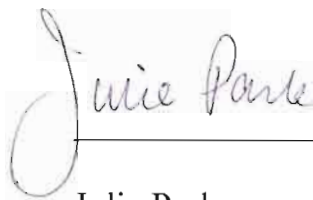


States of Mind:
Mental illness and the quest for
mental health in Natal and Zululand,
1868–1918

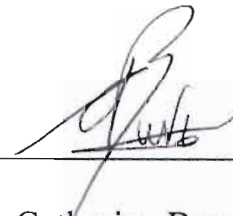
Julie Parle

A dissertation submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy in History at the University of KwaZulu–Natal
January 2004

I declare
that this dissertation has not been submitted to any other university
and
that it is my entirely own work
and
that I have given due acknowledgement of all sources.



Julie Parle



Dr. Catherine Burns
Supervisor





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*For
Steve Terry*

and

in

*honour of my parents
Judy Parle and Geoff Parle*

and

in

*memory of my grandmother
Florence Ivy Jackson (1906–1989)*

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ABSTRACT

In KwaZulu–Natal, South Africa, many of those who search for solace from mental illness draw on one or more of the three vigorous therapeutic traditions of healing to which the region is heir. Western psychiatry and its formal institutions have a long history in this region: in 1868, the Colony of Natal passed southern Africa’s first ‘lunacy legislation’; and in 1880, the Natal Government Asylum was opened on the Town Hill, Pietermaritzburg. Although founded on the precepts of nineteenth century liberalism, by 1910, the Pietermaritzburg Mental Hospital (as it was now known) increasingly reflected a national concern with a racialised ‘mental science’ and Natal psychiatry became somewhat marginalized within a broader network of national asylum administration. During World War I, too, the white citizens of Pietermaritzburg sought to have future expansion of the asylum halted, and its inmates hidden from public view. Although the story of Western psychiatry in Natal and Zululand is important for any history of mental illness in South Africa, in the nineteenth and early twentieth centuries, colonial psychiatry had relatively limited significance for the majority of people. Since the nineteenth century, African understandings of and treatments for illness have proved especially resilient, interacting with and at times adopting – and adapting – elements of Western biomedicine, as well aspects of healing strategies whose origins lie in Indian concepts of health and medicine first brought with indentured workers from the 1860s. For whites, as well as for Africans and Indians, committal to the asylum came, most typically, at the end of a lengthy quest to find a cure for mental illness. Throughout the nineteenth and early twentieth centuries, other sectors of healing proved to be remarkably flexible, offering new explanations for apparently new forms of illness – including insanity – that accompanied the political, economic and social upheavals of the time, as well as producing new therapies, strategies, and specialists to meet them. It is this variety of responses to mental illness, and ways of attempting to negotiate a path to a state of mind that might be termed ‘mental health’, that this dissertation traces.

ACKNOWLEDGEMENTS

This thesis has been a long time coming, as my family, friends and colleagues will know. To say that I am indebted to very many people will therefore come as no surprise, but, on paper at least, I should like to give some small recognition for the enormous generosity with which very many people have helped and supported me in this, as in much else.

Dr and Mrs K Fisser and Mr Roly Le Grange shared both precious memories of and sources from Town Hill with me. Without these it would not have been possible to have told some of the stories of former patients reflected in these pages, and I hope that my telling of them has vindicated their trust.

I began this dissertation when affiliated to the Department of Historical Studies at the University of Natal, Pietermaritzburg, where I was also a student in the 1980s. Bill Guest, the late Ruth Edgcombe, John Wright, Paul Thompson, and John Laband, bear, then, some of the credit – and none of the blame – for my training as a historian. Bill, Ruth, and more lately, friend and colleague, Jabulani Sithole, tried very hard to give me the time – and always the encouragement – to get on with “the PhD”. I’m very grateful. The staff at the UNP library were incredibly helpful: thanks to Carol Brammage, Jenny Aitchison and Rose Kuhn especially, but also to the desk staff who fetched and carried and reached levels I could not. Literally.

Alongside and in what at the time seemed like a parallel universe, was the time I spent as a member of Life Line, Pietermaritzburg. To say that the friendships forged there were and are essential, not only for myself, but also for, I hope, some of the insights that have sneaked through into this ‘academic’ work, is an understatement. To Afra, Alma, Ann B, Ann D, Alannah, Claudine, Debbie, Lesley, Morag, Nan, and other Core Group Members, for their unconditional listening and support, I shall be eternally thankful. The KZN Women’s Narratives Group, in its various incarnations, has also proved to be a wonderfully supportive space in which to voice my tentative thoughts and to try out my words. Thanks to Bongiwe Bolani, Catherine Burns, Marijke du Toit, Janet Giddy,

Ingrid Gouws, Mumsy Malinga, Thengiwe Magwaza, Vanessa Noble, Anne Shadbolt, Fiona Scorgie, Yvonne Slied, Louise Torr, Janet Twine, Cheryl Walker, June Webber, and Astrid von Kotze.

Friends and family who have supported me, and whom I hope will forgive my thesis-induced negligence, include: Steve Terry, Judy Parle, Brian Spencer, Geoff and Val Parle, Ann Tothill, Cheryl Lennox, Chris and Cathy Parle, Tim and Alison Parle, Cheryl, Bruce, Connor and Caitlin Stobie, Melissa Stobie and Patrick Cuddihy, Mairi-Anne and Marius Nel, Vivienne and Leon Macadam-Saad, Robert Houle, Floss Mitchell, Alix and the late Patrick Walker, Al Diesel and Mary Kleinenberg, Allison Drew, Jenny Wilkinson, Joan Gallagher, Allison Jones, the Jackson, Frost, and Matthews families, the Garlands, the Terrys, and the Sandercocks. All offered me continued interest in my issue of the moment and gave unstinting encouragement. Perhaps even more important, were the efforts to distract me when research and writing threatened to overwhelm my own state of mind.

So many people have given assistance, advice and become friends along the way: My thanks to Nsizwe Dlamini, Mxolisi Mchunu, Mairi-Anne Nel, Steve Sparks, Julian Brown, and especially the archival staff who really went out of their way to help me: Pieter Nel of the Pietermaritzburg Archives Repository must have special mention, as well as Judith Hawley, Unnay Narrine, Nisha Gopal, and Thami Ndlovu. At crucial times, several academics – far more wise than I – have commented on earlier versions of some of these chapters and given me references, encouragement, and invaluable advice that has saved me, I hope, from some embarrassing errors – Mark Coghlan, Bill Freund, Gerry Maré, Thembisa Waetjen, Philip Warhurst, Shula Marks, Jonathan Sadowsky, Lynn Thomas, Jeremy Martens, and Marcia Wright (the latter two who really rescued chapter 5, but who bear, it must be said, no responsibility for its quirks of interpretation), Karen Flint, Michael Mahoney, Vanessa Noble, Fiona Scorgie, and Helen Sweet.

I was fortunate enough to be awarded the University of Natal Doctoral Scholarship, and this enabled me to travel to conferences in the UK and the USA, where I met kindred

spirits and also got comments that have been woven into these pages. Similarly, some of the work represented here has been under the scrutiny of anonymous peer reviewers and journal editors. It is all the better for it.

Since 1998, I've been welcomed into the stimulating academic, and collegial, world of the University of Natal, at Durban, as first a student, and, more recently, as a colleague. To say that I am indebted to the generosity – whether it be the humanity, rigorous critique, or humour – of the staff and students in this department is to underestimate my respect and debt to all those who've been part of this embracing discipline. My thanks to Sandi Thomson for very many things, especially friendship, and for welcoming me into the Lunch and Book Clubs; Jeff Guy, especially for his commitment to history, to truth, and to scholarship; to Keith Breckenridge for his penetrating and insightful questions, and his patience with the departmental techno-twit; to Marijke du Toit for being a steadfast friend; and to Chad Martin, for being the devil on one shoulder, and the friend at my back. For Catherine Burns – compassionate friend, inspiring colleague, academic alchemist and dissertation midwife supreme, I thank especially for always urging me on to be bolder, and to believe that I had a contribution to make. Hers is no small gift.

One of the greatest pleasures of my time at UND has been getting to know and work with some gifted and generous students, who have not only made me welcome, but who have provided stimulation, friendship, and fun. I want to thank Prinisha Badassy, Suryakanthie Chetty, Julian Brown, Bernard Dubbeld, Nafisa Essop Sheik, Annie Devenish, Hazel Dunlevey, Musi Hadebe, Kameron Hurley, Vashna Jagarnath, Mandisa Mbali, Mxolisi Mchunu, Thami Sibiya, Stephen Sparks, and Barbara Wahlberg for making me feel at home in Durban. In this regard, thanks are due, too, to Steve Kotzé, Jason Barber, and Sonya Keyser.

Dissertations have a way of wrapping themselves around one's life. And vice versa. I have some special debts to acknowledge in negotiating the tricky balance this requires. To Mike Mahoney: for showing that friendship across boundaries is not only necessary,

but also, sometimes, possible. To Steve: for being there. Always. And to Mum: for believing in me right from the start.

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INTRODUCTION

In 1868 the government of the Colony of Natal passed southern Africa's first legislation that formalized the detention of persons 'dangerously insane' or 'of unsound mind'.¹ In 1880, nearly sixty such people were admitted to the newly constructed Natal Government Asylum, on the Town Hill, then on the outskirts of the capital city, Pietermaritzburg. Today, more than four hundred psychiatric patients are still accommodated at what is now called Town Hill Hospital. A second psychiatric facility in the city – at Fort Napier – took in patients from 1927.

The long history of psychiatry in Natal and Zululand has generally been overshadowed in the literature by that of the Cape Colony, but mid-nineteenth century Cape legislation for the certification and confinement of the mentally ill drew on the precedents set by the Natal Custody of Lunatics Law (No.1) of 1868, as did the later laws of the Orange Free State and the South African Republic.² The Cape also lagged behind in asylum construction: lunatics were first detained in gaols and hospitals and on Robben Island, and it was only with the opening of Valkenberg Asylum, which initially accommodated white patients only, in 1891, that a hospital designed specifically for mental patients was opened in that colony. While the Cape was the crucible for the development, by some colonial psychiatrists, of psychiatric theory and practice premised on grounds of racial difference, in Natal, although accommodated in different wards and receiving different food rations and subject to different disciplines, black and white patients were only finally fully segregated in the 1970s.

¹ Natal Custody of Lunatics Law (No.1) of 1868, 'To make provision for the safe custody of persons dangerously insane, and for the care and custody of persons of unsound mind'.

² This dissertation is concerned with the area that today is covered by the province of KwaZulu-Natal, South Africa. Although Zululand was only formally annexed by the Colony of Natal in 1897, British-colonist political and administrative control over the territory had been expanding steadily since the Anglo-Zulu War of 1879. Even before full administrative control of the Zulu territory had been achieved, however, some certified lunatics had been sent from Zululand to Pietermaritzburg and detained there. Moreover, Africans in Natal and Zululand had a shared linguistic, cultural and therapeutic heritage. I have referred to Natal and Zululand separately only where the distinction between the two has seemed pertinent, but have not made this explicit at every juncture.

Nor did Natal-based colonial psychiatrists contribute directly to the early elaboration of a specialist body of knowledge that associated insanity with race.

By 1910, the Natal Government Asylum (hereafter, NGA) accommodated more than 600 patients; only Pretoria had greater numbers. The Medical Superintendent of the NGA since 1882, Dr. James Hyslop, was one of the most respected 'mental specialists' in South Africa, and Pietermaritzburg remained a favoured posting for Assistant Medical Superintendents, who after Union were rotated around the country's mental hospitals. By 1918, the NGA had 797 patients, only 355 of whom were classified as 'white' or 'European'. Indeed, since the 1890s, black – African and Indian – patients had been in the majority at the NGA.

For these reasons – the early lunacy legislation and provisions for the accommodation of the insane; the numbers of patients admitted to the NGA; the long and influential career of James Hyslop – a study that charts the first fifty years of the profession of psychiatry in this region seems warranted. My intentions when I began my research were to do just that, to place the history of the institutionalisation of insanity in colonial Natal alongside those of similar institutions in southern Africa. In so doing I hoped – and still hope – in this dissertation to contribute to the small but growing number of histories of Western psychiatry and colonialism in this region. As such, I follow the path set by Megan Vaughan, Lynette Jackson, Harriet Deacon, Sally Swartz, Felicity Swanson, Shula Marks, Tiffany Jones, and others, in basing their studies on particular southern African asylums.³

³ Amongst others: M. Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Era' in *Journal of Southern African Studies*, 9, 2 (1983); H. Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910' (Ph.D. dissertation, Cambridge University, 1994); S. Swartz, 'Colonising the Insane: Causes of Insanity in the Cape, 1891-1920' in *History of the Human Sciences*, 8 (1995), 'The Black Insane in the Cape, 1891-1920' in *Journal of Southern African Studies*, 21, 3 (1995), 'Changing Diagnoses in Valkenberg Asylum, Cape Colony, 1891-1920: A Longitudinal View' in *History of Psychiatry*, vi (1995), and 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920' (Ph.D. thesis, University of Cape Town, 1996); F. Swanson, 'Colonial Madness: The Construction of Gender in the Grahamstown Lunatic Asylum, 1875-1905' (History Honours thesis, University of Cape Town, 1994) and "'Of Unsound Mind": A History of Three Eastern Cape Mental Institutions, 1875-1910 (unpublished M.A. Thesis, University of Cape Town, 2001); for Pretoria, Fort Beaufort and Queenstown Mental Hospitals (the latter was opened in 1922), see Robert Edgar and Hilary Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a*

A history of the NGA has the potential, too, to make a contribution to the scholarship of imperialism and madness more broadly, in that the continued accommodation of African, white and Indian patients at the asylum – or, as it was later termed later, mental hospital – for very nearly a century means that the Natal institutional experience of the management of the mad from all racial, class, ethnic and gender backgrounds has been more sustained than anywhere else in the region, if not unique in the British Empire.

While this study draws many parallels with studies of asylums, imperial medicine and insanity elsewhere – most especially in India, Nigeria and in the Cape Colony – it also seeks to highlight the ways in which the specific context of nineteenth and early twentieth century Natal and Zululand shaped, and constrained, the formal practices of colonial psychiatry. For example, asylums in Australia and Canada were not required to cater for large numbers of indigenous inhabitants. In contrast, in Natal and Zululand, white settlers were always in a minority *vis-à-vis* Africans, and, there was from the late nineteenth century, an immigrant Indian population of more-or-less equal number to settlers. Not only did the asylum have to come to reflect, in part, the race, class and gender dynamics of colonial Natal, but psychiatrists had no option but to acknowledge the limitations of their profession.

Nineteenth century Natal differs too from other imperial states with small settler populations. In India, for example, asylums were seldom racially-mixed, and the European mad who found themselves in the midst of the Raj were ultimately repatriated to their metropolitan points of origin. In Sierra Leone, Nigeria, Southern Rhodesia, and

Twentieth-Century South African Prophet (Johannesburg: Witwatersrand University Press, 2000); Shula Marks, "Every Facility That Modern Science and Enlightened Humanity Have Devised": Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910', in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999); L. Jackson's 1997 Columbia PhD dissertation is currently being reworked for a book publication entitled *No Asylum: The Social History of the Ingutsheni Mental Hospital and the Social Order in Colonial Zimbabwe*. See also, T. F. Jones, 'Prospects of a Progressive Mental Health System in 1940s South Africa: Hereditarianism, Behaviourism and Radical Therapies', paper presented at the Workshop on South Africa in the 1940s, Southern African Research Centre, Kingston, Canada, September, 2003. Jones's focus is on Tara Hospital in Johannesburg, which opened in 1946.

in Nyasaland – the asylums of which have been the focus of several important studies – the settler or colonial administrative population remained tiny, and the institutional setting for asylums was differently oriented, towards the custodial care of Africans, rather than of whites.⁴

Even in the context of South Africa, more narrowly defined, the history of the NGA, although in many ways following a very similar trajectory to that already charted by scholars who have written about asylums in the Cape and in the Transvaal, existed within a different nexus of relationships, constraints and possibilities. Its most influential early figure, for example, Dr. James Hyslop, was highly-regarded in elite colonial circles and was in no small part responsible for the prestige of the institution over the three decades that he was its Physician Superintendent. This meant that, by Union in 1910, the NGA was on a better footing than its Cape counterparts. Natal, too, appears to have been less than enthusiastic in implementing measures of thorough-going racial segregation of its legally-defined lunatics, and there were never any plans to construct a whites-only facility, such as Valkenberg in the Cape. Instead, following an *ad hoc*, pragmatic, though certainly discriminatory, process, by 1914, the NGA was effectively three – racially divided – institutions on the same grounds, under one management, and still overseen by one Physician Superintendent and his professional and nursing staff.

There is therefore a story to be told about the history of the NGA. But, while I have here gone some way towards redressing the gaps in the history of psychiatry in Natal and Zululand between the mid-nineteenth century and World War 1, this dissertation has somewhat different – and broader – aims. There are two main reasons for the widening of the scope of my study to encompass not only mental illness, but also mental health. The first relates to matters of methodology, for unlike the large amount of surviving evidence from the Cape asylums, very few NGA patient records have survived. This has placed severe limitations on attempts to construct either a clinical

⁴ See the section ‘Asylums in Africa: the creation of a colonial psychiatry’ later in this Chapter for fuller references to studies of asylums elsewhere in Africa.

or a social history of the experience of those legally deemed to be insane in colonial Natal and Zululand.⁵

Secondly, and perhaps more importantly, I attempt to address recent challenges to the significance of Western medicine – including psychiatry – its theory, practices, and its institutions, in the late nineteenth and early twentieth centuries. These recent critiques are of both the early triumphalist narratives of the heroism of early psychiatrists, and of the highly influential view from the 1970s onwards of medicine – and perhaps especially psychiatry – as an agent of social control. Responding to the social constructionist and Foucauldian views of modern psychiatry as a means of disciplining and neutralizing the troublesome and the socially marginal, questions have been raised about the extent of the influence of psychiatry and its practitioners outside the walls of the asylum. The role of the state, too, in initiating a ‘great confinement’ has also come under heavy fire from historians who have not restricted their research to the formal institutionalisation of asylum inmates, but who have researched the social history of madness.

In colonial societies such as Natal the limits to Western medicine and knowledge can be pointed to particularly clearly. As historian Karen Flint has recently described, the region is heir to three vigorous ‘therapeutic traditions’.⁶ African understandings of and treatments for illness have proved especially resilient, interacting with and at times adopting – and adapting – elements of Western biomedicine, as well aspects of healing strategies and remedies whose origins lie in Indian concepts of health and medicine first brought with indentured workers from the 1860s. Rather than seeking a cure for mental or bodily illness from Western psychiatrists, the majority of people

⁵ It is not my intention to attempt to establish the ‘reality’ or otherwise of individual instances of insanity. There are formidable obstacles to such an enterprise, including the changing definitions of categories of mental illness over time, the possibility that new forms of mental illness have arisen or, alternatively, disappeared, and the impossibility of unproblematically penetrating through the discursive constructions of madness by doctors and others. The thesis is concerned less with the constructions and elite identifications of insanity than with the attempts to cure or manage those who showed what their society recognized as madness.

⁶ K. E. Flint, ‘Negotiating a Hybrid Medical Culture: African Healers in Southeastern Africa from the 1820s to the 1940s’ (unpublished PhD dissertation, University of California, Los Angeles, 2001).

have historically first explored the options available in terms of the idioms and practices with which they were most familiar.⁷ It was usually only as a last resort that those exhibiting signs of insanity were certified and admitted to the NGA as a lunatic. For whites, as well as for Africans and Indians, committal to the asylum came, most typically, at the end of a lengthy quest to find a cure for mental illness, and in so doing, to attain a state of mind that today we would term mental health.

One of the major themes of this study, then, is to show just how tentative was the reach of Western psychiatry in Natal and Zululand in the five decades between the passage of the 1868 Natal Lunacy Act and the end of World War 1. Indeed, I argue that, far from being the dominant institutional or even discursive space where those experiencing distressing or disturbing states of mind, and those who attempted to help, console, cure or control them, met, colonial psychiatry – which was closely associated with asylum practice – was of limited significance.

More accessible, and for a long time, far more acceptable, were the strategies and therapies that Western biomedicine sought to displace. Throughout the time period I cover (and beyond), whites continued to administer proprietary medicines or to attend services promising to bring about a cure through faith healing; Africans consulted therapeutic experts who could diagnose mental ailments by identifying a troublesome spirit, but they also approached asylum authorities to take deeply disturbed family members off their hands; and Indians eschewed Western medicine at times, but also embraced elements of both indigenous African and Western healing therapies. In this story of medical pluralism, the NGA and its associated treatments and regimes gained legitimacy – and moved into the foreground for those seeking a path to mental health – only slowly, and unevenly. For instance, by 1918, people in the grips of some states of mind – being suicidal was one – were accepted as being more properly psychiatric patients than criminals: but this process occurred at different times for different

⁷ I touch on ‘Boer’ or ‘Dutch’ remedies in Chapter 4, but do not look at this therapeutic tradition in any depth as the treatments were usually self-administered and there is very little evidence in my sources of their use for mental illness. In the nineteenth century, Boer and, later, Afrikaner medical concepts and treatments had much in common with those practiced by Africans and do not fall neatly into either a ‘European’ or an ‘African’ therapeutic tradition.

'conditions' as well as for different groups of people, and in ways that were often associated with supposed racial and class proclivities. Nor, by 1918, had the strong stigma that being an asylum patient almost inevitably aroused abated significantly, and this, the psychiatrists of the early decades of the twentieth century believed, remained a severe hindrance in their efforts to cure mental illness, evidence of a rise in which, it was feared, pointed to a threat to the new state of South Africa.

Mental illness, mental health, and the 'three sectors of healing'

In using the term 'mental health' in relation to nineteenth and early twentieth century Natal and Zululand, a number of caveats need to be borne in mind, however. Firstly, the very concept of 'mental health' as a self-conscious sub-category of more general health is a relatively recent construct.⁸ Secondly, it proposes a model for understanding psychological distress that rests upon a particular construction of the relation between mind and body. In the West, from the eighteenth and nineteenth centuries, scientific medicine significantly expanded its claims about its ability to isolate, explain, and cure diseases and disorders of the mind. This rationalist epistemology that increasingly insisted on the material origins of illness within an individual, and on a distinction between the somatic and the psychological, did not necessarily lead to a smooth uniformity of therapies however, and what we may term 'Western psychiatry' was characterised by contestation between competing models and practitioners. Moreover, and as this study will show, the adoption of biomedicine,

⁸ S. Fernando, *Mental Health, Race and Culture* (Houndmills, Basingstoke and London: Macmillan and MIND Publications, 1991). Terminology was fluid throughout the nineteenth and early twentieth centuries. In Natal, the Natal Government Asylum (NGA) was, for a short time, known as the Natal Government Lunatic Asylum, and from around 1900 the NGA became known as The Pietermaritzburg Mental Hospital, and, later simply as Town Hill Hospital. The terms 'madness', 'lunacy', 'mentally ill', 'insane', 'mentally diseased', 'mentally defective', 'mentally disordered', 'psychiatric', and so on, reflected changing notions of the underlying causes of mental disease, although they were often used interchangeably. In the NGA records, medical personnel initially used the term 'insane', while the later records also refer to 'mental disorder'. Furthermore, contemporary records, including those of the colonial government, NGA correspondence and patient records, and published Blue Book Statistical Tables use the then current terminology of 'Europeans', 'Natives', and 'Indians'. In 1918 the category 'Coloured' was also used in the tables. Because of the indeterminacy of these racial classifications, it has been decided to retain the terms given in the records. That they are now unacceptable is acknowledged, and their use in this study is not intended to be offensive. This is also the case with such terms as 'epileptic', 'paralytic', 'idiot', and so on.

including psychiatry, as a naturalised 'first choice' in the battle against madness, was as much the outcome of processes of historical change for whites in this region, as it was for Africans and Indians.

A third important comment on a model that appears to set up 'mental health' and 'mental illness' as discrete states of mind, points out that this may be seen as problematic in that it

does not provide a neutral stance from which to analyse or represent the way 'other cultures' conceptualise disorders of the person and social behaviour. To begin with, the boundary between disorders of the mind (the province of psychiatry and neurology) and of the body (the province of internal medicine) is itself a cultural construction which underlies the segmentation of a class of illness we refer to as 'mental'.⁹

As Suman Fernando and others have shown, Western biomedical models of psychiatry are unusual in terms of world cultures in that they posit a strict separation between parts of the self, determined as 'mind', 'body', 'spirit/soul'. In this frame, wellness and illness have increasingly been seen in terms of purely physical phenomena, which can only be treated through medical expertise. Cultures beyond the West, however, it is suggested, have resisted the mind-body dualism, with significant implications for explaining the origins and healing of disease.

Yet, I would argue that, sufficiently contextualized and defined, the concepts of mental illness and mental health are useful ones in that they reflect shorthand expressions now widely acknowledged (if imprecisely articulated) of a universal human concern with 'illness as an area of problematic human experience'.¹⁰ For it is important to recognise that *all* societies have therapeutic systems – sets of beliefs and practices – designed to alleviate suffering. These systems may not all have the same definitions of illness or necessarily similar explanatory models of the origins of the discomfort, but all societies recognise behaviours and actions that are deviant,

⁹ Fernando, *Mental Health, Race and Culture*, p.2. Here Fernando is quoting G. M. White, 'Ethnographic Study of Cultural Knowledge of "Mental Disorder"', in A. J. Marsella and G. M. White (eds.) *Cultural Concepts of Mental Health and Therapy* (Dordrecht: Reidel, 1984), pp. 69-95.

¹⁰ This phrase is taken from Fernando, *Mental Health, Race and Culture*, p. 65.

unacceptable, or threatening, and have concepts of normality and abnormality. It is the nature of that 'normality' that is context and culture specific.

Conversely, all societies have a concept of desirable states of being that are characterized by 'something wider than the absence of mental illness'. Used in this sense:

“mental health” is a rubric, a label which covers different perspectives and concerns such as the absence of incapacitating symptoms, integration of psychological functioning, effective conduct of personal and social life, feelings of ethical and spiritual well-being and so on. But culture determines both the perception and level of concern in the case of each of these qualities.¹¹

Western societies, for example, tend to be highly concerned with the individual and autonomy, whereas, Fernando and others suggest, many Asian, African and 'other' cultures tend to play down a concern with the individual in favour of a concern with social relationships. Indeed, it has now become somewhat of an orthodoxy to stress that African therapeutic systems emphasize 'collective, social responses to afflictions' rather than individualistic diagnoses and treatments.¹²

A further and significant value of this broad concept of 'mental health', as I see it, is that it permits us to reject strict dichotomies between mental illness (insanity, deviance, pathology, madness) and a clearly-defined and recognizable state of health. Instead, psychological distress may be expressed in a variety of different forms and levels of intensity. Thus, mental illness/health should be regarded as a continuum, ranging from widely recognised and clearly named forms of deviant or disruptive behaviours ('madness') at one extreme, through to states of mind that are distressing

¹¹ Fernando, *Mental Health, Race and Culture*, p. 76. Fernando takes this quotation from Sudhir Kakar, *Shamans, Mystics and Doctors: A Psychological Inquiry into India and its Healing Tradition* (London: Unwin, 1984), no page reference.

¹² Edgar and Sapire, *African Apocalypse*, p. 46. The classic statement of the position is J. M. Janzen, *The Quest for Therapy in Lower Zaire: Medical Pluralism in Lower Zaire* (Berkeley and London: University of California Press, 1978). See also, T. Falola and D. Itavayar (eds.) *The Political Economy of Health in Africa* (Athens, Ohio: Ohio University Center for International Studies, Monographs in International Studies, Africa Series No. 60, 1992).

and even disturbing, but that do not require drastic measures (individual or collective) for their alleviation.

While the historiography of Western psychiatry is now vast, we know far less about African conceptions of mental illness and mental health in the nineteenth and early twentieth centuries, or how these may have undergone change as a result of socio-economic changes and interaction with colonialism and Christianity. What does seem clear, however, is that in south-eastern Africa, as elsewhere in the world, a range of means for the expression of psychological stress and conflict existed. Conceptually, however, Western approaches to healing have stressed divisions between mind, body and spirit – between medicine, magic and religion – and this has tended to encourage scholars to treat these as different entities: madness, witchcraft, spirit possession, and later, syncretic Christianity, for example. In so doing, there have been losses as well as gains. For instance, anthropological scholarship has done much to dispel the legacy of ignorant colonists who regarded the possession state, *uthwasa*, involuntarily experienced by African diviners, *izangoma*, as being an indication of an underlying psychopathology. On the other hand, there is a danger of romanticizing indigenous healing techniques as inherently efficacious because of their ‘cultural fit’.¹³ In societies where illness and misfortune are understood as being primarily *social* in origin, and not rooted in the individual – whether this be in psychobiology or in the individual’s relationships to others – to insist on boundaries between medicine, magic and religion is to fail to recognise the culturally and historically dynamic variety of therapeutic systems that also reflect the spectrum of mental health.

Moreover, as Leslie Swartz’s excellent overview of the relationship between mental health and culture in southern Africa today explains, there are a number of ways in which a person who is experiencing mental illness might seek relief.¹⁴ He divides mental health therapies and strategies into three ‘sectors’, though he stresses that the boundaries between them are permeable. Possibly the most recognizable of these is

¹³ For colonial misinterpretations of *utwasa*, see Edgar and Sapire, *African Apocalypse*, p. 45; for the dangers of romanticizing indigenous healing, see Leslie Swartz, *Culture and Mental Health: A Southern African View* (Cape Town: Oxford University Press, 1998), p. 88

¹⁴ Swartz, *Culture and Mental Health*, especially Chapter 4.

the professional, which today is almost exclusively associated with biomedicine, especially psychiatry and clinical psychology. As Swartz notes, 'this system is by far the most powerful in terms of budgets, degree of organization, and widespread recognition of expertise.'¹⁵ However, for most people world-wide, psychiatry is a last resort. Instead, as Swartz points out, it is in the popular sector which deals with 70 to 90 percent of 'illness episodes'.¹⁶ This sector is represented by a variety of individuals, including family members, neighbours, and support and self-help groups. It is these informal family and social networks that are the first port of call for many of us, and it is only when these fail – or when the intensity of mental distress becomes too great – that more formalized therapies may be sought. If these are thought to be necessary by far the greatest number of people turn to the third – or folk – sector. This comprises 'people who consider themselves healers by virtue of some special knowledge or quality which other people do not have.'¹⁷ Included in this sector would be 'African indigenous healers', and faith healers of any denomination.

Importantly, these 'sectors' of healing have been differently positioned at different times and in different places. The prominence today of a biomedically-based psychiatry, for instance, is a relatively recent phenomenon. In the nineteenth and early twentieth centuries, for many – including African, white and Indian inhabitants of this region – religious, spiritual, or folk healing was a first line of defence against mental illness. Even those more comfortable with the language and regimes of Western medicine often long battled their suffering within the world of the family and the walls of the home before the necessity of restraint against their own destructive impulses made removal to the asylum necessary. Some entered the asylum and found solace. Some were released, and returned, several times. For others, the resolution of their mental malady lay ultimately in their own hands, through self-inflicted death.

¹⁵ Swartz, *Culture and Mental Health*, p.78.

¹⁶ *Ibid.* This would appear to be the case across the world.

¹⁷ Swartz, *Culture and Mental Health*, p. 84.

It is this variety of responses to mental illness, and ways of attempting to negotiate a path to mental health, that this dissertation seeks, in broad outline, to trace. In so doing, it looks not only at the establishment and gradual expansion of the formal sector of professional psychiatry, but also at the continued vitality of the folk and popular sectors of healing in the period before 1918. One of the major themes of this study is the role of the NGA and Western psychiatry as an option – albeit usually a desperate and reluctantly taken one – amongst many employed in the management of madness in Natal and Zululand. However, it is also concerned to show how the other sectors of healing proved to be remarkably flexible, offering new explanations for apparently new forms of illness – including insanity – that accompanied the massive political, economic and social upheavals of the time, as well as producing new therapies, strategies, and specialists to meet them.

