted plants or flowers.

The production of texts in which white male insanity was feminised and domesticated had the effect of silencing their potential to be violent and dangerous and therefore a threat to order within the asylum, representative in this context of colonial authority. One example will illustrate the way in which the threat of violence was transformed into behaviour manageable for the asylum. Jan K, whose insanity first became apparent in 1876, had a mother 'not quite sane', and a brother who, having been discharged from Robben Island, killed their father and then himself. The family feared that Jan too was capable of murder. He was described as saying 'he will twist your neck for you, kick you until you burst etc'. The report goes on: 'all are afraid for his vengeance - fearing that if he is let loose again, he will certainly commit murder.' Once in the asylum the violence so graphically described in the admission texts was transformed into 'stupidity' and 'irritability'. He was said to work 'contentedly' in the garden day after day, and to be 'docile'.

Patient narratives II: eroticism and rebellion in the female white insane

The textual production of insanity in white men, and its containment, took place through domesticating and feminising descriptions of their behaviour; white women, on the other hand, were narrated as insane through texts in which rebellious, erotic, shameful and violent behaviour was foregrounded. These descriptions reinforced the appropriateness of their incarceration. Having been identified as insane, passivity, lack of ambition, and 'feminine' engagement with the

domestic, in men, was further evidence of 'insanity': these same qualities in women would have been markers of sanity. Valkenberg's white female patients were therefore everything that betrayed the domestic ideal of tidiness, cleanliness and domestic industry. Descriptions of these dirty and rebellious women also had the effect of suppressing not only violence committed against them before their admission, but also the violences against women inherent in colonial life. The following narratives amplify on these themes.

Dorothy F was admitted to Valkenberg in 1892. This was her first admission to an asylum, although she was said to have been ill since 1884. She is therefore an example of a woman being kept at home for long periods after having become insane. The Medical Certificates state that she was emaciated, haggard, maniacal, excitable, with erotic delusions. She believed her food was being poisoned, and that it was prepared in the kitchen by the same knife used to commit murder. She had attempted suicide by drowning.

Dorothy had had small pox, had subsequently become depressed, and thought herself 'disfigured'. She 'took to wandering'. She also said her father had a mistress and three illegitimate children. One Medical Certificate also states: 'wanders about aimlessly: has her natural affections quite perverted & uses most shameless language when spoken to by her relatives. She thought herself ill-used at home.' Explicit in these comments is the issue of her sexuality, which lies behind the 'perverted natural affections' and 'shameless language' commented on here. The issue of being ill-used at home becomes clearer as the story unfolds.

Unfortunately few notes from the early years of her admission survive. She was diagnosed as having mania. In 1903, she was recorded as having 'delusions of unworthiness'. The first Periodical Report, written in 1917 summarised her case thus far: 'At first she expressed foolish delusions made accusations against her father to the effect that he had raped her etc.' Until her death in 1944, she was recorded as spending many hours sitting with her hands folded tightly in her lap, or as 'messing about in the WC', washing, or using toilet paper, for a purpose unspecified. Her habits were consistently reported as clean, except in 1931, and again in 1933 and 1934, when she was said to be 'wet and dirty':

> She is stupid, asocial & indifferent. In speech is thick and indistinct. She gives little information. Her habits are dirty and she abuses herself. Her demeanour is foolish. She is at times cheeky and impertinent. She refuses to occupy herself. Her conversation is rambling and incoherent. She mutters to herself.

The note for 1934 is an important one, in terms of the attitude of male doctors to their female patients. It gives the impression that the person being described is a wilful, unruly child, disobeying authority. Masturbation in this note is linked semantically to dirtiness, defiance and deterioration of mental faculties.

Thus, Dorothy in every way subverted the ideal of domestic femininity: she was dirty, and openly experienced her body as sexual; she refused to work; she was also rebellious. This record did not only inscribe her as insane. It also silences the violence done to her body in the asylum, the rules of which demanded that she undertake domestic chores in a clean and obedient way, while denying her sexual desire. Moreover, to describe her as having erotic delusions suppressed the possibility that her father may have raped her before her admission. It is impossible to know whether he did rape her or not, but the fact that her story of having been raped was never considered as anything but delusionary in itself constitutes a violence, mirroring a society assuming the innocence of men, and the perversion of women, in narratives representing domestic sexual violence.

Another example of ways in which being a woman shaped perceptions and treatment of insanity, both inside and outside the asylum, can be found in the record of Ivy G, admitted to Valkenberg in 1916. A parent (it is unclear whether mother or father) wrote a letter to the superintendent at this time, giving a description of the course of the illness, which included vague delusions, imagining evil smells and 'weird fantasies'. The letter goes on:

> With all this her general temper has been very sweet in her lucid intervals; she always has strong powers of organisation for arranging social parties, picnics etc. And is fond of giving away to people, & her memory is wonderfully good; her chief defect is that she is entirely self-centred or almost so. So at last we were advised to put her under your care hopefully that a year or two under rule and discipline might put her right.

To understand asylum treatment as 'rule and discipline', and further, to consider this appropriate for the correction of 'self-centredness' in a woman, makes explicit a network of patriarchal relationships in which all women were expected to be self-effacing and subject to the rule and discipline of men. Ivy's parent did not perceive the asylum regime inaccurately in this respect. In July 1916, the notes read: 'Had to be put back to bed yesterday. She had been impudent & haughty all day, refusing to sit with "those low patients" & demanding better food, afternoon tea etc. She can be very wayward and troublesome.'

Like Dorothy, Ivy gave expression to the sexuality denied to 'sane' women. In October it was noted that she was 'erotic and suggests improprieties'. By 1921 she was said to 'require careful watching if males are in the ward.' She was also dirty, aggressive, and attempted to kiss doctors entering the ward. Far from benefiting from the discipline of asylum life, Ivy's behaviour simply became worse. For twenty-five years she was described as dirty, destructive and demented, and in the twenty-fifth year of her stay in Valkenberg, she was still adding to her repertoire of insane behaviours, this time by beginning to mutilate herself. She is more than an example of the failure of asylum treatment. It is important here to contrast women's 'insane' expression of desire with the sexuality of prostitutes, accommodated by society because they were constructed as performing sexual acts for money, not for pleasure. Ivy's narrative textualised society's need of an institution which could rule and discipline women's wayward minds and sexual bodies. In a society unable to accommodate the idea of women's sexual desire, permanent incarceration of women who gave it expression made possible the construction of 'sane' women as sexually passive.

The violent control of women's sexual desire in this colonial setting is also apparent in the record of Hester D. In 1912, the year of her admission to Valkenberg, her brother made this sworn statement about her:

> Some two years back my sister Hester worked hard for a school examination but failed to pass. This fact seems to have preyed on her mind. My sister is of a highly-strung and nervous disposition. Some five months ago her mental condition became alarming & I took the preliminary steps to have her removed to an Asylum. Her condition, however, improved very much & it was eventually found unnecessary to remove her. For the past week however, she has exhibited unmistakable signs of mental weakness. She has become melancholy, refusing to leave the house at all or to perform any of the light household duties, which hitherto she has performed cheerfully. We have experienced great difficulty in persuading her to take any food whatsoever. I am, therefore, of opinion that she is of unsound mind.

Her brother further stated to the doctors writing her Medical Certificates that she refused to eat, slept badly, and refused to speak. Mention is made of her pushing her keeper off a chair, which suggests that she came from a middle-class home, with sufficient money to employ someone to care solely for her. There is further evidence for this, later, as her brother took her out of Valkenberg for probation periods, and during those times he again employed a keeper.

Hester subverted the domestic ideal in a number of ways, all of which came together in the description of her as insane. That she had ambition beyond the confines of home and domesticity

is apparent in her determination to study. She refused to do domestic work. She also used physical violence in the attack made on her keeper.

The initial response to Hester's insanity was to admit her to Plumstead Sanatorium, a private institution, five months before she was admitted to Valkenberg, where she was given a clitoridectomy, probably because she had been found to masturbate[17]. A temporary improvement was noted. However, her behaviour soon deteriorated again, and by the time she was admitted to Valkenberg, she was depressed and refusing food.

Once in Valkenberg, Hester, like Dorothy, was described as 'subject to hallucinations', incoherent, foolish, childish, affected, occasionally impulsively violent, and 'unemployable'. Her habits were described as 'very filthy'. She was also described as 'very untidy', and needing 'every attention from nurses'. She was said to be 'lacking in comprehension', but also as 'refusing to speak'; as not knowing her own name, but also being 'troublesome'. In this way, she was inscribed as both dementing and rebellious, helpless and disobedient. This tension, which runs throughout many of the records of the white female insane, is central to the creation of these women's Otherness: they are positioned as simultaneously objects of care and of discipline. One note from Hester's record captures these contradictions. In 1921, the doctor wrote:

> Still refuses to speak. Grins in a foolish and vacant manner. The only sign she gave that she comprehended what was said to her was when the doctor said it was useless to detain her if she refused to speak, whereupon she vigorously nodded her head in agreement and walked out of the office.

Part of the violence committed against Hester within the asylum was the doctors' refusal to 'read' comprehension *as* comprehension. As the above note makes explicit, Hester was understanding what was said to her, but she was consistently treated as if she was beyond the reach of conversation. This act of violence is consistent with her treatment from the time of her clitoridectomy. Describing her as disobedient and violent not only justifies the violence with which she was treated; it silences the story of the men who refused her the space to express both thought and desire.

In the Valkenberg series, there are records of three white men whose insanity was attributed to overstudy and to masturbation or sexual activity. Johannes d T was a student of theology at the

17. To perform a clitoridectomy to correct the habit of masturbating in women was widely undertaken in America and Canada at the turn of the century. E.Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments of the Insane*, (New York, 1986). It was exceptional in the Cape. No other record of its having been done survives in Valkenberg's case records. It may have been used more frequently in private institutions, accommodating middle- and upper-class paying patients.

time of his breakdown in 1918. The doctor writing the Medical Certificate claimed that 'overstudy and consequent irritation of the erotic centres of the brain' were the cause of his nervous, impulsive and erratic behaviour. Once in Valkenberg it was noted that 'his mind is constantly dwelling on sexual matters'. He was also described as 'clean and tidy, quiet and well behaved'. Guy H was a teacher, admitted first to Valkenberg in 1907. His Medical Certificate states the cause of his insanity as overstudy. Once in Valkenberg he was said to 'masturbate excessively'. Jacob H, an apprentice apothecary and chemist, had his insanity attributed to 'too much study and overwork' by one doctor writing his Medical Certificate. Once in Valkenberg, he was said to be 'on intimate terms with patient F'. This series of cases illustrates the aetiological link being made between sexuality and exhaustion, applied equally to male and female patients. However, these cases make clear that masturbation in men and women was regarded differently. Women expressing their sexuality were morally reprehensible. Sexuality in men was perhaps intemperate, but nonetheless 'natural'.

Patient narratives III: black patients and the construction of child subjectivities

By being positioned discursively as doing domestic chores, white men were described as insane but docile, because feminised. Black men were not feminised in the same way. There were a number of reasons for this. To write of domesticity assumes the domestic scene as a discursive frame, and for doctors to write with such intimacy about daily routines was not in keeping with the preferred distance from the colonised subject. Apart from this, black men were needed as labour, and during the period 1891-1920, this often consisted of ground-clearing, road-building, and farming, none of which were discursively akin to female occupation. Because of black patients' utilitarian function in the asylum, even their insanity needed to be muted, especially those insane behaviours which disrupted work routines. The marking of black men as clean and obedient children, in keeping with their legal status in the colony, served the purpose of inscribing them as a malleable, intellectually infantile work force, and in need of parental care. The contradiction inherent in using 'children' to do hard labour will be discussed below.

An example of a patient narrative which represents a black man as a child is that of George N, 24 years old, single, and a 'Coloured' labourer in Paarl. He was admitted to Robben Island in 1910, and transferred to Valkenberg in 1916, with a diagnosis of dementia praecox. Prior to his committal, he had served a 4 year prison sentence, 1905 to 1909, for assault with intent to commit rape. He was again gaoled from May 1910 for six months with hard labour, for a crime unspecified in the papers. While in gaol he had been punished for 'laziness' and 'disobedience'.

The word 'disobedience' is evocative of a relationship of unequal power and is associated with rebellion of children against parental authority.

Two and a half months after his second conviction, he was examined by doctors with a view to his being placed in an asylum. One Medical Certificate described him as running about naked, and being 'at times noisy - at times silent'. Being noisy or silent has no necessary relationship to language, only to sound; and the phrase 'running about naked' suggests lack of adult inhibition rather than sexuality. Childishness was therefore embedded in the erasure of any adult potential. The Chief Constable of the convict station described him as laughing and grinning to himself, 'and if sharply spoken to, would cry like a child.' The gaoler described having to pick him up and carry him into the gaol from the yard, because he refused to walk in. In these statements, George's status as a child was made explicit both in the description of him 'crying like a child' and in the image of him being picked up and carried by his gaoler. The transformation of George from adult male to naked child was all the more remarkable in the light of his conviction for attempted rape.

George was transferred to Valkenberg from Robben Island in 1916, where he remained until he died, except for a brief period during which he was given leave of absence to stay with a nephew in Wellington. He died in 1946, and in the thirty years during which he lived in Valkenberg, the clinical notes and Periodical Reports describe him as 'foolish', 'dull and indifferent', 'childish' and 'simpleminded'. His relationship to the examining doctors was captured in descriptions of him as 'shy', 'sulky' and 'sheepish'. In a pattern typical of many of the records in the Valkenberg series, only when George was old was he allowed access discursively to adult status, being described as a 'nice, quiet, obedient, sociable, demented man'. The appearance of the word 'man' for the first time in 1943, after 33 years of absent nominalisation, or of being referred to as 'he' or 'patient', is an indication of the textual suppression of his adult status.

The inscription of black patients, both men and women, as children in the case records was not simply a matter of calling them 'childish'. The descriptions drew on a wide range of words all related to children's emotional and intellectual development and behaviour. For example, Louis B was said to be 'childish and mildly precocious'. The word 'precocious', suggesting behaviour older or more sophisticated than chronological age, positioned him unambiguously as developmentally young. Julia P was described as 'very childish and amusing to talk to'. To become an object of amusement in the context of a relationship in which she had little power positioned her as a pet or plaything.

The textualisation of black patients as childish suppressed not only their adult status, but also their ability to interrupt or interrogate the authority structures of the asylum. Evidence for the way in which inscription of childishness displaced adult challenge can be found in the juxtapositioning of child-descriptions with descriptions of disruptive or violent behaviour. For example, James S was said to be 'childish and full of silly and exalted ideas. Exhibits mannerisms and if interfered with is impulsive. Contented and happy.' 'Impulsive' in this context invariably related to physical impulsivity, such as lashing out with fists, wrestling, or kicking. To have described physical violence of this kind as 'impulsive', implying that it happened suddenly and disappeared as quickly, prevented it from being understood as a prolonged state integral to the patient's general state of being. Further, to have embedded this word in a text which included state-of-being descriptors such as childishness, silliness and contentment, robbed violence of its potential to threaten. A similar example is that of George N, described as childish, and as 'making rushes at times'. Julia P was said to be 'very childish', but was also described as 'throwing the furniture about'.

Patient narratives IV: black patients, labour and negotiated subjectivity

White men lost male adult status legally and materially when they entered the asylum; black men never had that status. Both inside and outside the asylum, black men were 'boys', committed to life-long labour for colonial institutions. The contradiction between the social and material construction of colonised subjects as children and their obvious 'manliness' in terms of physical strength is to be found throughout the narratives of the black male insane, replicating the contradictions in the textual construction of black men in all the colony's institutions. With the idea of the physical strength associated with manhood came the fear of black male hypersexuality and potential for violence, both of which were discursively contained through the strategy of infantilisation.

There were however patients who resisted ways in which they were positioned by doctors in the asylum. Asylums' reliance on their black patients as a source of labour, and therefore as important to their economic survival, gave patients limited access to locally-negotiated personal power. They were able from time to time to refuse to work, or to work in such a way that they received some personal benefit from their labour. Moreover, some case records indicate negotiation by patients of a subjectivity which is simultaneously compliant and rebellious.

An example is Margaret M, who on being questioned said she 'knows this is a place for mad people and admits she too is mad'. Consistently diagnosed as an imbecile or feeble-minded, she nonetheless was reported to be an excellent worker in the laundry. Evidence of a negotiated

subjectivity which gave expression to her resistance to being simply a good worker can be found in the following reports. In 1919 she was said to go to bed occasionally 'with vague pains all over (looks as if she wanted a few days rest from laundry where she works regularly)'. When she'd had her few days of rest, she would go back to work. In 1920, she was said to be a good worker, but 'unreliable, and has enough sense to do things on sly', in this way disrupting her obedient servant role. This pattern continued, and in 1933 she was said to be 'quite imbecilic - is a fair laundry worker but apt to be very stubborn when she will not carry out orders given to her'.