Psychiatry, alienists and asylums¹⁸

Part of the broader trend towards specialisation and professionalisation in medicine, Western psychiatry was forged as a distinct branch of scientific medicine in the 1800s. Thereafter followed a period of accelerating innovation as new categories of mental disease were identified, new causes of insanity proposed, and a range of new treatment regimes explored. Of central importance was a shift in both discourse and practice from ‘the custody of dangerous lunatics’ in asylums to the ‘care, control and treatment’ of the insane. The ‘madhouses’ of the Middle Ages gave way to the reformed institutions of the nineteenth century, with their emphasis on humane and ‘moral’ treatment. By mid-century, doctors of the mind – or ‘alienists’ – were increasingly confident that mental disease could be cured, or at least alleviated. The asylum was now seen as a progressive institution, ‘... indeed, the one truly effective site for the treatment of insanity.’¹⁹

¹⁸ The terms psychiatry and psychiatrist date from the early 1800s, but ‘specialists in mental diseases and disorders’ only began to use ‘psychiatrist’ widely in the 1900s. The term alienist does not appear in the records of Natal and Zululand, and in order to avoid the more cumbersome alternatives, I have used psychiatrist and psychiatry.

¹⁹ R. Porter, *The Greatest Benefit to Mankind: A Medical History Of Humanity from Antiquity to the Present* (London: HarperCollins, 1997), p. 494.

Flowing from these developments, the institutionalization of the mad was legitimated, and the authority of 'Physician, or Medical, Superintendents' to run asylums gained acceptance. Consequently, asylums were constructed in increasing numbers. It was in this context that the colonial asylums of India, Australia, and southern Africa were built. By 1900, however, the early optimism about the efficacy of reforms in asylum practices and regimes was giving way to disillusionment, as the newly built asylums were filled to overflowing. Madness, it seemed, was on the increase everywhere.²⁰

It is about this apparent increase in insanity – and the role played by the asylum in it – that debates in the history of psychiatry have been perhaps most heated. From the 1960s onwards, the anti-psychiatry movement – led by Thomas Szasz in the United States, Andrew Scull and R.D. Laing in the United Kingdom, and Michel Foucault in France – mounted a many-fronted attack on the asylum. Originating from different perspectives and concerns, this movement had three main beliefs:

mental illness was not an objective behavioural or biochemical phenomenon but a label; madness had a truth of its own; and, under the right circumstances, psychotic madness could be a healing process ...²¹

From the 1970s, feminist analyses of psychiatry added further fuel to the funeral pyre of legitimacy for asylums,²² and throughout the 1970s and 1980s it seemed clear in – intellectual and popular culture circles alike – that madness, like gender and race, was socially constructed. The asylum was the villain of the piece. A wider trend towards deinstitutionalisation that had been ongoing since the end of World War II – the result both of widespread use of psychotropic drugs, and economic imperatives – was now given further impetus.

²⁰ See E. Shorter, *A History of Psychiatry: A History of Psychiatry from the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), Chapters 1 and 2.

²¹ Porter, *The Greatest Benefit to Mankind*, p. 522.

²² For example, P. Chesler, *Women and Madness* (New York: Doubleday, 1975); M. Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (London: The Women's Press, 1979); E. Showalter, *The Female Malady: Women, Madness, And English Culture, 1830-1980* (New York: Pantheon Books, 1985).

Following the anti-psychiatry movement, critical histories of psychiatry and madness have proliferated. From the 1980s, however, many studies shifted their focus from broad over-arching theories of social control to more localised analyses of how psychiatric knowledge and practice were formed in specific locales and contexts. Such accounts frequently attempt to blend the themes of anti-psychiatry, feminist critiques, social constructionist interpretations of identity-formation, and Foucault's abstract schemata of changing epistemologies of knowledge of the mind and body. One of the most recent, James H. Mills' *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900*, clearly draws on Foucauldian notions of biopower and of the psycho-sciences in the construction of knowledge about, and surveillance and disciplining of, 'the Indian "mad"'.²³ His attention to the role of inmates' families and of the importance in the day-to-day running of the asylums by Indian orderlies and staff acts, however, as a check on those 'who still have a somewhat Fanonian vision of the colonial encounter' where medicine was fundamental to the colonial project.²⁴

Such a sense of contestation of medicine as a tool of empire is unfortunately lacking in some accounts of the history of psychiatry in southern Africa. Perhaps the most striking example is that of Alexander Butchart's *Anatomy of Power: European Constructions of the African Body*, a genealogical study of the texts and discourses that 'produced the African mind and body'. Butchart argues that it was in the asylum setting that a 'first glimpse of the African psyche as a possible object of knowledge occurred... as the effect of the psychiatric gaze to insane Africans...'.²⁵ He places and dates this 'first glimpse' precisely at 'Town Hill Hospital' in 1875. Sticking - like superglue - to a Foucauldian analysis, Butchart holds that: 'To search any earlier for signs of the African psyche is to

²³ J. H. Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900* (Houndmills, Basingstoke: Macmillan, 2000) p. 12. Thanks to Nafisa Essop Sheik for telling me about this book.

²⁴ Mills, *Madness, Cannabis and Colonialism*, p. 181.

²⁵ A. Butchart, *The Anatomy of Power: European Constructions of the African Body* (London and New York: Zed Books, 1998), p. 111. I agree that the asylums of southern Africa provided an early institutional context for the articulation of professional claims about 'the African mind', but, I would suggest, in nowhere near as comprehensive a manner as Butchart's analysis would have us believe.

toil under a delusion, for until the 1870s when special provisions were made for the identification, treatment and confinement of lunatics, the conditions necessary for its emergence had yet to exist'. True, the Natal Custody of Lunatics Act was passed in 1868, but in 1875 there was only a temporary lunatic asylum in Pietermaritzburg, and it is hard to see how the material conditions of, or medico-scientific knowledge about, lunatics in Natal - or elsewhere in southern Africa for that matter - were significantly different in 1875 than they had been a decade earlier. Butchart's approach has a certain teleology that brooks no escape or individual agency. Nor does it permit the possibility of African - and other - reshaping of Western views about medicine, psychiatry, mind, or body.

Questions of protest and resistance have, as Jonathan Sadowsky has pointed out, for the past several decades been important in the histories of both madness and of Africa. The searing anti-colonial writings of psychiatrist Frantz Fanon speak of colonialism itself as producing psychopathologies among the colonized: the swelling numbers of African asylum inmates under oppressive regimes being a direct product of the colonial condition, whether because of internalised anger or because of the complicity of psychiatry in detaining and labelling those who, in various ways, challenged the colonial order. Writers following Fanon – and with more than a nod to Foucault – such as John and Jean Comaroff, as well as Hilary Sapire and Bob Edgar – have gone on to highlight how cultural chasms could cause colonists to see some Africans as crazy, whereas the prophecies, insignia and public declamations and behaviours of such ‘mad men’ – and women – meant something very different to those who shared closer social worlds with those that outsiders deemed insane. For example, as Edgar and Sapire show, the Xhosa woman Nontheta Nkwenkwe, who was regarded by the South African state as being ‘hysterical’ and insane, commanded a large religious following amongst many Africans who believed her divinely inspired and certainly not mad.²⁶ The Tswana ‘madman’ – whom the Comaroffs met outside Mafeking – was regarded by the other patients as ‘an inspired healer.’²⁷ Even had he not been identified as a healer, for the

²⁶ Edgar and Sapire, *African Apocalypse*.

²⁷ J. L. Comaroff and J. Comaroff, ‘The Madman and the Migrant: Work and Labor in the Historical Consciousness of a South African People’ *American Ethnologist*, 14 (May 1987), pp. 191–209. The phrase appears on p. 191.

Comaroffs, this ‘madman’, with his *bricolage* clothing that combined elements reflecting different aspects of his conflicted rural–urban, peasant–proletariat world, conveyed a trenchant critique of colonialism and of capitalism: For these Western–trained anthropologists, he had ‘a message to decipher’, and in the very essence of his over–the–top, but out–of–kilter, assemblage of aspects of a changing world, could be seen as no less than ‘the voice of history.’²⁸

All this raises the knotty issue of madness *as* a form of resistance. By paying close attention to the actual utterings, claims, boasts, threats, and actions – ‘impulses or fantasies others would, literally only dream about’ – of those detained and confined as lunatics, Sadowsky shows how madness as a *social* phenomenon constituted a form of political expression. ‘The “symptoms” of Nigeria’s lunatics’, he explains, ‘and the psychiatric labels that were affixed can be understood as inchoate articulations of the stresses of colonial society.’ He adds: ‘There is, frequently, a relationship between madness and resistance to social order, even if madness does not actually constitute resistance.’²⁹ Similarly, the anthropologist Janice Boddy has shown how women’s participation in the *zār* cult in Sudan can be regarded as an expression of resistance to what would otherwise appear to be hegemonic male domination.³⁰ By extending these insights to Natal and Zululand in the nineteenth and early twentieth centuries, I hope to show that some forms of spirit possession, which both colonists and Africans themselves saw as pathological, can be regarded as critiques of a patriarchal social order that was itself coming under intense strain.

²⁸ Comaroff and Comaroff, ‘The Madman and the Migrant’, pp.191 and 193.

²⁹ J. Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley, Los Angeles and London: University of California Press, 1999), pp. 74-77, and Chapter 5. Quotations from pp. 76 and 77 respectively. Echoing Fanon’s observations, *apartheid* has often been described as ‘madness’ or ‘pathological’. See, for example, American Psychiatric Association, ‘Report of the Committee to Visit South Africa’, in *American Journal of Psychiatry*, 136, 11 (November 1979), p. 1506.

³⁰ J. Boddy, *Wombs and Alien Spirits: Women, Men, and the Zār Cult in Northern Sudan* (Madison: University of Wisconsin Press, 1989), esp. pp. 346 and 347.

In the 1990s, and in reaction to the dominance of Foucauldian-inspired studies, what the late Roy Porter and Mark S. Micale – both luminaries themselves in the history of psychiatry – call ‘Anglo-American empirical criticism’ particularly targeted the emphasis placed in discourse theory on the texts produced by doctors in constructing the categories of madness.³¹ Instead, drawing on the strengths of social history, the study of madness has moved outside the walls of the asylum, challenging the view that ‘the mental hospital replaced the family and community as the epicentre of care and control as a new regime of discipline and surveillance replaced social tolerance and individual liberty.’³² Several important recent collections of essays have focused on continuities in the history of social engagements with madness – for instance, through family and community care, private nursing, ‘alternative’ therapies, as well as the placement of family members in an asylum – rather than any stark rupture with the past.

In his typically acerbic style, Edward Shorter has remarked that: ‘the history of psychiatry is a minefield. ... The very richness of the sources makes it possible to demonstrate through selective quotation just about anything.’³³ The question of defining and identifying mental illness is likely to remain unresolved and contested, however: ‘hostage to the mind-body problem’, as Roy Porter put it, ‘buffeted back and forth between psychological and physical definitions of its object and its techniques.’³⁴ Nonetheless, whichever critical approach is used, we return again and again to the fundamental questions: who were the insane; why and how were they deemed to be so; by whom; and why?

³¹ M. S. Micale and R. Porter, ‘Introduction: Reflections on Psychiatry and its Histories’, in M. S. Micale and R. Porter (eds.) *Discovering the History of Psychiatry* (New York and Oxford: Oxford University Press, 1994), p. 23

³² P. Bartlett and D. Wright, ‘Community Care and its Antecedents’ in Peter Bartlett and David Wright (eds.) *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London and New Brunswick, NJ: The Athlone Press, 1999), p. 1. See also, J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*.

³³ Shorter, *A History of Psychiatry*, p. ix.

³⁴ Porter, *The Greatest Benefit*, p. 523.

Asylums in Africa: the creation of a colonial psychiatry

The history of psychiatry in Africa in the nineteenth and early twentieth centuries has also been substantially focused on asylums. These include Kissy Lunatic Asylum in Sierra Leone, Yaba and Aro in southwest Nigeria, Zomba in present-day Malawi, Ingutsheni in what is now Zimbabwe, as well as the asylums of the Cape Colony, at Robben Island, Grahamstown, Port Alfred, Fort Beaufort, and Valkenberg.³⁵

Writing in the early 1990s, Megan Vaughan, an important critic of the history of asylums and colonial psychiatry in southern Africa, asked the question: 'Foucault in Africa?'³⁶ In response, and with particular regard to the definition and confinement of 'lunatics', Vaughan concluded - as have many others who have grounded their research in the archive - that there was no 'great confinement' in Africa.³⁷ In this, she was a little disappointed, as the colonial setting had seemed to be a promising one for the possibilities of 'massive institutionalization for the purposes of maintaining social control'.³⁸ Instead, Vaughan comments that there were significant differences between '... the nature of the colonial power/knowledge regime and that described for Europe by Foucault'. She adds that:

(T)he medical power/knowledge complex was much less central to colonial control than it was in the modern European state. Colonial psychiatry did identify the 'lunatic' and sometimes incarcerated her or him, ... but in general the need to objectify and distance the 'Other' in the form of the madman or the leper, was less urgent in a situation in which

³⁵ L.V. Bell, *Mental and Social Disorder in sub-Saharan Africa: The Case of Sierra Leone, 1787-1990* (Westport, CT: Greenwood Press, 1991); Sadowsky, *Imperial Bedlam*; M. Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Era'; Lynette A. Jackson, "'Stray women' and 'Girls on the Move'": Gender, Space and Disease in Colonial Zimbabwe', in P. Zeleza and E. Kalipeni (eds.) *Space, Culture and Society in Africa* (Urbana-Champaign: University of Illinois Press, 1998), as well as the studies already cited by Deacon, Swartz, Swanson and Marks. Other South African mental hospitals opened in the period after this dissertation aims to cover - such as Queenstown, which opened in 1922 - and others, such as the Pretoria Asylum (also, later, called Weskoppies) feature in a number of historical studies, but there are - to my knowledge - no critical studies devoted to the histories of these institutions as such.

³⁶ M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: California: Stanford University Press, 1991), p. 8.

³⁷ Vaughan, *Curing Their Ills*, p.ix.

³⁸ *Ibid.*

every colonial person was in some sense, already 'Other'. This is a recurring theme in the literature on psychiatry in colonial Africa, in which the problem of the definition of the 'normal' and the pathologization of that 'normal' African psychology is ultimately more important than the subsequent definitions of the 'abnormal'.³⁹

Importantly, Vaughan also raises questions about the extent to which colonial medical discourses created 'subjects' as well as 'objects'. Rather than the development of the self-regulated 'speaking subject' through individualized forms of disciplinary power as described by Foucault, colonial psychiatry was concerned, in the main, with categorizing and controlling subject peoples as members of clearly identifiable *groups*. Vaughan recognises both the resilience of indigenous epistemologies of knowledge about illness, and – partially as a result of the uneven development of capitalism in Africa – the limitations of colonial power.⁴⁰

These caveats about the importance of the asylum in Africa do not mean that colonial psychiatry was without significance. Indeed, as many studies have illustrated, the evolution of scientific racism in the mid-nineteenth to mid-twentieth centuries had, as a central component, beliefs – purportedly grounded in objective scientific 'fact' – about 'the nature' and 'the character' of 'the African'. Whether inherently mentally deficient due to a smaller brain or a lower intelligence quotient, or increasingly insane as a result of deculturation arising from urbanisation and absorption into the wage economy, or possessed of an underdeveloped super-ego because of early weaning and indulgent child-rearing practices, or naturally given to outbursts of 'housemaid's hysteria', the African mind was of interest and concern to professional and lay-persons alike.⁴¹ Increasingly, 'knowledge' about the 'normal' African emphasised just how 'abnormal' and 'different' 'they' were. As Saul Dubow shows in his study of scientific racism in

³⁹ Vaughan, *Curing Their Ills*, p. 10.

⁴⁰ Vaughan, *Curing Their Ills*, p. 11.

⁴¹ For an overview of some of the ways in which 'the development of distinct disciplinary bodies of knowledge such as psychology, physical anthropology and social anthropology [contributed to] the quest to 'understand the native mind'', see S. Dubow, *Scientific Racism in Modern South Africa* (Johannesburg: Witwatersrand University Press, 1995), Chapter 6. This quotation is from p.197. Despite the obvious importance of scientific racism in the history of colonialism, segregation and apartheid, we should not forget the wider international context of the development of intellectual racism, racial prejudice, Social Darwinism, and eugenics.

southern Africa, in the late nineteenth and early twentieth centuries such beliefs became grist to the mill of segregationist discourses and practices.

From the 1880s, the first specialists in mental illness arrived in southern Africa from Britain – the majority were Scottish-trained – and attempted to reform or establish asylums that were in keeping with the most advanced institutions in Europe and the US. Themselves members of a branch of medicine that was in the process of establishing its efficacy and its legitimacy, their practices and writings have been seen by a number of scholars as contributing to the creation of psychiatric knowledge about both the colonisers and the colonised.

This process has been imaginatively and sensitively traced by Sally Swartz in her study based on Valkenberg Asylum in Cape Town in the period between 1891 and 1920.⁴² Skilfully combining a social profile of Valkenberg's patients and a discourse analysis approach of the statistical tables, committal certificates, other legally-required documentation, and patient records, Swartz shows how the history of asylums and psychiatry at the Cape – as elsewhere – was intimately bound up with the histories of class, race and gender as socially constructed categories. Further, she describes how a distinct form of psychiatric knowledge developed in the Cape:

(M)ale 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.⁴³

⁴² In addition to her work already cited, she has also published 'Shrinking: A Postmodern Perspective on Psychiatric Histories' in *South African Journal of Psychology*, 26, 4 (1995), and (with Leslie Swartz), 'Talk About Talk: Metacommentary and Context in the Analysis of Psychotic Discourse' in *Culture Medicine and Psychiatry*, 11 (1987).

⁴³ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape', p. 9. 'Universalism' in this context refers to the belief in the nineteenth and early twentieth centuries that all persons of a socially constructed group would manifest insanity in the same way, despite actual social or economic differences between members of the 'group'. Such groups were identified - by race, sex, ethnicity, or class - in terms of biological essentialism.

Since colonial psychiatry in the Cape made little or no effort to understand indigenous peoples, cultures, or understandings of mental illness. 'The Native' was therefore rendered 'unknowable' and untreatable.⁴⁴

Historians Lynette Jackson and Hilary Sapire have argued that the numbers of African asylum inmates rose largely as a consequence of South Africa's industrial revolution: 'Farm labourers, domestic servants, and urban workers whose crazed behaviours rendered them a danger to social peace were "arrested by the police, taken to gaol, and from there harried to the Asylum". ...'⁴⁵ As Shula Marks points out, however:

The incarceration of the black insane bore little relation to the labour and social control demands of an industrialising South Africa: given the far more efficient and direct ways in which capital disciplined a black work force and the small numbers of black insane who were institutionalised it would be rash to seek in these the *raison d'être* of the asylums.⁴⁶

Moreover, while the majority of African inmates were transferred to asylums from gaols after a prior arrest for disturbing or dangerous behaviours, as I shall show, it was not always the case that their committal was initiated by the state. On occasion, African families themselves applied to the police, district surgeon, or sometimes the asylum doctors directly for the committal of a volatile and sometimes uncontrollable family member who they themselves had termed 'mad'. Usually, this occurred only after some considerable time, during which they had approached local healers of various kinds, and restraints had been applied within the home.

As Marks comments, 'small, understaffed, chronically short of funds, it is difficult to see the asylum as a major agent of social control, at least of Africans.'⁴⁷ Indeed, echoing

⁴⁴ Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape', p. 8.

⁴⁵ Edgar and Sapire, *African Apocalypse*, p.39. They, and Lynette Jackson, suggest that it was African men in particular who were likely to come to the attention of the authorities, hence their numbers being vastly in excess of those of African women in asylums.

⁴⁶ Marks, "'Every Facility'", p. 271.

⁴⁷ Marks, "'Every Facility'", p. 270.

both Megan Vaughan – and Waltraud Ernst, who writes of British India in the first half of the nineteenth century – one can argue that, in South Africa there was no ‘great confinement’. The number of asylums – one in each province, except for the Cape, which in 1910 had five (Grahamstown, Port Alfred, Fort Beaufort, Valkenberg, and at Robben Island) – was small for a relatively large country (there were approximately ninety in the British Isles in 1850); and the numbers of persons confined as lunatics remained low. In 1890-1, for example, the Cape Colony, had a ‘total population of some 377,000 colonists and more than a million indigenous inhabitants, [but] fewer than 2,000 of the total were estimated to be “lunatic” or “idiotic”; of these only about a third (595) were actually in asylums, and fewer than half of these were “Coloured”.’⁴⁸ On Union in 1910, of the just under two million black subjects in the Cape, the number of registered insane stood at a little over 1,000.

The figures were similarly low in Natal. The 1904 the census recorded the following figures: whites 97,000; Indians 101,000; and 'Natives' 910,000, making a total population of a little over 1.1 million. In that year the NGA had 497 patients, of whom 218 were white, 98 were Indian, and 181 were African. By 1911, the Natal population had increased by another 85,739 persons, and the numbers of ‘total insane’ (all lunatics and idiots recorded in the census returns) stood at 1,227 – 296 white and 931 ‘Native or Coloured’, belying any mass definition of Natal and Zululand’s subjects as mad. But the figures are even more telling when we note that of these 1,227 just under half – 611 – were ‘registered insane’, in other words, in an asylum. The majority of those termed lunatics or idiots were, therefore, to be found outside the formal institutions of insanity in colonial Natal. Even more striking is the difference between the total and registered number of black insane persons: 931 to 361.⁴⁹ This large discrepancy clearly shows – as

⁴⁸ Marks, ““ Every Facility””, p. 271

⁴⁹ Figures – rounded off – are from SC. 14- '13, *Report of the Select Committee on Treatment of Lunatics*, May 1913 (Cape Town: Cape Times Limited, Government Printers, 1913), Tables G and H. There is a discrepancy – of 11 - between the number of white ‘registered insane’ and the number of white patients listed at the NGA at the end of 1911: this could reflect the difference between the numbers on the census date and at the end of the year. The Select Committee tables do not distinguish between African and Indian patients, but the NGA records give the numbers in 1911 at 261 white, 122 Indian, and 239 African. The proportion of the registered insane to per 10,000 population was listed as: White Males, 26.5; White Females, 24.07; Black Males, 5.4; Black Females, 1.4.

I shall discuss in more detail in Chapter 4 – that the situation in Natal was very like that of the Cape, and indeed the rest of South Africa, where ‘the vast majority of the mentally ill ... were nursed at home, within their families or, in the case of the homeless destitute, the difficult or dangerous, in small country gaols.’⁵⁰

The limits to psychiatry in Natal and Zululand, 1868-1918

The early lunacy legislation in Natal predated the impact of the mineral discoveries, and rather than being designed to nullify the growing numbers of African insane that were endangering the social order, it was passed at a time when economic depression had made poverty amongst white settlers publicly visible for the first time. Prompted by an imperial government that saw the provision of hospitals and lunatic asylums as an essential component of civilised, enlightened modernity, the Natal colonial government was always primarily concerned with insanity amongst whites, though this same liberal ideology meant that exclusions could not, overtly at least, be made in the name of race.

In relation to colonial southeast Asia, Ann Laura Stoler has argued that ‘European’ self-definition, and by implication, power, was perceived as being threatened by people who by entering into relationships of sexual and emotional intimacy with those other than their own ‘blood’, ‘ambiguously straddled, crossed, and threatened the imperial divides’. She describes how such interracial unions and their ‘mixed-blood’ progeny were an affront to the ‘interior frontiers’ of national identity.⁵¹ The policing of white sexuality was thus essential for the preservation of national, racial, and colonial boundaries. As Sally Swartz has described in her study of colonial psychiatry at the Cape: ‘In the colonial context, fear of insane women’s unruly, reproducing,

⁵⁰ Marks, “‘Every Facility’”, p. 271.

⁵¹ A. L. Stoler, ‘Sexual Affronts and Racial Frontiers: European Identities and the Cultural Politics of Exclusion in Colonial Southeast Asia’, in A.L. Stoler and F. Cooper (eds.) *Tensions of Empire: Colonial Cultures in a Bourgeois World* (Berkeley, Los Angeles and London: University of California Press, 1997), pp. 198-199. For southern African illustrations of the policing of white sexuality, see J. McCulloch, *Black Peril, White Virtue: Sexual Crime in Southern Rhodesia* (Bloomington and Indianapolis: Indiana University Press, 2000); and J. Martens, “‘Almost a Public Calamity’: Prostitutes, “Nurseboys”, and Attempts to Control Venereal Diseases in Colonial Natal, 1886-1890’, in *South African Historical Journal*, 45 (2001), pp. 27-52.

bleeding or lactating bodies was closely linked with anxiety about racial borders and racial purity.’⁵² In addition to the fears that insane women in the West would be conduits for the dilution of class barriers, as well as the potential mothers of mentally enfeebled children thus threatening the vigour of the nation, in colonies where settlers were in a minority, white women were regarded as particularly vulnerable to the stresses and strains of ‘civilisation’, rendering them too weak to preserve the social distance necessary for the maintenance of colonial social – and power – relations.⁵³

Insanity coupled with race thus took on dimensions that were focused somewhat differently from those in the Western metropole: black men and women who refused to restrict themselves to the ‘appropriate’ social niches that colonial society assigned to them could be regarded as mad; but so, too, were white men and women who similarly forgot, disregarded or rejected the niceties of their social status and racial milieu. An illustration of the allocation of the label insanity to a black man whose supposed pathology in part lay in his refusal to observe social propriety is Robert Tabete, who was arrested near Newcastle, Natal, just before Christmas 1916. His committal papers to the NGA noted that he ‘... talks at random, and interrupts [the] conversation of white people.’⁵⁴ Race, sexuality, and insanity were also anxiously watched, and white women who crossed class and racial boundaries were sometimes labelled mentally unstable. In 1899, for example, one such woman – who was reported to be living ‘immorally’ as she had three children by black men – came to the attention of the law. Despite a Natal District Surgeon’s report to the contrary, the Attorney General was of the opinion that ‘it is difficult to believe that the woman is sane’. He later instructed the local magistrate to ‘... warn her that she will be confined to the Asylum if she does not behave herself.’⁵⁵ The threat was half-hearted, however, and not carried out. Indeed, in order to

⁵² S. Swartz, ‘Colonialism and the Production of Psychiatric Knowledge in the Cape’, p. 101

⁵³ Swartz, ‘Colonialism and the Production of Psychiatric Knowledge in the Cape’, p. 113.

⁵⁴ Pietermaritzburg Archives Repository (hereafter PAR) Registrar Supreme Court (RSC) 1/27/1 R.S.C.N (M) 12/16, ‘Robert Tabete’. Form ‘Mental S.2: Medical Certificate Under the Mental Disorders Act, 1916’, certified by Reginald T. Vaughan, Registered Medical Practitioner, Newcastle’, 22 December 1916.

⁵⁵ PAR Colonial Secretary’s Office (CSO) 1635 1938/1889, Attorney General to Colonial Secretary, 3 March 1899.

put in perspective the role played by the state, including the asylum doctors, in confining certain categories of persons for madness, it is important to analyse a setting wider than of the asylum. The middle chapters of my study attempt to do this, and show that it was the families of the insane who were often the initiators of the process of committal, but only under circumstances and at a time when they themselves were forced to relinquish the care or control of the deranged person. Thus, the emphasis on the apparently high number of 'dangerous' white women admitted to colonial asylums can be seen as reflecting not so much the self-conscious need of a colonial state or its class and professional elites to patrol the social borders, but of the extent to which disturbed, but not – or, not yet – violent women were cared for within the home.

Waltraud Ernst has described that, in nineteenth century India, the European insane were similarly potential transgressors of class and racial borders, and early asylum construction by the East India Company was largely in response to the need to prevent the undermining of the colonial image – of and to itself – of fitness to rule.⁵⁶ These asylums were interim measures, however, as British subjects who had gone mad were sent back to Britain, where they would be both 'out of sight and out of mind'.⁵⁷ The impetus for asylum construction in Natal also came with an awareness of a growing number of deranged and demented 'Europeans'. Unlike India, however, as a settler colony, in Natal mad whites were not repatriated. Instead, indentured Indians in Natal who were found to be unsuitable for work by virtue of insanity were returned to India to face an uncertain future there. This meant that the numbers of Indian inmates at the NGA was kept artificially low. Indians in Natal experienced enormous psychological pressures because of the harsh conditions under which they lived and worked, and, it

⁵⁶ W. Ernst, 'The European insane in British India, 1800-1858: a case-study in psychiatry and colonial rule', in David Arnold (ed.) *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988), pp.27-44. Ernst has subsequently elaborated this argument in several other articles and in her book, *Mad Tales from the Raj: The European Insane in British India, 1880-1858* (London: Routledge, 1991).

⁵⁷ W. Ernst, 'Out of sight and out of mind: insanity in early-nineteenth century British India', in J. Melling and B. Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective*, pp. 245-267.

has been suggested, the high incidence of suicide amongst indentured workers at this time was a response to the exploitation and alienation that they encountered.⁵⁸

Although this high rate of suicide was of concern to both the government in India and the colonial administration in Natal, it was not one that was regarded as a matter for psychiatry. Until the twentieth century, self-destruction was seen as a criminal offence, and at best the result of a moral failing or cowardice. Nevertheless, the history of suicide in Natal and Zululand at this time can be considered in a history of mental illness and mental health for, I would suggest, at least three reasons. Firstly, as an illustration of the limits of colonial psychiatry, for, a lack of medical interest in suicide until the early twentieth century meant that an epidemic of self-destruction amongst indentured Indians went unchecked. Furthermore, the inability of the colonial state – including its medical professionals – to police or monitor Africans meant that African suicide went unnoticed and unrecorded, helping to fuel the later notion that Africans were incapable of experiencing depression and were highly unlikely to resort to suicide.⁵⁹ Secondly, considering the relationship between Indians, suicide, and colonial medicine serves as a way to turn attention to Indians in Natal, who would otherwise be overlooked in a conventional history of mental illness that examines only the presence of the mentally ill inside the formal institutions of insanity. Thirdly, it reflects the ways in which the NGA was regarded by some of its patients and their families. For, the nineteenth and early twentieth centuries witnessed a gradual change in attitude that secularised and medicalised several ‘conditions’, including suicide and alcoholism, turning popular and psychiatric views of sufferers from perpetrators to patients. This happened only slowly, and in this region it was a process that was first associated with

⁵⁸ See, especially, S. Bhana and A. Bhana, ‘An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911’, in S. Bhana (ed.) *Essays on Indentured Indians in Natal* (Leeds: Peepal Tree Press, 1990), pp. 137-187.

⁵⁹ M.D.W. Jeffreys, ‘“Samsonic” Suicide or Suicide of Revenge among Africans’, in *African Studies*, xi, 3 (1952), pp. 118-122. Quoted in P. Bohannan (ed.) *African Homicide and Suicide* (New York: Atheneum, 1967. (Originally published by Princeton University Press, 1960), pp. 9-10. This view was strongly expressed as recently as the 1950s by J. C. Carothers, *The African Mind in Health and Disease: A Study in Ethnopsychiatry*, WHO Monograph Series No.17 (Geneva: World Health Organization, 1953), but its roots can be traced at least as far back as nineteenth century colonial psychiatry. See Fernando, *Mental Health, Race and Culture*, esp.pp. 40-50; Swartz, *Culture and Mental Health*, Chapter 5; and J. McCulloch, *Colonial Psychiatry and ‘the African Mind’* (Cambridge: Cambridge University Press, 1995).

whites, whereas Indians and Africans who attempted or threatened suicide, or who were habitually drunk in public, were more likely to be punished by a court of law.

The low numbers of Indians at the NGA can also be explained by a marked antipathy on the part of Indians in Natal towards Western medicine and its institutions, including asylums. Even as it became more acceptable for whites to spend some time at the asylum as a cure for some states of mind, there was considerable social stigma attached to being certified as a lunatic, or having a family member at the NGA. By the early twentieth century, the NGA under Hyslop was attempting to counteract this negative perception by providing better, more comfortable private facilities for what were termed 'a better class of patient'. In the context of the times, this meant an even greater degree of segregation by race than had existed before. After World War 1, this was entrenched in ways, and to a depth, that it had not been before.