A similar case is that of Antonie M, who worked in the dairy, and was described as 'inclined to take an occasional day off on a trumped up excuse.' Edward F managed to negotiate acknowledgement from the staff of his unpaid labour. Noting that he worked well in the kitchen, one doctor commented that 'he is rather hurt if enough fuss is not made of him'. When feeling hurt, he would become 'irritable' and have to be 'managed' by the staff, before he would do more work. Daniel R negotiated power for himself in the kitchen by 'resenting interference' and by refusing instructions. This power was however only precariously his. When he was found paying himself for his labour by stealing meat, he was punished by being placed in the 'working party' , doing hard labour in the asylum grounds.

Black patients who refused to work altogether created for themselves a subjectivity which refused interpellation into the asylum's discourse of labour as 'moral treatment'. James S, having 'worked well' for thirty years, eventually refused to do any more. The note from this period is revealing:

> He has an exalted opinion of himself. He does not show me the respect which one of his class ought to do. His attitude is inclined to be aggressive and he states that he does not work, because he is not a bloody fool.
>
> He expresses bizarre delusions believing himself to be but 9 years old and he has no insight into the seriousness of his mental condition.

James' refusal to work on the grounds of not being a fool is extraordinarily powerful because it manipulated the widespread practice of inscribing patients as foolish, and despite that, or because of that, expecting them to work. If labouring was contingent on foolishness, then James had an escape-route, by naming himself 'not a fool'. James' stand is also powerful because it revealed his ironic and accurate analysis of patients' exploitation.

The note also made transparent the doctor's perception of his status. He expected respect from James because James was socially beneath him. His strategy for dealing with James' rebellion was to reinscribe him as insane. In this way, James' source of personal power accessed by refusal to provide free labour, is matched by the doctor's power to label him as irrational.

Six months later, James was said to understand that 'he was sent here because he was "mad". When asked if he is alright now he answers "Don't be silly, once mad, always mad" '. Once again, James made clear that he could not be pulled into a conversation the purpose of which was to 'prove' his madness. Simultaneously he undid the discourse of 'cure', 'treatment' or 'recovery' upon which the asylum's reputation as a humanitarian institution rested. Calling the doctor 'silly' again used the language of the case notes to ironic effect. These interactions constitute an illuminating summary of black patients' situation. They were regarded as children, and yet expected to work as adults; they were regarded as irrecoverable, and yet expected to have insight into their illness; and on top of that they were expected to act towards white staff in a way which confirmed their unequal status. Patients who rebelled against this punishing regime were labelled as aggressive or as terminally dementing.

The subjectivity of other black patients who refused to work sometimes is reflected not in what they say, but what doctors say about them. Henrietta d P, for example, was said to be 'treacherous and untrustworthy', after her quarrelsome nature led her to be removed from the laundry where she was supposed to work. She was also called 'very indolent' because she would not 'employ herself in any way'. In the same vein, Gilbert G who refused to work was called 'sulky, cunning and determined'.

There are occasional examples of black patients managing to negotiate power in ways which did not involve manipulation of their work situation. Maria P negotiated in dialogue with the doctor interviewing her a subjectivity in which she retained grandeur, while giving the doctor permission to see her differently: 'When asked her name she laughed inanely and muttered a lot of gibberish, saying I know you won't put that down: it's too grand.' This direct commentary on doctors' activity represents anything but an attitude of subservience. Nathaniel D, who spent 36 years in Valkenberg, was in general compliant, saying that the asylum was 'a grand place, used for keeping the boys straight that's all'. His use of the term 'boys' is a linguistic marker of his interpellation into the dominant discourse. However, he also would leave interviews with the doctor abruptly, saying that he had prayers to finish, in this way gaining control over the length of interviews.

Conclusion: a gendered and racial construction of insanity

It was in the daily rehearsal of a remarkably small number of sentences that the images of insanity became fixed, both within and without the asylum walls. In them doctors were positioned as rational, humanitarian (male) adults, caring for a homogeneous group of irrational, deluded, incoherent lunatics, many of whom came to be seen as childish.

As was described in Chapter Five, psychiatric theory, and in particular diagnostic classification, reinforced the textual production of uniformity among the patient population, through the unquestioned assumption that one 'dementia praecox' (for example) was much like another, irrespective of class, race or gender. The repetitive quality of the language in case records also mirrors the monotony of asylum life.

The gaze of asylum doctors was also however fundamentally gendered and racist. The doctors were men, and the male gaze positioned female patients in terms of common stereotypes of 'natural' femininity, and the interruption of that ideal figure of womanhood when they slipped loose from the rule and discipline of a patriarchal societal order. The doctors were white, and their gaze positioned black patients as 'naturally' subordinate and childish, capable of violence but susceptible to rule. In this way, asylum texts rehearsed both the 'natural' order and the multiplicity of 'unnatural' behaviours which constituted insanity. To the extent that individual 'cases' challenged race and gender 'frontiers', they could be used to reinforce the 'sanity' of those who conformed to expected roles.

Repetition in the case records conceals the complexity of their discursive goals. They had to perform a number of contradictory functions simultaneously. Patients had to be represented as insane in order to justify institutional care[18]. The case records also needed to represent the asylum as effective institutions, able to contain the disruptiveness of the certified insane. This meant that deviance which threatened social structures outside the asylum had to be translated into deviance containable by the asylum. Central to these paired discursive goals were the key terms 'dull' and 'demented', which represented patients as both passive and mentally incapacitated. Feminising white insane men, and describing women and black men as children also achieved the goal of representing insanity as domesticated, and therefore under control.

Finally, the records had to represent the doctors as knowledgeable about insanity itself, and therefore qualified to manage the insane. Textualised not only in case records, but also in correspondence and government publications, this knowledge reflected the full complexity of the discursive production of knowledge about the colonial insane, and the emergence of a uniquely colonial psychiatry.

18. In the absence of a well-developed welfare system, it would often have been easier to justify keeping patients in, than finding ways of discharging them.

Chapter Nine

CONCLUSION: COLONIAL PSYCHIATRY AND THE REPRODUCTION OF RACIST KNOWLEDGE IN TWENTIETH CENTURY AFRICA

Introduction

The tale of colonial racism is long and in some respects very simple. The economic exploitation of Africa and domination of indigenous populations by colonising minorities was predicated upon the discursive construction of African peoples as exploitable. Scientific racism was heavily implicated in the colonial enterprise, at every turn feeding colonial governments with the scientific 'facts' which justified exploitative political and economic policies[1]. These 'facts' changed in different historical periods, but were marshalled to 'prove' a single tenet: that black African peoples were inferior to white colonising populations.

The uniformity of opinion amongst scientists in diverse scientific disciplines about the inferiority of black Africans is remarkable, given the huge variations in geographical, cultural, political and economic contexts in which they worked. It is testimony to the extent to which racism reduces a wealth of variation to a single phenomenon, here encapsulated in the idea of 'the African', a mythical construction of central political and economic importance.

However, to identify the racist orthodoxy reproduced in scientific knowledges of the past is no more than a first step in the process of mapping a complex area of critical importance for our understanding both of history of the Cape, and of current scientific practices. This conclusion will suggest some of the ways in which the history of colonial psychiatry in the Cape may be used as a guide to further work.

(Colonial) psychiatry was/is not politically neutral

This dissertation has argued that the work of doctors in Cape asylums during the 1891-1920 period was fundamentally coloured by racist and sexist assumptions. Racial classification and gender overrode all other variables, including psychiatric diagnosis, in shaping the management of insane individuals in asylum settings. Doctors' assumptions about women and black peoples determined the 'facts' they gathered about their patients, the theories they wove to explain those facts, and the relationships they entered into with those under their care. The 'neutrality' claimed for their science, reinforced by its liberal humanist philosophical underpinnings, gave it credibility and power as an ideological tool, effectively exploited by successive colonising governments.

1. Dubow, *Scientific Racism*, documents the racist knowledges reproduced in the work of (for example) anatomists, anthropologists and archaeologists.

As the work of McCulloch demonstrates, the racism which characterised the birth of a distinctively colonial psychiatry in South Africa after 1891 was a feature of ethnopsychiatry as a discipline throughout colonial Africa, and for much of the twentieth century. McCulloch suggests that the racist orthodoxy of ethnopsychiatry centred upon two assumptions, 'that the colonial vocation was noble, and that the disabilities suffered by Africans were considerable'[2]. In the late nineteenth and early twentieth centuries, the arena for investigation was the body of black Africans, particularly brain structure. During the twentieth century, the body was abandoned as the potential site for evidence of the inferiority of black Africans, for the fertile fields of 'mentality', 'intelligence', 'temperament' and 'culture'[3]. These sites of exploration were locally and internationally influential in reproducing the idea of the black African as both different and inferior to 'the European'.

That psychiatry as a discipline mirrored and contributed to the colonial exploitation of Africa is thus becoming increasingly clear. Further studies of the relationship between psychiatric knowledges, both local and international, and colonialism are needed, but there can be little doubt at this point that they will confirm the already apparent overall pattern.

No science is politically neutral; all knowledge is exploitable for specific purposes by those with political and economic power. However, the ease with which psychiatric discourse in particular lends itself to interpellation into racist - or more broadly political - ventures, deserves close study[4]. The questions raised by the pattern, addressed in relation to psychoanalytic discourse, has barely been engaged with as a more general discourse phenomenon in colonial settings[5]. In this dissertation, I suggested that colonial asylum doctors readily asserted their knowledge of 'the native', despite overwhelming evidence from close scrutiny of official documents and case records, that they knew very little about their black patients. There were two reasons why colonial psychiatrists in Africa were in a position to assert themselves as particularly knowledgeable about indigenous populations. Firstly, psychiatrists had the economic and political power of the entire medical establishment behind them. Combined with this was their legal power in terms of

2. McCulloch, *Colonial Psychiatry*, p.138.
3. Dubow, *Scientific Racism*, and McCulloch, *Colonial Psychiatry*, map the history of this progression. For a discussion of its development in recent South African psychiatry, see L.Swartz, 'Transcultural psychiatry in South Africa', *Transcultural Psychiatric Research Review*, Part 1, **23**, 1986, 290-303, and Part 2, **24**, 1987, 5-30.
4. The work of Fanon (for example, *Black Skin, White Masks*, New York, 1967) is of central importance in this regard, as a counterpoint to the racist theories of ethnopsychiatrists such as Carothers (*The African Mind in Health and Disease: A Study in Ethnopsychiatry*, Geneva, 1953). 'Race' and 'culture' continue to be important descriptive categories within psychiatric knowledges. The political agendas they inevitably play into are seldom directly addressed. A.Dawes, 'Politics and mental health: The position of clinical psychology in South Africa. *South African Journal of Psychology*, **15**, 55-61.
5. See for example, H. Bhabha, 'Remembering Fanon: Self, psyche and the colonial condition,' in P.Williams and L.Chrisman, (eds.), *Colonial Discourse and Post-Colonial Theory*, (New York, 1993), 112-123.

identifying and institutionalising large numbers of people. The asylum populations under their gaze became the arena within which knowledge about their subjects could be both formulated and claimed as authoritative.

Secondly, as a discipline, psychiatry insists on the intimacy of connection between psychiatrist and patient, a 'knowing' which penetrates beyond the apparently self-evident currency of 'ordinary' social interaction. It is this ability of the psychiatric gaze to penetrate into the 'true nature' of the man or woman being scrutinised which positioned psychiatry as peculiarly powerful in formulating knowledge about indigenous peoples.

Psychiatry is not unique in having either a privileged gaze or a captive population on which to use it: prisons, schools, hospitals, and various industries are similarly positioned. The knowledges and power produced within these sites differ from one another. What is interesting about the history of psychiatry in colonial Africa is the extent to which it has been deployed in defining the form and the content of knowledges about black Africans, and the reasons for this need further exploration.

To argue that Cape colonial doctors working in asylums reproduced the social and economic practices of the governments for which they worked is simply to identify them as men of their times. Psychiatric knowledge about 'the native', or later, 'native mentality' or even later, 'the African mind' forwarded the colonial enterprise, not by providing new information, but by formalising and giving scientific sanction to widespread popular belief. Thus to describe the development of the discipline of psychiatry in the Cape Colony is to trace one instance of the structuring of knowledge by colonial contexts. It also draws attention to the ways in which knowledge, represented as objective, may be deployed as a means of maintaining historically specific lines of power.

(Colonial) psychiatry was/is not a unified enterprise

To focus solely on the racism implicit in the theories and practices of Cape colonial psychiatry fails to give sufficient weight to a number of its defining characteristics. Like the colonial regime to which it was attached, it was neither unified in its expressed aims, nor lacking in internal philosophical and ideological contradictions. Nowhere is this clearer than in the figure of Dodds himself. This dissertation has argued that Dodds made a substantial contribution to improving the care of the insane in the colony, regardless of their racial classification. In doing this, he was guided by the liberal humanist principles which characterised Cape medical practice as a whole. The universalism of psychiatric theory, which insisted on overriding similarities between peoples

regardless of their racial classification, was also implicated in shaping a dispensation which assumed the necessity for a uniform set of provisions for all the insane.

At the same time, the liberal humanist discourse in which discussion of insanity and its management was clothed, effectively concealed systematic disparities in provision made for white and black patients. An evaluation of the achievements and failures of Cape colonial psychiatry has to take account of the interdependence of its humanitarian rhetoric and goals, and its racism. The former created the space within which the latter came to operate, with contradictory effects. A look at provision of asylum accommodation will illustrate this point.

A glance at the history of dismal psychiatric provision in African countries to the north of South Africa underscores the importance of Dodds' contribution to provision of mental health care[6]. The steady growth of Cape asylum accommodation from the last decade of the nineteenth century is unique in Africa. Moreover, in a country which in every other respect failed to provide for the welfare of its poorest members in terms of living wages, access to medical care, adequate housing, and pensions, asylums provided a haven of sorts for homeless and disabled people. There is no evidence, during the 1891-1920 period, that asylum accommodation was provided on a relatively liberal scale as an attempt to control deviants or social and political troublemakers[7].

There is also evidence in the history of Cape colonial psychiatry in the 1891-1920 period, that careful measures were taken to guard against abuse of all asylum patients, regardless of racial classification or gender. However, within the framework of an apparently liberal dispensation, systematic deprivation and exploitation of black patients was taking place. These can be identified in the statistics concerning diet scales, death rates, and records of illnesses such as tuberculosis and enteritis. They can also be found in records of asylum labour. Disparities in provision depended on racial segregation, actively fostered by Dodds, and supported by all the doctors working under his supervision.

Study of the Valkenberg case records reveals the extent to which a universalising discourse emphasised the similarities, not the differences, between groups of the insane. However, there was a constant tension between doctors' overt insistence on the fundamental similarities between groups of the insane, and an underlying belief in difference on a racial basis. This contradiction

6. McCulloch, *Colonial Psychiatry*, pp.9-28.
7. This may have become the case in later decades, and the role played by South African mental hospitals in a context of severe political repression of the black population and general welfare under-provision would be a useful focus for further research.

becomes visible in three ways. It is apparent in patterns of word-choice, which characterise black patients in particular ways, and differentiate them in those respects from their white counterparts. It can be seen in the extent to which black patients were textually 'unknown', admitted and treated without the contextual information which would attach them to social identities beyond their insanity. Most importantly, it is apparent in doctors' failure to take account of diversity in their patients. The consequence of this was that they assumed white middle-class as the social and economic norm, from which 'insane' behaviour could be identified as deviating. Erasure of difference was therefore a major factor contributing to racist practice in asylums. Nowhere was this more starkly realised than in the failure to provide interpreters to assist with the task of interviewing black patients with inadequate knowledge of English.

Further research on the practices of colonial psychiatrists needs to take account of the complexity of the institutions within which care for the insane took place. Very little work has as yet been done on South African (or African) twentieth-century mental institutions. Such work would need to address the impact of treatment revolutions, particularly the use of electro-convulsive therapy, and psychotropic drugs, on colonising and indigenous populations, and also the impact of widespread economic, social and political change in local contexts. This research will need to engage with both the liberal-humanist intentions and the racist practices within colonial psychiatries in order to understand them.

Psychiatric colonialism and the erasure of the indigenous

While it is readily accepted that racism within psychiatry, in all its forms, needs to be addressed, the problems of psychiatric orthodoxy in general are less readily constructed as problematic. This dissertation has demonstrated that asylum doctors in the 1891-1920 period used knowledge imported largely from Britain, but also from Europe, in understanding, theorising about and documenting their patients. One consequence of this was erasure of the indigenous. Importation of psychiatric knowledge from Britain, and now also from the United States, is still a marked feature not only of South African psychiatry, but of psychiatry world-wide.