The history of the Natal Government Asylum before World War 1 straddles a shift from a colonial psychiatry based on mid-nineteenth century liberal humanism, to a more explicit utilitarianism that swept away what Harriet Deacon has described as the more 'muted' forms of racial segregation of the earlier period.⁶⁰ Deacon and Marks have also usefully illustrated that far from being the trendsetters in developing theories of racial difference believed to be grounded in scientific principle, in the main colonial psychiatrists and asylum practice responded to and reflected 'the consolidation of racist social practices outside the asylum.'⁶¹ It is necessary, therefore, to be aware of the very real limits to the power and influence of psychiatrists, of their knowledge, of the reach of the profession, and of the extent to which its expertise and its asylums were linked to state interests in policing the social order. This is *not* to argue that psychiatry was irrelevant in the management of madness before 1918, however. One of the major threads of the thesis is to show that it *became* more so, and not only for white patients. Indeed, there is evidence to suggest that by the close of my period of study, some

⁶⁰ H. Deacon, 'Racial Segregation and Medical Discourse in Nineteenth-Century Cape Town', *Journal of Southern African Studies*, 22, 2 (June 1996), p. 294; and Marks "'Every Facility'", pp. 282-286.

⁶¹ H. Deacon, 'Racial categories and psychiatry in Africa: the asylum on Robben Island in the nineteenth century', in W. Ernst and B. Harris (eds.) *Race, Science and Medicine, 1700-1960* (London and New York: Routledge, 1999), p. 102.

Africans in the region regarded the asylum as not only a legitimate, if drastic, option in their strategies for coping with the insanity of family members, but also that it was the responsibility of the state to relieve them of that burden.

This study explores the formative decades of the institutionalisation of insanity in this region. In doing so, I recognise both the impact of and limits to colonial psychiatry which, at this time was almost exclusively associated with the NGA. This then begs the question of what alternatives existed for the alleviation and control of mental illness at this time. By broadening my study to include the concept of mental health – rather than a strict definition of mental illness – it is possible to consider a range of healing concepts and options that would otherwise be excluded, but which were at the time – and perhaps now too – just as, if not more, important in the quest to banish mental illness and achieve a healed state of mind. These include beliefs about spirit possession, witchcraft, the phenomenon of hysteria, the continuing popularity of folk remedies and the proliferation of commercial cures and quacks, and finally, suicide. This range is reflected in the structure of the chapters, each of which has also been strongly shaped by the available sources, both the potential and the restrictions of which are discussed.

Sources and Structure

I begin by discussing the genesis of the Natal Custody of Lunatics Act of 1868, and consider its importance for the early legislation concerned with insanity in southern Africa. The first chapter also surveys the ‘three therapeutic traditions’ that co-existed and interacted in Natal and Zululand from the mid-nineteenth century, focusing on different, yet sometimes not dissimilar, ideas of insanity. This has made for a lengthy section of the thesis, but to separate the different strands of these – in broad terms - medical ideologies would, it could be argued, produce an artificially segregated history of health and healing in the region.

Chapter 2 turns to the institutional provision for the accommodation of those deemed to be insane, first at gaols and hospitals and at a series of temporary asylums and then, from 1880, at the NGA. The expansion of the asylum and the influence of James

Hyslop are described. I also have, from the sparse remaining records, compiled a profile of the patients who were admitted to the NGA, which identifies sex and race, as well as the most common aetiologies and diagnoses ascribed to patients. This was possible only up to 1909, for after that date, it becomes more difficult to trace the history of this particular institution.

The following three chapters, in different ways, illustrate the limits to colonial psychiatry. Chapter 3 does so by pointing out that, before 1918, a number of phenomena that today would fall under the rubric of mental health were met not with medical interest, but rather with official, legalistic and often punitive, responses. In focusing on the trial for witchcraft of eleven women, who called themselves the *amandiki* after the spirit that possessed them, I am not only able to explore changing African definitions of and treatments for madness, but also the considerable area of hazy confusion that prevailed when Western notions of consciousness, culpability and insanity came up against very different understandings of the causes of illness. On the other hand, by drawing the links between gender and hysteria in both Zululand and in the West in the nineteenth century, this chapter also points to some important areas of commonality, as well as touching on questions about madness and protest.

Following the path taken by recent studies that have somewhat dethroned the asylum as the major site for the treatment of the insane, and highlighting the continuities with past practices, Chapter 4 looks at the role played by families in caring for their mentally ill, as well as the several different paths to the asylum, whether via a gaol, hospital, or private nursing home. Primarily concerned to chart the various strategies used to combat mental illness, I show that in the search for solace, colonial psychiatry appeared to have had relatively little to offer. Instead, the folk and popular healing sectors responded dynamically to the growing demand for remedies and offered cures at the hands of religious healers of many different stripes, as well as spiritualists, and entrepreneurs who packaged and posted cures for love troubles, hysteria, alcoholism, and nervous debility, amongst other ailments.

Suicide amongst indentured Indians in Natal has already received considerable scholarly attention. In Chapter 5, however, rather than focusing specifically on its high incidence, I

seek to explain why so few Indians were admitted to the NGA in the decades between their arrival in the colony and 1916, when the last period of indenture came to an end. I also argue that race, class and gender influenced the chances of a suicidal person coming to the attention of the authorities. Indian suicides could not be hidden, but attempted or successful self-destruction by Africans and whites was far less likely to become public knowledge. This, I suggest, has left us with a skewed picture of the actual incidence of suicide in the past. Nonetheless, there are sufficient archival records – albeit not systematized as they are for Indians – to show that suicide amongst Africans was not entirely a ‘taboo surrounded by silence’. In addition, the only remaining NGA patient records, a single Case-Book for ‘Europeans’, shows that desiring or attempting self-harm was one of the most common reasons why, by the first decade of the twentieth century, whites were admitted as mental patients. By this time, accommodating suicidal persons at the NGA offered white Natalians a more socially acceptable alternative than the gaol, though considerable shame continued to be attached both to suicide and to the taint of insanity.

The final chapter returns the focus to the profession of psychiatry and to the asylum, which was by then known as the Pietermaritzburg Mental Hospital between Union in 1910 and the end of World War 1. This period saw several significant changes: the Mental Disorders Act of 1916 replaced the Natal Custody of Lunatics Act of 1868; the Hyslop era came to an end; and responsibility for the management of mental hospitals in South Africa had moved to the Department of the Interior, more particularly under Dr. J. T. Dunston, the Commissioner of Mentally Disordered and Defective Persons from 1916. This marked a decisive shift towards entrenched racial discrimination, grounded in scientific racism and eugenicist policies. This was not to go uncontested, and at least one psychiatrist who had worked under Hyslop – Dr. Harry Egerton Brown – was to later challenge some of Dunston’s more extreme views. The Pietermaritzburg Mental Hospital was by no means immune to broader trends in South Africa and different facilities were provided for white, Indian and African patients. Arguments for the retention of patients of different races on one site were made, however, on the grounds of the economies that could be achieved by the utilization of black inmate labour on the asylum estate rather than for motives based on the earlier liberal humanism that had provided the context for the establishment of the NGA fifty years beforehand.

The First World War has generally been acknowledged as watershed in the history of psychiatry: with the shock of the war, male hysteria exploded into clinical and public view, psychiatrists gained in respectability because of their role in treating shell-shock, and the task of coping with traumas of returning soldiers went some way towards lessening popular prejudice against those thought to be crazy. The 1920s saw, too, the growing influence of psychoanalysis and psycho-social explanations for individual mental maladies. Wulf Sachs, South Africa's first specialist in psychoanalysis, arrived in 1922.⁶² It was also a time of the intensification in much of the world of fears of racial degeneration, and the rise of ideologies, bolstered by the apparent expertise of doctors and scientists, that justified sterilization and ultimately the extermination of those deemed to be unfit to live. For reasons that pertain both to general developments in psychiatry as well as those that relate more specifically to its history in this region, this dissertation ends in 1918.

To trace the history of the experiences of insanity among people from Natal and Zululand in the period after 1918 would be, ironically, even more challenging than for the years covered here. For, while mental matters were of some concern to the new state, the statistics that are reproduced in the annual reports of the Commissioner of Mental Hygiene (as Dunston's post was renamed in the 1920s) combine data from the different institutions around the country. Furthermore, medical practitioners increasingly claimed a respect for patient confidentiality, and so clinical records were deliberately destroyed.⁶³ On the whole – saving the infrequent eruptions in the archive where patients, or former patients, or their families, requested release or challenged the state on grounds of wrongful committal – the stories of individual patients have largely disappeared.

⁶² See Saul Dubow's introduction to Wulf Sachs, *Black Hamlet*, introduced by S. Dubow and J. Rose (Johannesburg: Witwatersrand University Press, 1996).

⁶³ National Archives Repository, Pretoria (hereafter NAR) Director of Archives (hereafter ARH) 14 C11/13/17, 'Pietermaritzburg Mental Hospital'. Handwritten note 'Vide Interiors Minute No.51/34/29 of 14/XI/1930 that records under 7 years from this institution are not to be destroyed'. In accordance with this policy, the majority of records *were* destroyed.

Even were it possible, the question of whether their stories should be exposed remains a potentially controversial one. Scholars working from a background of medicine, including psychology and psychiatry, have usually observed a concern for patient confidentiality, and have deliberately omitted the full names of the people they written about. In other historical accounts, the names of individuals branded as mad have sometimes been subtly altered.⁶⁴ In a world where, paradoxically, self-help guides and groups abound and yet there is still considerable stigma and prejudice against mental illness or even the admission of psychological frailty, this is understandable.

My study, however, is derived from many stories, with many names: with the exception of the single NGA European Case-Book that has survived, all the records I have used have been public ones. In most instances, African and Indian patients are, in the sources, given only one name. Some of the stories – such as those of Livingstone Makanya and Thomas Phipson – have been told before, and it would have been pointless to have attempted to disguise them.⁶⁵ To alter the names of the dozens of people I refer to would have been cumbersome, and to reduce them to initials would have further stripped down their identity, compounding the translation of the complex experiences of people into psychiatric ‘cases’ that histories of medicine have sought to avoid. Arguably, the sympathetic retelling of the suffering borne by such people, and their search for solace, can contribute to a lessening of the marginalisation of the mentally ill both in the historical record, and in the present.

⁶⁴ Sally Swartz and Jonathan Sadowsky both use first names and an initial for the surname of the psychiatric patients they refer to. Shula Marks, in her *Not Either An Experimental Doll: The Separate Worlds of Three South African Women* (Durban and Pietermaritzburg: Killie Campbell Africana Library and University of Natal Press, 1987), has given Lily Moya a name that is close to, but not, her given name.

⁶⁵ For Thomas Phipson, see R.N. Currey (ed.) *Letters and other writings of a Natal Sheriff, 1815-1876, Selected and introduced and edited by R.N. Currey*, (Cape Town: Oxford University Press, 1968); and for Livingstone Makanya, M. McCord's *The Calling of Katie Makanya* (Cape Town: David Philip, 1995). My thanks to Jeremy Martens for drawing my attention to Phipson's story, to which I shall return several times throughout this study.

Chapter 1

‘Consistent With Humanity Itself’: Ideas of Insanity in the Nineteenth and early Twentieth Centuries

In some cases, though not I trust, in very many, the state of Colonial Hospitals and Lunatic Asylums would seem to be such as can hardly be deemed to be consistent with humanity itself.

Secretary of State for the Colonies, 6 April 1864¹

We only trust that the Government may soon be enacted to take active charge of persons with the two classes of imperfect minds – namely, those of idiots, or persons without ideas, and those who are insane, or who have frequently a superabundance of ideas, or one idea in too great activity. The whole modern system practised in cases of physical disease producing mental aberration, requires express establishment in a new sphere of action, as well as peculiar and well-selected attendants to aid in its right development.

Natal Almanac and Yearly Register, 1868²

Lunacy, Law and Liberalism in colonial Natal

On 31 October 1876, *The Natal Witness* reported that at about twenty minutes past ten on the night of 29 October, Mr. Thomas Phipson, formerly the Sheriff of Natal, had hanged himself from the window bars of the temporary lunatic asylum attached to the gaol at Pietermaritzburg. A provocative character who had often been an outspoken critic of the colonial government, Phipson had suffered from a ‘mental malady’ and, increasingly, violent fits of anger, for some time. Eventually, his family had felt that they had no option but to apply to have him certified as a dangerous lunatic and to have him ‘put under restraint’. According to his biographer, Phipson’s death ‘caused a sensation’, but the shame of his madness, the meanness of the temporary asylum, and the stigma of suicide, meant ‘his family dropped a curtain of silence over the whole affair.’³

¹ Pietermaritzburg Archives Repository (hereafter PAR) Government House (hereafter GH) 359, Circular Despatch from Secretary of State for the Colonies, 6 April 1864.

² *Natal Almanac and Yearly Register for 1868* (Pietermaritzburg: P. Davis & Sons, 1868), ‘Grey’s Hospital’, p. 87.

At the time of his suicide, Phipson was one of about fifty persons who were legally detained under the Natal Custody of Lunatics Law (no.1) of 1868, entitled 'To make provision for the safe custody of persons dangerously insane, and for the care and custody of persons of unsound mind'. Perhaps surprisingly, since Natal was then politically and economically overshadowed by the Cape Colony, this law predated similar legislation in the Cape by eleven years. Indeed, in his overview of the history of mental health law in South Africa, A. Kruger points out that:

it would seem that the Cape here followed the Natal legislation. A scrutiny of ... British lunacy Acts of the previous century did not reveal an Act from which the Natal Act was obviously copied, although the ideas ... can also be found in some of these Acts, and it would therefore appear as if the Natal Act of 1868 was a fairly original piece of drafting.⁴

Introduced to the Legislative Council by the then Lieutenant Governor, Robert Keate, in June 1868, the law owed its genesis to both the promptings of the imperial government, and to the economic climate of the mid-1860s which plunged the colony into a severe recession that made clearly visible the pressing need for the state to provide the institutional means of providing custody, if not care, for those who had 'imperfect minds'.

During the 1860s and 1870s, the Colonial Office in London became increasingly concerned with the reform of hospitals and lunatic asylums throughout the empire.⁵ In 1864, Secretary of State for the Colonies, Edward Cardwell, sent a Circular Despatch to the Governors of the Colonies referring to a request he had sent out the previous year

... requiring answers to one series of interrogations respecting Public Hospitals, and to another respecting Lunatic Asylums. ... I regret to find that, generally speaking, the state of these Institutions in the Colonies, though not perhaps worse than in England at a former period, is yet widely and deplorably different from what would be now considered in this country to be consistent with the humane

³ R.N. Currey (ed.) *Letters and Other Writings of a Natal Sheriff, 1815-1876, Selected and Introduced and Edited by R.N. Currey*, (Cape Town: Oxford University Press, 1968), pp. 22-23.

⁴ A. Kruger, *Mental Health Law in South Africa* (Durban: Butterworth, 1980), pp. 16 and 17

⁵ E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town: A.A. Balkema, 1958), p. 216.

objects they are designed to promote; whilst in some cases, though not I trust, in very many, the state of Colonial Hospitals and Lunatic Asylums would seem to be such as can hardly be deemed to be consistent with humanity itself.⁶

The Despatch went on to outline how the majority of hospitals and asylums in Britain had their origins in the ‘bounty and philanthropy of private persons; and [how] the beneficent spirit in which they originated has attended them continually, inducing by the efforts and care of those who took interest in them progressive improvement of structure, arrangements, management, and supervision.’ He acknowledged, however, that in the colonies the responsibility for establishing and maintaining such institutions could not be left to philanthropy, but would have to be ‘founded and supported from public funds’ being ‘dependent for their well-being on the Executive and Legislative Authorities.’⁷ Cardwell closed by asking for further information on the progress that had been made in the provision of public hospitals and lunatic asylums, statements on what was still required, and a ‘summary of the class of defects more generally prevailing’, saying that he was ‘confident that in the interests of humanity the exposition of the subject thus afforded will command, not only your own serious attention, but also, if necessary, that of the Legislature.’⁸

In response to this request, Lieutenant Governor Scott had been able to supply information on the recently completed Grey’s Hospital in Pietermaritzburg, but had had nothing to say about institutions for lunatics in the Colony, for there were none. The Legislative Council duly requested Scott to appoint a ‘Commission to enquire into and report as to the best available site for a Colonial Lunatic Asylum, the extent of Land required, etc., etc.,’⁹ but Scott left the matter in abeyance for his successor, John Maclean, who held office between December 1864 and July 1867. In the meantime, an Establishments Committee, comprised

⁶ PAR GH359, Circular Despatch from Secretary of State for the Colonies, 6 April 1864.

⁷ *Ibid.*

⁸ *Ibid*

⁹ PAR GH 1537 1908, Memoranda Concerning Lunatic Asylums, 19 September 1877 to 2 December 1907.

of Scott, the Colonial Secretary, the Mayor, 'and others' had identified a possible site for a future lunatic asylum, on land 'belonging to the War Department' at the upper end of Church Street near the garrison at Fort Napier.¹⁰ In March 1865, the Town Council of Pietermaritzburg voted in favour of granting 'to the Colonial Government a Site for a lunatic asylum in extent not more than ten acres.'¹¹ No decision was taken as to whether the proposed site could be used, however, and the matter stood for some years. Indeed, until the opening of Grey's Hospital, it was the gaol which 'for years answered the five-fold purpose of a gaol, hospital, workhouse, lunatic asylum, and penitentiary.'¹² However, from the time that its first patients were admitted, a number of 'mild lunatics' were also accommodated at the hospital. Others, presumably less peaceable, continued to be confined at gaols around the colony.

Grey's Hospital was named for Sir George Grey, the Governor of the Cape who had visited Natal in 1855 to establish its readiness for separate status under representative government. This took place the following year. Whilst in Pietermaritzburg, Grey had initiated plans for the construction of the colony's first substantial hospital. Historian of medicine in South Africa in the nineteenth century, Edmund Burrows, explains that it was to be financed 'partly from the annual Imperial grant of £40,000 for his conquest-by-civilization native policy. This Pietermaritzburg institution was intended to be the corresponding pillar – the Grey Hospital at Kingwilliamstown being the other – of his attempt to 'gain an influence over all the tribes between this Colony (i.e. the Cape) and Natal.'¹³

¹⁰ *Ibid.*

¹¹ PAR Pietermaritzburg Corporation (hereafter PC) 3/PMB 1/1/3, p.1031. Minutes, Town Council Meeting, 8 March 1865.

¹² Burrows, *A History of Medicine in South Africa*, p. 214 and A.F. Hattersley, *A Hospital Century: Grey's Hospital, Pietermaritzburg, 1855-1955* (Cape Town: A.A. Balkema, 1955), pp. 76-77. The first patients were admitted in May 1857, and the original main building was completed in 1862.

¹³ Burrows, *A History of Medicine in South Africa*, p. 214.

Grey, regarded by some as the ‘great civiliser’, represented the profoundly contradictory nature of nineteenth century liberalism. On the one hand, as Timothy Keegan explains, the individualistic and humanitarian principles on which it drew were highly influential in reform movements that ‘encompassed the fields of education for the masses, poor relief, judicial and penal institutions, treatment of the insane, leisure activities, and family reconstruction.’¹⁴ Legal equality before the law was also a central tenet. Western medicine, and its institutions, it was anticipated, would be part of the armoury of ‘civilisation.’ Thus, there were no restrictions placed on the treatment of Africans or Indians at Grey’s or other Natal colonial hospitals, nor at the public asylum that would be later be constructed. On the other hand, this ideology was entirely compatible with colonial subjugation, class distinctions, and discriminatory measures enacted in the name of bringing about ‘civilised’ norms and values amongst subject peoples.

In the Cape, fundamental to Grey’s policy was the dismantling of the rule of chiefs, and the expansion of Christianity.¹⁵ In Natal, however, in the mid-nineteenth century, the power of chiefs (albeit co-opted and reshaped by the Shepstone system of indirect rule) and the African homestead economy retained a greater degree of autonomy that eventually required more directly interventionist responses. Keegan identifies Grey’s governorship (1854-1861) as a time that saw a shift from the ‘optimistic and gradualist humanitarianism of an earlier age’ to a more openly ‘coercive and brutal policy of assimilation,’ that was increasingly based on a narrower base of utilitarian liberalism.¹⁶ In the second half of the nineteenth century, settler political and economic interests gained the upper hand, and a new period of imperial expansion – especially following the mineral discoveries – saw the crushing of independent African polities, including the Zulu kingdom in 1879, and a rejection of earlier assimilationist views. Instead, racial attitudes and policies hardened: this coincided with, and fed into, a developing scientific racism that homed in on, and sought to

¹⁴ T. Keegan, *Colonial South Africa and the Origins of the Racial Order* (Cape Town: David Philip, 1996), pp. 76-77.

¹⁵ Keegan, *Origins of the Racial Order*, p. 284.

¹⁶ Keegan, *Origins of the Racial Order*, p. 288.

prove, the differences between, rather than the common humanity of, peoples.¹⁷ In this, colonial psychiatry would play a part.

At the time of Grey's visit to Natal and for some considerable time thereafter, however, there were an almost insignificant number of Western biomedical practitioners practicing in the colony. Burrows puts the number at 'probably no more than a dozen licensed (medical) practitioners in Natal' in the late 1850s; and 'three decades later there were exactly one hundred.'¹⁸ There were no specialists in the care or treatment of those with 'imperfect minds'. Moreover, it was not the needs of the settlers, nor any large-scale attempt to introduce 'Christian medicine' for the region's African population, that secured the foundations of the nascent medical profession in Natal. Instead, this followed the introduction of indentured Indian labourers from the 1860s. On the insistence of the Indian Government, Indian Medical Officers were appointed to oversee the health of indentured workers, each operating within 'circles' of territory corresponding roughly to the various district-surgeoncies.¹⁹ Employers of indentured workers were obliged to contribute to the medical costs of their workers, including the construction of small hospitals. Grey's Hospital, however, continued to be the colony's major medical facility, and by 1868 was admitting nearly 600 patients – including some said to be 'lunatics' – per annum.²⁰

By this time, a brief period of prosperity and expansion – backed in part by expanding sugar cultivation and booming trade with the interior, but also precariously floated on a sea of easy credit and reckless speculation – had given way to less favourable conditions. During 'the dismal sixties', more particularly between 1865 and 1871, Natal experienced a severe economic setback that was accompanied by many bankruptcies, widespread

¹⁷ On p. 291 of *Origins of the Racial Order*, Keegan asserts – but does not substantiate the claim – that this scientific racism was more pronounced in Natal, where assimilationist ideas could not be countenanced than in the Cape.

¹⁸ Burrows, *A History of Medicine in South Africa*, p. 213.

¹⁹ Burrows, *A History of Medicine in South Africa*, pp. 213-4.

²⁰ Burrows, *A History of Medicine in South Africa*, p. 216.

unemployment and destitution, especially acute in the urban areas.²¹ For the first time, the existence of poverty and the colony's lack of welfare provisions became glaringly obvious. Grey's Hospital became, so the Town Council frequently complained, effectively a 'Poor House', taking in the elderly, the indigent, the dissolute, and the demented. In 1866 the Pietermaritzburg Town Council drew attention to the number of people, who were not necessarily 'proper subjects for admission' to Grey's:

Apart altogether from the class of individuals who seek and obtain admission to the Hospital on the grounds of their being sick and destitute, and therefore proper subjects for admission, there are others whose particular cases, while not warranting their reception, are such that the Government or Corporation, or both, cannot altogether neglect. These are the poor and the destitute whose sad cases are not infrequently brought under our notice, and the incurables who are unable to obtain a livelihood. There are also the insane – in some instances mild cases – where proper care and kind treatment might produce speedy recovery; yet it is to be regretted that no satisfactory provision has been made to meet their cases.²²

According to Burrows, in the following year, 1867, this prompted the Governor to appeal to the Cape

to admit Natal's lunatics to the Robben Island Asylum. The harbouring of "sixteen persons of unsound mind" in hospitals and gaols was "objectionable and impractical", he wrote. The Cape authorities declined this request on the grounds of limited accommodation, but offered the services of their Surgeon Superintendent and his staff if Natal was prepared to build houses for them on the Island. Rather than do this, the Natal Government decided to erect a temporary lunatic asylum at the Pietermaritzburg gaol which was already in use when Law No. 1 of 1868 made provision for the custody of lunatics within the Colony.²³

It was this temporary lunatic asylum at the gaol where Thomas Phipson killed himself.

²¹ J. Parle, 'The Impact of the Depression Upon Pietermaritzburg During the 1860s' (unpublished M.A. thesis, University of Natal, Pietermaritzburg, 1988).

²² PAR PC Town Council Minutes 1/1/3, Mayor's Minute, 4 August 1866. Quoted in Parle, 'The Impact of the Depression', pp. 101-102.

²³ Burrows, *A Medical History of South Africa*, p. 218. Unfortunately, Burrows gives no sources for this claim beyond, 'Personal Communication, Dr. M. Minde'. Max Minde was a psychiatrist who between the 1950s and 1970s wrote a series of articles for the *South African Medical Journal* on the early history of psychiatric services in South Africa.

A year prior to Phipson's death – in 1875 – as the colony's recovery from the economic depression finally gained momentum, another temporary asylum was built at a site on the Town Hill, a few miles outside the city. Why Phipson was not one of the thirty-seven inmates of this first asylum on the Town Hill (who had been transferred from a facility for lunatics in Longmarket Street that had existed since the early 1870s) is not known. It is likely, however, that his furious and self-destructive tendencies required that he be kept under closer restraint and watch than was possible at this new asylum.

The passing of the Custody of Lunatics Act of 1868 and the establishment of the temporary asylum in Longmarket Street coincided with the period of Governorship of Robert W. Keate. Keate was not popular, and had soon clashed with settler politicians over questions of financial control and the role of the Executive. When he left the Colony in 1872 – to take up a post in Sierra Leone – the *Natal Witness* referred to his term of office as 'one unending mistake'. It went on to add: 'We regret seriously that on his departure we are unable to point out one redeeming feature in his character, one palliating fact in his history. While we are glad that Natal has been relieved, we must express our earnest hope that no other Colony will be subjected to a like infliction.'²⁴ It is probably to Keate, however, that Natal owed its early legislative provision for lunatics. Before his arrival in Natal, Keate had been the Governor of Trinidad. From there he too had replied to the Despatch of 1863, and in May 1864, on the day before his departure to take up his new appointment in Natal, he had written to Cardwell pointing out that his report on the Trinidad Lunatic Asylum had been omitted from the digest of answers subsequently compiled. Cardwell was apologetic: 'The omission is the more to be regretted, as I find on examination of the enclosures of your despatch, that the reports, returns, and regulations of the Lunatic Asylum in Trinidad, are remarkably minute and complete ...'²⁵ He especially commended the 'care and attention given to the asylum' by Keate who had 'evidently taken much interest in it.' Keate's report had represented the asylum there as the exemplar of mid-nineteenth century enlightened

²⁴ *Natal Witness*, 16 April 1872. Quoted in Parle 'The Impact of the Depression', p. 186.

²⁵ PAR GH 359 105, Despatch 45, Edward Cardwell, Secretary of State for the Colonies, to Governor Keate, 1 July 1864.

psychiatric thinking and practice, using no mechanical restraints, but instead resorting occasionally to the seclusion of patients in rooms – padded or otherwise – as the only ‘discipline resorted to.’ Patients were kept occupied and amused in ‘household services, washing, needlework, working at trades, gardening, reading and writing, various games, music and dancing.’²⁶ The only defects reported by Keate related to sewerage and draining; but Cardwell was concerned too that the law under which the insane were apprehended provided exclusively for criminal lunatics.

The Natal ‘Custody of Lunatics’ Act of 1868 prioritised ‘dangerous lunatics’, but it also provided for the ‘safe custody of persons of unsound mind’, which included the suicidal and those whom the *Natal Almanac* referred to as ‘persons without ideas’, or ‘idiots’. The Bill appears to have been passed by the Natal Legislative Council with little fuss or comment. Keate’s personal interest in ensuring its passage was demonstrated when after its Third Reading and acceptance by the Council in July 1868, he withdrew the Bill and urged a small, technical amendment. It was re-passed on 3 August, and signed into law on 16 September 1868.²⁷ In his report on the Bill, Attorney General Gallwey explained how the previous procedures for identifying and restraining insane persons – which had followed Roman Dutch precedents – had been ‘troublesome and expensive’ in that they had required the appointment of a curator *ad litem* before ‘the alleged lunatic’ could be caused to appear before a court. Gallwey added that ‘until the Court pronounced judgement there was no legal right to detain a lunatic.’²⁸

By this Act, not only did the colonial state in Natal legally provide for the detention of those that were thought to be ‘not of sound mind’, it also, for the first time, shifted the

²⁶ *Ibid.*

²⁷ PAR Natal Colonial Publications (hereafter NCP), *Colony of Natal, Votes and Proceedings of the Legislative Council, Third Session, Fourth Council*, vol. XV, 1868 (Pietermaritzburg: Keith & Co., Government Contractors, 1868), V. ‘Index to, and abstract of, proceedings and Bills’, 3rd Session, 4th Council, 1868.

²⁸ PAR Attorney General’s Office (hereafter AGO) 1/10/2, pp. 227-229: Statement on Law No.1 1868, 1 October 1868.

responsibility for the definition of such states of mind from magistrates and the judicial authorities as represented by the Attorney General and the Lieutenant-Governor, to a different realm – that of medicine. It also indicated the need for facilities that could properly be termed a ‘Lunatic Asylum’. Furthermore, the Act reflected nineteenth century humanitarian liberal reformist ideals that emphasized the need for vigilance in overseeing the conditions under which the insane were detained and kept.

Clearly, this precocious legislation was important in establishing a framework for the institutionalisation of insanity in colonial Natal and elsewhere in this region, for despite recognition of several important shortcomings in the Act – including by the emergent psychiatric profession in Natal – the only modification came with the short Act (Law 8) of 1891, which merely clarified responsibility for the costs of maintenance of lunatics in asylums,²⁹ and it remained in force until 1916, when it was superseded by the Union of South Africa’s Mental Disorders Act. During the half-century that followed its enactment, the state and medicine would strengthen the alliance between them that had been first formally established in 1868, and the Natal government would honour the promptings of the imperial government to provide a lunatic asylum that, in avowed intent at least, was ‘consistent with the humane objects’ that such institutions were, by the mid-nineteenth century, ‘designed to promote.’³⁰

The Natal 1868 law is discussed at greater length in the next sections of this chapter, where its influence on mental health legislation in the rest of what would become South Africa is also considered. Thereafter, since the second half of the nineteenth century was

²⁹ Kruger, *Mental Health Law in South Africa*, pp.16 and 17 (footnote 58). He adds that a Bill containing the same provisions was published in the *Natal Government Gazette* on 2 July 1891. Law No. 8 of 1891 – preceded by Bill (No. 22 of 1891) posted in the *Gazette* on 23 June 1891 – promulgated on 21 July 1891, concerned the cost of maintenance of patients in a lunatic asylum, allowing for the costs of maintenance to be claimed against the estate of such a patient. The 1916 Mental Disorders Act remained in force, with a number of amendments until the passing of the Mental Health Act in 1973.

³⁰ PAR GH 359, Circular Despatch from Secretary of State for the Colonies, 6 April 1864.

a time of both consolidation and innovation in Western psychiatry, some of the major influences shaping psychiatric thought and practice are outlined. It is necessary, however, to recall that the power and reach of Western medicine, as well as the colonial state, although extending, were contained and restrained by the strength and resilience of indigenous African societies. African conceptions of health and healing as well as ways of understanding the origins of disease and disaffection remained particularly strong. Nor did the large numbers of Indians brought to Natal as indentured labourers embrace biomedicine, including psychiatry. Although the institutions of insanity in Natal would become important in the management of madness of people of all racial, ethnic and class backgrounds, for the most part – for whites, as well as for Africans and Indians – they represented only an alternative to much longer-established therapeutic traditions.