Case records from diverse international settings confirm the existence of a widely-used and standard case-record structure, despite some variation in content[8]. This is partly attributable to the

8. These are discussed by Barrett 'Clinical writing and the documentary construction of schizophrenia', Garfinkel *Studies in Ethnomethodology*; T.Hak, 'Psychiatric records as transformations of other texts', in S. Watson and R. Seiler (eds.), *Text in Context: Contributions to Ethnomethodology*, (Newbury Park, 1992), 138-155; Johnstone, *Users and Abusers of Psychiatry*; Luske, *Mirrors of Madness*; J. Reynolds, D. .Mair, and P.C.Fischer, *Writing and Reading Mental Health Records*, (Newbury Park, 1992); S.Swartz 'Sources of misunderstanding in interviews

application of standardised diagnostic and assessment tools, such as the DSM and the ICD classificatory systems, the Maudsley history format, and the Present State Examination. Underlying these tools are a set of common assumptions regarding the causes, symptoms and prognosis of mental illness, theorised in Britain and America and exported to countries all over the world, regardless of enormous variety in class, ethnic and cultural contexts. Interpellation into a global system of psychiatric knowledge explains partly the generation of unjform and univocal accounts of mental illness, no matter where they are written.

The large numbers of people in mental institutions all over the world are testimony to the power of psychiatry as a profession[9]. This is also evident in the widespread use of psychotropic medications, to which many millions of people world-wide are addicted[10]. Stigmatised and economically deprived and resourceless groups are particularly vulnerable to abuse through contact with the psychiatric industry, through wrongful incarceration, misdiagnosis or simply neglect[11]. In many cases such abuse is the direct result of Western psychiatric knowledge inappropriately deployed in multi-cultural settings[12]. This perpetuates the colonial relationship far beyond the boundaries of particular states and their colonial satellites.

The tension between a universalising psychiatric discourse and social, cultural and economic difference has always been a feature of South African psychiatric practice. Where difference is recognised, it tends to be reified and romanticised, the so-called 'culture-bound syndromes' being a good example of this process[13]. These syndromes tend to be theorised as an expression of the exotic, and their relationship to cultural models of health and illness is seldom addressed. Further research needs to address the interface between international psychiatric nosologies and culturally-specific manifestations of mental illness.

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with psychiatric patients'; and S.Swartz and L.Swartz 'Talk about talk: metacommentary and context in the analysis of psychotic discourse', *Culture, Medicine and Psychiatry*, 11, 1987, 395-416.

9 In 1988, the WHO estimated there to be 250,000,000 people in the world with severe mental illness. Many of these people spend periods of time in mental institutions. For variation in numbers from country to country, see Cohen, *Forgotten Millions: The Treatment of the Mentally Ill - a Global Perspective*, (London, 1988), pp.11-17.

10. For a discussion of colonising aspects of psychiatric histories, see S.Swartz, (in press), 'Shrinking: A postmodern perspective on psychiatric case histories.' *South African Journal of Psychology*. For a discussion of the widespread use of psychotropic medication, particularly in countries under-resourced with mental health practitioners, see D.Cohen, *Forgotten Millions*.

11. There is a growing body of literature on the ways in which both race and gender affect provision of care for the mentally ill. Black and women patients have at times borne the brunt of abuses in the psychiatric industry. See S. Fernando, *Mental Health, Race and Culture*, (London, 1991), and Ussher, *Women's Madness*.

12. Cohen, *Forgotten Millions*, p.40, sees the desire of psychiatrists to market their skills as universally applicable as the economic imperative behind under-emphasising cultural difference in mental illness. He suggests that 'international psychiatry can function only by excluding local differences, so the practice of the trade is curiously standardised all over the world.'

13. L.Swartz and D.Foster, 'Images of culture and mental illness: South African psychiatric approaches', *Social Dynamics*, 10, 1984, 17-25.

Colonial psychiatry and sites of resistance

This dissertation has argued that written documents play a central role in the creation of institutional consciousness. Constituted as the 'facts' which serve as knowledge, memory, and models of appropriate behaviour for the institution's members, they mediate 'lived actuality', the unwritten encounters which they purport to describe and organise. The Valkenberg series presents a picture of a primarily monotonous and orderly existence, disrupted occasionally by events attributed to the effects of mental disorder. However, there is also some evidence of patients' resistance to the regimes under which they lived. This resistance was displayed, albeit ambiguously, in the eruption of 'symptomatic' behaviour, in refusal to sleep, eat or work at appointed times, and also in failure to engage with the expected role of passive patient in conversations with interviewing doctors.

The fact that the case records contain no more than hints at the complexity and richness of patient subjectivities is powerful evidence of psychiatry's failure, as an institution, to engage with individual difference, multiple voices, and shifting identities. This dissertation has been able to do little more than suggest some of the complexity concealed by the case records, but it is nonetheless critically important to have done so. Failure to draw attention to areas of contradiction, ambiguity or tension would reproduce colonial psychiatry as both monolithic and omnipotent, and this would not be an accurate reading. Future research needs to explore further patient subjectivities as sites of resistance to psychiatric colonialism. There is an extensive archive of Colonial Office documents on insane patients, incorporating Medical Certificates, statements of relatives, transfer and discharge certificates, and results of hearings before Magistrates. Although the Valkenberg series contains material of this kind, it is limited to those who were, in a relatively unproblematic way, found to be insane, and were incarcerated often for lengthy periods. The Colonial Office papers include the records of a wide range of people destined for all the colony's asylums, some of whom entered the certification process, but were found to be sane. There are also extensive records of people who were tried for a crime but were found to be insane. This archive would amplify on perspectives other than those of doctors, which dominate in the Valkenberg series, and would add multiple voices to the univocal case record account.

The invisibility of gender

Research on the history and current practice of psychiatry in Africa has always been dominated by the issue of race. It is important to insist on gender as a site of exploration in colonial contexts. A number of reasons for this have been outlined in this dissertation. Psychiatric nosology is gendered, and both diagnosis and treatment differentiate between men and women. Little work has

been done the effects of this in colonial settings. That men outnumber women in psychiatric institutions throughout Africa is an issue which deserves detailed attention.

Black women in colonial Africa have been exposed to forms of exploitation and violence different from those which affected black men. These include sexual violence and prostitution, and the impact of colonialism on domestic life, particularly childcare practices. They have also had even less access than black men to economic and political power, to health care, and to social and geographic mobility. All of these potentially affect patterns of mental illness, and all need further study.

This dissertation has also drawn attention to the some of the effects on white women of living in a colonial society. Desire to protect them from real or imagined danger placed limits on their freedom. The social construction of women as sexually vulnerable to attack and to seduction made them the focus of anxiety about the purity of the white race. Policy concerned with limiting miscegenation and with institutionalising the feebleminded was primarily directed at white women[14]. The work of Don Foster on the history of the feebleminded in South Africa and Johann Louw on the eugenics movement needs to be extended with detailed histories of the institutions designed to control the white feebleminded population in the period immediately following Union. The particular effects of institutional policy and provision on white women would be a useful focus for research. As an area of study, it would have available as a resource a growing body of work on the history of the eugenics movement, and mental testing in South Africa[15].

Colonialism, psychiatry, and the challenges of the future

There are a number of reasons why the relationship between colonialism, psychiatry and power deserves our continued close attention. Perhaps most importantly, we still face the challenges of overcoming the legacy of our colonial past. This involves more than simply becoming conscious of, and resisting racist and sexist practice. It includes the massive task of rewriting South African history in ways which appropriately give voice to previously silenced stories. This history of colonial psychiatry in the Cape, which draws attention to the erasures it caused, has been one contribution to that rewriting.

14. Foster, 'Historical and legal traces 1800-1900'.
15. For discussion and analysis of eugenics and the field of mental testing in the first half of the century, see Louw, 'Eugenics, Christian-Nationalism and anti-democratic politics in South Africa; Dubow. *Racial Segregation and the Origins of Apartheid*; Fleisch, 'Social scientists as policy makers', and Foster, 'Historical and legal traces'.

The history of colonial psychiatry underscores the extent to which indigenous healing systems, and methods of dealing with insanity, were both undervalued and pushed aside by Western psychiatric knowledges and practice. As South Africa moves towards forging a new health care dispensation, serious consideration is being given to the need to incorporate indigenous health care systems with those of Western science. It is crucial that we have an understanding of the impact of the one on the other historically, and to use this understanding to maximise the possibilities of drawing on the best of both. There is a real danger of indigenous health care systems being interpellated into, and rendered ineffective by, Western science. Were this it happen, it would constitute another instance of colonialism.

South Africa has recently become a democratic nation, but the economic and social imbalances between groups divided by racial classification remain. The issue of redressing imbalances that has characterised the treatment of various groups of the insane in this country's history is now of critical importance. The task of engaging with the colonial in current psychiatric practices in this country could usefully take its historical roots as a starting point. To identify a colonial (imperialist) psychiatry may therefore be the first step in formulating a context-sensitive psychiatry which avoids racist and sexist practice.

REFERENCES

UNPUBLISHED SOURCES

Cape Archives, Cape Town

Colonial Office Papers, Local Government and Health Branch

CO 1430 Letters received by Colonial Office, 1889
CO 1470 Letters received by Colonial Office, 1889
CO 1485 Letters received by Colonial Office, 1891
CO 1485 Letters received by Colonial Office, 1891
CO 1488 Letters received by Colonial Office, 1892
CO 1524 Letters received by Colonial Office, 1890
CO 1527 Letters received by Colonial Office, 1892
CO 1576 Letters received by Colonial Office, 1893
CO 7158 Letters received by Colonial Office, 1895
CO 7175 Letters received by Colonial Office, 1894
CO 7176 Letters received by Colonial Office, 1895
CO 7177 Letters received by Colonial Office, 1896
CO 7178 Letters received by Colonial Office, 1897
CO 7179 Letters received by Colonial Office, 1897
CO 7180 Letters received by Colonial Office, 1898
CO 7321 Letters received by Colonial Office, 1899
CO 7322 Letters received by Colonial Office, 1899
CO 7323 Letters received by Colonial Office, 1901
CO 7324 Letters received by Colonial Office, 1902
CO 7324 Letters received by Colonial Office, 1902
CO 7325 Letters received by Colonial Office, 1902
CO 7608 Letters received by Colonial Office, 1901
CO 7849 Letters received by Colonial Office, 1904
CO 7916 Letters received by Colonial Office, 1904
CO 7918 Letters received by Colonial Office, 1904
CO 7919 Letters received by Colonial Office, 1905
CO 7971 Letters received by Colonial Office, 1904
CO 7973 Letters received by Colonial Office, 1904
CO 7975 Letters received by Colonial Office, 1905
CO 7977 Letters received by Colonial Office, 1905
CO 7978 Letters received by Colonial Office, 1905
CO 8053 Letters received by Colonial Office, 1908
CO 8061 Letters received by Colonial Office, 1905-9

Medical Departments

HOS 60	Old Somerset Hospital Case Book, 1868-1891
HOS 30	Old Somerset Hospital Correspondence, 1899
HFB 3	Fort Beaufort Asylum Correspondence, 1907
HFB 4	Fort Beaufort Asylum Correspondence, 1908
HFB 5	Fort Beaufort Asylum Correspondence, 1909
HGM 15	Grahamstown Asylum Case Book, 1904-1907
HGM 19	Grahamstown Asylum Case Book, 1893-1897
HGM 20	Grahamstown Asylum Case Book, 1902-1905
RI 181	Robben Island Asylum Lunatic Register, 1846-1904
MOH 1/61	Medical Officer of Health Correspondence, 1911
HVG 2/1/6	Valkenberg Mental Hospital Correspondence, 1916
PAH 1/7	Provincial Administration Hospitals Correspondence, 1911-1959

Miscellaneous

CCP 11/4/26	Civil Service Listings, 1891-1904

Manuscripts and Archives, University of Cape Town

Valkenberg Case Record Series, 1876-1920

Valkenberg Hospital Collection, Valkenberg Hospital, Cape Town

Lunacy Register, 1891-1915
Case Book, Male Admissions, 1891-1894
Case Book, Female Admissions, 1913-1914

PUBLISHED SOURCES

Government Publications

Acts and Ordinances

Ordinance 105 of 1833	Estates and Property of Lunatics
Ordinance 3 of 1837	Estates and Property of Lunatics
Ordinance 28 of 1866	Detention of Lunatics
Ordinance 31 of 1885	Lunacy Certification
Act 20 of 1879	The Lunacy Law Amendment Act
Act 35 of 1891	Lunacy Act
Act 1 of 1897	Lunacy Act
Act 14 of 1914	Lunacy and Leprosy Laws Amendment Act
Act 38 of 1916	Mental Disorders Act

Annual Reports on Government Hospitals and Asylums, and Reports of the Inspector of Asylums, 1875-1909

G.13-'76	Robben Island Infirmary, 1875
G.29-'83	Robben Island Infirmary, 1883
G.37-'91	Report for 1890
G.36 - '92	Report for 1891
G.17-'93	Report for 1892
G.24-'94	Report for 1893
G.16-'95	Report for 1894
G.27-'96	Report for 1895
G.20-'97	Report for 1896
G.28-'98	Report for 1897
G.21-'99	Report for 1898
G.25-'00	Report for 1899
G.41-'01	Report for 1900
G.70-'02	Report for 1901
G.55-'03	Report for 1902
G.55-'04	Report for 1903
G.57-'05	Report for 1904
G.32-'06	Report for 1905
G.31-'07	Report for 1906
G.41-'08	Report for 1907
G.41-'09	Report for 1908
G.25-'10	Report for 1909

Annual Reports of the Commissioner of Mentally Disordered and Defective Persons for the Union of South Africa, 1916-1920

U.G.50-'17	Public Health Report for 1916
U.G.31-'20	Report for 1916-1918
U.G.31-'21	Report for 1919
Unnumbered	Report for 1920
U.G.25-'29	Report for 1928

Censuses

G.6-'92 Census of 1891
G.19-'05 Census of 1904
U.G.32-'12 Census of 1911

Miscellaneous Government Publications

Codified Circular Instructions: Cape of Good Hope 1904, Cape Town, 1905.

Report of the Commission appointed to Enquire into Assaults on Women, U.G. 39-'18, 1913.

General Asylum Regulations, Government Notice 267 of 1892, Cape Town, 1892.

Rules for the Management of Asylums, Pretoria, 1913

Regulations for the Management of Hospitals for the Treatment of Mental Disease and Defect, Pretoria, 1914

BOOKS AND ARTICLES

Arnold, D. 'European orphans and vagrants in India in the nineteenth century', *The Journal of Imperial and Commonwealth History*, 7, 1979, 104-127.

Barrett, R. 'Clinical writing and the documentary construction of schizophrenia', *Culture, Medicine and Psychiatry*, 12, 1988, 265-99.

Barthes, R. *Mythologies*, St Albans: Paladin, 1973.

Barton, R. *Institutional Neurosis*, Bristol: John Wright & Sons, 1966.

Bennett, J.F. 'None so deaf: Stories of the experience of rape in New York, 1990-1991', unpublished Doctoral dissertation, Columbia University, New York, 1993.

Berger, J. *Ways of Seeing*, Harmondsworth: Penguin, 1972.

Berrios, G. 'Stupor: A conceptual history', *Psychological Medicine*, 11, 1981, 677-688.

Berrios, G. 'Delirium and confusion in the nineteenth century: A conceptual history', *British Journal of Psychiatry*, 139, 1981, 439-449.

Berrios, G. 'Descriptive psychopathology: Conceptual and historical aspects', *Psychological Medicine*, 14, 1984, 303-313.

Berrios, G. 'The psychopathology of affectivity: Conceptual and historical aspects', *Psychological Medicine*, 15, 1985, 745-758.

Berrios, G. 'Historical aspects of the psychoses: Nineteenth century issues', *British Medical Bulletin*, 43, 1987, 484-498.

Berrios, G. and H. Freeman, *Alzheimer and the Dementias*, London: Royal Society of Medicine Services Ltd, 1991.

Bhabha, H. 'Remembering Fanon: Self, psyche and the colonial condition,' in P.Williams and L.Chrisman, (eds.), *Colonial Discourse and Post-Colonial Theory*, New York: Harvester Wheatsheaf, 1993, 112-123.

Bickford-Smith, V. 'Dangerous Cape Town: Middle-class attitudes to poverty in Cape Town in the late nineteenth century', in C. Saunders, H. Phillips, and E. van Heyningen (eds.), *Studies in the History of Cape Town*, v.4, Cape Town: History Department and The Centre for African Studies, University of Cape Town, 1981, 29-65.

Bickford-Smith, V. 'Commerce, class and ethnicity in Cape Town, 1875-1902', unpublished Doctoral dissertation, Cambridge: Cambridge University, 1988.

Bickford-Smith, V. 'A "special tradition of multi-racialism"? Segregation in Cape Town in the late nineteenth and early twentieth centuries', in W. James and M. Simons (eds.), *The Angry Divide: Social and Economic History of the Western Cape*, Cape Town and Johannnesburg: David Philip, 1989, 47-62.

Bickford-Smith, V. 'The origins and early history of District Six to 1910', in S. Jeppie and C. Soudien (eds.), *The Struggle for District Six Past and Present*, Cape Town: Buchu Books, 1990, 35-43.

Bickford-Smith, V. 'The background to apartheid in Cape Town: The growth of racism and segregation from the mineral revolution to the 1930s', paper read at the University of the Witwatersrand History Workshop, Johannesburg, 1990.

Bickford-Smith, V. *Ethnic Pride and Racial Prejudice in Victorian Cape Town*, Johannesburg: Witwatersrand University Press, 1995.

Bradlow, E. 'Women at the Cape in the mid-nineteenth century', *South African Historical Journal*, **19**, 1987, 51-75.

Brink, E. 'Man-made women: Gender, class and the ideology of the *Volkmoeder*,' in C.Walker (ed.), *Women and Gender in Southern Africa to 1945*, Cape Town: David Philip, 273-293.

Bunn, D. 'The insistence of theory: Three questions for Megan Vaughan', *Social Dynamics*, **20**, 2, 1994, 24-34.

Burrows, E. *A History of Medicine in South Africa Up to the End of the Nineteenth Century*, Cape Town: A.A.Balkema, 1958.

Callaway, H. *Gender, Culture and Empire: European Women in Colonial Nigeria*, Chicago: University of Illinois Press, 1987.

Carothers, J. *The African Mind in Health and Disease: A Study in Ethnopsychiatry*, Geneva: World Health Organization, 1953.

Castel, R. *The Regulation of Madness: The Origins of Incarceration in France*, (trans. W.Halls), Oxford: Polity Press, 1988.

Caudill, W. *The Psychiatric Hospital as a Small Society*, Cambridge: Harvard University Press, 1958.

Cohen, D. *Forgotten Millions: The Treatment of the Mentally Ill - a Global Perspective*, London: Paladin, 1988.

Cohen, S. and A. Scull, (eds.), *Social Control and the State*, Oxford: Basil Blackwell, 1985.

Comaroff, J. 'Images of Empire, contests of conscience: Models of colonial domination in South Africa' , *American Ethnologist*, **16**, 1989, 661-685.

Comaroff, J. 'The diseased heart of Africa: Medicine, colonialism and the black body', in S. Lindenbaum and M. Lock (eds.), *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, Los Angeles, Berkeley and London: University of California Press, 1993, Chapter 13.

Conolly, J. 'The treatment of the insane before and after the advent of moral management', 1856, reprinted in V. Skultans, *Madness and Morals: Ideas on Insanity in the Nineteenth Century*, London: Routledge & Kegan Paul, 1975, 146-152.

Conry, J. 'Insanity among Natives in Cape Colony', *South African Medical Record*, **5**, 1907, 33-36.

Cooper, B. *Michel Foucault: An Introduction to the Study of His Thought*, New York: The Edwin Mellen Press, 1981.

Cooper, F. and A. Stoler, 'Introduction: Tensions of empire: Colonial control and visions of rule', *American Ethnologist*, **16**, 1989, 609-621.

Coupland, S. 'The causes of insanity, with especial reference to the correlation of assigned factors: A study of the returns for 1907', *The Journal of Mental Science*, **56**, 1910, 1-24.

Craig, B. 'The role of records and of record-keeping in the development of the modern hospital in London, England, and Ontario, Canada, c.1890- c.1940', *Bulletin of the History of Medicine*, **65**, 1991, 376-397.

Crais, C. *The Making of the Colonial Order*, Johannesburg: Witwatersrand University Press, 1992.

Crammer, J. *Asylum History: Buckinghamshire County Pauper Lunatic Asylum*, London: Gaskell, 1990.

Davids, A. 'The revolt of the Malays: A study of the Cape Muslim reaction to the nineteenth century smallpox epidemics', in C. Saunders, H. Phillips, and E. van Heyningen (eds.), *Studies in the History of Cape Town*, v.4, Cape Town: History Department and The Centre for African Studies, University of Cape Town, 1981, 47-49.

Davids, A. '"My religion is superior to the law": The survival of Islam at the Cape of Good Hope', *Kronos*, 1987, 57-71.

Dawes, A. 'Politics and mental health: The position of clinical psychology in South Africa', *South African Journal of Psychology*, **15** , 55-61.

de Beer, C. *The South African Disease: Apartheid, Health and Health Services*, Johannesburg: South African Research Services, 1984.

Deacon, H. 'Place of tobacco trees: 19th century institutions', in N. .Penn, H. Deacon and N. Alexander, *Robben Island: The Politics of Rock and Sand*, Cape Town: Department of Adult Education and Extra Mural Studies, University of Cape Town, 1992.

Deacon, H. 'A history of the medical institutions on Robben Island, Cape Colony, 1846-1910,' unpublished Doctoral dissertation, Cambridge: Cambridge University, 1994.

Digby, A. *Madness, Morality and Medicine: A Study of the York Retreat 1796-1914*, Cambridge: Cambridge University Press, 1985.

Digby, A. 'Quantitative and qualitative perspectives on the asylum', in R. Porter and A. Wear (eds.), *Problems and Methods in the History of Medicine*, London, New York and Sydney: Croom Helm, 1987, 153-174.

Digby, A. '"A medical El Dorado?" Colonial medical incomes and practice at the Cape', *Social History of Medicine*, 7, 1995, 463-479.

Dodds, W. , A. Strahan, and T.D.Greenlees, 'Assistant medical officers in asylums: Their status in the specialty' , *The Journal of Mental Science*, **52**, 1890, 43-50.

Dowbiggin, I. *Inheriting Madness: Professionalization and Psychiatric Knowledge in Nineteenth-Century France*, Berkeley and Oxford: University of California Press, 1991.

du Toit, Q. 'Valkenberg: 100 years of devoted care', booklet prepared in celebration of Valkenberg's centenary, 1991.

Dubow, S. *Racial Segregation and the Origins of Apartheid in South Africa, 1919-36*, London: The MacMillan Press Ltd, 1989.

Dubow, S. '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: MacMillan, 1991, 148-177.

Dubow, S. *Scientific Racism in Modern South Africa*, Cambridge: Cambridge University Press, 1995.

Dunston, J. 'Mental hygiene', *South African Medical Record*, **13**, 1915, 20-34.

Dunston, J. 'The problem of the feebleminded in South Africa', *The Journal of Mental Science*, **67**, 1921, 449-458.

Eisenberg, L. 'The social construction of mental illness', *Psychological Medicine*, **18**, 1988, 1-9.

Ernst, W. *Mad Tales from the Raj: The European Insane in British India 1800-1858*, London: Routledge, 1991.

Estroff, S. *Making it Crazy: An Ethnography of Psychiatric Clients in an American Community*, Berkeley: University of California Press, 1985.

Fairclough, N. *Discourse and Social Change*, Cambridge: Polity Press, 1992.

Fanon, F. *Black Skin, White Masks*, New York: Grove Press, 1967.

Fernando, S. *Mental Health, Race and Culture*, London: Macmillan, 1991.

Fisher, L. *Colonial Madness: Mental Health in the Barbadian Social Order*, New Brunswick: Rutgers University Press, 1985.

Fleisch, B. 'Social scientists as policy makers: E.G. Malherbe and the National Bureau for Educational and Social Research, 1929-1943', *Journal of Southern African Studies*, **21**, 3, 1995, 349-73.

Foster, D. 'Historical and legal traces, 1800-1900' in S. Lea and D. Foster (eds.), *Perspectives on Mental Handicap in South Africa*, Durban: Butterworths, 1990, 21-70.

Foucault, M. 'The order of discourse' Inaugural Lecture at the College de France, given 2 December 1970. Reprinted in R. Young (ed.), trans I. MacLeod, *Untying the Text: A Post-Structuralist Reader*, Boston, London and Henley: Routledge, 1981, 51-78.

Foucault, M. *Madness and Civilisation: A History of Insanity in the Age of Reason*, London: Tavistock, 1971.

Foucault, M. *The Archaeology of Knowledge*, New York: Pantheon, 1972.

Foucault, M. *Discipline and Punish: The Birth of the Prison*, tr. A. Sheridan, London and New York: Peregrine Books, 1977.

Foucault, M. *The History of Sexuality*, v.1, New York: Pantheon, 1978.

Fowler, R. 'Power', in T.A.van Dijk, (ed.), *Handbook of Discourse Analysis, v. 4: Discourse Analysis in Society*, London, Academic Press, 1985, 61-82.

Fox, D. *So Far Disordered in Mind: Insanity in California 1870-1930*, London and Berkeley: University of California Press, 1978.

Frederickson, G. *White Supremacy: A Comparative Study in American and South African history*, Oxford: Oxford University Press, 1981.

Garfinkel, H. *Studies in Ethnomethodology*, Englewood Cliffs: Prentice Hall, 1967.

Garton, S. *Medicine and Madness: A Social History of Insanity in New South Wales 1880-1940*, New South Wales: Kensington, 1988.

Giliomee, H. 'The Beginnings of Afrikaner Nationalism, 1870-1915', *South African Historical Journal*, **19**, 1987, 114-124.

Gillis, L., R. Elk, O. Ben-Arie, and A.Teggin, 'The Present State Examination: Experiences with Xhosa-speaking patients,' *British Journal of Psychiatry*, **141**, 1982, 143-147.

Gilman, S. *Difference and Pathology: Stereotypes of Sexuality, Race and Madness*, Ithaca and London: Cornell University Press, 1985.

Gilman, S. *Disease and Representation: Images of Illness from Madness to AIDS*, Ithaca and London: Cornell University Press, 1988.

Gilman, S. *The Jew's Body*, New York and London: Routledge, 1991.

Gilman, S. *Health and Illness: Images of Difference*, London: Reaktion Books, 1995.

Goffman, E. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Harmondsworth: Penguin, 1961.

Goldin, I. 'The reconstitution of Coloured identity in the Western Cape', in S. Marks and S. Trapido (eds.), *The Politics of Race, Class and Nationalism in Twentieth Century South Africa*, London: Longmans, 1987, 156-181.

Gove, W. (ed.), *Deviance and Mental Illness*, Beverly Hills: Sage, 1982.

Greenlees, T.D. 'Insanity among the Natives of South Africa', *The Journal of Mental Science*, **41**, 1895, 71-78.

Greenlees, T.D. 'A statistical contribution to the pathology of insanity', *The Journal of Mental Science*, **48**, 1902, 645-666.

Greenlees, T.D. 'Statistics of insanity in Grahamstown Asylum', *South African Medical Record*, **3**, 1905, 217-24.

Greenlees, T.D. 'Lunacy legislation in Cape Colony', *The Journal of Mental Science*, **56**, 1910, 261-272.

Grob, G. 'Class, ethnicity and race in American mental hospitals 1830-1875', *Journal of the History of Medicine and Allied Sciences*, 1973a, 207-29.

Grob, G. *Mental institutions in America: Social policy to 1875*, New York: The Free Press, 1973b.

Grob, G. 'Reflections on writing the history of American Psychiatry', paper read at the Triennial European Association for the History of Psychiatry Conference, London, 1993.

Gulich, E. and U. Quasthoff, 'Narrative Analysis', in T.A.van Dijk, (ed.), *Handbook of Discourse Analysis, v. 2: Dimensions of Discourse*, London: Academic Press, 1985, 169-197.

Hak, T. 'Psychiatric records as transformations of other texts', in S. Watson & R. Seiler (eds.), *Text in Context: Contributions to Ethnomethodology*, Newbury Park: Sage, 1992, 138-155.

Hall, S. 'Encoding/decoding', in *Culture, Media, Language*, S. Hall, D. Hobson, A. Lowe and P. Willis (eds.), London: Hutchinson University Library, 1980, 128-38.

Hallett, R. 'Policemen, pimps and prostitutes - Public morality and police corruption in Cape Town, 1902-1904', in C. Saunders (ed.), *Studies in the History of Cape Town*, v. 1, Cape Town: History Department and The Centre for African Studies, University of Cape Town, 1979, 1-41.

Halliday, M.A.K.and R.Hasan, *Cohesion in English*, London: Longman, 1976.

Halliday, M.A.K. *Language as a Social Semiotic: The Social Interpretation of Language and Meaning*, London: Edward Arnold, 1978.

Hare, E. 'The two manias: A study of the evolution of the modern concept of mania', *British Journal of Psychiatry*, **138**, 1981, 89-296.

Hawkes, T. *Structuralism and Semiotics*, London: Methuen & Co, 1977.

Hyam, R. *Empire and Sexuality: The British Experience*, Manchester: Manchester University Press, 1990.

Ingleby, D. 'The social construction of mental illness', in P. Wright and A. Treacher (eds.), *The Problem of Medical Knowledge: An Examination of the Social Construction of Medicine*, Edinburgh: Edinburgh University Press, 1982, 123-143.

Knapman, C. *White Women in Fiji, 1835-1930: The Ruin of Empire*, Boston: Allen and Unwin, 1986.

James, W. and M. Simons (eds.), *The Angry Divide: Social and Economic History of the Western Cape*, Cape Town, David Philip, 1989.

Johnstone, L. *Users and Abusers of Psychiatry: A Critical Look at Traditional Psychiatric Practice*, London: Routledge, 1989.

Kilpin, R. *The Romance of a Colonial Parliament*, London: Longmans, Green and Co, 1930.

Kisekka, M. 'Gender and mental health in Africa', in E. D. Rothblum & E. Cole (eds.), *Women's Mental Health in Africa*, New York: Haworth Press, 1990, 1-13.

Kraepelin, E. *Lectures on Clinical Psychiatry*, T. Johnstone (trans. and ed.), London: Tindall and Cox, 1904.

Kraepelin, E. *Dementia Praecox and Paraphrenia*, trans., R. M. Barclay, ed., G. Robertson, E. Edinburgh: E. & S. Livingstone, 1919.

Kruger, A. *Mental Health Law in South Africa*, Durban: Butterworth, 1980.

Laubscher, B.J.F. *Sex, Custom and Psychopathology: A Study of South African Pagan Natives.* London: Routledge & Kegan Paul, 1937.

Littlewood, R. and M. Lipsedge, *Aliens and Alienists: Ethnic Minorities and Psychiatry*, Harmondsworth: Penguin Books, 1982.

Lloyd Andriezen, W. 'On the bases and possibilities of a scientific psychology and classification in mental disease', *The Journal of Mental Science*, **45**, 1899, 257-90.

Loughlin, K. 'Reconstructing the individual: The transformation in case history techniques 1900-1930', paper read at the European Association for the History of Psychiatry, Triennial Conference, London, August 1993.

Louw, J. 'Eugenics, Christian-Nationalism and anti-democratic politics in South Africa between the two world wars', paper read at the Psychology and Societal Transformation Conference, University of the Western Cape, 1994.

Louw, J. and S. Swartz, 'Structuring social relationships through discourse and architecture: The case of a colonial asylum', paper read at European Society for the History of the Social and Behavioural Sciences, Paris, 1994.

Luske, B. *Mirrors of Madness: Patrolling the Psychic Border*, New York: Aldine de Gruyter, 1990.

MacKenzie, C. *Psychiatry for the Rich: A History of Ticehurst Private Asylum, 1792-1917*, London: Routledge, 1992.

MacLeod, R. and M. Lewis (eds.), *Disease, Medicine and Empire*, London: Routledge, 1988.

Marks, S. and N. Andersson, 'Issues in the political economy of health in Southern Africa', *Journal of Southern African Studies*, **13**, 1987, 177-186.

Marks, S. and S. Trapido, 'The Politics of Race, Class and Nationalism', in S. Marks and S. Trapido, *The Politics of Race, Class and Nationalism in Twentieth Century South Africa*, London: Longman, 1987, 1-70.

Marks, S and S. Trapido, *The politics of race, class & nationalism in twentieth century South Africa*, London: Longman, 1987.

Marks, S. *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession*, Johannesburg: Witwatersrand University Press, 1994.

Marsh, N. *Towards Racial Health*, London: Routledge, 1918.

McClintock, A. *Imperial Leather: Race, Gender and Sexuality in the Colonial Contest*, New York and London: Routledge, 1995.

McCulloch, J. 'The empire's new clothes: Ethnopsychiatry in colonial Africa', *History of the Human Sciences*, **6**, 1993, 35-52.

McCulloch, J. *Colonial Psychiatry and 'the African Mind'*, Cambridge: Cambridge University Press, 1995.

McGovern, C. 'The myths of social control and custodial oppression: Patterns of psychiatric medicine in late nineteenth-century institutions', *Journal of Social History*, **20**, 1986, 3-23.

Meade, T. and M. Walker (eds.), *Science, Medicine and Cultural Imperialism*, London: MacMillan, 1991.

Mercier, C. 'The statistical tables', *The Journal of Mental Science*, **50**, 1904, 672-79.

Mitchinson, W. 'The Toronto and Gladesville asylums: Humane alternatives for the insane in Canada and Australia?', *Bulletin of the History of Medicine*, **63**, 1989, 52-72.

Moyle, D. 'Drawing the line: The early history of lunacy in South Africa', unpublished paper, Psychology Department, UCT, 1987.

Nandy, A. *The Intimate Enemy: Loss and Recovery of Self under Colonialism*, Bombay and Calcutta: Oxford University Press, 1983.

Noble, D. 'The therapeutic environment', 1853, reprinted in V. Skultans (ed.), *Madness and Morals: Ideas on Insanity in Nineteenth Century*, London: Routledge & Kegan Paul, 1975, 145-146.