The Natal Custody of Lunatics Law, No. 1 of 1868

The 1868 Act provided for ‘the safe custody of, and the prevention of crimes being committed by, persons dangerously insane, and also for the care and maintenance of persons who are insane, but not dangerously so.’ It stipulated that any person who showed ‘derangement of mind’ or who attempted suicide could be arrested and indicted, and brought before a Resident Magistrate. This official would then be required to

call to his assistance any two medical practitioners (one of whom shall, if practicable, be the District Surgeon); and, if upon the view and examination of the said person so apprehended, and upon proof upon oath by the two medical practitioners to the effect that in their opinion such person is a dangerous lunatic, or a dangerous idiot, and on any other proof, the said magistrate shall be satisfied that such person is a dangerous lunatic, or a dangerous idiot, then it shall be lawful for such magistrate, by warrant under his hand, to commit such a person to some gaol or public hospital, within the said colony, there to be kept in strict custody until such person shall be discharged by order of one of the judges of the Supreme Court, or shall be removed to some public lunatic asylum by order of the Lieutenant Governor for the time being, as hereinafter provided.³¹

³¹ PAR NCP 5/2/3-5/2/10, (Natal) Law No. 1, 1868, ‘The Custody of Lunatics Law’

Section 3 allowed for 'one or more of the relatives or guardians of any insane person' to apply to one of the Judges of the Supreme Court, or a Resident Magistrate to have a lunatic or dangerous idiot certified as insane. Under Section 7, if the insane person had no relative or guardian easily accessible such an application could be made by '... any person or society under whose protection or care such insane person shall actually be for the time being...'.³² In the case of Indian inmates, when facilities for the long-term housing of the mentally ill became available after 1880, it was not infrequent that this application was brought by their employers in Natal.

The 1868 Act did not attempt to define lunacy or insanity. Nor was there any provision for treatment: instead, lunatics – whether dangerous or not – were to be 'restrained' and 'confined' and placed under 'care, control and custody'. This could be in a gaol, or in a hospital, or in a 'lunatic asylum', which was defined as 'any hospital, or portion of any hospital, within the colony, which may, from time to time, be appointed by the Lieutenant Governor for the custody of insane persons.'³³

This law firmly entrenched colonial legal and medical practitioners as the authorities who had the power required to define and detain lunatics. Both entry to and exit from gaol, hospital or a 'public asylum' (though none such yet existed) were conditional upon the issuing of medical certificates. Release from gaol and transfer to an asylum could be granted by a Supreme Court judge, or the Lieutenant Governor. Several safeguards, against maltreatment and of the unlawful detention of sane persons, were also built into the Act, nonetheless the mechanisms for detaining and committing 'ordinary lunatics' were inadequate, probably technically illegal.³⁴

³² (Natal) Law No. 1, 1868, Section 7.

³³ (Natal) Law No. 1, 1868, Section 1.

³⁴ This point is made by several authors. See, for example, D. Foster and S. Lea, *Perspectives on Mental Handicap in South Africa* (Durban: Butterworths, 1990), p. 35. The Resident Surgeon - later Physician or Medical Superintendent - of the NGA, James Hyslop, criticized the Act because of its stress on dangerousness (as opposed to, say, 'chronic and quiet' forms of mental illness) in several of his Annual Reports in the period of his tenure, 1882-1914. See A. Kruger *Mental Health Law in*

Following the British M'Naghten Rules of 1844, Section 4 of the Natal Act established the principle of acquittal of a criminal offence on the grounds of insanity. Should a court find a prisoner to be insane at the time of the commission of a crime, he [sic] would be held over in strict and safe custody 'in such place and in such manner as to the Lieutenant Governor shall deem fit.'³⁵ Of course, verification of insanity was sometimes both elusive and vexatious, and in Natal and Zululand in the nineteenth and early twentieth centuries – no less than elsewhere and in other times – madness could be feigned by those who wished to avoid the full stricture of criminal law. Both police officers and District Surgeons found themselves having to observe suspected criminal lunatics in their cells, and to offer an opinion as to whether or not they were masquerading as madmen. Yet further complications emerged when Natal's legal authorities were faced with cosmological and legal systems that violated Western conceptions of rationality and consciousness. This was highlighted particularly clearly in a 1910 court case – to be discussed in detail in a later chapter – involving eleven African women accused of practising witchcraft in Zululand, yet also considered to be the victims of a form of hysterical mania over which, they said, they had no control. In this case Western psychiatry was largely regarded as irrelevant in determining these women's fate: rather, their culpability, or otherwise, was a matter for the law courts, not for medicine, to decide.

Further sections of the 1868 Act served to protect the interests of those certified and detained as lunatics. Provision was made for criminal lunatics in detention to enjoy 'the same liberty and privilege of seeing [his] friends and legal advisers at all reasonable times, which he would have had in the gaol or other prison from which he may have been removed.' Should insanity be confirmed, however, and the person confined to an asylum, then the Law required that Official Visitors be 'required to visit each such lunatic asylum at

South Africa, Chapter 1, for a discussion of the centrality of dangerousness in legal provisions for the detention of lunatics since Roman times.

³⁵ (Natal) Law No.1, 1868, Section 4.

least once every day, unless prevented by illness or other sufficient cause, and shall, from time to time, make such reports to the Colonial Secretary as may be required by the order of the Lieutenant Governor.³⁶ The Lieutenant Governor could order the examination of a person's mental condition on the request of a relative. Furthermore, whereas relatives, guardians or friends could apply for a person to be confined as a lunatic, they could also petition the Lieutenant Governor to have an inmate, even one 'still labouring under insanity' discharged, provided that 'such relative or friend shall be willing to undertake the charge of, and to support, such insane person'. This required that the friend or relative entered 'sufficient recognizance for the peaceable behaviour of any such dangerous lunatic or idiot before a Resident Magistrate, or one of the Judges of the Supreme Court.' The discharge could be revoked if the recognizance was broken.³⁷

Thus, the confinement of the mentally ill was a matter that could, to a certain extent, be negotiated between the colony's legal and medical authorities, and those who might agree to be responsible for the welfare and good behaviour of the person certified as being of unsound mind. While inmates themselves often petitioned for their own release – with mixed results – those who had strong family backing for their discharge were better positioned to be granted release from confinement. In one particularly poignant case – that of Emma Lovett – a family campaign to have her released into their care after she had spent several years at the NGA following her intentional drowning of her youngest child led to tragedy when, after six quiet years living in Stanger with her son, daughter-in-law and their children, she killed a grandchild by throwing scalding water over her.³⁸

³⁶ (Natal) Law No.1, 1868, Sections 3 and 10.

³⁷ (Natal) Law No.1, 1868, Section 12. Referring to the Cape 'Lunacy Act' of 1879, which was almost identical to Natal's 1868 Act, Kruger calls this section 'interesting', but does not explain in what way if any it is unusual. He goes on to say that the closing provisions of both Acts – which indemnified anyone who had anything to do with the detention of an insane person prior to the enactment of the Lunacy Acts, 'strongly suggest' that prior procedures had existed in both colonies. Kruger, *Mental Health Law in South Africa*, p. 14.

³⁸ PAR Minister of Justice and Public Works (hereafter MJPW) 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908.' Thanks to Jeff Guy, who located the case of Emma Lovett and brought her to my attention.

The 'Custody of Lunatics Act' was passed at a time when those thought to be mentally ill to the extent that they posed a threat to themselves or to others were detained in the colony's hospitals or gaols. The Act, however, clearly anticipated a time when a 'public asylum' would exist for the detention of lunatics and 'idiots'. It also established that the costs of 'maintenance in [such] an asylum' be 'defrayed out of colonial revenue'. Where an inmate possessed sufficient means to provide for his or her maintenance, however, it was lawful for the 'keeper' of the designated asylum to 'agree with any relative, guardian, or friend of such lunatic or idiot, for his maintenance whilst detained therein....' These costs could then be reimbursed 'out of any funds or property belonging to such lunatic or idiot.'³⁹ Responsibility for payment of Indian patients, the majority of whom were destitute indentured labourers, would, however, become a sharp bone of contention between employers and the state. From inception of the earliest legislative framework for the custody of the mentally ill in Natal, costs were an important concern, and those who could afford to pay for their own keep or who could draw on family or other supportive networks would enjoy a less harsh experience of detention in a gaol or asylum. In the context of colonial Natal, as elsewhere in the region, such disparities fell largely – but not invariably – along racial lines.

Mental health legislation in South Africa, 1868-1914

Natal's 1868 'Custody of Lunatics Act' appears to have provided something of a template for much of the mental health legislation enacted in the regions that, in 1910, became South Africa. As A. Kruger points out, in the Cape Colony until 1879 at least 'the authority for the detention of the mentally ill ... was based on highly questionable powers.'⁴⁰ Roman-Dutch law had no explicit provisions for the detention of the mentally ill or of dangerous lunatics, though in the eighteenth and early nineteenth centuries there are instances of confinement in private hospitals, gaols, and later, on Robben Island.

³⁹ (Natal) Law No.1, 1868, Sections 8 and 9.

⁴⁰ Kruger, *Mental Health Law in South Africa*, p. 8.

Only in the 1860s did the Cape Colonial Office issue instructions to resident magistrates on the procedures necessary for the detention of 'lunatic patients'. Circular no. 28 of 1866 required them to

apply for authority to forward any "lunatic patient" to an Asylum on a form enclosed with the circular [known as 'lunacy certificates'], on which the magistrate had to state the personal particulars of the patient as well as the duration of the existing attack, whether the patient is dangerous to others and the "cause of the insanity, if hereditary". The form had to be accompanied by the medical certificates of two duly licensed medical practitioners, which each contained "Facts indicating insanity or idiocy observed by myself" and "Facts indicating insanity or idiocy communicated to me by others."⁴¹

Such supporting 'evidence' of insanity or idiocy, as well as an emphasis on the alleged dangerousness of lunatics would remain the cornerstone of legal and medical justifications of the incarceration of the insane into the next century. While Natal, by the 1868 Act, created the legislative authority for this process, in the Cape Colony such detentions and subsequent confinements took place in a legal vacuum until the passing of Act 20 of 1879. This Cape 'Lunacy Act' of 1879 was virtually a verbatim copy of the 1868 Natal 'Custody of Lunatics Act', with the exception of Section 7 of the latter legislation.⁴² This applied to situations where an 'insane person [had] no relative or guardian within the colony or none accessible without inconvenient delay', making it lawful for 'any person or society under whose protection or care such insane person shall actually be for the time being, shall, for the purposes of the preceding section, [to] be deemed the guardian of such insane person'. The reasons for this omission are not known, but it may have been that the presence in Natal from 1860 of significant numbers of indentured Indian workers without relatives or legally-appointed guardians, prompted the legislators to allow for employers to apply to have mentally ill labourers certified as insane. This provision was not exploited solely by employers of indentured workers,

⁴¹ Kruger, *Mental Health Law in South Africa*, pp. 8-9. On p. 12, footnote 49, Kruger explains that from 1862 to 1865 circulars were issued by the Cape Colonial Office outlining the procedure to be followed when the mentally ill were to be detained and confined.

⁴² (Natal) Law No.1, 1868, Section 7.

however. Both Africans and whites who demonstrated alarming mental states were, on occasion, referred to resident magistrates for certification by those who had chosen or who had been forced to accommodate them, most notably police officers and District Surgeons.

As already noted, at the time of the formulation of the Natal 1868 Act, that colony was also in the depths of a severe economic depression that saw escalating poverty, crime, and drunkenness, among the settler populations of the towns of Pietermaritzburg and Durban. Once the pull to the Diamond Fields became a major force for social dislocation from the late 1860s onwards, many poor, elderly, and otherwise socio-economically marginal colonists found themselves without the financial and familial networks necessary for comfortable survival in turbulent economic times. The very visibility of such 'distress' gave greater urgency to the call for welfare measures in Natal at that time, and this may have suggested the need for a provision such as that contained in Section 7 to the Natal legislators.⁴³ In contrast to the early provision of separate asylums for European and 'native' insane in British India in the eighteenth and nineteenth centuries, as described by Waltraud Ernst, the institutions for the care and custody of the insane in Natal were, from the start, not reserved for the colony's whites.⁴⁴ The pressure to regulate and expedite the means of certifying insanity as well as calls for the building of a public lunatic asylum did however coincide with Natal's first experience of widespread poverty and unemployment amongst whites, and pressure on the state to alleviate a lack of welfare.

After the granting of Responsible Government status to the Cape in 1872 there followed a flurry of reforms in health-related laws. As Burrows puts it: 'The Colonial Parliament ... legislated generously and almost breathlessly on medical matters after 1879, as if to make up for the shortcomings of its predecessors. It showed itself competent to legislate for

⁴³ For a fuller discussion, see Parle, 'The Impact of the Depression.'

⁴⁴ W. Ernst, 'The European insane in British India, 1800-1858: a case-study in psychiatry and colonial rule', in D. Arnold (ed.) *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988), pp. 27-44.

public health, for research and for the control of the medical profession and its ancillaries.’⁴⁵ Between 1879 and 1899, the Cape government passed no fewer than nineteen bills covering medical matters, from lunacy, leprosy, contagious diseases, alcoholism, and public health. Although the Cape 1879 Act was clearly copied from the Natal 1868 Act, and despite the latter’s early moves to provide a public asylum for its mentally ill, it was not Natal but the Cape where innovations in lunacy legislation occurred during the late nineteenth century. Whereas the only addition or alteration to the Natal 1868 Act was Law 8 of 1891 (which concerned maintenance costs) in the Cape in 1891 a new Lunacy Law (Act 35) – 72 sections long – repealed the 1879 Act. This Act was more clearly derived from the English Lunacy Act of 1890; albeit a much-shortened version of that mammoth law, that ran to 342 sections. While maintaining many of the procedures and provisions already laid down by the Natal Law, the Cape 1891 Lunacy Law has been described as being ‘much more ambitious’. For instance, it made a clear distinction between ‘dangerous lunatics’, ‘criminal lunatics’ and, in Part III, ‘Lunatics Not Dangerous or Criminal’. The Act also recognized that, in practice, it was not always possible to secure the examination of supposed lunatics by two medical practitioners and that, if necessary, one was sufficient. Sections 27 and 28 stipulated that, following certification, the magistrate should issue a ‘summary reception order’, which legitimated detention of the certified lunatic for a period not exceeding one month. The Attorney General would receive a copy of this order and was appointed *curator ad litem*. An application for details of the reasons for the detention could be brought before Court by the detained person or by his or her relatives. If not contested, or if such an application was denied, further detention of the patient was ordered by a Judge, and the Colonial Secretary then ordered the person’s removal to an asylum.⁴⁶ A further significant change to the Cape legislation was enacted under the Lunacy Act of 1897, which made provision

⁴⁵ Burrows, *A Medical History of South Africa*, p. 332.

⁴⁶ Kruger, *Mental Health Law in South Africa*, pp. 14-16. Kruger points to the many similarities between this Law and the Mental Health Act of 1973.

for ‘voluntary patients’, an addition that Kruger refers to as ‘a milestone in the development from detention to treatment.’⁴⁷

In the Orange Free State and the South African Republics ‘lunacy legislation’ shadowed closely the earlier Natal and Cape legislation. The Orange Free State’s Ordinance 16 of 1891 repeated the same provisions as in the 1868 Natal and 1879 Cape Acts. Kruger details the additional introductory provisions to this law:

Section 1 provides that there shall be a lunatic asylum at Bloemfontein for the treatment and detention of the mentally ill that will be called “het krankzinnigengesticht”. Section 2 empowers a commission with the management of the institution, and s 3 determines that the regulations of the institutions shall be made known. Part II of Chapter 94 deals with the support of pauper lunatics and sick persons, and provides in s 18 that State aid shall be given for the support of proven pauper lunatics.⁴⁸

In the South African Republic, Act 9 of 1894 drew heavily on the 1891 Cape Act. One section allowed the arrest of suspected lunatics if, in the opinion of a constable that person posed a threat to ‘public safety’; another, the apprehension of an ‘idle lunatic person’. As with the Cape law, summary orders of detention were to apply for one month. In 1902, Proclamation 36 superseded the 1894 Act: this legislation provided for ‘voluntary patients’, as well as for ‘urgency cases’ to be detained – following application by the family as well as a medical certificate – for seven days. Restrictions on the use of ‘mechanical means of bodily restraint’ were also stipulated.⁴⁹ In 1893 – by Act 4 of that year – and in 1906, the Orange River Colony – with Ordinance 13 – brought that territory’s ‘law relating to lunatics’ in line with the more recent Cape and Transvaal legislation with regard to the provisions for summary reception orders, voluntary patients and mechanical restraints.

⁴⁷ Kruger, *Mental Health Law in South Africa*, p.16.

⁴⁸ Kruger, *Mental Health Law in South Africa*, p. 20.

⁴⁹ Kruger, *Mental Health Law in South Africa*, pp. 18-19. Kruger does not spell out the circumstances under which these means of restraint were permitted.

After Union in 1910, the four provinces retained their distinct legislation ‘relating to lunatics and persons affected with leprosy’: this remained the situation until the passage in 1916 of the Mental Disorders Act.⁵⁰ Although the legislative reforms adopted by the Cape, and later the interior territories, were not copied in Natal, the colony which had taken the initiative in providing a legislative framework for the lawful custody of lunatics, the procedures and principles that they embodied were as much a feature of the detention and custody of that colony’s mentally disturbed subjects as they were elsewhere in southern Africa. Furthermore, the person most experienced in the certification and treatment of insanity in colonial Natal, Dr. James Hyslop – who was Medical Superintendent of the Natal Government Asylum for more than thirty years – was of the opinion that although ‘the Natal Lunacy Law’ was ‘very crude and simple’, and that ‘the Cape and the Transvaal have the most excellent laws which I often envy them having’ – it was an effective instrument for expediting the institutionalisation of those thought to be insane.⁵¹ Indeed, by 1910, in terms of patient numbers, the NGA was the second largest in southern Africa, and had the highest ratio of white patients to ‘general population’ in the Union.⁵² This was not, Hyslop insisted, because there were ‘more insane’ in Natal, but because the law allowed people to be ‘admitted more readily to asylum in Natal than they are in other parts of the Union’. He admitted also that this legal leniency required that ‘the Colonial Secretary and the Medical Superintendent of the Asylum in Natal [to take] considerable

⁵⁰ The ‘Lunacy and Leprosy Laws Amendment Act’ of 1914 left provincial legislation intact while facilitating the transfer of lunatics between the former colonies. The 1916 Act - “To consolidate and amend the laws in force in the several Provinces of the Union, relating to the detention and treatment of mentally disordered and defective persons and to make further provision as to the institutions in which such persons may be received, detained and treated” – was proclaimed on 1 November 1916. With only minor amendments, it remained the country’s legal provision for the mentally ill until 1973. This Act and its implications will be discussed in the final chapter of this dissertation.

⁵¹ SC. 14- '13, *Report of the Select Committee on Treatment of Lunatics*, May 1913 (Cape Town: Cape Times Limited, Government Printers, 1913), pp. 51-53. Evidence of Dr. James Hyslop, 16 April 1913.

⁵² National Archives Repository, Pretoria (hereafter NAR), Prime Minister’s Office (PM) 1/1/322 184/2/1913, ‘Public Health: Extension of Lunatic and Leper Asylums’, Memorandum from Dr. J.T. Dunston and Mr. P. Eagle to Acting Secretary for the Interior, 22 December 1912, p. 8.

responsibility under the law.⁵³ Hyslop, however, had never found himself challenged in a Natal law court for the wrongful incarceration of a person in the asylum. Indeed, lunacy law and psychiatric practice in Natal were especially closely aligned during the career of James Hyslop, the colony's first appointed psychiatrist.

Minds over Matter: Mental illness and the professionalization of psychiatry

In a memorable passage, Roy Porter describes the increasingly common experience of those deemed to be insane over the course of the nineteenth century. He explains that, in the preceding century, care (or control) of the mad was in the first instance a family or community responsibility; treatment was not primarily a medical concern and that even such madhouses that did exist were more likely to reflect their founding religious, charitable or welfare principles than to be concerned with the medical treatment of insanity. In the nineteenth century, however:

All this was to change. ... as the development of psychiatric medicine made it first common, then routine, and finally almost inescapable, for the mentally ill to be treated in what were successively called madhouses, lunatic asylums and then psychiatric hospitals, where they increasingly fell under the care of specialists.⁵⁴

The elaboration of knowledge about madness, the legal framework for establishing insanity, the rapid construction and spread of asylums as specialized sites for the treatment of lunacy, and the staking of professional identity and authority by psychiatrists, were significant features of the nineteenth century. While following several different theoretical trajectories both within and between countries such as Britain, Germany, France and the United States, by World War I psychiatry had a firmly established scientific-medical, legal, and institutional basis. To be sure, it was never the sole – or uncontested – voice of authority on the origins and amelioration of mental illness, but it had by that time become a

⁵³ *Select Committee, 1913*, p. 49. Evidence of Dr. James Hyslop, 16 April 1913.

⁵⁴ R. Porter, *The Greatest Benefit to Mankind: A Medical History Of Humanity from Antiquity to the Present* (London: HarperCollins, 1997), pp. 493-494.

dominant force in the definition and detention of those who were said to be mad.

As Sally Swartz notes, psychiatric theory and practice in southern Africa were closely based on British precedents. This seems especially clear in the Cape Colony where the 1891 Act drew on the English Lunacy Act of the previous year. Furthermore, British – to be more specific, Scottish – trained physicians and psychiatrists formed the majority of the medical personnel in both that colony and in Natal. The development of the colonial psychiatric profession was closely bound up with the institutionalisation of insanity in the growing numbers of public asylums throughout the West and its colonial possessions, including Natal and the Cape, throughout the nineteenth century. Ties between the nascent psychiatric profession in the colonies and the metropole were maintained through the meetings of local branches of the British Medical Association, conferences and visits to Britain by doctors and administrators of asylums for lunatics, and publication in British-based scientific, medical and ethnographic journals. Such connections ensured that there was a flow of psychiatric knowledge from the metropolis through the empire. Importantly, this was not a one-way stream, however. Swartz has shown that in the Cape, and James H. Mills in India, in the mid- to late- nineteenth century, physicians and psychiatrists based in colonial asylums produced knowledge about those within their custody, knowledge that fed into metropolitan discourses and policies towards their imperial subjects.⁵⁵ Indeed, the history of colonial psychiatry cannot be divorced from the wider milieu in which it occurred, one that saw the often violent subjugation, economic undermining, and political marginalization of indigenous peoples as well as the shaping of societies in ways that were deeply fractured along lines of race, class and gender.

⁵⁵ See S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', Chapter 5, for a detailed discussion of the ways in which Cape colonial psychiatrists such as Dodds (Valkenberg), Greenlees (Grahamstown) and Conry (Fort Beaufort), contributed to the construction of sexist and racist 'scientific' knowledge in the late nineteenth and early twentieth centuries. Their publications in the British medical and psychiatric journals ensured the flow of information to the metropole, and reinforced colonialist discourses and practices. For India, see J.H. Mills, *Madness, Cannabis and Colonialism: The 'Native-Only' Lunatic Asylums of British India, 1857-1900* (Houndmills and London: Macmillan Press, 2000), Chapter 2 "'The Lunatic Asylums of India are Filled with Ganja Smokers": Asylum Knowledge as Colonial Knowledge'.

The development of psychiatry in colonial Natal followed, in broad outlines, that of the Cape Colony. There was at least one important difference, however. Some Cape ‘mad-doctors’ of the late nineteenth and early twentieth centuries published studies of ‘African mentality’, contributing to the creation of an apparently scientific basis on which to base discriminatory and inferior care for the ‘insane native’, and by extension, all Africans. Sally Swartz and Felicity Swanson have been particularly concerned with the writings and practice of Dr. Thomas Duncan Greenlees, Medical Superintendent of the asylum at Grahamstown from 1890, but they also regard Dr. William Dodds, Inspector of Asylums and Medical Superintendent at Valkenberg from 1891, and Dr. John Conry of Fort Beaufort asylum in the eastern Cape, as being directly complicit in creating a ‘distinctly colonial psychiatry’ that was explicitly based on ‘biological models of racial difference rooted in Social Darwinism and evolutionary theories’ which was ‘used to justify aggressive segregatory and discriminatory measures in the management of the black insane in the Eastern Cape after 1890.’⁵⁶ Greenlees, in particular, has received considerable coverage for his explanations of African insanity as being the consequence of physiological difference, especially of the brain. In an article published in the *Journal of Mental Science* in 1895 he wrote: ‘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.’⁵⁷ Swanson explains that: ‘Colonial psychiatrists such as Dodds and Greenlees derived their professional power, status and credibility within the framework of late nineteenth century positivist biomedical knowledge and training that understood mental illness as an organic disease of the brain and nervous system.’⁵⁸

⁵⁶ F. Swanson, “‘Of Unsound Mind’: A History of Three Eastern Cape Mental Institutions, 1875-1910’ (unpublished M.A. Thesis, University of Cape Town, 2001), p. 22.

⁵⁷ T. D. Greenlees, ‘Insanity among the Natives of South Africa’, *Journal of Mental Science* (January) 1895, p. 75. Also quoted by Swanson in “‘Of Unsound Mind’”, p. 40.

⁵⁸ Swanson in “‘Of Unsound Mind’”, p. 28.

Greenlees, however, was not necessarily typical of mid- to late nineteenth century medical superintendents in southern Africa. Shula Marks, for instance, has offered a more tempered view of the career of Dodds, whom, she notes, was ‘no theorist’⁵⁹ Similarly, in Natal, no racialised scientific theory along the lines taken by Greenlees was publicly articulated by psychiatric professionals. Indeed, while James Hyslop, Medical Superintendent of the Natal Government Lunatic Asylum from 1882 to 1914 enjoyed a dazzling career in colonial military and medical circles, he published only one scientific paper on aspects of his clinical practice, and contributed little directly to the emergence of the growing body of psycho-medical theory about madness. Leaving no professional or personal papers, Hyslop remains something of an enigma, though his career and indisputably important influence in Natal will be explored in more detail in later chapters. We do know that he was a graduate of Edinburgh University in 1879, and ‘subsequently specialis(ed) in mental diseases at Berlin, Vienna, and Munich’⁶⁰; he had also served for a short time as Assistant at Morningside Asylum outside Edinburgh, before taking up the appointment at the NGA. His training as a physician and practice as a psychiatrist then were rooted in the educational and epistemological centres of Western thought about the nature of insanity and the appropriate methods of managing madness. Hyslop’s career as a psychiatrist in Natal reflected both the major influences of Western ideas about insanity and a more pragmatic engagement with the inequalities of a colonial society that he embraced.

Although there were seismic shifts in the ways of understanding the aetiology and diagnosis of mental disorders during the nineteenth century, in many ways, psychiatry then was no different from that which came before – or after – in being ‘torn between two visions of mental disease.’⁶¹ The first of these visions, that which emphasizes chemical or

⁵⁹ S. Marks, “‘Every Facility That Modern Science and Enlightened Humanity Have Devised’”: Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910’ in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), p. 272.

⁶⁰ Obituary, *South African Journal of Science* (hereafter *SAJS*), 14 (1917-1918), p. 22.

⁶¹ E. Shorter, *A History of Psychiatry: A History of Psychiatry from the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. 26.

physiological abnormalities and malfunctioning of the brain and the body is generally known as 'biological psychiatry'. The second vision, of course, is that which explains the origins of mental primarily in 'the psychosocial side of patients' lives, attributing their symptoms to social problems or past personal stresses to which people may adjust imperfectly.'⁶² Edward Shorter writes:

This bifurcation of vision was present at the very beginning of the discipline's history. At the beginning, the biological version was predominant. With the sole exception of Esquirol and his romantic theories about the "passions", the psychiatrists of the founding generation believed that the cause of mental illness lay in the integuments of the brain and that psychiatry was in a sense reducible to neurology. (The two disciplines were considered the same.)⁶³

In the early 1800s, physician-psychiatrists across Western Europe and in the United States sought the biological basis of insanity in 'lax' blood vessels in the brain, in the 'irritation' or 'compression' or 'weakness of nerve fibres', and in 'delusive sensations'. Many physicians – as typified by the German doctor Johann Greding – conducted autopsies on mental patients in an effort to find physical lesions or 'developmental anomalies' that they believed to be characteristic, and constitutive, of madness. With these early moves towards a psychiatry grounded in biological causes, came also an awareness that certain families or generations could manifest particular forms of mental disturbance, such as melancholia and suicide, over time, of heredity in other words. Physical therapies for the alleviation of mental – and the ensuing bodily – suffering included bleedings, purgings, emetics and enemas, as well as plant-based medications, the application of heat, stroking of the body,

⁶² *Ibid.*

⁶³ Shorter, *A History of Psychiatry*, p. 27. Jean-Etienne Esquirol (1772-1840) was a pupil of the early nineteenth century French psychiatrist Philippe Pinel (1745-1826). Considered the 'father of modern psychiatry', Pinel was an early advocate of the asylum as a therapeutic institution. Esquirol developed Pinel's ideas into that of 'the therapeutic community' where patients and physicians lived together in a structured setting and regime. Esquirol drew his theories of the origins of madness from Romanticism: his 1802 doctoral thesis focused on the role of the "passions" in mental illness. See Shorter, Chapter I 'The Birth of Psychiatry', in *A History of Psychiatry*. Interestingly, Roy Porter observes that Pinel 'had picked up some of his ideas from folk wisdom'. See Porter, *The Greatest Benefit to Mankind*, p. 495.

and exposure to red-hot irons and mustard plasters, the latter to draw out irritants that lay beneath the skin.⁶⁴

Yet, concurrently with this vision of the somatic origins of mental illness there developed a second powerful strand of modern psychiatry, one that did not necessarily eschew physiological causes of madness, but which did look to institutional and behavioural modifications of the lunatics' world to bring about an improvement in his or her mental state, if not a full cure. Drawing from the insights of Pinel and others before him, this approach held mental – or psychological – factors to be more influential than physical pathology in causing derangement of mind. After 1835 the term 'moral insanity' came into professional psychiatric parlance: it gave credence to the view that some mental afflictions, if by no means all, were caused by 'faulty thoughts'. Flowing from this was the realization that it was through the careful redirection of a sufferer's thoughts and emotions that recovery could be effected. The therapeutic philosophy and practice to which this gave rise became widely known as *le traitement moral* ('moral treatment' or 'moral therapy').⁶⁵ With its roots in long-established techniques for the management of the mad in various institutional settings – private hospitals and asylums most notably – moral treatment stressed calm, and a system of discipline and routine ultimately designed to facilitate self-regulation by the patient. Also important was meaningful occupation, whether at work or through supervised amusements. Central to the success of the regimen was the person of the asylum doctor – authoritative, sure and reassuring, often powerful and charismatic – and the institutional setting in which moral treatment was to be best carried out: the asylum.

'Moral treatment' had diverse origins and innovators in the late eighteenth and early nineteenth centuries. It had its sceptics and detractors, but by the mid-1800s, it had become 'the gold standard of enlightened asylum administration.'⁶⁶ It also went hand-in-hand with

⁶⁴ Shorter, *History of Psychiatry*, pp. 27-28.

⁶⁵ *The Greatest Benefit to Mankind*, p. 495. As Edward Shorter explains, in French 'moral means "mental", not "moral"'. Shorter, *History of Psychiatry*, pp. 19-20.

⁶⁶ Shorter, *History of Psychiatry*, p. 21.

the rapid proliferation of asylums across Western Europe and the United States. The asylum has occupied a central place in the history of psychiatry and of mental illness ever since. As Roy Porter notes, the forging of Western psychiatry as a distinct branch of scientific medicine in the 1800s was part of the broader trend towards specialisation and professionalisation in medicine. By mid-century, doctors of the mind – or 'alienists' – were increasingly confident that mental disease could be cured, or at least alleviated. The asylum was now seen as a progressive institution, '...indeed, the one truly effective site for the treatment of insanity.'⁶⁷

James Hyslop studied, visited and practised at number of the most important sites of Western European psychiatric knowledge in the middle decades of the nineteenth century: Edinburgh, Berlin, Munich and Vienna. There is an absence of firm evidence, but it nonetheless seems fair to speculate that he drew on the different emphases given to psychiatric medicine in these different locales before coming to Natal in 1882. In Scotland, care of the mentally ill had long been a matter of state concern, whereas in England it was not until the 1890 Lunacy Act that 'voluntarism rather than state intervention was the rule.'⁶⁸ Between 1772 and 1857, 'seven asylums were erected in Scotland all under Royal Charter ... and governed by Local Boards of Management. In 1857, the Scottish Lunacy Act was passed, which made provision for general supervision of the insane under a General Board of Control to see that these hospitals were provided and paid for out of local rates.'⁶⁹ Indeed, while moral therapy and asylum management 'blossomed' throughout Britain in the early decades of the nineteenth century, Scotland established itself as a 'one of the most progressive settings'⁷⁰ for an emergent psychiatric profession,

⁶⁷ Porter, *The Greatest Benefit*, p. 494.