Omer-Cooper, J. *History of Southern Africa*, London: James Currey, 1987.

Oppenheim, J. *'Shattered Nerves': Doctors, Patients and Depression in Victorian England*, Oxford: Oxford University Press, 1991.

Packard, R. 'Tuberculosis and the development of industrial health policies on the Witwatersrand, 1902-1932', *Journal of Southern African Studies*, **13**, 1987, 187-209.

Parker, I. 'Discourse: Definitions and contradictions', *Philosophical Psychology*, **3**, 1990, 187-204.

Parker, I. *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*, London: Routledge, 1992.

Parry-Jones, W.Ll. *The Trade in Lunacy: A Study of Private Madhouses in England in the Eighteenth and Nineteenth Centuries*, London: Routledge & Kegan Paul, 1972.

Phillips, H. 'The local state and public health reform in South Africa: Bloemfontein and the consequences of the Spanish 'flu epidemic of 1918', *Journal of Southern African Studies*, **13**, 1987, 187-209.

Phillips, H. 'South Africa's worst demographic disaster: The spanish influenza epidemic of 1918', *South African Historical Journal*, **20**, 1988, 57-73.

Porter, R. *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*, Harmondsworth: Penguin, 1987.

Potts, M. and R. Fido, *'A Fit Person to be Removed': Personal Accounts of Life in a Mental Deficiency Institution*, Plymouth: Northcote House, 1991.

Rambaut, D. 'Care-taking in large asylums', *Journal of Mental Science*, **49**, 1903, 45-52.

Reynolds, J. F., D. Mair, and P. C. Fischer, *Writing and Reading Mental Health Records*, Newbury Park: Sage, 1992.

Ripa, Y. *Women and Madness: The Incarceration of Women in Nineteenth-Century France*, trans. C. du Peloux Menage, Cambridge: Polity Press, 1990.

Rose, N. *The Psychological Complex: Psychology, Politics and Society in England, 1869-1939*, London: Routledge and Kegan Paul, 1985.

Rose, N. 'Calculable minds and manageable individuals', *History of the Human Sciences*, **1**, 1988, 179-200.

Rose, N. *Governing the Soul: The Shaping of the Private Self*, London: Routledge, 1989.

Russell, R. 'The lunacy profession and its staff in the second half of the nineteenth century, with special reference to the West Riding Lunatic Asylum', in W. F. Bynum, R. Porter, and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry, v.3*, London: Routledge, 297-315.

Saunders, J. 'Quarantining the weak-minded: Psychiatric definitions of degeneracy and the late-Victorian asylum', in W. Bynum, R. Porter and M. Shepherd (eds.), *The Anatomy of Madness: Essays in the History of Psychiatry*, v. 3. London: Routledge, 1988, 273-96.

Savage, G. 'The influence of surroundings on the production of insanity', *The Journal of Mental Science*, **37**, 1891, 529-35.

Scheff, T. (ed.), *Labelling Madness*, Englewood Cliffs: Prentice Hall, 1975.

Scull, A. *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*, London: Penguin, 1979.

Scull, A. *Social Order/ Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, London: Routledge, 1989.

Scull, A. 'Michel Foucault's history of madness', *History of the Human Sciences*, **3**, 1990, 57-67.

Scull, A. *The Most Solitary of Afflictions: Madness and Society in Britain 1700-1900*, New Haven: Yale University Press, 1993.

Seedat, A. *Crippling a Nation: Health in Apartheid South Africa*, London: International Defence and Aid Fund for Southern Africa, 1984.

Sharpe, J. *Allegories of Empire: The Figure of Woman in the Colonial Text*, Minneapolis: University of Minnesota Press, 1993.

Shortt, S.E.D. *Victorian Lunacy: Robert M. Bucke and the Practice of Late Nineteenth Century Psychiatry*, Cambridge: Cambridge University Press, 1986.

Showalter, E. 'Victorian women and insanity', in A. Scull (ed.), *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, London: The Athlone Press, 1981, 313-336.

Showalter, E. *The Female Malady: Women, Madness, and English Culture, 1830-1980*, New York: Pantheon, 1985.

Simkins, C. and E. van Heyningen, 'Fertility, mortality and migration in the Cape Colony, 1891-1904', *The International Journal of African Historical Studies*, **22**, 1989, 79-111.

Sinason, V. *Mental Handicap and the Human Condition*, New Directions in Psychoanalysis, London: Free Association Books, 1992.

Skultans, V. *Madness and Morals: Ideas on Insanity in Nineteenth Century*, London: Routledge & Kegan Paul, 1975.

Smith, D. 'The social construction of documentary reality', *Sociological Inquiry*, **44**, 1974, 257-268.

Smith, D. *Texts, Facts and Femininity: Exploring the Relations of Ruling*, London and New York: Routledge, 1990a.

Smith, D. *The Conceptual Practices of Power: A Feminist Sociology of Knowledge*. Boston: Northeastern University Press, 1990b.

Spivak, G. C. 'Can the subaltern speak?', in P. Williams and L. Chrisman, (eds.), *Colonial Discourse and Post-Colonial Theory*, New York: Harvester Wheatsheaf, 1993, 66-111.

Still, A. and Velody, I. (eds.), *Rewriting the History of Madness: Studies in Foucault's 'Histoire de la folie'*, London: Routledge, 1992.

Stoler, A. 'Rethinking colonial categories: European communities and the boundaries of rule', *Comparative Studies in Society and History*, **31**, 1989, 134-161.

Stoler, A. 'Making empire respectable: The politics of race and sexual morality in twentieth-century colonial cultures', *American Ethnologist*, **16**, 1989, 634-660.

Stoler, A. 'Sexual affronts and racial frontiers: European identities and the cultural politics of exclusion in colonial Southeast Asia', *Comparative Studies in Society and History*, **34**, 1992, 514-551.

Stoler, A. *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things*, Durham and London: Duke University Press, 1995.

Stone, A., C. Pinder-Hughes, J. Spurlock and J. Weinberg, Committee to visit South Africa, 'Report of the Committee to Visit South Africa', *American Journal of Psychiatry*, **136**, 11, 1979, 1498-1506.

Strahan, S. 'The propagation of insanity and allied neuroses', *The Journal of Mental Science*, **36**, 1890, 325-47.

Swaisland, C. *Servants and Gentlewomen to the Golden Land: The Emigration of Single Women from Britain to Southern Africa, 1820-1939*, Pietermaritzberg: University of Natal Press, 1993.

Swanson, F. 'Colonial madness: The construction of gender in the Grahamstown Lunatic Asylum, 1875-1905', Unpublished History Honours dissertation, Cape Town: University of Cape Town, 1994.

Swanson, M. 'The sanitation syndrome: Bubonic plague and urban native policy in the Cape Colony, 1900-1909', *Journal of African History*, **18**, 1977, 387-410.

Swartz, L. and D. Foster, 'Images of culture and mental illness: South African psychiatric approaches', *Social Dynamics*, **10**, 1984, 17-25.

Swartz, L. 'Transcultural psychiatry in South Africa', *Transcultural Psychiatric Research Review*, Part 1, **23**, 1986, 290-303, and Part 2, **24**, 1987, 5-30.

Swartz, S. and L.Swartz, 'Talk about talk: Metacommentary and context in the analysis of psychotic discourse', *Culture, Medicine and Psychiatry*, **11**, 1987, 395-416.

Swartz, S. 'Sources of misunderstanding in interviews with psychiatric patients', *Professional Psychology: Research and Practice*, **23**, 1992, 24-29.

Swartz, S. 'Changing diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: A longitudinal view', *History of Psychiatry*, **6**, 1995a, 431-451.

Swartz, S. 'Colonising the insane: Causes of insanity in the Cape, 1891-1920' *History of the Human Sciences*, **8**, 1995b, 39-57.

Swartz, S. 'The black insane in the Cape, 1891-1920', *Journal of Southern African Studies*, **21**, 1995c, 399-415.

Swartz, S. 'Shrinking: A postmodern perspective on psychiatric histories', *South African Journal of Psychology, in press.*

Thomson, M. 'Sterilisation, segregation and community care: Ideology and solutions to the problem of mental deficiency in inter-war Britain', *History of Psychiatry*, **3**, 1992, 473-98.

Tomes, N. 'The Anglo-American asylum in historical perspective', in J. Giggs and C. Smith (eds.), *Location and Stigma*, London: Unwin Hyman, 1988.

Tucker, G. *Lunacy in many lands*, Sydney: Charles Potter, Government Printer, 1887.

Turner, T. 'A diagnostic analysis of the casebooks of Ticehurst House Asylum, 1845-1890', *Psychological Medicine*, Monograph Supplement **2**, 1992.

Urquhart, A. 'The Morison lectures. - On insanity, with special reference to heredity and prognosis', *The Journal of Mental Science*, **53**, 1907, 233-321.

Ussher, J. *Women's Madness: Misogyny or Mental Illness?*, New York: Harvester Wheatsheaf, 1991.

Valenstein, E. *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments of the Insane*, New York: Basic Books, 1986.

van Heyningen, E. 'Cape Town and the plague of 1901', in C. Saunders, H. Phillips and E van Heyningen (eds.), *Studies in the History of Cape Town*, v.4, Cape Town: History Department and Centre for African Studies, University of Cape Town, 1981, 66-107.

van Heyningen, E. 'Public health and society in Cape Town 1880-1910', unpublished Doctoral dissertation, Cape Town: University of Cape Town, 1989.

van Heyningen, E. 'Poverty, self-help and community: The survival of the poor in Cape Town, 1880-1910', *South African History Journal*, **24**, 1991, 128-143.

Vaughan, M. *Curing Their Ills: Colonial Power and African Illness*, Cambridge: Polity Press, 1991.

Vaughan, M. 'Colonial discourse theory and African history, or has post-modernism passed us by?', *Social Dynamics*, **20**, 2, 1994, 1-23.

Walker, C. (ed.), *Women and Gender in Southern Africa to 1945*, Cape Town: David Philip, 1990.

Wallerstein, I. 'The construction of peoplehood: Racism, nationalism, ethnicity', in E. Balibar and I. Wallerstein, *Race, Nation, Class: Ambiguous Identities*, London: Verso, 1991, 71-85.

Ware, V. 'Moments of danger: Race, gender, and memories of Empire', *History and Theory*, **31**, 1992, 116-137.

Warwick, R. 'Mental health care at Valkenberg Asylum 1891-1909: Aspects of its origins and operation,' unpublished Honours dissertation, Department of History, Cape Town: University of Cape Town, 1989.

Wing, J. K. and G. Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960-1968*, Cambridge: Cambridge University Press, 1970.

Wing, J. *Reasoning about Madness*, Oxford: Oxford University Press, 1978.

APPENDIX 1 a

Case records in the Valkenberg Series

The columns give the following information:

1. file number
2. date of first admission
3. date of admission to Valkenberg
4. age
5. marital status
6. class of attack
7. occupation
8. initial diagnosis
9. outcome
10. date of income

WHITE MALE ADMISSIONS

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
ME514	1876	1899	33	S	4	Cook	Mania chr	Died	1926
ME2024	1877	1891	22	S	5	None	Imbecile	Died	1929
ME1890	1885	1899	31	S	3	Trader	Mania	Died	1928
ME1636	1889	1916	25	S	6	Carpenter	Imb deme*	Died	1926
ME12	1889	1891	36	S	4	Farmer	Mania	Died	1941
ME1619	1893	1893	33	M	4	Carpenter	Mania chr	Died	1942
ME337	1895	1897	34	M	2	Farmer	Mania chr	Died	1949
ME428	1896	1896	22	S	3	Bank clerk	Melanchol	Died	1937
ME1633	1897	1897	31	S	1	Speculator	Melanchol	Died	1952
ME607	1899	1899	33	M	3	Chemist	Mania	Died	1947
ME1662	1900	1908	26	S	3	None	Mania	Died	1927
ME829	1901	1901	25	S	1	Labourer	Melan chr	Died	1958
ME813	1901	1901	24	S	4	Student	Maniaimpl	Died	1942
ME2579	1901	1901	15	S	1	None	Mania	Disch	1936
ME1299	1901	1901	27	M	2	Missionary	Melanchol	Died	1939
ME840	1901	1901	27	S	2	Farm/soldie	Mania	Died	1943
ME1974	1901	1901	26	S	1	Farmer	Mania	Died	1939
ME908	1902	1902	23	M	1	Clerk	Mania	Died	1950
ME1202	1902	1902	36	S	3	Carri build	Melan acu	Died	1934
ME997	1902	1902	28	S	4	Dispens ass	Mania	Died	1942
ME894	1902	1902	24	S	1	Clerk	Melancho*	Died	1940
ME1376	1903	1903	26	S	1	Com travele	Melan acu	Died	1942
ME1625	1903	1916	26	S	3	Farmer	Hebephren	Died	1942
ME2351	1903	1903	25	M	3	Blacksmith	Sen melan	Died	1937
ME2146	1903	1903	52	M	1	Shepherd	Melan acu	Died	1929
ME1134	1903	1903	50	S	2	Gardener	Melan acu	Died	1940
ME2373	1904	1904	55	W	1	Farmer	Mania acu	Died	1927
ME1251	1904	1904	49	M	1	Mason	Melan acu	Died	1939
ME1184	1904	1904	26	S	1	Labourer	Melan ac	Died	1947
ME1632	1904	1916	38	S	1	Carpenter	Mania	Died	1939
ME1246	1904	1904	35	S	1	Bookkeeper	Melan acu	Died	1928
ME1944	1904	1904	28	S	4	Civil serva	Melanchol	Died	1947
ME1387	1905	1905	27	S	3	Farmer's as	Maniacu	Died	1944
ME1375	1905	1905	33	S	1	fireman	Mania acu	Died	1935
ME4060	1905	1905	17	S	3	Clerk	Hebephren	Died	1937
ME1352	1905	1905	22	S	4	Polisher	Mania acu	Died	1954
ME1290	1905	1905	31	M	1	Farmer	Mania acu	Died	1938
ME1447	1906	1906	57	S	6	Traveller	Del insan	Died	1933
ME2365	1906	1906	42	M	3	Doctor	Mania rec	Died	1940
ME1492	1906	1906	36	S	6	Quarryman	Mania acu	Died	1953
ME1609	1907	1907	39	M	4	Convict gua	Dem rec	Died	1934
ME1610	1907	1907	37	W	6	Mech Eng	Mania?	Died	1950
ME1706	1907	1908	26	S	1	Teacher	Mania Chr	Died	1958
ME1655	1908	1908	50	S	2	Mason	Mania rec	Died	1925
ME1626	1908	1910	50	M	4	Gen dealer	Del non-s	Died	1946
ME1725	1908	1908	49	M	1	Farmer	Melan rec	Died	1940
ME1744	1909	1909	25	S	1	None	Melan rec	Died	1959
ME1884	1909	1909	32	S	4	Music teach	Melan rec	Died	1931
ME1769	1909	1909	40	S	5	Labourer	Imbecile	Died	1929
ME2846	1910	1910	71	W	3	Minister	Melanchol	Disch	1928
ME1552	1911	1911	42	M	4	Rwy foreman	No trace	Died	1948
ME1961	1911	1911	66	D	1	Pauper	Del non-s	Died	1925
ME1985	1911	1911	26	S	3	Upholsterer	D P	Died	1944
ME2087	1911	1911	22	S	4	None	Epilepsy	Died	1929
ME2113	1912	1912	28	M	4	Farmer	Del non-s	Disch	1936
ME2086	1912	1912	31	S	4	Engine fitt	D P	Died	1940