⁶⁸ Shorter, *History of Psychiatry*, p. 35

⁶⁹ This information was found at http://web.ukonline.co.uk/scotlandgenealogy/hartwood_hospital_was_in_its_hey.htm accessed on 22 July 2003.

⁷⁰ Shorter, *History of Psychiatry*, p. 38.

and its seat of medical education was Edinburgh University. Here, lectures in psychiatry were given from the early 1850s, several decades before their regular appearance in London. Hyslop's medical training and experience in his homeland likely exposed him to both moral therapy in asylum practise and to a theoretical grounding in the organic nature of mental illness that was becoming prominent at the time. Throughout his tenure at the Natal Government Asylum, Hyslop was to adhere to the principles – though not always the practice – of moral therapy as instituted by such Scottish luminaries as William Alexander Francis Browne, who as head of the Montrose Asylum had been an early advocate of the abolition of physical restraints for patients. Browne was also the author of the oft-quoted treatise *What Asylums Were, Are and Ought to Be*. Published in 1837, this extolled the guiding principles of 'kindness and occupation' in the treatment of the insane, and of the material structures in which this should take place, in asylums that were 'spacious', 'light' 'elevated' ... and... 'surrounded by extensive and swelling grounds and gardens.'⁷¹ This too was the aspiration of the Natal colonial authorities in the 1870s as they drew up plans for the NGA, and under Hyslop's management at least some of these ideals were realised, at least for some.

As Saul Dubow and Timothy Keegan, among others, have pointed out, however, 'Scottish Enlightenment' thinking also gave rise to a form of scientific racism.⁷² Dubow identifies the work of 'the controversial Edinburgh anatomist' Robert Knox as being a 'landmark' in the conception of racial determinism. Knox, who had been an army surgeon in the Eastern Cape, published *The Races of Man* in 1850 and sought, on the basis of comparative anatomy, to establish racial differences and then to link these to national characteristics.⁷³ It is likely that Hyslop was exposed to ideas such as those put forward by Knox, as they were highly influential in mid-Victorian society. While

⁷¹ Quoted in Porter, *The Greatest Benefit*, p. 494. See also Edward Shorter, *History of Psychiatry*, p. 43.

⁷² Keegan, *Origins of the Racial Order*, p.91 and Saul Dubow, *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995), pp. 15 and 27-28.

⁷³ Dubow, *Scientific Racism in Modern South Africa*, p. 27.

practising in Natal, Hyslop showed interest in the dissection of brain tissue in the search for ‘organic lesions’, but he left no record of whether he was specifically investigating alleged differences in brain structure, size or function, either across or between ‘races’.

In Continental Europe, which Hyslop visited in the early 1880s, in contrast to England and the United States, medicine – including psychiatry – was directed to a much greater extent by the state. The establishment of asylums followed state directives in many regions, and they flourished alongside a plethora of private institutions, clinics and spas that catered for ‘the alcoholics, the morphinists, the epileptics, and the mentally retarded.’⁷⁴ Indeed, it is important to remember that while this period saw the medicalisation of many mental ailments, with alienists thrust (some would say thrusting) into the professional spotlight, beyond the walls of the asylum time-honoured therapies and remedies continued to be employed. ‘Nerve specialists’ proposed a variety of cures both in and outside hospitals and private clinics. Old and new treatments such as hydrotherapy, homeopathy, fashionable diets and regimes, patent pills and mixtures, and new ‘scientific’ techniques such as electric stimulation, hypnotism and mesmerism, jostled with the new psychiatry for patients’ favour, and for their pockets.

Nor did psychiatrists immediately gain uncontested authority in determining who could be deemed to be an ‘insane person’. On the one hand, through the nineteenth century the administrative procedures, including certification by medical practitioners, the keeping of standardized patient records in Case Books from 1853 onwards, the recruitment and training of nursing staff by Physician Superintendents of asylums, and so on, was formalized into a set of practices that were increasingly acknowledged as being the bailiwick of doctors of the mind. On the other hand, however, they faced some resistance from powerful professions that historically had played a significant role in determining issues of madness and culpability, most notably religious groups and the law. Both organized and evangelical Christianity, for example, continued to regard some behaviours – such as the excessive consumption of alcohol, or masturbation – in terms of sinfulness

⁷⁴ Shorter, *History of Psychiatry*, p. 34.

rather than as medical or mental illnesses. Non-establishment ‘healing churches’ – grouped loosely under the umbrella term ‘the Metaphysical Movement’, the most well-known of which were Christian Scientists – emerged in some strength in the latter part of the century. They rejected the authority of medicine in favour of faith, but these ‘mind cure sects’ failed to solve the problem of mental illness. Moreover, as Norman Dain illustrates in his overview of the history of anti-psychiatry in the United States, Christianity and psychiatry were not inherently in opposition. Moral treatment regimes in asylums after all were not infrequently accompanied by religious services and many of the most active campaigners for humane treatment of the mentally ill came from established religion, most notably the Quakers.⁷⁵ Just as it is important to remember that there was no single ‘psychiatric profession’ that spoke univocally on matters of madness, nor was there a uniform religious reaction to the secularisation of medicine. Indeed, Dain argues that in ‘contrast to the turmoil in medicine that threatened the authority of the general practitioner in the first half of the nineteenth century, the new profession of psychiatry enjoyed much public prestige.... Elite religious and secular groups alike initially considered moral treatment highly successful and worthy of public support’⁷⁶

Both lawyers and psychiatrists came to agree that if a person could be found to be the victim of a mental disease, then the person was not responsible for his or her actions. However, there were murky areas in both medicine and law in determining insanity. This was in part because:

Much of the nineteenth century was spent with lawyers and psychiatrists speaking different languages and operating with different concepts. Lawyers spoke a ‘voluntarist’ discourse, assuming behaviour was voluntary and explicable in terms of Folk Psychology concepts: intentions, desires, beliefs and character flaws. On the other hand, psychiatrists spoke in a ‘determinist’ discourse, assuming that the presence of physical illness undermined the voluntariness of everyday action and amounted to insanity.⁷⁷

⁷⁵ N. Dain, ‘Anti-Psychiatry in the United States’, in Micale and Porter (eds) *Discovering the History of Psychiatry*, pp. 415-444.

⁷⁶ Dain, ‘Anti-Psychiatry in the United States’, p. 418.

⁷⁷ L. Reznick, *Evil or Ill? Justifying the Insanity Defence* (London and New York: Routledge, 1997), pp. 25-26.

Especially problematic was the knotty issue of establishing whether or not those who had committed a crime, and knew that they had done so but who nonetheless claimed that they could not control their actions, should be held to be criminally responsible. From the 1840s, some – but not all – psychiatrists subscribed to the theory that ‘there was a form of insanity evidenced by immoral and illegal acts committed by an essentially rational person. To jurists, along with clergymen, among others, this theory of moral insanity converted all crime to mental disorder: It medicalised crime and hence threatened to undermine the criminal justice system.’⁷⁸

As psychiatry sought to claim scientific status, so it also laid claim to expertise in the field of determining insanity. Even after the adoption of the M’Naghten Rules of 1844, which established guidelines to establish ‘the legal basis for criminal insanity and responsibility’, jurists continued to dispute the validity of psychiatric ‘models of consciousness and conduct [and the] boundaries between the bad and the mad remained contested, as did the public role of psychiatry.’⁷⁹ For instance, law courts were not obliged to call medical experts. Indeed, they continued to rely upon the testimony of relatives, police, and general practitioners or district surgeons as to the mental state of the accused throughout the period covered by this study. As James H. Mills shows for India in the mid to late-nineteenth century, this was perhaps even more important in situations where Western magistrates were called upon to decide whether subject peoples were criminally culpable or mentally ill.⁸⁰ So, too, in colonial Natal and in Zululand not only did doctors, let alone government officials and employees, who observed awaiting trial prisoners, have little or no experience of or expertise in identifying bona fide mental disturbance, but they were frequently over-stretched in their responsibilities and therefore only the most visibly deranged – usually excessively violent or unusually uncooperative -

⁷⁸ Dain, ‘Anti-Psychiatry in the United States’, p. 422.

⁷⁹ Porter, *The Greatest Benefit*, p. 501.

⁸⁰ Mills, *Madness, Cannabis and Colonialism*, pp. 82-90.

inmates would be immediately recognized as potentially insane. In such circumstances the evidence given by relatives or associates of 'criminal lunatics' could prove to be decisive in swinging a judgement of 'not guilty by reason of insanity'.

In colonial Natal, as elsewhere in much of Africa, indigenous categories of both illness and healing were often alien to Western legal and medical precepts. Questions of responsibility for criminal actions were particularly exercising when the perpetrators claimed that they had been compelled or commanded by witches or spirits to behave in ways that Western law condemned. Some administrations relied on the services of court 'Native assessors' in giving locally-informed opinions about madness; others called on testimony by African elders and Native Policemen.⁸¹ Indigenous healers were, however, more likely to be regarded as part of the problem, as 'wicked' if not themselves the victims of forms of mental illness, especially hysteria, than as valued experts on insanity. Hyslop and, his later successors as Medical Superintendents at the asylum were sometimes called upon to examine criminals suspected of mental deficiency or deviance, but colonial psychiatrists were not automatically called to give evidence on the sanity or otherwise of 'dangerous lunatics'.

In the case of the 1910 Zululand trial (to be discussed in Chapter 3) of the women known as the *amandiki* for the crime of witchcraft, white doctors and missionaries, African elders and policemen, as well as legal authorities gave their opinions on whether or not the women were sane or not guilty by reason of being afflicted by hysterical mania, but neither James Hyslop nor his asylum deputies, were called to give expert advice. This is in contrast to the case of one John Hooper, who in late 1902 and early 1903, apparently stole 'a trunk containing Bank Vouchers, photographs, silver card case, clothing, jewellery, Transvaal coins, and other items, all the property of Henry Hinds [as well as] ... a Box containing cutlery, clothing, crockery, and other articles; property of Sarah

⁸¹ This will be discussed in greater detail in Chapter 3. See also Megan Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies*, 9, 2 (April 1983), pp. 219 and 234.

Craft... [and] ... 12 Bank Notes, each vale of 10 pounds, and moneys amounting to 50 pounds sterling; from [hotel] resident James Young.’⁸² Chief Justice Henry Bale referred to Hooper’s distinguished military record ‘in South Africa and in Egypt’ but commented that doubts had been raised about his ‘responsibility for what [he] had done’. Hooper was examined by Hyslop and the District Surgeon. Hyslop found Hooper to be ‘malingering, and certified accordingly’⁸³ and Bale was obliged to sentence Hooper to eighteen months with hard labour. Hooper subsequently persuaded the District Surgeon that he was mentally unsound and the prisoner was admitted to the Asylum, from whence he escaped, making it as far as Bloemfontein where he committed further crimes before being rearrested some months later. Stung by criticism from the Resident Magistrate of Lion’s River for the seeming ease with which Hooper and several others had apparently duped the medical authorities and then absconded from the NGA, Hyslop nonetheless defended the District Surgeon, stating: ‘If he means to insinuate that Hooper by his actions deceived the District Surgeon, who certified as to his mental condition, he is, I submit, casting a most unjustifiable slur on that Officer, who presumably is quite well qualified to judge of the mental condition of a prisoner under his care as the Magistrate...’⁸⁴

All this seems to suggest that it was not uncommon for suspected ‘criminal lunatics’ to be examined by medical and psychiatric doctors before trial – or for ‘dangerous lunatics’ such as the murderer Michael Kennedy (said to be a ‘chum of his’ [Hooper’s] who, whilst

⁸² PAR Registrar of the Supreme Court (hereafter RSC) 1/1/17 4/1903, Supreme Court Case, ‘Rex versus John Hooper, Theft Criminal Sessions, February 1903.’ There were occasions on which Hyslop *et al* gave expert witness testimony on the state of mind of Africans charged with criminal offences. For example, see Secretary for Native Affairs (hereafter SNA) 1/1/138 178/91, ‘Release of a Native “Zezela” from the Asylum’, 4 March 1891.

⁸³ PAR Colonial Secretary’s Office (hereafter CSO) 1739 1903/7411, ‘Magistrate, Lion’s River Division, Forwards Letter from Criminal Lunatic Michael Kennedy, 26 May 1903’, and James Hyslop, Medical Superintendent, NGA, to Colonial Secretary, 4 August 1903.

⁸⁴ A notable fellow escapee was Michael Kennedy, who was also admitted to the NGA, only to escape on 1st June 1903. See PAR CSO 1739 1903/7411, ‘Magistrate, Lion’s River Division, forwards Letter from Criminal Lunatic Michael Kennedy, 26 May 1903’, and James Hyslop, Medical Superintendent, NGA, to Colonial Secretary, 4 August 1903, and subsequent correspondence through August 1903.

‘temporarily insane due to excessive drinking’ had murdered ‘an Indian’ in Howick on the same day that Hooper had gone on his thieving spree) – to be admitted straight into the Asylum whilst it was determined whether or not they were mentally fit to stand trial. Overall, though, I have not been able to find many cases where expert psychiatric testimony was called for at trial. One record nonetheless indicates that Hyslop at least had a high standing in South African legal circles, for in 1893 when the Crown at the Cape Colony guaranteed the fees and travel expenses to Beaufort West that Hyslop had quoted for attending (presumably giving evidence) the trial of ‘Sheppard for Murder’. Apparently, Hyslop had told Sheppard’s brother that he charged a guinea a day, and the Cape Colony was prepared to reimburse him to a total of ‘an aggregate of fifty pounds.’⁸⁵

One situation in which the testimony of friends, relatives or employers was more often sought than that of those claiming to have expert insight into insanity was in cases of suicidal acts. It was not until the mid to late twentieth century that suicide was regarded as a psychiatric, rather than legal, matter and attempted suicide decriminalized.⁸⁶ However, and as the admission papers from 1916 show, many of the committals of white patients to the NGA were effected after firm intention of self-killing had been made. Indeed, attempted suicide accounted for far many more committals than did murder or other forms of ‘criminal lunatics’. Africans and Indians expressing suicidal ideation, however, were not generally admitted to the NGA. This was despite the fact that indentured Indians exhibited high rates of suicide and that self-murder was not unknown amongst Africans. As I shall argue in Chapter 5, race, class and gender were important variables in bringing persons ‘dangerous to themselves’ to the notice of medical and legal officials, influencing whether or not they would be committed to the asylum at Pietermaritzburg.

⁸⁵ PAR Attorney General’s Office (hereafter, AGO) I/8/43 109A/1893, Attorney General’s Office, Cape Town, to Attorney General, Pietermaritzburg, Natal, 4 September 1893.

⁸⁶ Suicide as a mental health and as a legal issue will be considered in more depth in Chapter 5.

Body and Mind: gender, class and race in Western psychiatry

From the first decades of the nineteenth century asylums across the West attempted to institute therapeutic, rather than merely custodial, care for the insane. Whereas successes were achieved through moral therapy in responding to the needs of some patients, by the close of the century there had been an explosion in the numbers of people being committed to the lunatic asylums. The following figures, as recorded by Shorter, illustrate this starkly: in the United States, average annual admissions climbed from 31 in 1820 to 182 in 1870, the average number of patients per asylum rising from 57 to 473. In Germany the rate of confinement grew from one psychiatric inpatient for every 5,300 population in 1852 to one for every 500 in 1911. By 1911, asylums in France, originally designed for 500 patients, housed more than a 1,000. 'In England, asylum inmates had more than doubled from 1.6 per 1,000 population in 1859 to 3.7 per 1,000 in 1909. In 1827, the average asylum had housed 116 patients; in 1910 the number reached 1,072.'⁸⁷

By 1900 the early optimism about the efficacy of reforms in asylum practices and regimes was giving way to disillusionment, as the newly built asylums were filled to overflowing. Madness, it seemed, was on the increase everywhere. It is about this apparent increase in insanity – and the role played by the asylum in it – that debates in the history of psychiatry have been perhaps most heated. This may be an irresolvable dispute: what might be termed broadly social constructionist arguments, such as those of Andrew Scull, Thomas Szasz, Michel Foucault, and R. D. Laing (among others), regard this vast swelling of asylum inmates as the effect of the professionalization of psychiatry and of the aggressive expansion of a capitalist and state ideology across Europe that could not tolerate the continued untrammelled existence of the socially marginal or unproductive poor.⁸⁸ On the

⁸⁷ Shorter, *A History of Psychiatry*, pp. 46-47.

⁸⁸ This is a debate that has generated much heat – and ink: for a helpful recent overview of the major issues, see Joseph Melling's 'Accommodating madness: new research in the social history of insanity and institutions' in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914*, pp. 1-30, and Andrew Scull's 'Rethinking the History of Asylums', pp. 295-315, in the same volume.

other hand, neo-apologists such as Edward Shorter argue for an actual increase in the numbers of the mentally ill over the course of the nineteenth century.⁸⁹ Shorter cites epidemic infectious diseases, such as neurosyphilis and meningitis, social problems such as widespread alcoholism, and changes in family structure and in attitudes towards the care of the ill that made it easier and more acceptable for disruptive relatives to be placed in asylums.⁹⁰ In the latter view, rather than professional psychiatry colonizing formerly tolerated eccentricities and turning them into pathological states of mind, or the asylum sucking in society's irrational and irksome rejects, there was a growing need to shelter the ever-increasing population of those who were genuinely disordered in mind and body, and for whom previous social safety-nets no longer existed.

If the therapeutic initiatives within the asylum appeared to have become exhausted by the opening of the twentieth century, in other sites investigations and research into the origins of psychiatric illnesses had gathered a critical momentum. This was true both of clinical studies that attempted to trace the sources of insanity through biological mechanisms, and radical new insights into the human psyche and its dysfunctions. In both arenas, it was the German-speaking world rather than in Britain or the United States that was at the cutting-edge. In what later became Germany, competing universities gave rise from early in the 1800s to a vigorous tradition of academic – including psychiatric – medicine. While here too there were expanding asylum patient populations there was also the establishment, contemporaneous with the 'larger nineteenth-century current toward research in medicine in general', of institutionally-based teaching and systematic research intended to identify different mental 'diseases' through careful delineation of the 'relationship between mind and brain'.⁹¹ A leading medical centre emerged at Berlin, where in the late 1870s or early 1880s James Hyslop would be one of the many foreign

⁸⁹ Shorter, *A History of Psychiatry*, p. 50. Here he argues that the family increasingly came to view itself as an emotional unit, rather than being based on ties of property and lineage. The mad could no longer be tolerated as they disrupted the family's definition of itself as a harmonious unit.

⁹⁰ I will consider this argument in the context of Natal and Zululand in Chapter 2.

⁹¹ Shorter, *History of Psychiatry*, p. 70.

doctors to visit, and it was here that psychiatric thought was increasingly dominated by the conviction that 'every mental disease is rooted in brain disease'.⁹² Hyslop also visited Munich, which boasted a major psychiatric research centre. At Vienna, another of Hyslop's destinations after his graduation from Edinburgh, neuropathology and biological psychiatry also occupied prominent status in late nineteenth century.

The search for the 'organicity' of mental diseases was taken up by a broad spectrum of medical investigators, not all of whom were psychiatrists. One important area of research concerned epilepsy. Variouslly termed both the 'sacred disease' and the 'falling sickness', in the West epilepsy had a paradoxical tradition, being regarded as either a 'disgraceful disease' or as a sign of divine blessing, and later as a Romantic spark of the artistic creative genius. Consensus as to the exact presentation of epilepsy remained fluid for much of the nineteenth century and many patients who exhibited dementia, idiocy, mania and other symptoms were also diagnosed as epileptic. Under the exploratory realm of neuropathology, however, 'localization theories laid the foundations for a solid grasp of the relations between seizures and the brain abnormalities responsible for irregular electrical discharges'.⁹³ As historians of epilepsy and medicine have noted, however: 'One possibly ambiguous consequence of this tide of neurological research was that it tended to conflate – or, at least, perpetuate the conflation of – epilepsy with mental disorder ... Epileptics were frequently herded with the insane in madhouses.'⁹⁴ Despite, or perhaps because of, the identification of epileptic seizures with misfiring neurons, medical misunderstandings of its underlying causes continued as, as even in the late 1800s and early 1900s epilepsy was attributed to masturbation, stigmatised as a form of insanity, and, for the influential Italian criminologist Cesare Lombroso, intimately linked to criminality. In France, Germany and the United States exclusive institutions for

⁹² This pithy phrase is that of Wilhelm Griesinger (1817-1868) who has been termed the founder of German university psychiatry.

⁹³ G. Berrios and R. Porter (eds), *A History of Clinical Psychiatry: The Origin and History of Psychiatric Disorders* (London and New Brunswick, NJ: The Athlone Press, 1995), Chapter 6 'Epilepsy', p. 169.

⁹⁴ *Ibid.*

epileptics were constructed from around 1850, but in Natal admissions to the NGA of patients described as ‘epileptic’ continued through to World War I and beyond. When we take into account Hyslop’s recorded complaints about the number of ‘idiots’ and ‘epileptics’ at the NGA,⁹⁵ it seems that this was probably more the consequence of the absence of alternative facilities than it was of any deliberate practice.

The neurological turn could also be seen in investigations into another malady that had long been the concern of doctors of the mind: hysteria. In France, the charismatic and for a time extremely influential pathologist Jean-Martin Charcot – chief physician at the Salpêtrière from 1862 to 1893 – claimed that hysteria was a genetically-transmitted disease of the nervous tissues. This diagnosis did not live much beyond the end of the century, however, and the close association between hysteria and femininity that had existed for centuries and which was so dramatically on show in Charcot’s weekly demonstrations of female hysterics, was severely dented by the horrors of World War I that induced unprecedented manifestations of ‘hysterical’ symptoms in men.

The history of hysteria as a diagnostic category that has both waned and gained in popularity is an excellent entry point into the vast literature that exists on the relations between madness, medicine, and gender. For, notwithstanding the millennia-long association of women and unreason in the West (if not everywhere) as Elaine Showalter has most famously described, it was only from the late eighteenth century that in the popular, literary, medical, and cultural mind madness became a distinctly ‘female malady’.⁹⁶ Initially portrayed as ‘the appealing madwoman’, female lunatics came to personify some of the major concerns of the time: As victims of cruel and abusive husbands who had them locked away their plight helped propel a moral crusade for asylum and legislative reform; as fictional characters in novels, plays and opera the

⁹⁵ *Natal Blue Book, 1900*. Natal Government Asylum.

⁹⁶ See E. Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (London: Virago Press, 1987), Introduction.

‘victimized madwoman became almost a cult figure for the Romantics’⁹⁷; and as the majority of inmates in asylums, due in part to their greater longevity, as the nineteenth century progressed,⁹⁸ women became more and more the archetypal psychiatric subject. Moreover, less benign visions of women who were out of their minds with lust or anger also emerged, apparently embodying a threat to the patriarchal gender order of society. Feminist scholars of Western psychiatry have linked the social and ideological context of the late 1800s when middle-class women were pressing for a wider sphere of female rights in politics, law, education and employment, to an increased concern with ‘the female nervous disorders of anorexia nervosa, hysteria and neurasthenia.’ [In response to such an ‘epidemic’ arose] the ‘... Darwinian “nerve specialist” ... to dictate proper feminine behavior outside the asylum as well as in, to differentiate treatments for “nervous” women of various class backgrounds, and to oppose women’s efforts to change the conditions of their lives.’⁹⁹

For the nineteenth century also saw new medical rationales for the linkages between women’s bodies and their supposedly fundamentally irrational nature, which, it was widely believed, predisposed them to certain forms of insanity. Greater knowledge of female physiology underscored the notion that a woman’s life cycle – ‘bounded by the pivotal crises of puberty and menopause and reinforced each month by her recurrent menstrual flow’¹⁰⁰ – made her vulnerable to the exigencies of her reproductive organs.

⁹⁷ Showalter, *The Female Malady*, p. 10.

⁹⁸ There is some debate about whether or not women constituted the majority of asylum patients in the 1800s. This was the assertion made by Phyllis Chesler in her influential book *Women and Madness* (New York: Doubleday, 1975), but many scholars have since disputed this. See, for example, R. W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley and Los Angeles: University of California Press, 1978), pp. 123-4, and the excellent review by Nancy Tomes ‘Feminist Histories of Psychiatry’ in M. S. Micale and R. Porter (eds.) *Discovering the History of Psychiatry* (New York and Oxford: Oxford University Press, 1994), pp. 348-383.

⁹⁹ Showalter, *The Female Malady*, p. 18.

¹⁰⁰ C. Rosenberg-Smith ‘Puberty to Menopause: The Cycle of Femininity in Nineteenth Century America’, in M. Hartmann and L. W. Banner (eds.) *Clio’s Consciousness Raised* (New York: Harper & Row, 1974), p. 24, also quoted in J. Busfield, *Men, Women and Madness*:

Menstruation, childbirth, lactation and menopause were all times at which women's already generally deficient intellect and weaker 'will' rendered them especially susceptible to the vagaries of their emotions and passions. If women presented signs of madness, these could be said to have been precipitated by 'exciting causes', more immediate environmental triggers (such as 'love affairs' and 'parturition') that merely unleashed an underlying tendency towards unbalanced behaviour that was more characteristic of women than of men. Whether in the biological psychiatry of the late 1800s, the psychoanalytic approach of Sigmund Freud or, as we shall see, in the minds of missionaries, doctors and government officials in places such as colonial Natal, it was hysteria that remained the quintessential female mental condition. Indeed, '98 percent of the hysteria cases at Edinburgh Infirmary [in the late 1800s]... were female.'¹⁰¹ Understood at the time as an affliction of the body that affected the mind, hysteria was also thought to be the consequence of the female's inability to channel her nervous energy in acceptable ways.

The notion of the ideal woman that predominated in the era of the emergence of modern psychiatry was one that emphasised docility, delicacy, restraint, and refinement. Medical opinion held that defiance of this behavioural and emotional identity could be dangerous for women for, as Roy Porter remarks '(m)ale medical opinion warned, sternly and ceaselessly, that the woman who trespassed beyond the domestic sphere would suffer psychiatric collapse.'¹⁰² One corollary of this powerful ideological construction of femininity was that all women could potentially fall victim to madness at some point, if they strayed too far from their essential nature. To quote Porter once more: 'It was ... the somewhat less disturbed woman living in society – the nervous case, the hysteric, the so-

Understanding Gender and Mental Disorder (Houndmills, Basingstoke and London: Macmillan Press, 1996), p. 149.

¹⁰¹ E. Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London: Picador, 1998), p. 16.

¹⁰² R. Porter, *A Social History of Madness* (London: Phoenix, 1996), pp. 118-119.

called 'neurasthenic' – who came under a distinctively penalizing psychiatric gaze.'¹⁰³ Furthermore, it was axiomatic that the female of the species – or at least the middle and upper class variety anyway – needed to preserve her 'nervous energy' or 'life force'. Hence, treatments for hysterical symptoms, depression, neurasthenia, neurosis, nervous strain, and other forms of mental depletion that were not sufficiently extreme to have the sufferer certified as insane stressed passivity, domesticity and 'rest'. That these 'cures' replicated the patriarchal demands of the time, and very likely exacerbated the psychological suffering of the women thus treated, has been one of the major critiques of Western psychiatry ever since.

In colonial contexts, as many scholars have recently explored, gender, class, mental (in)stability and sexuality all intertwined in ways that reflected colonial anxieties about the social order. As Sally Swartz comments: 'The implications of seeing women as at the mercy of their reproductive organs were far-reaching for those women described as insane.'¹⁰⁴ White women were widely regarded as being especially vulnerable to giving way to madness, not only because of their frailties as *women*, but as *white* women, with weaker bodies and minds, they were doubly subversive for they were thought to be more inclined to break down under the strain of climate, as well as the exigencies of colonial life. Even more dangerously, they were also held to be less able to withstand the temptations of sexual relations with black men. This dovetailed with a construction of black men as highly sexualised predators, whose intimate proximity to white women – particularly within the domestic space – posed a threat to colonial racial exclusivity, and ultimately, rule.¹⁰⁵ The supposed hyper-sexuality of black women, a typical colonial

¹⁰³ Porter, *A Social History of Madness*, p. 118.

¹⁰⁴ Swartz, 'Colonialism and the Production of Psychiatric Practice at the Cape', p. 100.

¹⁰⁵ This is an enormously important area of recent scholarship but one that, because of space constraints, is not fully developed here. See my preliminary comments in the Introduction, as well as citations to the works of Stoler, McCulloch and Martens there. Also, A.L. Stoler, 'Carnal Knowledge and Imperial Power: Gender, Race and Morality in Colonial Asia', in J.W. Scott (ed.) *Feminism and History* (Oxford: Oxford University Press, 1996), and Stoler, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things* (Durham

trope, not only served to gloss over the reality that it was white men who were the primary perpetrators of sexual violence, but also – as we shall see in Chapter 3 – meshed with nineteenth and early twentieth century notions of the close and causal links between women, their bodies and their propensities for irrational, extreme and incomprehensible behaviours.

The paradigm of research that scrutinized the tissues, nerves and fibres of the human brain and body, as revealed through painstaking autopsies and microscopic studies of cells and cerebral connections, of lobes and lesions, would underpin a wealth of brilliant anatomical bio-pathological findings that served the clinicians' claims to scientific objectivity well.¹⁰⁶ They did not necessarily lead, in the short term at least, to major improvements in the treatment and care of the victims of the mental diseases so exhaustively examined. It is tempting to refer here to Foucault's concept of the 'clinical gaze',¹⁰⁷ for it conveys something of the growing sense of distance between medicine and its objects of study that biological psychiatry appeared to exemplify around the turn of the last century. This is the language of Alexander Butchart's analysis of the operation of colonial psychiatry in South Africa. Indeed, he specifically – albeit anachronistically – refers to 'Town Hill Hospital in Pietermaritzburg' as being the site where, in 1875, 'the first glimpse' into the African psyche occurred.¹⁰⁸ While not denying the power of Foucault's insight, especially for its highlighting of the discourse of distance that constituted doctor-patient relations in psychiatry as in other branches of biomedicine,

and London: Duke University Press, 1995). S. Swartz's Chapter 5, 'Race and Gender in South African Medical Knowledge' covers the literature well and extends the analysis far more deeply than I can in this study, which is not exclusively focused on Western psychiatric knowledge.

¹⁰⁶ The studies of the organic basis of the psychiatric symptoms produced in neurosyphilis were especially significant here.

¹⁰⁷ M. Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, translated by A.M. Sheridan (New York: Vintage Books, 1994); originally published in 1963.

¹⁰⁸ A. Butchart, *Anatomy of Power: European Constructions of the African Body* (London and New York: Zed Books, 1998), p. 111.

there were other important strands to Western mental medicine in the 1800s and 1900s that helped to propel this discipline in different directions.

Edward Shorter describes how, by the first decade of the twentieth century, the paradigm of biological psychiatry appeared to have ended in a *cul-de-sac*. Instead, it was eclipsed by a new vision of psychiatric illness. This 'new approach saw illness vertically rather than cross-sectionally: trying to understand the patient's problems of a given moment in the context of his or her lifetime history, in contrast to the biological approach of trying to correlate the symptoms of the moment with neurological findings and with brain findings postmortem.'¹⁰⁹ Two major figures are associated with the reorientation of psychiatry at this time: Emil Kraepelin and Sigmund Freud. Since the influence of the latter was hardly felt in southern Africa before the First World War, his contribution to psychiatry will only be noted here, but Kraepelin's revision of some of the most fundamental tenets of Western thinking about the diagnosis and prognosis of madness were more immediately felt in colonial psychiatric circles.