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
ME2130	1912	1912	39	M	4	Compositor	Dels syst	Died	1941
ME2094	1912	1912	40	S	6	Draper assi	Organic d	Died	1925
ME3033	1912	1912	40	S	3	Teacher	Mania rec	Disch	1930
ME2245	1913	1913	21	S	1	Porter	Melan rec	Died	1940
ME2205	1913	1913	21	S	1	Farm worker	Mania rec	Died	1956
ME2287	1913	1913	39	S	2	Motorman	Melan rec	Died	1950
ME2232	1913	1913	30	S	3	Storekeeper	Mania rec	Died	1953
ME2217	1913	1913	23	S	5	None	Cong imb	Died	1927
ME2156	1913	1913	28	S	3	Farmer	Mania rec	Died	1948
ME2376	1914	1914	30	S	1	Clerk	Hebephren	Died	1947
ME2350	1914	1914	39	S	5	None	Imbecile	Died	1949
ME2348	1914	1914	25	S	3	None	D P	Died	1970
ME2384	1914	1914	21	S	1	Carpenter	D P Heb	Died	1956
ME2545	1915	1915	54	?	1	?	Psychosis	Died	1931
ME2018	1915	1915	20	S	2	Clerk	Catatonia	Died	1947
ME2067	1915	1915	36	S	4	Gardener	Mania	Died	1946
ME2495	1915	1915	55	S	1	Billiard ma	Manic-dep	Died	1931
ME2585	1915	1915	36	M	1	Clerk	Psychosis	Died	1939
ME1666	1916	1916	37	S	3	Labourer	Epilepsy	Died	1944
ME1560	1916	1916	55	W	6	Carpenter	Dem paral	Died	1939
ME1588	1916	1916	30	S	1	Rwy foreman	D P Heb	Died	1957
ME1526	1916	1916	61	S	1	Farmer	Heb	Died	1925
ME1653	1916	1916	30	S	1	Labourer	D P Heb	Disch	1929
ME1554	1916	1916	58	S	1	Clerk	Senile	Died	1935
ME1719	1917	1917	35	M	3	Rwy shunter	Epilepsy	Died	1938
ME1682	1917	1917	44	M	2	Labourer	None	Unkno	
ME1732	1917	1917	34	S	3	None	Epilepsy	Died	1938
ME1853	1917	1917	42	S	3	Com travel	Epilepsy	Died	1927
ME1747	1917	1917		S	4	Carpenter	Epilepsy	Disch	1929
ME1825	1917	1917	55	S	4	None	Manic-dep	Died	1931
ME1896	1918	1918	30	S	4	None	D P Heb	Disch	1938
ME1940	1918	1918	66	W	2	Farmer	Sen dem	Died	1929
ME1978	1918	1918	40	M	3	Farmer	Manic-dep	Disch	1931
ME1958	1918	1918	28	S	4	Musician	D P Para	Died	1946
ME1909	1918	1918	69	M	2	Mason/brick	Senile	Died	1938
ME1914	1918	1918	30	S	4	Clerk	D P Heb	Died	1946
ME1891	1918	1918	58	W	1	Farmer	Manic-dep	Died	1932
ME1871	1918	1918	25	S	3	Farmer	Hebephren	Died	1928
ME2117	1919	1919	47	S	6	Bank clerk	D P Cat	Died	1932
ME2029	1919	1919	29	S	2	Soldier	D P Heb	Died	1944
ME12	1919	1919	23	S	2	Gunner	D P Heb	Died	1976
ME2033	1919	1919	27	S	6	Soldier	D P Heb	Died	1945
ME2233	1920	1920	35	M	1	Trader	Manic-dep	Died	1928
ME2154	1920	1920	51	M	1	Musician	Manic-dep	Disch	1920
ME2196	1920	1920	25	S	6	Soldier	Schiz*	Disch	1943
ME2158	1920	1920	18	S	5	None	Imbecile	Died	1946
ME2166	1920	1920	28	S	3	Clerk	Epilepsy	Died	1949
ME2218	1920	1920	46	M	4	Contractor	Korsakows	Died	1931
ME2165	1920	1920	20	S	6	Labourer	D PSimple	Disch	1932
ME2207	1920	1920	58	S	3	Pensioner	Melan inv	Died	1942
ME2182	1920	1920	58	S	2	None	Paranoid	Died	
ME2177	1920	1920	27	M	4	Soldier	GPI	Died	1926
ME2393	1920	1920	29	S	2	Miner	D P Simpl	Died	1954
ME2144	1920	1920	39	M	4	Pipe fitter	Epilepsy	Died	1938

BLACK MALE ADMISSIONS

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
MC43	1895	1916	24	S	3	Vagrant	Mania Rec	died	1943
MC53	1898	1917	22	S	2	Labourer	Chr Mel	Died	1954
MC252	1902	1921	24	S	2	Labourer	Melanchol	Died	1940
MI5	1904	1921	35	M	6	Groom/pauper	Mania	Died	1940
MC7	1905	1916	36	S	4	Labourer	Mania Acu	Died	1952
MC17	1906	1916	35	?	6	Unknown	Mania acu	Died	1951
MN45	1906	1920	53	M	3	Labourer	Del mania	Died	1947
MC1283	1906	1916	60	M	6	None	Mania rec	Died	1951
MC61	1906	1917	22	S	1	Labourer	Man recen	Died	1958
MC24	1907	1916	27	S	6	Unknown	Mania	Died	1943
MC 30	1908	1916	22	S	2	Not given	Cong imbe	Died	1960
MC9	1908	?	23	S	4	Labourer	Prim dem	Died	1970
MC35	1909	1916	36	S	6	Labourer	Mania	?	?
MC31	1910	1916	24	S	6	Labourer	Rec mania	Died	1947
MC67	1911	1917	45	M	3	Labourer	Man recen	Died	1946
MN5	1911	1916	28	?	3	Servant	Mania rec	Disch	1950
MC134	1913	1920	29	S	3	Labourer	Mania*	Died	1968
MC97	1913	1919	30	?	1	Labourer	Mania rec	Died	1948
MC222	1913	1920	21	S	1	Shoemaker	Epilepsy	Died	1941
MC162	1914	1920	25	S	3	Blacksm ass	Schiz	Died	1953
MN2	1915	1916	27	?	1	Labourer	Depressi*	Died	1936
MC57	1916	1917	45	M	4	Labourer	Del Insan	Died	1943
MC166	1916	1920	34	M	2	Fruiterer	Schiz heb	Died	1962
MC10	1916	1916	32	S	6	Milk boy	Imbecile	Died	1961
MC142	1916	1920	35	S	6	Tailor	Imbecile	Died	1946
MC207	1917	1920	37	S	3	Butcher	Man-depre	Died	1942
MC77	1917	1917	37	S	2	Painter	Dem Para	Died	1948
MC112	1917	1920	22	S	2	Tailor	Mania del	Disch	1954
MC258	1917	1921	29	M	1	Fireman	Mania	Died	1931
MC96	1917	1919	22	S	4	Labourer	Schiz heb	Died	1945
MN17	1918	1919	45	M	1	Seaman	Schiz par	Died	1941
MC124	1918	1920	25	S	5	None	Feeble	Died	1958
MC151	1918	1920	36	M	1	Labourer	Mania	Died	1974
MC105	1918	1920	25	S	4	None	Feeblemi	Died	1961
MC88	1918	1919	19	S	5	None	Imbecile	Died	1944
MC98	1918	1919	17	S	5	Labourer	Imbecile	Died	1948
MC157	1918	1920	36	S	6	Brickmaker	Schiz cat	Esc?	
MC125	1918	1920	41	S	4	Labourer	Mania del	Died	1960
MC92	1918	1919	32	?	?	Labourer	Dem Para	Died	1922
MC200	1919	1920	28	M	3	Cabinet make	Schiz heb	Died	1968
MC198	1919	1920	23	S	1	Labourer	Schiz cat	Died	1973
MC167	1919	1920	25	S	6	Feather sort	Schiz heb	Died	1941
MC145	1920	1920	19	S	1	Labourer	D P	Died	1950
MC196	1920	1920	36	W	1	Labourer	D P Heb	?	?
MC228	1920	1920	31	S	1	Labourer	Imbecile	Disch	1948
MC165	1920	1920	28	S	4	Labourer	D P Heb	?	?

WHITE FEMALE ADMISSIONS

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
FE193	1888	1896	34	S	6	Dom servant	Mania chr	Died	1934
FE99	1892	1892	33	S	4	None	Mania	Died	1944
FE76	1892	1892	19	S	1	Student	Mania	Died	1961
FE223	1896	1896	30	S	4	None	CMD	Died	1934
FE279	1897	1897	57	S	4	Not given	Not given	Died	1930
FE1705	1898	1908					Mania chr	Disch	
FE791	1899	1899	32	S	3	Teacher	Melanchol	Died	1945
FE896	1901	1901	27	S	3	None	Epilepsy	Died	1928
FE1357	1901	1918	52	M	3	Housewife	Manic-dep	Died	1946
FE1396	1902	1902	34	S	3	Dom servant	Mania*	Died	1931
FE1517	1902	1902	32	M	3	Domestic dut	Epilepsy	Died	1938
FE1114	1903	1903	31	M	3	Housewife	Melan ac	Died	1949
FE1045	1903	1903	35	S	5	None	Imbecile	Died	
FE1354	1905	1905	42	S	3	None	Mania acu	Died	1943
FE1344	1905	1905	26	M	1	Housewife	Mania acu	Died	1944
FE2563	1905	1905	39	W	3	Housewife	Melan acu	Died	1961
FE2255	1906	1906	50	M	6	Housewife	Melan ac	Died	1931
FE1622	1907	1907	28	S	3	None	Mania chr	Died	1951
FE1545	1907	1907	26	M	1	Dom service	Melanc re	Died	1952
FE1839	1908	1908	58	W	4	None	Del non-s	Died	1945
FE1913	1909	1909	23	S	4	None	Dem sec	Died	1940
FE1330	1910	1910	22	S	6	None	Mania rec	Died	1964
FE1887	1910	1910	35	M	3	Housewife	Mania rec	Died	1934
FE1879	1910	1910	50	W	1	None	Melan acu	Died	1928
FE2539	1911	1911	52	S	4	Teacher	Manic-dep	Died	1932
FE2036	1912	1912	50	S	1	Cook	Del non-s	Died	1929
FE1998	1912	1912	21	S	2	Housewife	Mania rec	Died	1942
FE2072	1912	1912	21	S	3	None	Epilepsy	Died	1930
FE2050	1912	1912	44	M	2	Housewife	Del syste	Died	1933
FE2051	1912	1912	40	W	1	Nurse	Melan rec	Died	1925
FE2038	1912	1912	45	S	1	None	Melan acu	Died	1942
FE2148	1913	1913	21	S	2	None	Mania rec	Died	1956
FE2149	1913	1913	27	S	3	None	Mania acu	Died	1953
FE1335	1914	1918	32	M	3	Housewife	Mania rec	Died	1961
FE2343	1914	1914	60	W		None	Del non-s	Died	1935
FE2389	1914	1914	70	W	3	None	Mania	Died	1929
FE2385	1914	1914	36	S	1	None	Hebephren	Died	1950
FE1509	1914	1914	40	M	3	Housewife	Mania	Disch	1933
FE2327	1914	1914	17	S	5	None	Imbecile	Died	1934
FE2076	1914	1914	38	S	3	Not given	Mania rec	Disch	1929
FE1374	1915	1915	62	W	1	Housewife	Alc insan	Died	1933
FE2494	1915	1915	42	M	4	Housewife	Manic-dep	Died	1957
FE1173	1916	1916	65	W	3	Midwife	Manic-dep	Died	1936
FE1198	1916	1916	22	S	1	Tailoress	D P Heb	Died	1957
FE1151	1916	1916	36	S	4	Teacher	D P Heb	Died	1956
FE1910	1917	1917	50	M	3	Housewife	Manic-dep	Died	1925
FE1242	1917	1917	46	W	3	Not given	Epilepsy	Died	1933
FE1247	1917	1917	33	M	1	Housewife	D P Para	Died	1941
FE1225	1917	1917	17	S	3	None	D P Cat	Died	1944
FE1231	1917	1917	60	W	6	Housewife	Mania rec	Died	1928
FE1289	1918	1918	16	S	5	None	Epileptic	Died	1951
FE1287	1918	1918	39	M	3	Housewife	Epilepsy	Died	1937
FE1380	1918	1918	35	S	1	Teacher	D P Cat	Died	1925
FE2139	1918	1918	40	S	4	None	D P Cat	Died	1954
FE1424	1918	1918	37	M	4	Housewife	Epilepsy	Died	1941
FE1285	1918	1918	47	M	3	Housewife	Manic-dep	Died	1966

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
FE1331	1918	1918	57	M	3	Housewife	Trauma	Died	1942
FE1344	1918	1918	49	M	3	Housewife	D P	Died	1940
FE1292	1918	1918	24	S	2	None	D P Cat	Died	1965
FE1442	1919	1919	30	S	5	None	Idiocy	Died	1929
FE1481	1919	1919	28	M	1	Housewife	Manic-dep	Died	1937
FE1446	1919	1919	?	?	?	?	?	?	?
FE1415	1919	1919	52	W	2	Housewife	Conf insa	Died	1925
FE1399	1919	1919	50	M	1	Housewife	Melanchol	Died	1925
FE416	1919	1919	23	S	1	Student	Schiz cat	Disch	1936
FE1451	1919	1919	36	S	2	Housekeeper	D P Para	Died	1960
FE1437	1919	1919	21	S	2	None	D P	Died	1959
FE1407	1919	1919	35	M	1	Telephonist	D P Para	Died	1960
FE1490	1919	1919	50	W	4	None	CMD	Died	1934
FE1387	1919	1919	35	S	4	Housewife	D P Cat	Died	1937
FE1537	1920	1920	60	S	3	None	Epilepsy	Died	1929
FE2256	1920	1920	16	S	5	None	Feeblemin	Disch	1937
FE1542	1920	1920	38	S	3	None	Moral imb	Died	1937
VB230	1920	1920	28	S	6	None	Psychopat	Disch	1930
FE1571	1920	1920	46	S	3	None	D P Para	Died	1956
FE1531	1920	1920	84	W	3	Not given	Senile de	Died	1926

BLACK FEMALE ADMISSIONS

fileno	adm1	vmha	ag	m	a	occupation	diag1	outco	date
FC162	1893	1920	46	W	4	Cook	Mania	Died	1958
FC1	1904	1904	23	S	1	Dom servant	Melan acu	Died	1955
FC131	1905	1920	50	S	6	Washerwoman	Manic-dep	Died	1935
FC154	1909	1920	39	M	3	Housewife	Melan rec	Died	1948
FC145	1909	1920	28	M	4	Housewife	Puer mani	Disch	1933
FC101	1910	1920	32	S	3	Dom servant	Hypomania	Disch	1926
FC204	1912	1920	20	S	1	Dom servant	Schiz heb	Disch	1931
FC128	1912	1920	47	W	1	Dom servant	Recent ma	Died	1948
FC201	1912	1920	50	W	4	Not given	Man chron	Died	1935
FC200	1913	1921	22	S	6	Wood-gathere	Imbecile	Died	1968
FC12	1913	1920	24	M	1	Housewife	Schiz heb	Died	1963
FC153	1917	1920	22	S	2	Dom servant	Schiz	Disch	1932
FC253	1919	1919	56	W	1	Washerwoman	Senile	Died	1920
FC171	1920	1920	30	S	3	Not given	Manic	Died	1969
FC152	1920	1920	43	D	1	Housewife	Schiz heb	Died	1937
FC164	1920	1920	35	M	1	Housewife	Mania	Died	1965
FC240	1921	1921					GPI	Died	1949
FC412	1924	1924					Imbecile	Died	1926

APPENDIX 1 b

Case material referred to in the dissertation: file number, first name, and surname initial

FOLDER NUMBERS, FIRST NAMES, AND SURNAME INITIALS OF CASE RECORDS REFERRED TO IN THE DISSERTATION

FC 1	Joanna W
FC 101	Julia P
FC 12	Henrietta d P
FC 128	Maria P
FC 131	Christina C
FC 164	Maria A
FC 171	Eliza P
FC 200	Margaret M
FC 201	Sarah S
FE 1114	Louisa F
FE 1151	Ivy G
FE 1225	Rachael K
FE 1231	Magdalena C
FE 1247	Isabella G
FE 1292	Maisie L
FE 1357	Maria B
FE 1622	Mary W
FE 193	Rosina S
FE 1998	Hester D
FE 2050	Amelia O
FE 2076	Ethel H
FE 223	Emma C
FE 2256	Mary E
FE 2343	Margaretha G
FE 279	Rosina M
FE 76	Annie B
FE 99	Dorothy F
MC 10	Edward F
MC 105	Christopher L
MC 125	Ferdinand H
MC 134	Hendrick B
MC 142	Jimmy S
MC 157	Philip S
MC 162	Herman L
MC 165	Carl M
MC 166	Frederick W
MC 200	Gilbert G
MC 24	Daniel R
MC 258	William R
MC 30	Jacob v W
MC 31	George N
MC 53	Adam M
MC 61	Jacobus A
MC 67	Phillip D
MC 7	Nathaniel D
MC 77	James S
MC 92	Louis B
MC 96	Jacobus P
MC 98	Louis B
ME 1134	John A
ME 12	Jan K
ME 1610	Joseph B
ME 1619	John W
ME 1626	Adriaan T
ME 1632	Thomas B
ME 1633	John I
ME 1655	Attiliop R
ME 1662	William M
ME 1706	Guy H
ME 1896	Johannes d T
ME 1985	Ralph H
ME 2024	James R
ME 2117	Thomas F
ME 2146	Pieter D
ME 2154	Alfred N
ME 2376	Francis J
ME 4060	Frank R
ME 514	Paul M
ME 607	Stephen D
ME 840	Alfred H
ME 894	John C
ME 997	Jacob H
MN 17	John L
MN 2	Antonie M
MN 45	Booi T
MN 5	Jim

APPENDIX 2

Tables

These tables contain the statistical information from which figures 1 - 22 were drawn.

AGES IN QUINQUENNIAL PERIODS OF ADMISSIONS TO VALKENBERG, 1891-1906: PERCENTAGE IN EACH GROUP

AGE	M	F
	n = 937	n = 591
10-14	0.11	0.68
15-19	2.99	5.92
20-24	9.07	9.14
25-29	13.98	13.87
30-34	15.80	12.01
35-39	15.37	12.01
40-44	11.85	12.86
45-49	9.28	9.98
50-54	6.30	6.4
55-59	5.87	4.06
60-64	3.95	4.06
65-69	2.13	4.57
70-74	2.03	2.03
75-79	0.43	0.85
80 AND OVER	-	0.68
UNKNOWN	0.85	0.85

TABLE 1a

AGE, VALKENBERG SERIES TO 1906: PERCENTAGE IN EACH GROUP

AGE	M	F
	n = 40	n = 17
10-14	0	0
15-19	5.0	6.25
20-24	15.0	0
25-29	32.5	12.5
30-34	20.0	43.75
35-39	12.5	12.5
40-44	2.5	6.25
45-49	2.5	0
50-54	5.0	12.5
55-59	5.0	6.25
60-64	0	0
65-69	0	0
70-74	0	0
75-79	0	0
80 AND OVER	0	0
UNKNOWN	0	0

TABLE 1b

AGE, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

AGE	ME	FE	MC	FC[1]
	n = 110	n = 76	n = 46	n = 16
10-14	0	0	0	0
15-19	2.7	6.6	6.5	0
20-24	12.7	11.8	23.9	31.25
25-29	24.5	9.2	23.9	6.25
30-34	15.5	13.2	10.9	12.5
35-39	14.6	17.1	21.7	12.5
40-44	7.3	7.9	2.2	6.25
45-49	3.6	6.6	6.5	12.5
50-54	5.5	11.8	2.2	12.5
55-59	8.2	4	0	6.25
60-64	0.9	5.3	2.2	0
65-69	2.7	1.3	0	0
70-74	0.9	1.3	0	0
75-79	0	0	0	0
80+	0	1.3	0	0
UNKNOWN	0.9	2.6	0	0

TABLE 1c

[1]. In the tables which follow, `ME', `FE', `MC' and `FC' refer to the racial classification on the folders, `Male European', `Female European', `Male Coloured', and `Female Coloured' respectively.

MARITAL STATUS OF ADMISSIONS TO VALKENBERG, 1891-1906: PERCENTAGE IN EACH GROUP

MARITAL STATUS	M n = 935	F n = 591
Single	51.66	40.44
Married	40.53	45.01
Widowed	5.13	13.87
Divorced	0	0
Unknown	2.67	0.68

TABLE 2a

MARITAL STATUS, VALKENBERG SERIES TO 1906: PERCENTAGE IN EACH GROUP

MARITAL STATUS	M n = 40	F n = 17
Single	72.5	62.5
Married	25.0	31.25
Widowed	2.5	6.25
Divorced	0	0
Unknown	0	0

TABLE 2b

MARITAL STATUS, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

MARITAL STATUS	ME	FE	MC	FC
	n = 110	n = 76	n = 46	n = 16
SINGLE	69.09	52.63	65.22	43.75
MARRIED	23.64	27.63	21.74	25.0
WIDOWED	5.45	17.11	2.17	25.0
DIVORCED	0.91	0	0	6.25
UNKNOWN	0.91	2.63	10.87	0

TABLE 2c

RELIGION OF ADMISSIONS TO VALKENBERG, 1891-1909: PERCENTAGE IN EACH GROUP

RELIGION	M	F
	n = 2578	n = 2434
DRC[2]	25.10	37.18
ANGLICAN	31.57	30.03
CATHOLIC	10.20	8.87
OTHER CHRISTIAN[3]	20.45	16.03
JEWISH	6.36	4.03
UNKNOWN	6.32	3.86

TABLE 3a

2. Dutch Reformed Church.
3. This category includes: Prebyterian, Lutheran, Wesleyan, and Baptist churches.

RELIGION, VALKENBERG SERIES TO 1909: PERCENTAGE IN EACH GROUP

RELIGION	M	F
	n = 49	n = 21
DRC	28.89	30
ANGLICAN	35.56	30
CATHOLIC	8.89	5
OTHER CHRISTIAN	8.89	20
JEWISH	4.44	10
NO RELIGION	2.22	0
UNKNOWN	11.11	5

TABLE 3b

RELIGION, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

RELIGION	ME	FE	MC	FC
	n = 110	n = 76	n = 46	n = 16
DRC	31.81	31.58	17.39	12.5
ANGLICAN	32.73	28.95	26.08	50.0
CATHOLIC	5.45	7.9	4.35	6.25
OTHER CHRISTIAN	13.64	14.47	28.26	18.75
JEWISH	6.36	11.84	0	0
MOSLEM	0	0	4.35	6.25
NO RELIGION	0.9	0	2.17	0
UNKNOWN	9.09	5.26	17.39	6.25

TABLE 3c

OCCUPATION OF MALE ADMISSIONS TO VALKENBERG, 1891-1906: PERCENTAGE IN EACH GROUP

OCCUPATION	No	%
Professions	62	6.64
Soldiers sailors police	88	9.42
Miners	18	1.93
Farmers	127	13.6
Retailers traders clerks	197	21.09
Artisans craftsmen skilled labour	221	23.66
Unskilled labour	135	14.45
Other	5	0.54
Unknown/ unemployed	81	8.67

TABLE 4a

MALE OCCUPATIONS, VALKENBERG SERIES TO 1906: PERCENTAGE IN EACH GROUP

OCCUPATION	No	%
Professions	4	11.11
Soldiers sailors police	1	2.78
Miners	2	5.56
Farmers	7	19.44
Retailers traders clerks	8	22.22
Artisans craftsmen skilled labour	8	22.22
Unskilled labour	2	5.56
Other	2	5.56
Unknown/ unemployed	2	5.56

TABLE 4b

MALE OCCUPATIONS, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

OCCUPATION	WHITE	BLACK
	n = 110	n = 46
Professions	10	0
Soldiers sailors police	7.27	4.35
Miners	2.73	0
Farmers	14.55	0
Retailers traders clerks	18.18	2.17
Artisans craftsmen skilled labour	24.55	21.74
Unskilled labour	6.36	52.17
Other	2.73	0
Unknown/ unemployed	13.64	19.57

TABLE 4c

OCCUPATION OF FEMALE ADMISSIONS TO VALKENBERG, 1891-1906: PERCENTAGE IN EACH GROUP

OCCUPATION	No	%
Professions	38	6.45
Housekeepers cooks	16	2.72
Dressmakers shop assistants	20	3.4
Domestic service	57	9.68
Domestic duties	294	49.92
Other	13	2.21
Unknown unemployed	151	25.64

TABLE 4d

FEMALE OCCUPATIONS, VALKENBERG SERIES TO 1906: PERCENTAGE IN EACH GROUP

OCCUPATION	No	%
Professions	1	6.67
Housekeepers cooks	0	0
Dressmakers shop assistants	0	0
Domestic service	2	13.33
Domestic duties	5	33.33
Other	1	6.67
Unknown unemployed	6	40

TABLE 4e

FEMALE OCCUPATIONS, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

OCCUPATION	FE	FC
	n = 76	n = 16
Professions	7.9	0
Housekeepers cooks	2.63	6.25
Dressmakers shop assistants	2.63	0
Domestic service	3.95	43.75
Domestic duties	32.9	31.25
Other	2.63	6.25
Unknown unemployed	47.37	12.5

TABLE 4f

CLASS OF ATTACK OF ADMISSIONS TO VALKENBERG, 1891-1906: PERCENTAGE IN EACH GROUP

CLASS[4]	M	F
	n = 940	n = 591
FIRST	41.17	33.16
SECOND	14.36	9.48
THIRD	20.43	27.07
FOURTH	17.02	24.87
FIFTH	2.23	4.74
UNKNOWN	4.79	0.68

TABLE 5a

CLASS OF ATTACK OF VALKENBERG SERIES, 1891-1906: PERCENTAGE IN EACH GROUP

CLASS	M	F
	n = 40	n = 17
FIRST	37.5	12.5
SECOND	10.0	0
THIRD	25.0	50.0
FOURTH	17.5	18.75
FIFTH	2.5	6.25
UNKNOWN	7.5	12.5

TABLE 5b

CLASS OF ATTACK, VALKENBERG SERIES: PERCENTAGE IN EACH GROUP

CLASS	ME	FE	MC	FC
	n = 110	n = 76	n = 46	n = 16
FIRST	30.0	21.1	23.9	47.1
SECOND	12.7	9.2	13.1	5.9
THIRD	21.8	36.8	17.4	17.6
FOURTH	21.8	15.8	15.2	17.6
FIFTH	4.6	6.6	6.5	0
UNKNOWN	9.1	10.5	23.9	11.8

TABLE 5c

4. Class of attack was defined in the following way: First class, first attack and within three months on admission, Second class, first attack above three, and within twelve months on admission, Third class, not first attack, and within twelve months on admission, Fourth class, first attack or not, but of more than twelve months on admission, and Fifth class, congenital.

MALE ADMISSIONS TO VALKENBERG 1891-1920, NUMBERS RESIDENT AND PROPORTION OF THOSE RESIDENT RECOVERED OR DIED BY 31ST DECEMBER EACH YEAR

YEAR	NO ADMITTED	TOTAL RESIDENT	% RECOVERY	% DIED
1891	42	37	5.41	2.70
1892	12	36	13.89	5.56
1893	18	34	17.65	11.76
1894	14	39	12.82	2.56
1895	14	41	9.76	9.76
1896	34	59	15.25	3.39
1897	75	101	15.84	8.91
1898	92	137	23.36	9.49
1899	75	153	22.87	9.15
1900	85	150	20.66	12.66
1901	62	150	18.66	12.66
1902	88	183	16.39	8.74
1903	80	204	12.74	7.84
1904	85	216	17.12	8.79
1905	88	213	16.43	11.73
1906	73	215	14.88	9.30
1907	58	210	14.28	9.04
1908	63	216	11.11	11.57
1909	43	221	5.42	7.69
1916/8	192	443	9.70	11.51
1919	154	461	9.97	10.62

TABLE 6a

FEMALE ADMISSIONS TO VALKENBERG 1891-1920, NUMBERS RESIDENT AND PROPORTION OF THOSE RESIDENT RECOVERED OR DIED BY 31ST DECEMBER EACH YEAR

YEAR	ADMITTED	TOTAL RESIDENT	% RECOVERED	% DIED
1891	33	21	28.57	4.76
1892	15	33	3.03	0.00
1893	12	36	11.11	5.56
1894	7	37	10.81	5.41
1895	12	39	17.95	5.13
1896	34	74	8.11	0
1897	33	85	7.06	4.71
1898	57	119	10.92	4.20
1899	58	157	8.28	2.55
1900	45	163	9.95	7.36
1901	35	164	11.22	4.26
1902	50	178	8.88	7.87
1903	51	194	4.80	8.76
1904	45	185	12.24	3.78
1905	50	192	9.48	5.21
1906	45	186	9.28	4.84
1907	37	194	5.83	4.12
1908	41	197	8.51	6.09
1909	33	207	3.91	2.90
1916/8	110	370	7.29	7.29
1919	107	362	12.98	8.28

TABLE 6b

RACIAL CATEGORISATION OF ADMISSIONS TO VALKENBERG 1916-1918, NUMBERS IN EACH CATEGORY RESIDENT AND PROPORTION OF THOSE RESIDENT RECOVERED OR DIED BY DECEMBER 31ST 1918

RACE	ADMITTED	TOTAL RESIDENT	% RECOVERED	% DIED
ME	115	378	10.84	10.84
FE	92	370	7.29	7.29
MC	70	59	1.69	16.94
MN	7	6	16.66	-

TABLE 6c

RACIAL CATEGORISATION OF ADMISSIONS TO VALKENBERG 1919, NUMBERS IN EACH CATEGORY RESIDENT AND PROPORTION OF THOSE RESIDENT RECOVERED OR DIED BY DECEMBER 31ST 1919

RACE	ADMITTED	TOTAL RESIDENT	% RECOVERED	% DIED
ME	126	382	11.78	10.47
FE	107	362	12.98	8.28
MC	23	70	1.42	11.42
MN	5	9	-	11.11
MI	1	-	-	-

TABLE 6d

SUMMARY OF 1,803 TOTAL ADMISSIONS TO VALKENBERG 1891-1909, INCLUDING 190 TRANSFERS: PERCENTAGES IN EACH CATEGORY.

	M	F	T
Recovered	36.2	35.2	35.8
Relieved	10.0	10.4	10.2
Not Improved	11.3	7.5	9.3
Died	22.2	17.2	20.0
Remaining	20.3	29.7	24.7

TABLE 7a

INITIAL DIAGNOSES OF VALKENBERG SERIES[5]

DIAGNOSIS	WHITE MALE	WHITE FEMALE	BLACK MALE	BLACK FEMALE
	n = 110	n = 76	n = 46	n = 16
Mania	8.2	2.6	28.3	18.8
Melancholia	8.2	4	6.5	6.25
Dementia praecox	25.5	32.9	21.7	31.3
Manic-depression	9.1	25	2.2	18.8
Hebephrenic	10	0	2.2	0
Presenile delusional insanity	2.7	2.6	4.4	0
Epilepsy	8.2	11.8	2.2	0
Alcoholic	1.8	1.3	0	0
GPI	5.5	0	0	0
Dementia senile	4.6	4	0	12.5
Dementia paranoid	6.4	0	6.5	6.25
Imbecile/ idiocy	5.5	2.6	15.2	6.25
Feebleminded	0.9	4	10.9	0
Psychopathic	1.8	2.6	0	0
Other organic	0.9	2.6	0	0
Not given	0.9	2.6	0	0

TABLE 8a

5. For changes made to diagnoses after admission, see details of case series, Appendix 1.

APPENDIX 3

Examples of forms and certificates used in lunacy administration

1891 - 1920

Certificates, Statements, &c., in regard to

Annie B

[Registered No.* 76]

(1). MEDICAL CERTIFICATE (A).

a. Name in full. I, the undersigned,a Julius Petersen

being a duly licensed Medical Practitioner in this Colony, and in actual practice, hereby certify that I, on the 15 day of Jan 1892,

b. Town or place. atb Woodstock, in the district of Cape

c. Name in full. separately from any other Medical Practitioner, personally examinedc Annie B

d. Residence. e. Occupation. of Woodstock d

School girl and that the said A

is a person of unsound mind, and a proper person to be taken charge of and detained under care and treatment, and that I have formed this opinion upon the following grounds, viz.:—

f. 1. Appearance. 2. Conduct. 3. Conversation. 1st. Facts indicating Insanity or Idiocy observed by myself.f

Excited appearance, strange conduct afraid of people, wants to run away. Conversation incoherent & rambling cannot converse rationally says there are living things in her bowels which are eating her, & puts them by devils etc. etc.

g. State the information, and from whom. 2nd. Facts indicating Insanity or Idiocy communicated to me by others.g

Her Aunt informs me that she has to be watched, wants to run away from home occasionally violent, & says she will take her own life

(Signed)

Dated this 16th day of January, 1892, at Capetown

NOTE.—The medical gentlemen certifying must not be assistant one to one another, nor in partnership with each other, and are requested to state the facts upon which their opinion has been formed; e.g., delusions (specifying the nature of the delusions), incoherence, imbecility, fatuity, alteration of conduct and affections, dirty habits, &c.

Two independent Certificates are required in each case, except in a case of emergency, and must be transmitted, together with the statement annexed, duly filled up to the Medical Superintendent of the Asylum, or the patient will not be admitted.

* To be filled in by Superintendent of Lunatic Asylum.

648—24/1/23—10,000

MAGISTRATE 16 MAR 1923 CAPE TOWN

MENTAL S. 2.

MEDICAL CERTIFICATE UNDER THE MENTAL DISORDERS ACT, 1916.

[*Sections* 6 (1), 8, 9 (1), 27 (2) *and* 32 (3) *and General Regulation* 24.]

I, the undersigned, Reginald [illegible] (Name in full.) being a duly registered medical practitioner residing at Lancaster House Greenpoint do hereby certify that on the 14th day of March 1923 at 2 Osborne Villas Sea Point I personally examined Maud Mary ..., a Married (Occupation.) of 2 Osborne Villas Sea Point (Address), and am of the opinion that he is a mentally disordered or ~~defective person~~ within the meaning of the above-mentioned Act, and as such requires care, treatment, and control. *(*In cases of urgency, where it is expedient either for the welfare of the person in respect of whom the application is made or in the public interest that the said person should be placed under care and treatment before a reception order can be obtained, add:* I hereby further certify that the matter is one of urgency.) *(*Where application is being made for detention in private house, add:* I hereby further certify that it would be safe and convenient that the said person should be received and detained as a single patient under the said Act, instead of in an institution.) R.J.

*Delete and initial matter in parentheses if inapplicable.

1. The following are the facts observed by me on the occasion of the examination aforesaid, on which my opinion is based :—

That Maud Mary talks continuously in a rambling & incoherent manner, She makes accusations of immorality against her husband which I believe to be untrue.