The 'Kraepelinian revolution' was brought about through adoption of the practice of systematic observation of the course of mental illness in a patient over a long period of time. On this basis of observing common eventual outcomes, Kraepelin deduced that there were several 'principal types' of psychiatric illness. Reviewing and revising his findings in successive editions of his monumental textbook, *Compendium der Psychiatrie*, by the late 1890s Kraepelin had decided that the myriad forms of insanity that were then being identified and named could – if not due to an underlying physiological cause (such as neurosyphilis) – in fact, be divided into two large categories: 'illnesses involving an affective component, and those without an affective component.'¹¹⁰ Excessive exaltation and desperate depression were therefore not evidence of distinct diseases, but instead manifestations of the former psychiatric disease grouping, that now termed 'manic-depressive psychosis'. Psychoses characterized by disturbed thoughts but without notable

¹⁰⁹ Shorter, *History of Psychiatry*, p. 99.

¹¹⁰ Shorter, *History of Psychiatry*, p. 107.

affective change were grouped under the rubric of ‘dementia praecox’.¹¹¹

Marking a massive rupture from more than a thousand years of practice that had based the naming of a mental illness on symptoms with very specific causes (Shorter cites ‘monomania’, ‘moon madness’ and ‘old maid’s insanity’ as examples), the new psychiatry admitted that the aetiology of illnesses could remain unknown. Certainly, there did not have to be a direct correlation between a single lesion, or malformed nerve tissue, and a mad person’s individual manifestation of insanity. What was also crucially important was that Kraepelin and his adherents postulated that these major mental illness groupings had divergent prognoses. The majority of those who suffered from the cyclical manic-depressive ailments could expect some improvement to occur spontaneously, if by no means instantly; for the majority of “d.p.” patients, however, the prognosis was less encouraging, as more likely than not, in this era of at best palliative treatments, dementia lay at the end of the road.

From the gloomy weight of sin and divine intervention, through late Enlightenment optimism about the malleability of human nature towards an improved future, through postivist science that sought to establish the material causes of madness, over the course of the nineteenth and early twentieth centuries, influential ideas about the nature of insanity underwent profound change in the West. By the *fin-de-siècle* much of the early optimism had been lost. Asylums were filled to overflowing with both new and chronic long-term patients, for whom hope of recovery seemed a remote prospect. Biological psychiatry had, to be sure, revealed the organic basis of several major psychiatric illnesses, but much remained opaque. ‘Alienists’ asserted their primacy in the field of psychiatric knowledge, but their failure to satisfactorily elucidate the origins of insanity and their as yet woefully inadequate means of managing mental suffering meant that a wide spectrum of cures and practitioners continued to compete in the quest to secure mental health.

¹¹¹ Dementia praecox – premature dementia – would later be renamed ‘schizophrenia’. For a helpful overview of both the clinical and the social histories of schizophrenia, see Chapter 13 ‘Schizophrenia’ by J. Hoenig and T. Turner in Berrios and Porter, *A History of Clinical Psychiatry*, pp. 336-359.

Nineteenth century Western medical science, including psychiatry, drew on complex and sometimes contradictory views about the nature of the relationship between the human body and the mind. Liberalism, for instance, pointed to the universality of human nature. Yet, at the same time, difference and hierarchies were not foreclosed within such an epistemological mindset: the positing of the biological and mental inferiority of women was one example, as already discussed. Indeed, many have argued that modern formulations of race – to take another important example – were made possible precisely because differences were ‘recognised and elaborated within liberal discourse’.¹¹² Identifying perceived physical and mental differences through the supposedly objective sciences of measurement, classification, and the ordering of typologies could – and did – provide a powerful rationale for paternalism that found its expression in the ‘civilising mission’ of colonial expansionism. Thus, many of the branches of nineteenth century sciences that impinged on the identification of the mentally diseased or deviant, such as phrenology, comparative anatomy and physiology, have been closely associated with the development of a pernicious scientific racism, both in the West and elsewhere. And yet, this same humanitarian liberalism, with its corollary of a rights-based discourse, could constrain the expression of unmitigated domination. Racism and universalism could coexist, if not always comfortably.

Psychiatry, in the nineteenth and early twentieth centuries, showed ample evidence of both the biologist and the environmentalist tendencies within medical science more generally. The former was clear in the elaboration of the theories that observable physical characteristics were indicative of internal propensities or abilities such as intelligence, the ability to experience and express certain emotions (such as guilt or depression), and a capacity to appreciate the benefits of ‘civilisation’. Darwin’s evolutionary paradigm, increasingly albeit contentiously popularised from the mid decades of the century, simultaneously underlined the universality of humanity as a single ‘race’, and helped to

¹¹² See discussion by Harriet Deacon in her ‘Racial categories and psychiatry in Africa: The asylum on Robben Island in the nineteenth century’, in W. Ernst and B. Harris (eds) *Race, Science and Medicine, 1700-1960* (London and New York: Routledge, 1999), pp. 101-122.

further a belief that ‘individual (human) “races” were “varieties” or “subspecies’ .. [with] ... each race ... being subject to continual modification and development rather than to a static set of inherited characteristics.’¹¹³ ‘Race’, of course, was at this time conceived in terms of hierarchies, with body type – including colour, physiognomy, cranial and pelvic capacity, angle and slope of nose and forehead, and so on – apparently indicating position and potential along the human spectrum. In this way, Jews, the Irish, Indians, and Africans, were deemed inferior ‘races’, whose apparent cultural inferiority was linked to their material and mental inheritance.

Indeed, it is not necessarily helpful to make a stark distinction between these two approaches to then current thinking about the origins of illnesses, since, for example, ‘race’ and ‘culture’ were not easily disentangled. An oft-quoted illustration of this comes from the United States in the mid-1800s, when the *New Orleans Medical and Surgical Journal* of May 1851 published a paper titled: ‘Report on the Diseases and Physical Peculiarities of the Negro Race’, by S. A Cartwright. In this paper, two diagnostic categories said to be ‘peculiar to black people’ were described. These were, firstly, ‘...“dysathenia aethiopis”, ‘described as a disease affecting both mind and body, with “insensibility” of the skin and “hebetude” of mind, commoner “among free natives living in clusters by themselves than among slaves in our plantations, and attacking only such slaves as live like free negroes in regard to diet, drinks, and exercise, etc.”’¹¹⁴ This condition manifested itself in theft, in wanton damage to property, and in gratuitous challenges to ‘overseers and fellow servants’. The cause, as identified by Cartwright, was said to be ‘negro liberty’, more specifically, the lack of ‘some white person to direct and take care of them’. The second condition, ‘drapetomania’, was termed the ‘disease causing slaves to run away.’ Its cause was not, as one might imagine, the condition of slavery itself, but using frightening cruelty or instead ‘treating them as equal’.

¹¹³ S. Fernando, *Mental Health, Race and Culture* (Houndmills, Basingstoke and London: Macmillan and MIND Publications, 1991), p. 14.

¹¹⁴ S A Cartwright, ‘Report on the Diseases and Physical Peculiarities of the Negro Race’, in *New Orleans Medical and Surgical Journal*, May 1851, pp. 691-715. I have drawn this quotation from S. Fernando, *Mental Health, Race and Culture*, p. 36.

Ideas of race were necessarily bound up with those about heredity. When the early nineteenth century optimism about the possibilities of moral treatment and institutional reform became overwhelmed by the sheer volume of people being confined to asylums, this ‘therapeutic pessimism bred a new hereditarianism’.¹¹⁵ In this view, individuals, families, and whole societies were threatened by an accumulated burden of inherited traits and behaviours that were especially evident in a society’s ‘degenerates’, more especially its criminals, alcoholics, and lunatics. What Roy Porter describes as a ‘degenerationist model’ became systematized through the course of the 1800s. This model was explained by

both organic and social factors ... [and] ... as cumulative over the generations, descending into imbecility and finally sterility. A typical generational family history might pass from neurasthenia or nervous hysteria, through alcoholism and narcotics addiction, prostitution and criminality, to insanity proper – and finally utter idiocy. Once a family was on the downward slope the outcome was hopeless.¹¹⁶

Abnormal and psychopathological states of mind were therefore intimately connected to social class, as well as to race and gender. The linkages between psychopathology and race was especially apparent in the identification of one category of mental patients – previously commonly called ‘idiots’ – on the basis of their supposed resemblance of a particular ethnic or ‘racial’ group. In his 1866, ‘Observations on the Ethnic Classification of Idiots’ British asylum physician, John Langdon H Down noted the ‘superficial facial features and behavioural attributes of those idiots that he referred to as ‘typical Mongols’. As Mark Jackson explains, in Down’s opinion ‘the ”ethnic features” of “mongolian idiots” were largely the result “of degeneracy arising from tuberculosis in the parents”’¹¹⁷ While giving name to a label that would stick for more than a century, and in doing so furthering the alienation of an already misunderstood group of patients, Down’s conclusions were

¹¹⁵ Porter, *The Greatest Benefit*, p. 510.

¹¹⁶ *Ibid.*

¹¹⁷ M. Jackson, ‘Changing depictions of disease: Race, representation and the history of ‘mongolism’, in Ernst and Harris (eds.) *Race, Science and Medicine, 1700-1960*, p. 171.

nonetheless challenging for what Jackson terms ‘polygenist beliefs’ that racial divisions were fixed. Instead, Down claimed, “‘(t)hese examples of the result of degeneracy among mankind ... appear to me to furnish some arguments in favour of the unity of the human species.’”

Whereas degenerationism became, by 1900, ‘part and parcel of European culture’, being ‘picked up by the eugenisists, by the social hygienists intent on combating mental retardation with sterilization, and by antidemocratic political forces with a deep hatred of “degenerate” groups such as homosexuals and Jews’,¹¹⁸ according to Shorter, the paradigm held sway over academic European psychiatry for a relatively short period of time, and by the end of the first decade of the twentieth century had generally been discredited in such circles. The stark, and tragic exception, was Germany, where by the 1930s, ‘(a)cademic medicine ... on the whole stood waist-deep in the Nazi sewer.’¹¹⁹ Abuses of psychiatric diagnosis and treatment were of course not confined to Hitler’s Germany; nor are notions of racial purity and perfectibility peculiar to any discrete historical era, but in the period leading up to World War I, the profession of psychiatry would both reflect and reinforce a concern with race and sex that would differentiate people on the basis of supposedly inherited physiological characteristics. Its methods of describing and deciphering the sources of insanity had, by that time, acquired a large measure of authority and were undoubtedly hugely significant for the many tens of thousands of persons around the world who were committed to lunatic asylums, treated in private clinics or at spas and rest homes, or who identified themselves as suffering from mental illness and who sought solace through psychiatric regimes or psychoanalysis.

As biomedical practitioners fanned out through the world, some consciously as part of the ‘civilizing mission’, others propelled by professional prospects, Western psychiatry would

¹¹⁸ Shorter, *History of Psychiatry*, p.99.

¹¹⁹ *Ibid.*

be practised in places very far from its genesis.¹²⁰ In Africa – as in Asia and elsewhere – its aetiological and nosological categorizations, its secular and materialist explanations, and later, its treatments, would be applied to peoples who had very different ways of understanding the origins and the meanings of madness. These ideas were not immediately overthrown, but nor were Western psychiatry and its remedies wholly rejected. While much recent scholarship has focused on the role of the asylum and of professional psychiatric knowledge and practice in creating an exploitative racialised science in the colonized world, little attention has been given to how local people received the institutions and ideas of insanity that were brought by Westerners in the nineteenth and early twentieth centuries. Moreover, once we acknowledge both the flexibility and the resilience of indigenous ‘non-Western’ ways of diagnosing and treating illness, including mental illness, an understanding of such becomes a crucial perspective in the history of health and healing, however defined.

States of mind: African and Indian therapeutic traditions

Drawing on a wealth of contemporary writings, historical syntheses, and critiques from a variety of perspectives, it is all too easy to recount a history of post-Enlightenment conceptions of mental illness as well as the rise of the psychiatric profession in the West. Unfortunately, the same cannot be said for elsewhere in the world, where we know far less about how theories and therapeutics of madness may have undergone change throughout the nineteenth and early twentieth centuries as a result of massive socio-economic changes and indigenous interactions with colonialism and with Christianity. As historians Bob Edgar and Hilary Sapire have commented:

Much research on changing conceptions and healing of mental disorders in twentieth-century African societies is still needed. A vast literature exists about changing Western psychiatric practices, about the constant abandonment of old

¹²⁰ On the factors fanning the expansion of medical professionals to South Africa in the late 1800s and early 1900s, see A. Digby, “‘A Medical El Dorado’? Colonial Medical Incomes and Practice at the Cape’, *Social History of Medicine*, 8, 3 (1995).

classifications and their replacement by 'new' disorders. Similarly, it is clear from anthropological accounts that although Africans continuously sought out 'traditional' cures for their mentally distressed, both the cultural expressions and treatments of behavioural and affective disorders changed markedly in the first three decades of the [twentieth] century under the impact of shattering social change associated with intensified migrancy and urbanization.¹²¹

In tracing such a history, the difficulties are both epistemological and methodological: the former because, as outlined in the Introduction, Western scientific biomedicine, as seen perhaps most especially in psychiatry, is unusual in terms of world cultures in that it has increasingly insisted upon a separation between parts of the self, determined as 'mind', 'body', and 'spirit/soul'. Western thinking and subsequent scholarship, with its division of mind, body and spirit – and thus of medicine, magic and religion – speaks of madness, witchcraft, spirit possession, and, in the context of Africa, syncretic Christianity, as being distinct phenomena. However, as Suman Fernando and many others have explained, most cultures beyond the West have resisted the mind-body dualism, with significant implications for explaining the origins and healing of disease, and I would suggest, instead, that it is helpful to regard such phenomena as a variety of culturally and historically dynamic therapeutic systems that reflect the spectrum of mental health.

In writing a history of responses to psychological distress, then, methodological difficulties arise from the absence of a discrete practice of mental healing where the body and mind are regarded as compartmentalized entities, and where the individual's illness is conceived in contradistinction to the well-being of the social grouping with which he or she identifies. Precisely for these reasons, in the history of African healing of mental

¹²¹ R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 2000), p. 48. Given the limited number of available ethnographic and other treatises from the late nineteenth and early twentieth centuries that are in any way concerned with mental illness in this region, it is not surprising that this section shows considerable overlap with the sources drawn on by Edgar and Sapire, and by Karen Flint, and Leslie Swartz. My archival research – more fully detailed in later chapters – leads me to give somewhat of a different emphasis however in that I am concerned not with the experiences of a person such as Nontetha Nkwenkwe, wrongly incarcerated as a madwoman, but with the ways that broad diagnostic categories such as *indiki* may have been manifested, and have changed, in the half century before 1918. This leads to a rather different narrative than that suggested by the life story of Nontetha Nkwenkwe.

illnesses, for example, there is no written tradition of ‘Great Men’ who have specialized in insanity, or of the identification and naming, at specific times and places, of carefully delineated manifestations of madness. For a region where therapeutic practices were, and still are, largely passed down by word and through apprenticeship, there is the additional burden for the historian in sifting through written sources that by and large were generated by authors who were either (or both) uncomprehending of, or unsympathetic to, indigenous understandings of health and illness. Such sources as we do have – from colonial officials, missionaries, biomedical doctors, ethnographers, and through court cases and hospital and asylum records – nonetheless can tell us something of the story of the search for mental health in south-eastern Africa in the nineteenth and early twentieth centuries.

As Karen Flint has recently explored, the region that today is KwaZulu-Natal is heir to three medical traditions – African, European, and Indian – that over the past century-and-a-half have been engaged in processes of both contestation and of cultural exchange. Her study of the interactions of these three streams of therapeutic beliefs and practices from the 1820s to the 1940s clearly shows that Western biomedicine has not simply been a hegemonic ‘tool of empire’, and that ‘traditional’ indigenous healing practices and medicines are by no means as unchanging as both Western commentators and present-day ‘traditional healers’ have often insisted.¹²² Rather, ‘Western’ medicine is one, and

¹²² K. E. Flint, ‘Negotiating a Hybrid Medical Culture: African Healers in Southeastern Africa from the 1820s to the 1940s’ (unpublished PhD dissertation, University of California, Los Angeles, 2001), Introduction, and p. 2. At a workshop on health, healing and oral history held by the Department of Historical Studies at the University of Natal, Durban, in July 2003, a number of traditional healers insisted on the unchanging nature of African diagnostic categories, ailments, and treatments as revealed by ancestors. The specificity of certain ‘African’ complaints – such as said to be caused by *indiki* or *ufufunyane* possession – bears striking similarities to the notion of ‘culture bound syndromes’ put forward by Western medicine. It will be an important part of my argument in Chapter 3 of this dissertation that these categories of illness have been historically constructed and that careful attention needs to be paid to their manifestations at particular times and places. For recent reflections on African healing, professionalization of healers and claims to curative authenticity, see Annie Devenish, ‘Negotiating Healing: the Professionalisation of Traditional Healers in Kwazulu-Natal between 1985 and 2003’ (unpublished M.A. thesis, University of Natal, Durban, 2003).

usually not the first, of a range of options utilized, and biomedicine has been simultaneously appropriated and resisted by African health practitioners. Furthermore, there have been ‘borrowings’ both ways between ‘African medicine’ and the healing traditions brought to Natal by indentured workers and Muslim merchants from India from the 1860s. For instance, while ‘Indian *izinyanga*’ (herbalists) and traders have long been an important part of the *umuthi* trade, as well as ‘Indian herbs’ and powders forming components of some *umuthi* preparations, some ‘African’ forms of affliction, such as that identified by possession by an *ufufunyane* spirit, have been known to trouble Indians.¹²³

Flint raises important questions about the exclusivity or otherwise of ‘Zulu’ medicine, but she also identifies a ‘central core of beliefs’ that was ‘dynamic and changing’. Such a core drew on wider geographical and historical therapeutic understandings of the nature of the relationships between people, their bodies, illness, and the polity in which they lived. In sub-Saharan Africa, Bantu-speaking peoples shared significant common aspects of medical culture, including ‘... similar surgical and non-invasive therapeutic techniques, an occupational division between healers who only use herbs [*izinyanga* in isiZulu] and those who heal through clairvoyant means [*izangoma* in isiZulu], and a maxim of “no cure-no pay”.’

Likewise each group developed their own medical and ritual specialists, learned to use plants that grew locally, and experienced therapeutic innovations. Evidence of an ancient common medical heritage, however, can be found in several medical word cognates such as *ti* – medicine; *nganga* – doctor; and *ngoma* – diviner. Furthermore, John Janzen argues that cultures throughout central and southern Africa share a unique historical healing institution that demonstrates linguistic, behavioral, and structural similarities.¹²⁴

What is clear is that in this region, as elsewhere in the world, a range of means for the expression of psychological stress and conflict has always existed. For instance, African

¹²³ H. Kuper, *Indian People in Natal* (Pietermaritzburg: University of Natal Press, 1960), pp. 258-259.

¹²⁴ Flint, ‘Negotiating a Hybrid Medical Culture’, pp.49-50. For a recent re-examination of the concept of *ngoma*, see R. van Dijk, R. Reis and M. Spierenburg (eds.) *The Quest for Fruition through Ngoma: Political Aspects of Healing in Southern Africa* (Oxford: James Currey, 2000).

societies clearly recognized different forms of 'mental' afflictions 'that manifested themselves in frenzied, violent, and irrational acts, in dysphoric, melancholic states, as well as in the "loss of the senses" which included stupors and fits.'¹²⁵ A variety of states of mind and mental capacity, some of which would only be differentiated and named in Western psychiatry in the 1800s and 1900s are suggested by the following isiZulu terms recorded in the early 1920s:

manetha: 'a person whose brain is soft and who is not all there'; *nathanatha*: 'a half-witted person'; *mpompa*: 'to be delirious; to speak as a lunatic; speak nonsense'; *nqe*: 'mental anxiety or uneasiness; a vulture'; *yenjane*: 'an idiot; a person not responsible for his own act'; *yingayinga*: 'a half-witted person'.¹²⁶

Epilepsy was understood to be a distinct, incurable, and sometimes hereditary condition, called *isithuthwane*.¹²⁷ Many of these terms suggest the recognition of underlying organic causes. According to the anthropologist, Harriet Ngubane, inherited disorders were known as *ufuzo* (resemblance). Some diseases were understood not to be 'the result of any personal malice or a fault of the patient; they just happen.'¹²⁸ Such illnesses – ranging from the common cold to epidemics of smallpox – are generically called *umkhuhlane*. Ngubane, who wrote in the 1970s, provided a wealth of information about a contemporary African lexicon of illnesses. Although her work implies a static, unchanging, set of disease labels – such as *indiki* or *ufufunyane* – it is nonetheless helpful in showing that *umkhuhlane* ('natural') ailments could include forms of 'madness', known as *uhlanya*, and *umhayizo*, which Ngubane identifies as a form of hysteria 'whereby [the affected person would] weep aloud uncontrollably'.¹²⁹ Contact with stones that had fallen from the heavens instantly caused

¹²⁵ Edgar and Sapire, *African Apocalypse*, pp. 44-45.

¹²⁶ *The King Cetywayo Zulu Dictionary*, compiled by R.C. A. Samuelson (Durban: Commercial Printing, 1923). My thanks to Karen Flint for this information.

¹²⁷ H. Ngubane, *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyuswa-Zulu Thought and Practice* (London: Academic Press, 1977), footnote 1, p. 150.

¹²⁸ Ngubane, *Body and Mind in Zulu Medicine*, p. 23.

¹²⁹ Ngubane, *Body and Mind in Zulu Medicine*, footnote 1, p. 150. The changing nature of the symptoms and behaviours said to be caused by these illnesses will be discussed further in Chapter 3.

anyone who touched them to become *izinhlanya* (insane).¹³⁰ Contrary to colonists' convictions that clothing mattered little to Africans, persons going about naked in inappropriate places were agreed to be insane.¹³¹ Dangerous and anti-social acts – such as setting fire to one's dwelling or that of neighbours, as well as attempting to commit suicide – were also beyond the bounds of normal, acceptable behaviour.

A kind of derangement, known as *ibharu*, was experienced after excessive consumption of alcohol, whereafter 'the craving, or "ibharu"... for animal food becomes so strong that (unless they can satisfy it in a legitimate manner), the neighbour, white or black, is robbed of sheep, goats, or fowls.'¹³² Further forms of illnesses, including insanity, could be caused by *abathakathi* (witches), by sorcery; or, as in *qungo*, 'insanity, caused by failing to get purified after killing another';¹³³ from failure to observe certain rituals; or by possession by alien or ancestral spirits. In such cases, the source of the illness having been divined by an *izangoma*, rituals and sacrifices would be performed. Significant differences existed, however, in the type of spirit possession: for example, spirits that were said to possess an *izangoma* were those of ancestors that had reached the desired complete state of spiritual being. Here, the state of being possessed – called *uthwasa* – was unbidden by the initiand, and could cause considerable anguish if resisted indefinitely. Ultimately, however, the possession of the diviner was seen as being for the good of society, and she would avoid unclean situations and use white symbols to emphasize her purity and her special association

¹³⁰ A-I Berglund, *Zulu Thought-Patterns and Symbolism* (London: C. Hurst & Company, 1976), p. 353.

¹³¹ On inappropriate nakedness as a recognized 'symptom of madness' by Nigerians, see J. Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley, Los Angeles and London: University of California Press, 1999), p. 15. In contrast, the Comaroffs describe how 'inappropriately clothed' Africans could be regarded by colonists as madmen: J. L. Comaroff and J. Comaroff, 'The Madman and the Migrant: Work and Labor in the Historical Consciousness of a South African People' *American Ethnologist*, 14 (May 1987), pp. 191–209, esp. pp. 191 and 203.

¹³² *Natal Blue Book on Native Affairs, 1902*, A14, Resident Magistrate, Estcourt, 12 January 1903. Thanks to Mike Mahoney for this reference.

¹³³ *The King Cetywayo Zulu Dictionary*.

with the purity of the ancestral spirits.¹³⁴ Once fully initiated, the *izangoma* retained her status for life. In contrast, other forms of spirit possession, such as *indiki* and, later, *ufufunyane*, were not at all benign. Nor did they necessarily bestow upon the members of the possession cult a significantly enhanced social role. Instead, they caused both physical and mental suffering that had to be alleviated.

Whereas colonial observers often dismissed the experience of the calling of a diviner through *uthwasa* as itself a form of insanity or hysterical illness, for Africans this was far from the case. Rather, it was the threat of madness that was averted by accepting the calling from the ancestors, or to use anthropologist Axel Ivar-Berglund's term, 'the shades'. Indeed as Berglund's seminal work, *Zulu Thought-Patterns and Symbolism* illustrates, the power of the fear of madness in Zulu-speaking societies has been strong. He explains that while the presence of the shades was taken for granted, in general 'one maintains a certain distance from them, unless specific circumstances require their very close presence. It is this specific relationship of intimate closeness and nearness that is described by *ukufukamela*, 'brooding', as a hen broods over her chickens.'¹³⁵ *Ukufukamela* occurred in times of crisis, and 'excessive brooding of the shades' could signal further dangers, and was very much feared:

It brings about *ukuhlanya* (to rave, to go mad, be insane; become wild, ungovernable; act in a wild manner). Besides being a humiliating epithet, the very thought of becoming *uhlanya* is a matter of great concern and avoided at all costs. Informants [of Berglund's] have said that the only reason for ceasing in attempts to bar the shade when a person is called to become a diviner is the fear of becoming *uhlanya*. ... (I) f they (the shades) wish to show the man that they require him and he is stubborn, refusing all the time (to become a diviner), they can cause him to

¹³⁴ Ngubane, *Body and Mind in Zulu Medicine*, p. 142.

¹³⁵ Berglund, *Zulu Thought-Patterns and Symbolism*, p. 127. Berglund writes of the mid-to late-twentieth century, and there is of course the danger of over-generalizing and de-historicizing his observations. Indeed, the uncritical appropriation of the 'anthropological present' is a major problem in the historiography of healing in this region with the work of Harriet Ngubane – also from the mid-1970s – being often quoted as representing a timeless statement of fixed definitions of ailments and their associated meanings. Nonetheless, in this case the general stigma against and fear (and awe) of madness in societies around the world would, I think, add credence to the view that these were also general tendencies in isiZulu-speaking societies in the late 1800s and early 1900s as they were in the mid-1970s.

become *uhlanya*, just brooding over him. That is the worst thing, even worse than sickness.¹³⁶

The shades' brooding could cause a person to become an *izihlanya*, a mad-person, or one with 'mental disturbances' and an even more extreme form of madness was *ukuhlanya okumqedayo umuntu* ('the insanity which finishes a man'). Berglund's informant recounted that this was caused by *inkosi yamadlozi* (the 'lord of the shades'), and underscored its seriousness: "'That is the bad insanity. There is no healing from it, there being no medicines against it. The person just dies. He is eaten up by that insanity, eaten up completely.'" ¹³⁷ An *izangoma*, however, had successfully negotiated the path to their vocation, and would 'never get sick in the head.'

Once recognized as a practising *izangoma*, however, it was diviners themselves who were regarded as posing a danger to others. For ordinary persons, prolonged proximity to a diviner could result in someone being 'stricken with the sickness of the head'. One *izangoma* told Berglund that he prepared special prophylactic medicines for his two wives to take so as to protect them from the *uhlanya* that could contaminate them as the consequence of the shades' brooding. The symptoms of such *uhlanya*, if not successfully averted, were initially dispersed through the body, then caused 'difficult dreams', 'visions in the day'; and '(t)hen the head becomes painful. That is where it stops.'¹³⁸

Medicines, madness and sexuality were intimately linked in healing practices. For instance, herbalists observed strict rules of abstention whilst preparing medications and ritual celebrations, abjuring the comforts of warmth, meat, beer, and sexual intercourse. The connections between the practices of the *izinyanga* and ritual celebrations have been described by Berglund as 'all parts of efforts in restoring healing, well-being and prosperity to men, animals and land'. He goes on to add that '(t)heir work and actions

¹³⁶ Berglund, *Zulu Thought-Patterns and Symbolism*, p. 128.

¹³⁷ Berglund, *Zulu Thought-Patterns and Symbolism*, p. 142 and p. 170.

¹³⁸ Berglund, *Zulu Thought-Patterns and Symbolism*, pp. 128-129.

high status and influence. By the end of the second decade of the twentieth century ethnographers were stating that the overwhelming majority of *izangoma* were women, and women were apprenticed as herbalists only 'when no sons could carry on the family tradition or when the ancestors indicated otherwise.'¹⁴¹

Flint points out that Natal was exceptional in that the state gave legal recognition to African herbalists, empowering chiefs to licence them under the Natal Native Code of 1891. So, while there was a preponderance of women as diviners or diagnosticians, it was male healers who gained the – often unwilling, to be sure – support of the colonial state and who would later go on to become the majority members of the professional associations of 'traditional healers' that emerged in the 1930s.¹⁴² In the meantime, women sometimes formed their own healing groups – such as the *amandiki* to be discussed in a later chapter – in response to new forms of illnesses that, it was commonly believed, were sweeping through the region, some of which would come to affect women almost exclusively.

Until the early twentieth century, it was usual for African healers to have their patients brought to them. Diagnosis of ailments followed the close observation of symptoms. In his *Zulu Medicine and Medicine-Men*, A. T. Bryant noted 'to him the symptoms are the disease, and the great rule of pathology is: As many symptoms, so many diseases.'¹⁴³ In addition, given the aetiological understanding of the origins of illnesses that might have been caused by an infringement of ritual observances or by sorcery, an intimate knowledge of the patient's personal state of being as well as his or her relationships with family, lineage, homestead and polity were also crucial in correct diagnosis. For healers it was their 'task ... to get to know as much as possible about the patient's social situation,

¹⁴¹ Flint, 'Negotiating a Hybrid Medical Culture', p. 72.

¹⁴² K. E. Flint, 'Competition, Race and Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century', *Social History of Medicine*, 14, 2 (August 2001), pp. 199-221.

¹⁴³ Bryant, *Zulu Medicine and Medicine-Men*, p. 15.

are, either directly or indirectly, associated with sexuality to a greater or less degree and play an important role in the minds of both themselves and the people among whom they work'.¹³⁹ In order to fulfil their role successfully, sexual desires had to be suppressed. On completion of their duties, however, herbalists (who were usually males) and other ritual officiates were not only allowed to resume sexual relations with their wives, but this was seen as absolutely necessary, as further abstention courted the risk of insanity for the male. A specifically gendered condition was *umhayizo*, described above as a form of hysteria. Believed to be caused by the 'throwing' of love medicines by young men, a woman (usually young) experiencing *umhayizo* underwent powerful symptoms of bewitchment where she was inextricably drawn to the home of her suitor.¹⁴⁰ Resisting the 'charms' brought about pain, wailing and screaming, and sometimes, even death.

African healers themselves underwent a process of specialization and professionalization in the nineteenth and twentieth centuries. Although never absolute, this process appears to have been accompanied by a more rigid gendered division of healing practices, with men being more usually *izinyanga*, being recognised as *izangoma* only in situations of

¹³⁹ Berglund, *Zulu Thought-Patterns and Symbolism*, pp. 338-339. Berglund explains that herbalists were chiefly male and that the 'underlying thought-pattern is the close tie and, frequently, identification between semen and the shades'. Failing to expel semen could lead to an 'excess of brooding,' which, as we have already seen, could lead to madness.

¹⁴⁰ 'Ihabiya' or 'Ihabiyo' first appears in dictionaries in A. T. Bryant's 1906 *Zulu-English Dictionary*: 'n. Medicine or love charm of any kind (of modern introduction from Natal) used by young men to cause a girl to hayiza, i.e. to throw her into fits of shouting hysteria in which she repeatedly cries out hayi! hayi! or hiya! hiya!' 'Hayiza - Have the Native crying hysteria, i.e. cry out involuntarily hayi, hayi, hayi, as hysterical girls, or hysterical men who have become witchdoctors'. In C.M Doke, D.M. Malcolm, J.M.A. Sikakana, and B.W. Vilakazi, *English-Zulu Zulu-English Dictionary* (Johannesburg: Witwatersrand University Press, 1990) '*ihabiya*' - "n. 1. Medicine or love-charm used by young men to cause a girl to have hysterical fits. 2. Hysterical fit [cf. *umhayizo*]" '*hayiza*' - "v. [>perf. -hayizile; pass. hayizwa; ap. hayizela; caus. hayizisa; umhayizo; umahayiza.] Have the Native crying hysteria; rave (as girls who are believed to be affected by charms); be hysterical." Several authors note the similarity between the peculiar cry made under an attack of *umhayizo* and that during *uthwasa* (the state of possession by the *amadlozi* of those called to undergo training as *isangoma*), but historically there have many significant differences between *umhayizo* and *uthwasa*. Also, A. T. Bryant, *Zulu Medicine and Medicine Men* (Cape Town: C. S. Struik, 1966 [1911]), pp 70-71. See J. Parle and F. Scorgie, 'Bewitching Zulu Women: *Umhayizo*, Gender and Witchcraft in Natal', unpublished paper presented at the African Studies Association conference, Houston, Texas, USA, November 2001.

and thereby determine the illness of the individual, personally and socially.’¹⁴⁴ Even critics of African healers acknowledged that therapeutic benefits that consultations could bring about. Both Bryant and James McCord, for example, spoke of the impressive ‘psychic power’ of the ‘Zulu medicine man’. For Bryant ‘...the secret of many Kafir cures, and, it may be added, of many Kafir ailments, is not in the action of matter on matter, of drug on flesh, but in those occult regions where mind works on mind and mind on flesh’¹⁴⁵ Both the biomedical doctor and the Catholic priest were familiar, if not altogether at ease, the language and alleged power of ‘psychic healing’ as well as with mesmerism and hypnotism. Their descriptions of the therapeutic relationship between, what they termed ‘witchdoctors’ and their clients, presages, however, both the ‘talking cures’ popularised by Western psychology, especially from the early 1900s, and the more recent findings that the ‘placebo effect’ precludes any simple distinction between the ‘regions where the mind works on mind and mind on flesh.’¹⁴⁶

The naming of diseases on the basis of symptoms is strongly reminiscent of the multiple forms of madness, especially manias, enumerated in the West in the early nineteenth century, but stood in notable contrast to the emerging universalism that characterized professional psychiatry from the mid-1800s. For African healers, local and individual variations of illness were deeply significant, giving vital clues as to the underlying causative phenomena of the illness, and thereby indicating the correct curative

¹⁴⁴ Edgar and Sapire, *African Apocalypse*, p. 47.

¹⁴⁵ PAR PMB 3/1/12/11 30/15, James McCord, ‘The Zulu Witch Doctor and Medicine Man’, MSS contained in correspondence between Lt Colonel Foxon, Chief Magistrate, Pietermaritzburg and Colonel Campbell Watt, Natal Medical Council, on ‘Native Medical Facilities’, 27 and 29 April 1918. Bryant, *Zulu Medicine and Medicine Men*, p. 16.

¹⁴⁶ For a history of hypnotism and suggestion – and an overview of recent findings about ‘the placebo effect’ – see D. Forrest, *Hypnotism: A History* (London: Penguin, 2000), esp. pp. 247 and 273.

methods.¹⁴⁷ Furthermore, as the term *ukufa kwabantu* indicates, certain forms of illness were believed to affect only African peoples: *umhayizo* was one such.¹⁴⁸

While identifying states of mind and behaviours that were clearly recognized as madness, as with African medicine in much of the continent, in Natal and Zululand ‘conceptions of health and illness are [and were] holistic in the sense that well-being is considered to refer to mental and bodily state’.¹⁴⁹ Healing strategies were [and are] also multiple, with the distressed, diseased, or demented seeking solace from a variety of sources, including ‘traditional’ African healers, and from spiritual healers of a variety of faiths, as well as from biomedical and psychiatric practitioners. This range of therapies beyond the reach and scope of Western-based psychiatry will be the subject of Chapters 3 and 4. However, from the late 1890s, the majority of persons admitted to the Natal Government Asylum were black (and amongst these, African males were in the majority) and this raises important questions about whether they were the target of colonial attitudes that stigmatised problematic ‘Natives’, or whether the asylum became an important new alternative for Africans in the options available for managing their mad.

Much of the literature on the treatment of insane Africans before the advent of public asylums emphasizes the rupture with pre-colonial indigenous practices that incarceration in such an institution represented. Edgar and Sapire comment that ‘a major contrast between African healing cultures, with their emphasis on collective, social responses to afflictions and those of Western psychiatry was the absence in the former, of traditions of separating the deranged and disruptive from their communities.’ They quote the Reverend Henri Phillippe Junod’s observations on Tsonga society, in which he claimed

¹⁴⁷ See L. Swartz, *Culture and Mental Health: A southern African View* (Cape Town: Oxford University Press, 1998), pp. 66-67.

¹⁴⁸ An illustration of this can be found in PAR Accession A4/59, A. Cowles, ‘A Love Tragedy’ in *Flash Lights into Zulu Homes* [n.d.], p.11.

¹⁴⁹ See Sadowsky, *Imperial Bedlam*, p. 14, and Chapter 2, ‘The Nineteenth Century: From Pity to Alarm’. For a discussion of pluralistic healing practices in the treatment of *umhayizo* in KwaZulu-Natal today, see Parle and Scorgie, ‘Bewitching Zulu Women: *Umhayizo*, Gender and Witchcraft in Natal’.

that segregation of lunatics from society was ‘unknown’ and that ‘only in the most extreme instances, when dangerous madness seized a person, was physical restraint and forcible restraint adopted.’¹⁵⁰

In truth, we know very little at all about nineteenth century African attitudes towards lunatics, dangerous or otherwise, and to place too strong a faith in ‘collective responses to afflictions’ and in seeing ‘satisfactory healing [as] directed toward achieving social and psychological reintegration of patients and their community,’¹⁵¹ can be misleading for it seems likely that few societies that did not possess some effective means of incarceration could tolerate disturbing individuals in their midst. Along with their European contemporaries, many African families certainly did attempt to keep those whom they considered mad within the homestead, if there were the human and family resources available to do so. When the afflicted person showed signs of increasing instability and especially of violence, however, there was little alternative but recourse to the local version of the stocks which Junod details, or to tie the lunatic up.

Although imperfectly reproduced and therefore unclear on a number of small points, a deposition by *kholwa* peasant farmer and preacher James Mkize, brother of Bennie, to the Resident Magistrate of Umzimkulu, Natal, early in December 1916, illustrates these points vividly, and is worth quoting at length.

I am a resident of Rasmani’s Location in this district. My brother Bennie Mkize is of unsound mind. He first developed insanity while a youth. He is married and has four children. He is very much easily [?] and very irritable. He used to be afflicted with derangement of mind for about a year at a time. He used to make big sounds of howling and speak in English. He understands the English Language. In his speech he is rational. Only on the 29th November, 1916 he had been to plough his lands and returned to [?] Ephraim Mkize’s kraal from the lands and howling and without receiving any provocation assaulted Ephraim’s wife Lena Mkize by hitting her on the face and shoulders with his fists and caused her to bleed through the nose and mouth. I came up to the [?] and when he saw me he left the woman and attacked me by grabbing [?] hold of me and we fell down to the ground and struggled on the ground and during the struggle on the ground he smashed me

¹⁵⁰ Edgar and Sapire, *African Apocalypse*, pp. 45-46.

¹⁵¹ Edgar and Sapire, *African Apocalypse*, p. 47.

about the face. [Brothers] Ephraim and Simon Mkize then came up and hit him with sticks as we were struggling on the ground. He is really dangerous to the members of my kraal and that of Ephraim's. In August, 1916 he came to Ephraim's kraal and assaulted Ephraim without a cause. He is now afraid to come to my kraal at night and wanted to come into the house through the window. When I got up and gave him a hiding with a stick when he went about saying I had shot him with a gun. He now says as he has assaulted and hit Ephraim's wife he is going to assault mine. He once disturbed the Congregational service which was being conducted by me. He once stopped me from preaching by saying I should be [quiet] during the service. All this is through his insanity. It will be [remembered?] that this Bennie is the one who through the same insanity chopped his right thumb clean off with an axe. The Archdeacon has tried all his best to make him live in Clydesdale but he could not avail. There are several minor [intimate?] matters he always commits and we are now tired of him and ask the Government to look after him. I and my brothers are unable to support him whilst in hospital and cannot afford to look after our own families and himself. If Bennie will be allowed to be at large will cause much trouble to one of the families of the abovementioned kraals. If he would be taken into custody at once it would be much better. The children are very much afraid of him. He sometimes howls all night long and no one feels [secure?] when in this passion. He used to be tied up for about a year before. We consider that his insanity and derangement increases as he gets older. Formerly he used to allow us to tie him up, now it is a great matter to get at him and have him tied up. The Government should surely relieve us of the responsibility we are in.¹⁵²

I do not dispute that the asylum was usually a last resort for African – and white – families needing assistance in the control of the insane, but it is surely significant to note the agency of the families concerned and their sense of the state's responsibility in relieving them of a brother who had become a menace both to himself and to his community.

The third set of therapeutic traditions that are of significance in the history of this region are those associated with Indians from the mid-nineteenth century. Brought in response to

¹⁵² PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 8/16. 'Bennie Mkize of Rasmani's Location, Umzimkulu.' 21st December 1916. Bennie Mkize was taken to the gaol at Umzimkulu by his brothers on 7th December and was noted as being 'about 50 years old' and an Anglican convert'. He was then taken immediately to the NGA and in his Medical Report, Dr Sinclair Black, then Physician Superintendent at the NGA, found him to be: '... of unsound mind suffering from the maniacal phase of manic-depressive insanity. [And noted on 18th December 1916] He has been highly excited and quite uncontrollable and has required seclusion.'

the 'labour question' of Natal, just over 150,000 Indians came to Natal as indentured labourers between 1860 and 1911. There was a hiatus of immigration between 1866 and 1874 following economic depression in Natal and complaints about harsh treatment by some workers returning to India after the completion of their contracts. The system was reintroduced partly as a result of the reforms implemented after the Coolie Commission Report of 1872, and many of those who came to Natal after this date as indentured workers settled permanently in Natal after the expiry of their contracts. In the following decades, a second, smaller, group of Indians came to the Colony as a result of their own initiative to engage in trade and commerce. They were commonly referred to as 'Passenger Indians'. Whereas indentured workers were overwhelmingly Hindu, the latter were largely Muslim.¹⁵³ Both were regarded with ambivalence by Natal's whites. Dependent on Indian labour for the continued viability of many enterprises, whites nonetheless felt increasingly threatened by the growing numbers of Indians in the Colony. The 1904 Census had showed 101,000 Indians to 97,000 whites. Pressure to end the immigration of Indians mounted and hostility towards Indians, dubbed an 'Asiatic Menace', grew. By the eve of the First World War, the indenture system was also now facing opposition from the emerging nationalist movement within India, which portrayed it as a humiliation for the country.¹⁵⁴ The system was ended in 1911.

As objects of medical scrutiny, Indians feature prominently in the archival records, particularly those of the Protector of Indian Immigrants and the Indian Immigration Office. However, despite the resilience and relevance of religious, cultural and healing beliefs, Indian medical practices in Natal and Zululand in the 1800s and early 1900s remain woefully under-researched: even harder to discern are the ways that Indians in Natal defined and attempted to defeat mental illness in this time period. Very few persons of

¹⁵³ For a helpful overview, see A. Diesel and P. Maxwell, *Hinduism in Natal* (Pietermaritzburg: University of Natal Press, 1993). Indentured workers were drawn from the southern Indian state of Madras, as well as from the northern states of Bihar and Uttar Pradesh. 'Passenger Indians' also included some Hindus.

¹⁵⁴ B. Freund, *Insiders and Outsiders: The Indian Working Class of Durban, 1910-1990* (Pietermaritzburg: University of Natal Press, 1995), pp. 5–6.

Indian origin or descent were admitted to the NGA before 1918. Nor until the mid-twentieth century were ethnographers concerned to document Indians' cosmological, sexual, spiritual or material lives. Indeed, the one issue whereby Indians could (at least from the perspective of the early twenty-first century) be expected to have become a major focus of colonial psychiatric concern – their apparently abnormally high rates of suicide – failed to elicit medical attention of any but the most cursory kind. The reasons for this will be explored in Chapter 5. Clearly, however, Indian immigrants to Natal were not immune from psychological suffering. What follows is a brief and highly tentative attempt to sketch out some of the major concepts that might have informed their responses to mental illness at a time before a direct engagement with – and by – Western biomedicine, including psychiatry, would bring the experience of psychological distress and disease of South Africa's Indians within the ambit of documentary sources.

As with striving to understand African aetiologies, nosographies, and therapies of insanity it is important to note that Indian conceptions are also 'holistic' in the sense that 'medical illness is not separate from religious problems and practices ... This 'holism' ... includes the individual, the spiritual world, the physical environment and the cosmos, to a greater or lesser extent.'¹⁵⁵ Within Hinduism, the central concepts of illness and treatment are drawn from the Ayurveda traditions that have formed the basis of healing practices for millennia. In a flexible interaction with humoral theories of the body's composition and reflecting a medical pluralism that has more lately encompassed Western biomedicine, such 'medical' beliefs and practices are both prophylactic and therapeutic, and may involve ritual, prayer, meditation and medication, as well as exorcism and dietary regimes. Moderation, control and responsibility are important ideals for the 'healthy' person. It is not surprising then that:

The treatment in Ayurveda for 'mental' disorders is not differentiated from that for bodily illness; and there is no systematic theory of 'mind' and 'mental processes as there is in Western thought, although [there are] some forms of therapy for

¹⁵⁵ Fernando, *Mental Health, Race and Culture*, pp. 152-159. The quote is from p. 152. See also Dinesh Bhugra, 'Hinduism and *Ayurveda*: Implications for managing mental health' in D. Bhugra (ed.) *Psychiatry and Religion: Context, Consensus and Controversies* (London and New York: Routledge, 1996), pp. 97-111.

“restraining the mind” ... In addition, ‘purification’ by, for example, purges and enemas, and ‘pacification’ by decoctions that tranquillise, counteract depression and strengthen the nerves may be used.¹⁵⁶

Diagnostic experts could be Ayurvedic practitioners, or exorcists, mystics and astrologers. All were concerned with identifying and then rectifying the relationship between an individual/body, mind, and the cosmos. Within this broader frame, madness (unmada) was identified as manifested in behaviours and states of mind that would have been recognizable – though perhaps differently explained – by both African and Western medicine, such as:

“emptiness of the head”, anorexia, “fatigue, unconsciousness and anxiety in improper situations”, various aches and pains and frequent appearance of certain types of dreams; the latter include “incoherent speech”, laughter and dancing in inappropriate situations, emaciation, excitement, “observance of silence” and aversion of cleanliness. The particular combination of distinctive features denotes the type of insanity ... [I]nsanity is divided into five types, four caused vitiation of dosas (humours) and one by “exogenous agents”. The latter includes madness caused by possession ...¹⁵⁷

The source of the spirits could be elders, ancestors, or supernatural beings who induced seizures. Epilepsy, however, was understood to be a distinct disease. Further external causes included changes in climate or the seasons, which were understood to be especially disturbing, and sorcery, curses, and ‘the evil eye’ could also potentially be powerful originators of illness. According to Dinesh Bhugra: ‘In general, insanity is said to be the result of an inappropriate diet; disrespect towards the gods, teachers and the twice-born (the brahmin); mental shock due to excessive fear or joy and faulty bodily activity ... (T)he diagnostic systems did involve collecting both subjective and objective information.’¹⁵⁸

In responding to all ailments – the distinction between corporeal and mental typologies being indistinct – the cornerstone of treatment was the restoration of balance, including to the mind. Ayurvedic treatments thus included drugs, the wearing of amulets, observation of

¹⁵⁶ Fernando, *Mental Health, Race and Culture*, p. 153.

¹⁵⁷ *Ibid.*

¹⁵⁸ Bhugra, ‘Hinduism and *Ayurveda*’, p. 107.

spiritual and scriptural rites and ceremonies, the paying of homage to gods through prayers and sacrifices, and strict observation of dietary requirements. Bhugra speaks helpfully of therapeutic relationships as ‘using the bridge of religion and religious values,’¹⁵⁹ and he explains that meetings of devotees and worshippers of various deities were (and are) often occasions where possession states were experienced. He adds that possession states ‘are accepted as a way of expressing distress.’

Most indentured Indians were housed initially in barracks, on sugar estates, and compounds, in overcrowded, squalid and unhygienic conditions that presumably made daily worship and purification rituals difficult. However, historians of Hindu religious culture and worship in Natal, Alleyn Diesel and Patrick Maxwell, point to the rapidity with which nineteenth century Indian immigrants to the region established small shrines and temples to ‘their favourite deities.’¹⁶⁰ Early temples, first of wattle and daub, and then of wood and iron construction, date from the 1860s. Across the region, a significant number of temples were devoted to the worship of Shakti, the ‘Divine Mother’, especially the ferocious Mariamman, ‘the patron of rain and the heal[er] of infectious diseases.’ One festival that was apparently celebrated very shortly after the arrival of Tamil-speaking indentured workers was that dedicated to Draupadi, which culminates in devotees walking across burning coals. Propitiation of Draupadi could restore purity, and also bring about ‘great blessings.’¹⁶¹

Religious observances at larger temples came after the 1880s. In that decade, for instance, three substantial temples were built in Durban. In 1885, a petition was sent to the Colonial Secretary requesting land for a temple in Estcourt.¹⁶² Consulted by the Colonial Secretary

¹⁵⁹ Bhugra, ‘Hinduism and *Ayurveda*’, p. 107.

¹⁶⁰ Diesel and Maxwell, *Hinduism in Natal*, p. 5 and pp. 22-23. On p.22, they state that some of the oldest temples are the Umgeni Road temple complex in Durban, the Siva Soobramoniar and Marriaman Temples in Pietermaritzburg, and the Isipingo Rail Marriaman Temple.

¹⁶¹ *Natal Witness*, 18 April 1927, quoted by Diesel and Maxwell, p. 53: ‘The custom was introduced by the Tamil Hindus to South Africa upon their arrival from India.’

¹⁶² PAR Colonial Secretary’s Office (hereafter (CSO) 1018 1885/2041, ‘Several Indians, Estcourt. Application for a site for a temple in the town of Estcourt’, 5 May 1885.

on the matter, the Protector of Indian Immigrants did not raise any objections to the granting of the application for a grant of land for the temple, but the accompanying application by a Subra Reddy to be appointed as a priest was rejected on the grounds that his name was a clear indication that he was not of the 'Brahmin caste'. The Protector's letter to the Colonial Secretary reveals both the prejudices of colonial attitudes towards Hinduism, and the extent to which its practices were followed in Natal in the mid-1880s. He wrote

I find that a certain class of Indians are apt to impose on their fellows by playing upon their superstitions, they style themselves Brahmins, and claim to exercise priestly functions without in a majority of cases anything to support them, but sharp wit and self-confidence and succeed in duping those who believe in them and who pay handsomely for the privilege of their counsel. I believe imposition of this kind is extensively practiced here ...¹⁶³

Early Hindu architecture and sculpture in Natal is usually associated with either Kristappa Reddy or Kothanar Ramsamy Pillay. Pillay had been an indentured worker in the Mauritian canefields, but came to Natal as a free Indian, paying his own passage. Fatima Meer describes him as 'a man of many talents, playing the veena and thambura, sketching and writing and producing plays which he presented at Rawat's Picture Palace ... He is remembered as being of temperamental nature, suffering bouts of depression, when he destroyed works that he had created.'¹⁶⁴

In 1903, the Committee of the Hindu Temple in Depot Road, Durban, claimed that there were 'over a thousand adults' who worshipped at their shrines. They petitioned the government to allow them to appoint a new priest.¹⁶⁵ A similar petition was drawn up on behalf of the Shri Vishna Temple in Umgeni in 1909: it requested permission for 'Mr

¹⁶³ PAR CSO 1018 1885/2041, 'Several Indians, Estcourt. Application for a site for a temple in the town of Estcourt', 5 May 1885. Louis Mason, Protector of Immigrants to Colonial Secretary, 10 June 1885.

¹⁶⁴ F. Meer, *Portrait of Indian South Africans* (Durban: Avon House, 1969), p. 178.

¹⁶⁵ PAR Immigration Restriction Department (hereafter IRD) 779/103, 'Durban: Petition of Three Hindoos For A Special Consent to the Entry [sic] of a Hindoo Priest to Take Charge of the Temple', 1903.

Lutchman Panday to travel to India to recruit two priests to officiate at the temple.¹⁶⁶ The official response was negative. Conflating Hindu and Muslim worshippers and priests, the reply was dismissive. It referred to an earlier ‘application of certain Mohammedans ...for so-called “priests”’. It went on: ‘The Colony is full of them. In the past seven months we have issued Certificates of Domicile to no less than 19 men who have sworn that they belong to the priesthood...’ One, in the opinion of the official, had been a ‘mere gardener’, whose ‘interests were more material than spiritual’ and who was representative of the many who were ‘mere charlatans who in their spare time practised “Eastern mummery”’.¹⁶⁷

Muslim immigrants also soon established places of worship. An early ‘Passenger Indian’, Abubaker Jhaveri, purchased a plot of land in Grey Street in Durban in 1880, and by the end of the century this was the heart of a mosque complex that is still an important site of worship. Less orthodox Muslim traditions were also represented, including those of some of the Sufi orders. Shaikh Ahmed, later known as Badsha Pir – ‘the first and most legendary South African Indian saint’ – had arrived amongst one of the first ships bringing indentured labourers to the colony.¹⁶⁸ Within a short space of time, however, he was released from his servitude (apparently having performed a number of miraculous feats) and had become a *mazwap*, who withdrew from the world and abjured the usual concerns with personal appearance. According to Fatima Meer, many thought he was mad. The shrine erected in his name, and another to honour Sufi Sahib who arrived in Natal around 1900, drew thousands of devotees searching for ‘blessing and relief from physical and emotional stress.’¹⁶⁹ Indian healers – often resented by white doctors – were also operating from at least the 1880s. They

¹⁶⁶ PAR IRD 1276/1909, ‘G.E. Driver, Durban: Applies on Behalf of the Shri Vishna Temple, Umgeni, for Permission to Introduce into Natal Two Priests to Officiate at this Temple’, 1909.

¹⁶⁷ *Ibid.*

¹⁶⁸ Meer, *Portrait of Indian South Africans*, pp. 201-203.

¹⁶⁹ *Ibid.* There were also Indian converts to Christianity, including Catholicism, from the early 1860s.

tended to both Indian and African patients.¹⁷⁰ Also particularly well-known amongst both Indians and Africans for practising 'black magic' were the Zanzibaris – descendants of Muslim freed slaves from the east coast of Africa – who were settled on the Bluff at Durban from the 1870s to the 1960s. Their reputation as herbalists, and ability to cast out demons, spirits and spells, was still widespread (and feared) in the 1970s.¹⁷¹

Historians of psychiatry and empire have shown that, from the mid-1800s at least, indigenous concepts and treatments of madness began to interact with Western ideas of insanity. 'Hysteria', for example, became a diagnosis that was made by African healers in the early twentieth century and was also a category of illness that enjoyed great currency in China well after it had disappeared as a common condition in the West.¹⁷² Many historians, however, stress the alienating process of the medicalisation of mental disorders that the intruding ideology brought, and highlight in particular the alien nature of the mental asylum as a physical and discursive space for the custody of 'Native' lunatics. For instance, discussing late nineteenth century India, James H. Mills stresses healing here was *social*, rather than *moral* (in the sense of instilling within the individual a sense of morally correct behaviour), and that there was no local institution that in any way resembled colonial lunatic asylums. He goes on to compare the physical and spatial organization of Indian healing temples with that of colonial psychiatric facilities:

¹⁷⁰ I am indebted to Karen Flint for raising the issue of Indian-African interactions and medical-cultural interchange in KwaZulu-Natal. She is currently undertaking further detailed research into this area, which she began in her dissertation. There she notes that, in Natal, indentured workers were forcibly brought within the ambit of biomedicine, that Indian healers were innovative in using locally-grown herbs, but also speculates that there may have been a shortage of Ayurvedic practitioners in the nineteenth and early twentieth centuries. See her 'Negotiating a Hybrid Medical Culture', Chapter 6, 'Indian *Izinyanga* and *Umuthi* Chemist Shops: African and Indian Transactions in the Late Nineteenth and Early Twentieth Century'.

¹⁷¹ See Z. K. Sedat, 'The Zanzibaris in Durban': A Social Anthropological Study of the Muslim Descendants of African Freed Slaves Living in the Indian Area of Chatsworth' (unpublished Masters Thesis, University of Natal, Durban, 1973), p. 256.

¹⁷² Edgar and Sapire, *African Apocalypse*, p. 47 and B-Y. Ng, 'Hysteria: A Cross-Cultural Comparison of its Origins and History', *History of Psychiatry*, x (1999), pp. 287-301

The asylum design emphasizes the separation of functions. In the asylum there were distinct spaces for sleeping in, for cooking in, for working and walking in and in which treatment would be dispensed for physical illness. In contrast [at the healing temple near Bharatpur as described by Sudhir Kakar] at any one moment there is a welter of activity all within the same space. “Patients”, their relatives and the priests eat, sleep, pray and exorcise all in the same courtyards which they share with local urchins and stray dogs.” ... This spatial contrast reflects a more profound difference in the aims and approaches, indeed in the understanding of mental illness, between the culture from which the lunatic asylum emerged in early modern Western Europe and the cultures in which the healers and temple practitioners developed in India.¹⁷³

Following Kakar, and, in a phrase strongly reminiscent of that used by Edgar and Sapire, Mills notes “the involvement and the integration of the patient’s relatives in the healing process.” In Natal, there can be no doubt that those Indians admitted to the NGA – mostly as a result of applications for committal by employers – experienced their confinement as an alienating, perhaps even punitive. The lack of stable family networks and dire poverty that was the norm for indentured workers at that time meant that they were isolated for the duration of their time at the asylum, and faced an uncertain future if discharged. The characterisation of colonial asylums as ‘total institutions’ and the notion of patients’ families being prevented from participating in the care of the committed is one that will be challenged in subsequent chapters. However, it may be that until Indian family and other social and welfare networks (such as the Aryan Benevolent Society, for Hindus, which opened in 1913; and the Muslim Juma Musjid Trust, formed in 1916) began to consolidate – in the early twentieth century – the asylum was, for Indians who migrated to Natal and Zululand, initially a most alien institution.¹⁷⁴ On the other hand, it is doubtful that the majority of those experiencing disturbing states of mind found

¹⁷³ Mills, *Madness, Cannabis and Colonialism*, pp. 130-131.

¹⁷⁴ This is an area which requires far greater research. For early ventures in Muslim social, religious and economic networks for the destitute and otherwise afflicted, see Sedat, ‘The Zanzibaris in Durban’, p.39 and G. Vahed, ‘Uprooting, Rerooting: Religion and Community among Indentured Muslim Migrants in Colonial Natal, 1860–1911’ *South African Historical Journal*, 45 (2001), pp. 191–222.

themselves psychiatric patients at all. Indeed, James Hyslop was convinced that ‘free Indians’ were reluctant to refer ‘insane’ family members to the NGA.¹⁷⁵

That so few Indians were admitted to the NGA in the period before 1918 suggests two, not mutually exclusive, possibilities: firstly, that Indians exhibiting psychological disturbance were only sent to the asylum once they became physically threatening or, alternatively, because they were so ‘dull and stupid’ as to not be able to work at all; and secondly, that Indians in such mental states undertook to alleviate their own illness through means that have not left documentary sources, but which might be suggested by the existence of temples and festivals and a rich tradition of healing practices that span the spectrum of medicinal, herbal, and spiritual healing. In other words, that it was by their own hand that they sought to achieve equitable states of mind. That these might have included suicide as a final option also needs to be considered.

Conclusions: A plurality of paradigms

From the 1860s, in Natal, the presence of persons who were regarded as having either a ‘superabundance of ideas’, or who held one idea ‘in too great activity’, or those who were ‘without ideas’ at all, become visible to those interested in the histories of mental illness and mental health in this region. Early and mid-nineteenth century reformist humanitarian liberalism in Britain led to an upsurge of charitable and legislative interest in the welfare of the insane in Britain, and across her formal empire. This led to the passing of the Natal Custody of Lunatics Act of 1868, a precocious law that was to provide a template for much of the ‘lunacy legislation’ of the four territories that, in 1910, would comprise

¹⁷⁵ For the reluctance of ‘free Indians’ to refer ‘insane’ family members to the NGA, see Natal Government Gazette vol. XXXIX No. 2262 Tuesday, September 20 1887, Government Notice No. 430, 1887, *Report of the Commission appointed to inquire into and report upon the Indian Immigration Laws and Regulations of the Colony, and on the general condition of the Indian population of Natal*, Chapter XXVIII, p. 59. (This Commission was commonly referred to as the Wragg Commission). See this Commission, and the next chapter of this dissertation, for comparative figures on Indians, Africans and whites at the NGA.

South Africa, and which was only substantially modified by the Mental Disorders Act of 1916. The Act, too, predated the impact of the mineral revolution in South Africa, with the hardening of racial attitudes and policies that ensued thereafter.

Natal also took the lead in establishing psychiatric facilities for its mentally ill subjects. The Natal Government Lunatic Asylum, which was opened in 1880, replaced a series of temporary asylums that had been situated first at Pietermaritzburg's gaol, and later on the grounds outside the city on the Town Hill, where the NGA would be built. Headed for more than thirty years by Dr James Hyslop as its Physician Superintendent, the NGA was southern Africa's first purpose-built public asylum. This institution, with its 'peculiar and well-selected attendants', remained the primary site of detention, and sometimes care, for the colony's legally-defined mentally ill – both black and white – until well into the twentieth century. As a specialist in mental diseases, Hyslop epitomized the overlapping, sometimes apparently contradictory, paradigms of nineteenth and early twentieth century ideas about the physiological and material origins and meanings of madness, and he was influential in shaping the treatment regimes of the NGA.

This chapter has attempted to explore something of the milieu in which Hyslop and other physicians and psychiatrists of his time formed their ideas about insanity. I would not wish to depart from the observations of other scholars of the history of colonialism and mental illness, including in southern Africa, who have argued that the practice of colonial psychiatry was predicated upon principles and operated within paradigms that were profoundly shaped by assumptions about race, class and gender that led both directly and indirectly to the provision of facilities and standards of care that were divisive and discriminatory.

However, it is important not to overstate the power of colonial ideologies and institutions in the nineteenth and early twentieth centuries. To speak of the discourse of objectification of the mad, and to highlight the power of alienists to create categories of troublesome persons who were neutralized by being incarcerated in asylums, is to grant too much influence to a profession that was itself in the messy process of formation, and

to its institutions that were limited in their reach. It is also to deny agency to those whose states of mind were subjectively experienced as disquieting, and which could become disturbing, even violent and dangerous, to the sufferer and for those with whom he or she came into contact.

In Natal and Zululand in the half-century before the end of World War I, ideas of insanity propagated by Western-trained physicians would come to influence and interact with two other highly important therapeutic traditions, which can roughly be termed as 'African' and 'Indian', which were themselves fluid and which exchanged ideas and treatments for ailments that were recognized as being forms of insanity. As Western conceptions and understandings of, and just responses to, insanity were linked to contemporary notions of humane treatment, African and Indian paradigms of healing were intertwined with conceptions of the relationships between individuals and their social setting.

For both Africans and Indians, the range of healing possibilities for madness – as practiced by healers, diviners, astrologers, exorcists, priests, and others – remained wide. Western biomedical concepts (such as forms of disturbed behaviour such as 'hysteria') and institutions (such as hospitals and asylums) became part of a range of African and Indian responses to the experience of madness. For the majority of the mentally ill of the region, as elsewhere, however, the asylum represented a final option that was resorted to after the search for solace through home remedies and care, or the attentions of local and self-identified healers from a variety of backgrounds had been exhausted. This was probably as true for whites as it was for Africans. For Indians in this time period, family or voluntary admissions to the NGA were rare, and thus the asylum for Indians becomes part of a strategy in the care of the mentally ill only somewhat later.

The following chapters attempt to trace something of the variety of strategies that were employed in the responses to mental illness in Natal and Zululand in the period between the legislation of 1868 and 1918. Chapter 2 focuses on the early provision of asylums and especially the NGA; Chapters 3 and 4 look 'beyond the walls of the asylum'; and Chapter

5 considers the relationship between race and suicide as played out in colonial Natal. The final chapters return to the ideas of insanity that were influential at the time of the passage of the Mental Disorders Act of 1916 and reflect on the place of psychiatry in Natal at the end of World War 1.