2. In pursuance of Section 21 of the said Act, I make this further statement with respect to the said person :—

(*a*) The following facts, indicating mental disorder or defect on the part of the said person, have been observed by me on occasions other than the date of examination aforesaid (*set out date or approximate date of observation and facts observed*) ~~[illegible]~~ R.J.

(b) The following facts concerning the said person, indicating mental defect, have been communicated to me by (*set out facts communicated by other persons, together with the names and addresses of such persons*) :—

The said sister de Villiers states that she has been in Valkenberg before that she was discharged a month ago & has been mad since again. Says that she only murdered herself that she talks about a child having been murdered & that she is not able to make any sense at present days.

* Delete classes to which patient does not belong.

*(c) In my opinion the said person may be properly classified as being mentally disordered, ~~or mentally infirm~~, ~~or an idiot~~, ~~or imbecile~~, ~~or feeble-minded~~, ~~or moral imbecile~~, ~~or epileptic~~.

(d) In my opinion the factors which have caused the mental disorder or defect of the said person are the following: not known

† Insert "is" or "is not".

(e) In my opinion the said person † not homicidal.
suicidal.
dangerous.

If dangerous, in what way

(f) The following treatment has been employed for the said person in respect of his mental condition (describe treatment, if any) :—
has been at Valkenberg on previous occasions

(g) The said person's present bodily health and condition are as follows (describe bodily condition, etc., with special reference to the presence or absence of communicable disease or recent injury) appears to be in fair health but not suffering from any communicable disease

‡ See section 22, sub-sections (1) and (2).

I hereby declare that I am not prohibited by the ‡ "Mental Disorders Act, 1916," from signing this certificate.

SUMMARY RECEPTION ORDER.

[*Lunacy Act*, 1897 : *Section* 10.]

WHEREAS it has been made to appear to me (1) .... [illegible] .... (1) Insert name of Magistrate.

Resident Magistrate of the district of .... Cape ....

by information on oath, that (2) .... John [illegible] .... (2) Insert name of lunatic.

of .... [illegible] ....

is deemed to be a lunatic, and whereas (3) .... [illegible] .... (3) Insert names of medical practitioners, or practitioner (Section 9).

and (3) .... [illegible] ....

.... medical practitioners, have examined

the said (2) .... John ....

and furnished me with certificates† as to (4) .... his .... mental state : and whereas (4) Insert "his" or "her."

upon consideration of the certificates of the said medical practitioners, and after due enquiry I am satisfied that the said (2) .... John [illegible] .... is a lunatic, and

*(a) *is not under proper care, treatment, and control, and is a proper person to be taken charge of and detained under care and treatment*

~~*(b) *is cruelly treated and neglected by* (5) .... *who has care or charge of* (6) .... *and is a proper person to be taken charge of and detained under care and treatment*~~

~~*(c) *whereas* (5) .... *who has care, treatment, or control of* (6) .... *consents to the issue of the order hereby given*~~

Nota.—The clause a, b, or c applying to the case to be retained and the alternative clauses ruled out.

(5) Insert name of person in charge of lunatic.

(6) Insert "him" or "her."

I do hereby direct you (7)†† .... [illegible] .... (7) Insert designation if any or otherwise name of person to whom lunatic is to be delivered.

.... [illegible] Asylum ....

to receive the said (2) .... John ....

and to detain (6) .... him .... in (8) .... the [illegible] Asylum .... (8) Insert name of asylum or other place of detention.

for a period *not exceeding one month*, subject to such further order as may be made in regard to (6) .... him.

Given under my hand at .... Cape Town ....

this .... 27th .... day of .... February .... 19 02.

....

Resident Magistrate.

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† *In terms of Section 10 no Medical Certificate can be accepted for the purposes of this Order, unless the certifying Medical man has personally examined the alleged lunatic not more than fourteen clear days before the date of the Order.*

†† *Should it be intended with the concurrence of the certifying Medical Practitioners to commit the lunatic to some place other than an Asylum or Gaol, the Medical Practitioners should be requested to add the following clause on their Certificates :—" I further certify this case to be a suitable one for committal to the charge of [specify name and address of proposed custodian]."*

A1946.3000.1.1902.

Name of patient with Christian name at length.... Annie

Sex and Age...... about 19 years (Female)

Nation: If European, to what country belonging, how long in the Colony .... Irish (Colonial born)

If coloured, to what tribe or race belonging .... White

Married, single, or widowed.......... Single

Condition of life and previous occupation (if any)........ School Girl

The religious persuasion, as far as known.......... Roman Catholic

Whether proceeded against under Act No. 20 of 1879 or otherwise.......... no

Previous place of abode, and district.............. always at Woodstock

Whether first attack, and if not, how many previous attacks.......... first

Age, if known, on first attack.................. 19 years of age

When and where previously under care and treatment...... not treated before

Duration of existing attack.................. within five days

Whether subject to epilepsy .... no fits of any kind known

Whether suicidal.............. Yes

Whether dangerous to others.............. No

Cause of Insanity and whether hereditary.......... Hereditary

Whether friends and relatives are able to pay for maintenance in an Asylum, and if so, to what extent.......... Not able to pay

Name and address of relative to whom notice of death to be sent...... David

St Mary's Cottages Station St Woodstock

Special circumstances, if any, preventing the patient being examined separately by two medical men........ None

(Signed)........ [signature] Resident Magistrate.

Asst. for Res. Magistrate

Dated this...... 18th ...... day of ...... June ......, 1892..., at ...... Mowbray near Capetown

Note.—No patient will be received into an Asylum without this Statement being properly filled up, and if any particulars required by this Statement be not known, the fact should be so stated.

FURTHER PARTICULARS TO BE SUPPLIED BY APPLICANT AS TO PERSON IN RESPECT OF WHOM APPLICATION IS MADE.

Age ~~75~~ 60 Sex Female

Whether single, married, widowed, or divorced Widowed

Condition of life and occupation Housewife Religious persuasion D.R. Church

Country of birth Cape Province

If not born in Union of South Africa, date of arrival —

If not white South African, nationality —

If coloured, tribe or race —

Whether first attack No If not, age at first attack Not known

Number of former attacks (if any) Many Duration of present attack 3 Years

Place of abode at commencement of present attack Tokai Rd Retreat

When and where under care, treatment, or control during present attack At home

When and where under care, treatment, or control during previous attacks 30/8/16 to 8/4/17 at Valkenberg Mental Hospital

Whether epileptic or not Yes Whether suicidal or not No

Whether dangerous to others, and (if so) in what way No

Whether any near relative of said person has at any time been or now is of unsound mind, or mentally infirm, or idiot, imbecile, feeble-minded, or markedly eccentric; or has suffered or now suffers from: (*a*) epilepsy, (*b*) hysteria, (*c*) neurasthenia, (*d*) spasmodic asthma, (*e*) chorea, or (*f*) alcoholism. If so, state degree of relationship and particulars as to complaint:— Not known

RELATIVES OF SAID PERSON.

Relationship.	Name.	Address.
Daughter	Margaretha C	Tokai Rd Retreat.
Step daughter-in-law	Mrs E	Do.

In my opinion those of the above-mentioned relatives marked with a cross are in a position to contribute to the maintenance of the said person.

This application is accompanied by a medical certificate by Dr. Lippert of Wynberg, dated the* 7 day of May 1917.

Signature of Applicant.....

Magdalena Registered No. F723.

Admitted 4.5.14 District Wynberg Non-paying
Age 60. Section of Act Epileptic ~~Yes~~
Birthplace Cape Province Date of Order 12.3.14 Suicidal No
In Tvl. since Previous attack 4 Dangerous No
Race or Tribe S. African Age first Att. 58
State Widowed. Previously treated At home Causes: Previous attack
Children Duration present Att.
Domicile
Occupation Housewife
Religion D.R.Church
Friend's Address Margaret Tokai Rd Retreat

PHYSICAL. Nourishment Weight Temperature

Deformities
Scars, Injuries
Skin
Glands
Cranium
Face
Ears
Palate
} normal

Cardiovascular System. No Cornit
Pulse high tension
Arteries atheromatous

Respiratory System. Healthy

Alimentary System. Healthy

Teeth nearly all absent except a few carious roots: pyorr
Throat normal
Tongue clean, soft + flabby appearance

Urogenital System.

Urine. S.G. Reaction Albumen Sugar
Deposits
Penis Testicles
Menstruation

Nervous System.

Visus
Nystagmus nil Auditus good
Strabismus nil
Ptosis nil
Movements slow
Pupils = Outline circular Size medium
Reaction: Light, Shade, Consensual, Accommodation } very sluggish

Corneal Reflex Pharyngeal Reflex
Fundus

Speech slow, muttering & mumbling

Writing -

Mobility -

Spasms -
Atrophy -
Tremors tremors of fingers
Reflexes, triceps, supinator, patellar, Achilles, plantar, cremaster, abdominal

normal

Gait slow & tottering
Station -
Ataxia
Sensibility, touch, localization, pain, paraesthesia, thermal, muscular, vibration

-

C. S. Fluid

Summary Mental Condition.

Appearance

Psychomotor reaction

Emotional Tone

Behaviour

Impulses
Association of Ideas

Consciousness
Attention
Comprehension
Answering
Memory: Remote
Recent
Current
Impressionability
Orientation: Self
Time
Surroundings
place
Insight

Hallucinations

Delusions

Intellectual capacity

Habits

DIAGNOSIS ON ADMISSION: Manic-Depressive

After Discharge or Death

[illegible] Was in bed lying with her mouth open and I could not get any replys to my questions. She mutters to herself in a very low tone and [illegible] not make any se[nse] in what she said.

Dr. [illegible] McAteer

Silly expression. Sitting up in bed muttering to herself. Very difficult to get her to speak. When she does, speaks in almost a whisper. Speech very difficult to understand.

FAMILY HISTORY, obtained from:

Father, Father's side, Mother, Mother's side, brothers, sisters, children, consanguinity of parents, nervous, mental, physical diseases, peculiarities, habits.

PREVIOUS PERSONAL HISTORY, obtained from:

Legitimacy, birth, infancy, childhood, education, character, temperament, habits, adult life, occupation, marriage, children (legit.), accidents, convictions.

FIRST PERIODICAL REPORT ON A MENTALLY DISORDERED OR DEFECTIVE PATIENT.

[*Mental Disorders Act*, 1916, *Sections* 25 *and* 38.]

NOTE.—The first Periodical Report only should be on this form and the subsequent reports on form Mental S. 15.

Institution or other place..... VALKENBERG MENTAL HOSPITAL

Name of patient, in full..... Nathaniel

Registered number, if any..... MC 7

Section of Act under which detained..... Sect. I

Date of admission..... 12/8/05 ~~1/7/15~~ Age on admission..... ~~36~~ 25

Under which class or classes patient is properly classified..... I

Causes of mental disorder or defect..... No Fam

Whether hereditary..... No Fam

Diagnosis at present date..... Manic Depressive Insanity

Prognosis..... Below Average

Whether patient is { homicidal (1)..... No. / suicidal (1)..... No. / dangerous(1),..... No.

(1) Insert "yes" or "no."

Was admitted to

History of course of case and symptoms previous to admission.....

Robben Island 12.8.05. Diagnosed as Religious Mania. He talked very readily and did not work for money and could work for a week on faith. He had been about 1 year peculiar according to the statement of his Brother and use to wander about on the mountain side talking nonsense to himself. He had religious delusions which were intermitted. had hallucinations of sight. Attempted to escape on one occasion.

23 OCT 17

[OVER.]

History of case since admission (special reference should be made to the conduct of the patient and any acts of violence or of tendency to be dangerous to self or others)

Was transferred from Robben Island 1.7.16. appeared suspicious and continued with hallucinations of sight. He still prays for hours at nights and seems to have improved both mentally and physically of late. ~~Presenile delusional insanity~~. His bodily health is good, and works well.

Is continued detention necessary either for the patient's own good or in the public interest ..... If so, is the present institution the most suitable for treatment .....

Recommendations ..... Do remain here.

(Sgd.) .....

~~Physician Superintendent, or Medical Attendant.~~ Assistant

Instructions .....

.....

Commissioner Mental Disorders.

Place .....

Date .....

DEPARTMENT OF THE INTERIOR
13 NOV 1917
PRETORIA

Lunacy Form No. 29, Cape.
Lunacy Form No. 22, O.F.S.
Lunacy Form No. 27, Transvaal.

APPLICATION FOR AUTHORITY FOR THE TRANSFER OF A PATIENT FROM ONE ASYLUM TO ANOTHER.

I, the undersigned, A. D.Pringle.

being desirous to transfer "NATHANIEL

at present a Patient in Robben Island Mental Hospital.

from the said ~~Asylum~~ Mental Hospital to the Valkenberg Mental Hospital.

hereby request the authority of the Secretary for the Interior for such transfer; and I subjoin a Statement of Particulars regarding the said "NATHANIEL and a Medical Certificate with respect to his mental and bodily condition.

.....(1)

Actg.Physician Superintendent.

(1) State Degree of Relationship, or other capacity in which Applicant stands to Patient, and full Address.

Dated at Robben Island this 17th. day of April, 1916.

STATEMENT.

1. Christian Name and Surname of Patient at length	"NATHANIEL
2. Sex and Age	Male 36 years.
3. Nationality, whether European or Coloured	Coloured.
4. Previous Place of Abode and District ...	Wynberg.
5. Date of Admission into Asylum	12th. August, 1905
6. Whether first Attack	? Yes.
7. Age (if known) on first attack	24 years.
8. When and where previously under Treatment	----------
9. Duration of existing Attack to present date.	About 12 years.
10. Whether subject to Epilepsy	No.
11. Whether Suicidal	No.
12. Whether Dangerous to others	No.
13. Christian Name and Surname, and Place of Abode of nearest known Relative of the Patient, and Degree of Relationship (if known), and whether any member of the Family known to be or to have been Insane	Mother. Mrs.Martha Benjamin's Cottage. Wilson,Street, Wynberg. Unknown.

(2)

Dated at Robben Island this 17th. April. day of 1916.

(2) To be signed by the Medical Superintendent.

MEDICAL CERTIFICATE.

I, the undersigned, A.D.Pringle.

being a duly qualified Medical Practitioner in this Province, hereby certify that I have this day at (1) Robben Island Mental Hospital personally examined

(1) Name Asylum.

"NATHANIEL

at present a Patient in the ~~said Asylum~~ Mental Hospital, and with respect to his Mental State, I certify that He is of [illegible] mind. He is simple & childish. States he has been here a [illegible] years & wants his head cut off & get a new one on. Requires institutional care. ; and with respect to his Bodily Health and Condition, I certify that

" it is average

and I further certify that, in my opinion, there is nothing in the Mental or Bodily Condition of the Patient to contra-indicate removal to the Valkenberg Mental Hospital.

....

Dated at Robben Island this 4th day of April, 1916.

AUTHORITY FOR TRANSFER OF PATIENT.

I hereby authorize the transfer of the above-named patient from the

Robben Island Asylum

to the Valkenberg Asylum.

Secretary for the Interior.

Department of the Interior.

Pretoria, ...

5 JUN 1916

LUNACY FORM No. 1A.

ADDITIONAL MEDICAL CERTIFICATE REQUIRED IF PERSON CERTIFIED OVERLEAF IS TO BE DEALT WITH BY URGENCY ORDER UNDER SECTION 4 OF THE LUNACY ACT, 1897.

(1) Insert name in full.

I the undersigned,(1)..... do hereby certify that, on the.....19....., I personally examined ..... being the alleged lunatic named on the Medical Certificate overleaf, and that it is expedient(2)..... that .....should be forthwith placed under care and treatment in the (3).....

(2) Insert "for his [or her] welfare," or "for the public safety," as the case may be.

(3) Insert name of Asylum or Prison.

(4) Signature of Medical Practitioner.

(4).....

NOTE.—*This Certificate ceases to be valid unless the patient is admitted into an Asylum or Prison within three clear days of the date of Medical Examination.*

C.—APPLICATION FOR DISCHARGE.

PHYSICIAN

I hereby request the authority of (1).....

..... for the discharge of (2).....

..... [(2) If the patient is not recovered add: I undertake that.....shall be properly taken care of and shall be prevented from doing injury to.....self or others.]

(Signature).....

Address..... Date.....

C1.—MEDICAL CERTIFICATE.

I, the undersigned, being a registered Medical Practitioner, do hereby certify that I have this day seen and personally examined (2).....

.....and that the said person is, as to mental state: (*a*) recovered; (*b*) relieved: (*c*) unrelieved; that..... detention in an institution is, in my opinion, no longer necessary, and that..... may be safely placed in the care of (1).....

.....

I further certify that in my opinion.....is (or is not) capable of managing.....own affairs.

(Signature).....

Address..... Date.....

(1) Designate Physician-Superintendent, or Commissioner. (2) Full name of patient. (3) Delete and initial matter in brackets if inapplicable. NOTE.—The clause [(*a*), (*b*) or (*c*)] applying to the case to be retained, and the alternative clauses struck out. (4) State name, degree of relationship, or other capacity in which person in charge stands to patient, and full postal address.