Chapter 2

The Fools on the Hill : The Institutionalisation of Insanity in Natal and Zululand, 1860-1910¹

Natal Government Asylum
Pietermaritzburg
6th April 1909

To H.E. Sir Matthew Nathan
Governor of Natal
Sir,

I again appeal to you for my release. That my incarceration here is wrong is well known. I was brought here by my husband John Gilbert Anderson, c/o Wilson Bookseller, Durban under false pretences and have been kept under compulsion for six months. There is no doubt whatever that I have been kept here for criminal purposes. I especially request an interview with you if anything which I have said in my communications seems inexplicable. I should like to defend myself against the said John Gilbert Anderson as I have not been told what reasons he gave for my incarceration here. I again request, and this is important, that neither Dr Hyslop nor Dr Aitken, medical attendants in this Asylum be consulted in this matter. Mr Walker Town Clerk, Pietermaritzburg may be referred to, if necessary.

I again appeal to you for my release and for an opportunity to see justice done to John Gilbert Anderson on account of the brutal treatment I have received in this place.

I was refused the use of pen and ink by the attendants.

I am, Sir, Your obedient servant,

Madeline Anderson²

¹ The title of this chapter is a play on the late medieval and early modern European labelling of the insane as 'fools', and on the name that was given to the Natal Government Asylum in the twentieth century, Town Hill Hospital. It also owes not a little to the lyrics of the Beatles' *The Fool on the Hill*. For a discussion of the symbolism of the myth of the 'Ship of Fools' (where the insane were said to be removed from their formerly accommodating communities and confined to a ship with 'a crew of fools and misfits'), see S.L. Gilman, *Seeing The Insane: A Cultural History of Madness and Art in the Western World* (New York: John Wiley & Sons and Brunner/Mazel, 1982), pp.44-49.

² Town Hill Hospital, Pietermaritzburg. Natal Government Asylum (hereafter NGA), (European) Patient Case-Book XI, Admission number 2489. This letter was found between pages 984 and 985, and is written in pencil. The sentence 'There is no doubt whatever that I have been kept here for criminal purposes.' has been underlined in blue pencil, presumably by Dr. Hyslop or Dr. Aitken. Mrs. Madeline Anderson. was admitted to the NGA on 4 September 1908 at the age of 34, and diagnosed as 'Melancholic'.

The Natal Govt Asylum
Pietermaritzburg, Natal
June 3rd/06

Dearest Kitty,

Excuse lead pencil. I'm in a lunatic asylum. I'm a Punch and Judy Show. I'm the Kid. Nurse I want more pudding. Give me more pudding. Give me pudding always. I'm thin. You're thin, you're scraggy. Whack! Whack! - Go to bed. (Down goes the curtain.)...

Stop crying, Kitty. I'm only playing at Punch and Judy Show. I'm in a lunatic asylum. I must adapt myself to circumstances. I am guarding you.

Yours, as always, D. Morrison Jacobs³

N.M Hospital
P.M. Burg
Natal
26 July 1915

To Chief u Diki
Mngeni Court
Pietermaritzburg

I say this letter must be forwarded to the court. I am requesting to be released from the Asylum, because my sickness needs to be treated by 'native doctors' (izinyanga zabantu). There is a person I know by the name of Sicoco who can treat this sickness. As I mentioned in the beginning, I do not want anybody to stand next to me because that makes me sicker. A sickness caused by demons can only be treated by 'African medicine'; therefore I need to go to Sicoco Qwabe.

I ask you my lord, because even whites have failed to treat me, they do not give me medicine to prevent these demons. Demons irritate them and they become confused in such a way that they cannot see anything.

My mother comes and leaves not having seen me, because I am locked inside here, this troubles my heart.

Sicoco is a registered native doctor, and he pays tax to the chief. The reason why I want to go to him is that this sickness confuses whites.

Sobantu is my witness, I am staying here and I fight with no one. He mentions that some diseases are not curable. And he even informed a doctor about that. He says they have experienced the hardships of this world and I informed a doctor about that.

I want to go with my mother to Sicoco.

Lubimba of Teteleku has written this letter, requesting him to forward it to you....⁴

³ NGA (European) Patient Case-Book XI, p. 379. This Case-Book covers the 'European' patients admitted between 1904 and 1908, and traces the clinical histories of these patients until their death, discharge, or the transfer of their records to 'loose leaf folders' in 1919. This has been excerpted from a much longer letter pinned to p.379, with a further letter dated 25 May 1906. The patient, David Morrison Jacobs – admission number 2085 - had been admitted to the NGA on 2 April 1906. Aged 29, and described as a Jewish pauper, he was termed 'clearly insane'.

⁴ Pietermaritzburg Archives Repository (hereafter PAR), Chief Native Commissioner (hereafter CNC) 211 1915/978, 'Application of Lubimba ka Teteleku who is in the Asylum, Pietermaritzburg to be released and treated by a Native Doctor, 28 July 1915'. The document, is in *isiZulu*, and was written on lined, A4 paper, in clear handwriting. It appears to have been dictated, but to whom it is not indicated. This translation into English was done by here by

The Ambiguities of Asylum

Law No. 1 of 1868 established the legislative basis for the official certification and incarceration of lunatics in the Colony of Natal, but the material conditions for the safe care and custody of those who were confined as such saw little immediate change or improvement. The economic setbacks of the 1860s, which in the early 1870s were only compounded by an exodus of diamond-hungry seekers of fortune and fresh opportunities, meant that plans to establish a public lunatic asylum had to be stalled until some of the wealth of the diamond fields began to find its way from Kimberley to Natal. It was not until almost a decade after the passage of the 'Lunacy Act', that the Colonial Secretary was, in 1877, able to authorise the expenditure of £20,000.00 for the construction of a new lunatic asylum on the Town Hill, then on the outskirts of Natal's capital city, Pietermaritzburg. The removal of the mentally ill from makeshift asylums and from the local gaol, to a facility – to be based on 'the latest and most approved design' – was both symbolically and materially representative of a settler vision of 'civilised values'.⁵ The first building of the Natal Government Lunatic Asylum, southern Africa's first purpose-built institution for the insane, was opened in 1880.⁶

Until 1927, after which the disused military barracks at Fort Napier were utilized as a second mental hospital in the city, the Natal Government Asylum (NGA) remained the chief site of detainment in the region for those – white, African and Indian, men and women – who were certified insane. Although accommodated from its earliest years in different wards, white and black patients were attended by the same

Mxolisi Mchunu, August 2002. The last page appears to be missing.

⁵ G. Fouché, 'Mental Health in Colonial Pietermaritzburg', in J.P.C. Laband and R. Haswell (eds.) *Pietermaritzburg: A New History of an African City* (Pietermaritzburg: University of Natal Press and Shooter and Shuter, 1988), p. 186.

⁶ The NGA was not, of course, the first lunatic asylum in southern Africa. Lunatics had long been housed, or detained, in general hospitals and in gaols. Robben Island had an asylum for lunatics from the 1840s, and the Grahamstown Asylum was opened in 1875. Both of these asylums, however, were converted military barracks. For the history of the Robben Island lunatics see, H. Deacon, 'The Medical Institutions on Robben Island 1846-1931' in H. Deacon (ed.) *The Island: A History of Robben Island, 1488-1990* (Cape Town and Johannesburg: Mayibuye Books and David Philip, 1996).

professional medical staff, and occupied the same grounds, until well into the twentieth century.⁷ Only from the 1970s, when Indian patients joined Africans at Fort Napier, was the hospital exclusively racially segregated. Today, the asylum – now known as Town Hill Hospital – still accommodates more than four hundred psychiatric patients of all races.

The asylum is necessarily of central importance for any study of the history of insanity. As a formal institution for the accommodation of those deemed to be mad, the asylum represents a tangible focus for a notoriously fickle phenomenon. Generating records – architectural plans, committal papers, patient records, doctor's reports, financial statements, laundry bills, drug and medication requisitions, statistical tables, and much more – the documentary wealth spun out by individual institutions is indeed invaluable. Such records of individual asylums have formed the basis of the hitherto small number of scholarly studies of the history of psychiatry in southern Africa, and have done much to show how these institutions were deeply embedded within the milieu in which they operated. They have shown, in particular, that colonial psychiatry and asylums were governed by ideas and practices that entrenched a discriminatory provision of South African psychiatry with its roots in the colonial period, but which found its apogee under *apartheid*.

Asylums are however, profoundly ambiguous institutions. In its literal translation, the term 'asylum' is a place of refuge and of sanctuary; it exists to safeguard those within it who are threatened by an existence outside its walls. At the same time, lunatic asylums especially, have become strongly associated with the notion of the protection of that outside society from those confined within the boundaries of the asylum

⁷ Short pieces about the NGA (later, the Pietermaritzburg Mental Hospital) appear in the general texts on medical history in South Africa, including E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town: A.A. Balkema, 1958) and M. Gelfand and P. Laidler, *South Africa: Its Medical History, 1652-1898, A Medical and Social Study* (Cape Town: C. Struik (Pty) Ltd., 1971). For a slightly fuller treatment, see G. Fouché, 'Mental Health in Colonial Pietermaritzburg', in Laband and Haswell (eds.) *Pietermaritzburg: A New History of an African City*. See also S.K. Shirley, 'Shifts in Societal Perceptions of Mental Retardation Concurrent with Social, Economic and Political Changes' (unpublished Ph.D. thesis, University of Natal, Pietermaritzburg, 1996).

buildings and grounds. Sanctuary for the sick has become security for the sane. Asylums may thus be simultaneously places of retreat and of confinement, and of refuge and restraint. Capturing the multiple experiences and meanings of persons confined to an asylum is by no means an easy or straightforward enterprise. This is in no small measure because the surviving sources on the patients in southern African asylums – especially African patients – are scarce. And, even where such sources exist, there are formidable problems in attempting to interpret the ‘voices of the mad’.

Take, for instance, the quotations taken from the three letters with which I preface this chapter, written by patients — or inmates, the terminology is problematic in either case — of the NGA in the early part of the twentieth century. While they do indeed represent a fascinating, rare echo of the voices of those who were confined as mental patients at the NGA, they also illustrate the difficulties of attempting to interpret such writings. At first glance, the letter written by Madeline Anderson appears to be entirely accessible and rationally comprehensible to us. It raises concerns long debated by historians and critics of psychiatry: the custodial nature of the asylum; the criminalizing and stigmatizing as ‘mad’ of troublesome and unruly elements of society – especially women – by a patriarchal society or a centralising state; the spectre of wrongful incarceration. The extract from the letter to Kitty by David Morrison Jacobs, on the other hand, seems quite clearly to belong in the realm of the insane, the irrational, the illogical, and possibly, the ahistorical. Yet, a different perspective on these patients and their mental state emerges when we learn that whereas Anderson was still a patient in late 1919, when we lose track of her, Jacobs was released ‘cured’ after only three and a half months. Given these different fates, how are we to gauge the contents of these communications, and the sanity or otherwise of their originators? For these, and many other patients, was the NGA a refuge – from their madness within, or from a world that was for some time overbearing and threatening? Or, were otherwise merely eccentric and harmless persons confined for the convenience of others?

The last letter, written by or on behalf of Lubimba kaTeteleku, is perhaps the most interesting of all, for testimony of the experiences of African asylum patients is

extremely rare. Here, Lubimba kaTeteleku's letter to the Chief Magistrate of the district praying for his release from the NGA not only echoes the many letters addressed by 'European lunatics' to persons of authority requesting discharge, but also hints at the alienation that he experienced in an institution that cut him off from his family, from medical practitioners and paradigms that he understood, and probably from many of his fellow asylum inmates who, because of racial and class privilege, were accorded different standards of care. Lubimba's letter is interesting in another respect: in it he makes reference to Sobantu, to Bishop John William Colenso, who had died in 1883. Although difficult to establish with any degree of certainty, it seems likely that Lubimba kaTeteleku was a son or grandson of Thetheleku kaNobanda, Chief of the Mphumuza at Zwartkop, just outside Pietermaritzburg. Historian John Lambert points out that Thetheleku kaNobanda (died: 1899) was an influential chief, who attempted to safeguard African interpretations of law and chiefly power.⁸ He was not a *kholwa* – 'believer', or Christian, however, and the reference to Sobantu is intriguing. If Lubimba was indeed of this chiefly lineage, his presence at the NGA in 1915 may be indicative of a shift towards the acceptance of the asylum by some African families as a place of last resort for the custody of family members who were of unsound mind, raising questions about the extent to which the NGA had, in the decade before World War 1, become an institution of insanity that was utilized *by* as well as *for* Africans.

Despite the profound difficulties of attempting to reconstruct a history of the NGA that reflects the experiences of both its managers and its inmates, nonetheless it is an important institution in the past, as well as in the present, formalized management of madness in South Africa. This chapter focuses on the first three, foundational, decades of the NGA, from 1880 to 1910. It does so in several ways, and for several reasons: Firstly, in its first thirty years, the NGA was closely associated with the career and interests of Dr. James Hyslop, who arrived in the colony in the early 1880s, 'a decade when medical specialization was still almost unheard of'.⁹ Hyslop not only shaped –

⁸ See J. Lambert, *Betrayed Trust: Africans and the State in Colonial Natal* (Pietermaritzburg: University of Natal Press, 1995), esp. pp. 33-35 and 129-130. Lubimba kaTeteleku's literacy marks him out, too, as an unusual African asylum inmate.

in multiple ways – the institution of insanity in colonial Natal, but also played a significant role in the colony’s military, mental/psychiatric, and public health affairs, and in so doing, enhanced his own profession’s status. At the time of his death in 1917, Hyslop was ‘widely regarded as the doyen of the profession’ and ‘one of the most generally respected medical men in South Africa’.¹⁰ Although under-funded and with small numbers of qualified staff, by World War 1 South Africa’s ‘mental services’ were firmly established and increasing in significance to the national state. By this time, with nearly 800 patients at the Pietermaritzburg Mental Hospital – as the asylum was now known – Natal had the second highest number of institutionalized psychiatric patients in the country, and, after the more-recently constructed Valkenberg Asylum in Cape Town, Pietermaritzburg remained a preferred posting for South African psychiatrists. According to Dr. Archibald Douglas Pringle, one of the reasons this was so was because of the variety of clinical and administrative experience that professional ‘asylum doctors’ could gain at the NGA.¹¹ For, unlike Valkenberg – which until 1916 accommodated only whites – from the late 1890s, the majority of inmates at the NGA were black, in other words, African or Indian. As I have already begun to indicate, the growing numbers of African asylum inmates in particular should not be seen merely as a reflection of a punitive state seeking the endorsement of its policies by colonial psychiatrists, but African attitudes towards lunatic asylums were also significant. Indians remained under-represented as asylum inmates in relation to the total numbers of Indians in Natal and Zululand throughout the period of my study. Some of the reasons for this will be touched on in this chapter, and then discussed in much greater depth in Chapter 5, which examines the relationships between indentured Indian workers, medicine and the colonial state, particularly with regard to the high incidence of suicide among Natal Indians.

The formation of the Union of South Africa in 1910 moved responsibility for the

⁹ E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century*, p. 219.

¹⁰ *Ibid.*

¹¹ National Archives Repository, Pretoria (hereafter NAR), Colonial Secretary (hereafter CS) 986 20397, ‘Dr A. D. Pringle’. Pringle to Acting Secretary, Department of the Interior, 14

administration and management of the country's mental hospitals to the Department of the Interior. After Union, by which time Hyslop was in any case less involved with the day-to-day running of the NGA, the centre of financial and administrative power shifted decisively to Pretoria, and more particularly, to the Commissioner for Mentally Disordered and Defective Persons, Dr. J. T. Dunston. While the period of the asylum's existence under Hyslop was not without friction between the Medical Superintendent and the colonial government, his access to the persons in positions of authority was much more direct and immediate than that of his successors, and since the NGA remained the sole institution for the insane in Natal and Zululand, he did not have to compete with other asylums for resources. Staffing, too, remained under the direction of Hyslop, who called on his connections in Scotland to put forward promising young 'mental specialists' to serve as Assistant Superintendents. Some of these – such as Pringle – would later enter the Union's 'mental services'. After Union, the Department of the Interior and Dunston took charge of the appointment of professional psychiatrists across the country, but until then, the medical men and the senior women nursing staff at the NGA were hand-picked by Hyslop.

A second important shift occurred at around the time of Union and intensified over the following decade, one that is characterized in significant ways by the contrasting ideas of the origins and implications of insanity represented in the persons of Hyslop and Dunston. As Shula Marks has commented, until the late nineteenth century, most hospitals in the Cape – and this is true for Natal – took in patients of all races. Wards and facilities were, to be sure, often divided and provisions allocated on an unequal basis according to race, but this was justified largely on grounds 'that smack of pragmatism and prejudice rather than any systematic medical or racial theory'.¹² The universalism of Enlightenment liberalism, which underpinned the colony of Natal's investment in a major institution for the insane, also underlay the broad management principles employed by Hyslop and those who worked with him at the NGA. As with

August 1911.

¹² S. Marks, "Every Facility That Modern Science and Enlightened Humanity Have Devised": Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910' in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge,

Dodds at the Cape, Hyslop espoused no systematic theories of racial difference based on medical, biological, mental or eugenic grounds.¹³ In large part, such a move occurred after Union, and in Natal was associated with the influence of Dunston, and was resisted – if only in its more extreme forms – by at least one of the province’s psychiatrists, most notably Dr. H. Egerton Brown.¹⁴

The third reason for restricting this chapter to the period before 1910 relates to sources. In the case of the NGA, these present us with something of a paradox. For, we are faced with both too much and too little information. On the one hand, the residents of the NGA in the nineteenth and early twentieth century were perhaps the most categorized and enumerated group of any people in this region. From 1870 onwards, the Natal *Blue Books* carry an annual report about the – at first temporary – asylum and its inmates. In increasingly elaborate and more finely calibrated categories we are given an almost overwhelming amount of statistical data on the numbers of admissions, their sex, race, age, the duration of their 'attack', the length of their stay at the NGA, the probable cause of their 'insanity', their prognosis, the diseases that killed them, their occupation before admission, their marital status, and so on. It is my attempt to interpret these statistical tables which forms the second half of this chapter.

Furthermore, a fair amount of correspondence relating to the NGA can be found in the collections of the various branches of government which were involved with the admittance, maintenance or release of patients, such as the Colonial Office, the Supreme Court, the Public Works Department, the Indian Immigration Office, and, occasionally, in Resident Magistrates' Reports. However, while the committal procedure *should* have left a veritable paper-chain, of medical certificates and legal documentation, it has not, and there is no coherent set of documents that refers to the NGA or to its patients. Assuming the practice in Natal to have been the same as that in the Cape – and this does seem likely – most documentation pertaining to the

1999), pp. 268-291. See esp. p. 269.

¹³ Marks, "Every Facility", p. 285.

¹⁴ For Dr. H. E. Brown's career at the Pietermaritzburg Mental Hospital, see Chapter 6.

committal of patients was kept at the NGA itself. Sometime after 1910 these documents were lost or destroyed.

We also have precious little clinical information: until around 1916, Hyslop and his later deputies, Drs Skinner, Aitken, Glashan, and Pringle, entered clinical information in large leather-bound Case-Books. The Case-Book format was laid down by the British Lunacy Act of 1853. In Natal, it appears that separate Case-Books were kept for 'Europeans', 'Natives', and 'Indians'. At Valkenberg, separate books were kept for men and women. After 1916, patient notes were recorded in loose-leaf folders, none of which have survived for Pietermaritzburg. Indeed, patient records were destroyed by order.¹⁵ Several of the Case-Books survived at Town Hill Hospital until about 1980, but only one remains today.¹⁶ This Case-Book represents the admission notes on 251 'European' patients admitted to the asylum between 1904 and 1908, with some of the entries being updated until the patient's records were transferred to the new folder format. This single Case-Book represents the only extant medical information about a limited number of asylum patients and while I draw on some of those records here – and also from some of the remarkable notes and letters that are tucked between its pages – there are severe limitations in its use as a historical source.

¹⁵ I've searched long and hard for clinical information from Natal: little seems to have survived. An empty folder – NAR Director of Archives (ARH) 14 C11/13/17 – marked 'Pietermaritzburg Mental Hospital' at the National Archives Repository in Pretoria has the following notation written by hand, ' Note. Vide Interiors Minute No.51/34/29 of 14/XI/1930 that records under 7 years from this institution are not to be destroyed', which suggests that records *over* seven years were destroyed. The published excerpts from the Mental Hospitals' annual reports in the 'teens to 1930s frequently contain more information on the state of the asylum farm's livestock (prizes won by pigs at the Natal Royal Show, for example) than they do clinical trends.

¹⁶ Former Town Hill Hospital administrative officer, Mr. Roly Le Grange has preserved this Case-Book, and also the Staff Offences Register from 1927-1960. I am extremely grateful for the opportunity to study these sources in depth, and wish to extend my thanks to Mr. Le Grange and the administration of Town Hill for temporarily entrusting them to me. The surviving Case-Book is number XI. In his short article, published in the *South African Medical Journal* (hereafter *SAMJ*) in 1956, Dr. M. Minde describes two patient Case-Books from the NGA which contained the records of 253 cases 'numbered consecutively in order of admission' from 23 July 1864 to 27 December 1884, showing that patient records were kept long before the NGA itself was constructed and even in advance of the 1868 Act. M. Minde 'Early Psychiatry in Natal' in *SAMJ*, 30, 24 (March 1965), pp.287-291. Of these Case-Books, by 1998, there was no sign.

While the kind of details contained in the Case-Book give us fascinating, often poignant, glimpses into some of the people represented in the statistical tables, because of their formulaic nature and because of the limited space provided for doctors' observations, Case-Books provide us with very limited information about asylum inmates. Furthermore, as Sally Swartz's finely-nuanced study of the Valkenberg series (248 patient folders from the period 1891-1920) demonstrates, rather than unproblematically reflecting the often inchoate experiences of madness, the majority of surviving documents can be read as texts that reveal more about how professionalized psychiatric knowledge was constructed, than about the patients themselves.¹⁷ More specifically, she demonstrates that the forms and tables in both the Case-Books and on the documentation later contained in the loose-leaf folders provided physicians with guidelines for describing forms of insanity, and in doing so they stripped 'lunatics' of their individual identity, transforming them from people to 'cases'. This was doubly so in the case of black patients.

In the absence of case material for Africans and Indians in any form whatsoever, we simply do not know how fully the NGA physicians recorded the medical and mental condition of black inmates. The analysis of the *Blue Book* aetiological tables given below, and later commentary by Dr. Harry Egerton Brown, suggests psychiatric knowledge about black patients was usually sketchy, and that the relevant patient records – where they did exist – reflected this lacuna. This chapter does not, then undertake the sort of discourse analysis of patient records undertaken by Sally Swartz. Since the white patients at the NGA were, from the late 1890s onwards, in the minority, an over-concern with the single remaining, 'European' Case-Book would be an unwarranted re-inscription of the marginalisation of the mad, more particularly the African and Indian mad, in colonial Natal. For this reason – and because only one such source has survived anyway – it seems unlikely that it is possible to (re)construct

¹⁷ See especially her Chapter 4, 'The Official Certificates and Forms: Categories of Lunacy Administration At the Cape', and Chapter 7, 'Lexical Sets and the Representation of Acute and Chronic Insanity in the Valkenberg Case Records', in S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920' (unpublished PhD thesis, University of Cape Town, 1996).

a psychiatric profile of the NGA patients. Nor has it proved possible to locate the records of a single individual that are substantive enough to form a case study such as that of 'Isaac O.' by Jonathan Sadowsky, in his study of the institutions of insanity in colonial Nigeria.¹⁸ What can be done, however, by careful scrutiny of the published annual reports and statistical tables, is to give the outlines of a social profile of those officially deemed to be insane .

This chapter, then, covers the early history of the institutionalisation of insanity in colonial Natal and Zululand. Before outlining the history of the NGA between 1880 and 1910 – its material expansion, its staff, and its patients – it looks briefly at the temporary asylums that were provided for the mad in 'Maritzburg's midst before the transfer of between fifty and sixty lunatics to the new asylum in 1880. Thereafter, the statistical information available to us from the asylum reports published annually in the *Natal Blue Books* is used to sketch out answers to the fundamental questions that must be asked in any social history of madness: who were the insane; why and how were they deemed to be so; by whom, and why? The chapter makes the case for the NGA as an institution which has been of no small significance in the management of madness, by both blacks and whites, in this region for more than 120 years, but it closes by pointing to – and the following three chapters go on to explore – the very real limits to the impact and influence of the formal institutions of insanity in Natal and Zululand in the period before World War 1.

'That miserable place': accommodating insanity, 1860-1880

Before work could begin on the public asylum on the Town Hill, 'lunatics, epileptics and idiotics' were accommodated at gaols and hospitals around the colony. One of the earliest indications we have of the existence of the institutionalised restraint of lunatics in the region comes from the *Natal Blue Book* of 1861, which recorded that Grey's Hospital in the capital city also received

¹⁸ J. Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley and Los Angeles: University of California Press, 1999), esp. Chapter 5 'The Confinements of Isaac O.: A Case of "Acute Mania"'.

Lunatics from all parts of the Colony ... Patients who can pay are charged 1s. 1d. per diem for their maintenance at this Institution, as also at Durban Hospital; this charge is exclusive of extra medical comforts, and clothing, which are charged in addition. Those persons whose servants are admitted into Hospital, are also charged for a limited period, at the above rate for whites, and 7d. per diem for native servants.¹⁹

One of these patients could well have been 'E. Grant' who, in January 1861 was 'confined at Grey's Hospital as a Lunatic', and about whom Erskine, the Colonial Secretary, wrote to the Attorney General that 'His Excellency is anxious in the event of [his] being released from custody that some authority over him should if possible be delegated to his father.'²⁰ In 1867, there were five 'insane' white patients at Grey's.²¹

The pressure of numbers grew, very probably increasing as the economic recession bit most deeply in the mid-1860s. At this time, the colony lacked the resources to provide effective relief to those who were most vulnerable or hardest-hit, and Grey's Hospital became, in effect, a Poor House.²² It seems likely that these social factors played a role in prompting an increase in mental illnesses at the time, and/or in fanning fears about an apparent escalation. The 1868 Natal *Blue Book* records the presence of twenty-four 'inmates', now housed at a 'Temporary Asylum at the Pietermaritzburg Gaol. The colonial government was already finding it necessary to vote £58.8.2 for the 'Enlargement, Lunatic Asylum, Pmb.'²³ The Durban Gaol had also accommodated

¹⁹ PAR *Natal Blue Book for 1861* (hereafter NBB) Return of Charitable Institutions, 1861, pp.324-5. It is not clear whether the patients were all white and brought servants with them who could be either white or 'native; or whether these charges are for the care of servants of either race.

²⁰ PAR Attorney General's Office (hereafter AGO) 1/8/5 12A(1861), Colonial Secretary to Attorney General, 16 January 1861.

²¹ A. Rose, 'Grey's Hospital', in Laband and Haswell (eds.) *Pietermaritzburg: A New History of an African City*, pp.182-185.

²² For a fuller discussion, see J. Parle, 'The Impact of the Depression Upon Pietermaritzburg During the 1860s' (unpublished M.A. thesis, University of Natal, Pietermaritzburg, 1988).

²³ NBB 1868, Return of Charitable and Literary Institutions.

four lunatics during that year.

Since little in the way of documentation concerning the inmates of these temporary asylums has survived, the circumstances surrounding their confinement are obscure. We do know that, from the start, male inmates outnumbered females. In 1874, for example, the temporary asylum accommodated five women and thirty-two men.²⁴ However, only fragments of the lives of those affected by madness can be glimpsed today. For instance, the Resident Magistrate, Umvoti, complained to the Attorney General in 1864 of a Mr Foster Gray who had lived on the lam at the Hotel in Greytown for some months, and who was 'at times very violent and requires the attention of two or three men'. The Magistrate locked Gray up even though he doubted that he had the necessary authority, pleading that he needed to do so 'for the peace and safety of the inhabitants here'. Gray, however, was found to be sane by 'medical men in Pietermaritzburg'.²⁵ Three years later, the Resident Magistrate of the same district applied to have a 'dangerously mad native' conveyed to Pietermaritzburg, the District Surgeon having found him to be 'non compos mentis and unfit to go at large'.²⁶ An African woman, named only as Umfulala, was accused by a Mr. Hulett in 1870 of 'a trivial theft': the Clerk of the Peace, Durban, regarded her as insane – for what reason we do not know, except that he noted that she claimed that her child had been taken away from her – and wanted to have her transferred to the asylum, but said that she was unlikely to survive the journey to the city in a cart or wagon.²⁷ From the asylum itself, John Foley petitioned the Lieutenant Governor for release, 'to enable him to proceed to his Wife and family and seven children'. Dr

²⁴ *NBB* 1874, Lunatic Asylum Returns. Although a matter of some on-going controversy, it seems that in British and US asylums at this time there were approximately equal numbers of male and female patients. In Natal males always outnumbered females. Some of the reasons for this will be explored below.

²⁵ PAR AGO 1/8/5 19A/1864, Resident Magistrate, Umvoti to Attorney General, 9 March 1864 and 17 March 1864.

²⁶ PAR AGO 1/8/5 19A/1864, Resident Magistrate, Umvoti to Attorney General, 21 October 1867. Emphasis in original.

²⁷ PAR AGO 1/8/12 130A/1870, 'Umfulala', Clerk of the Peace Officer, Durban to Attorney General, 25 March 1870.

Charles Gordon, however, was of the opinion that Foley was still ‘of unsound mind.’ He added ‘He is noways [sic] improved by his residence in the Lunatic Asylum, and no further fitted to attend to any business than he was before his admission.’²⁸

In 1865 the Pietermaritzburg Town Council had voted to grant to the Colonial Government a ‘Site for a lunatic asylum in extent not more than ten acres.’ This site was at the top end of Church Street, near the base of the garrison.²⁹ It was not until 1873, however, that the Council was formally approached by the government to release the land, and by this time a site of a hundred acres was mooted.³⁰ The Council counter-offered fifty. The burgesses of Pietermaritzburg were less than pleased, however, and 115 petitioners signed a Memorial objecting to the grant. Unfortunately, the Memorial itself has not survived, but at least one Councillor objected to it, saying that the site chosen by the government was suitable – and indeed that it was at that time being ‘used only by Kafirs and others, for every disgusting purpose repugnant to Public decency’ – and that the petition had been signed ‘without due and deliberate consideration.’³¹ The Council bowed to the pressure, however, and decided to offer the government fifty acres of land ‘provided that it be not within 1 mile of the City, and does not abut on any of the main roads.’³² Writing in 1955, historian of Pietermaritzburg, Alan Hattersley’s view of this decision is charitable. He points out that there had been many criticisms of the siting of Grey’s Hospital on the main road into the city, and overlooking the town cemetery: ‘Fortunately,’ he writes,

the Town Council had been unwilling to have “another building of a melancholy character at another entrance to the city”, with the result that a new site, immediately below the Briar Ghyll property of Joseph Henderson, was approved. It was chosen by Dr. Sutherland and Councillor Sam Williams and,

²⁸ PAR AGO 1/8/20 182A/1878, ‘John Foley, now an inmate of the Lunatic Asylum, forwards letter to the Attorney General enclosing petition for His Excellency the Lt Governor’, 23 June 1878.

²⁹ PAR Pietermaritzburg Corporation (hereafter PC) 3/PMB 1/1/3, p. 1031. Minutes, Town Council Meeting, 8 March 1865.

³⁰ PAR, PC 3/PMB 1/1/4, p. 802. Minutes, Town Council Meeting, 14 March 1873.

³¹ *Ibid.* The Councillor was a Mr. Harmsworth.

³² *Ibid.*

and conformed closely to the suggestions of the Lunacy Commissioners in London, who had advised that asylums should be “elevated above the surrounding country, not overlooked or intersected by public roads”.³³

The Town Council Minutes, however, reflect the ambiguity – simultaneously necessary and threatening – with which asylums were regarded. The fifty acres of land finally agreed upon was on the Town Hill, and at least a mile outside the city. The Mayor’s Minute of May 1873 expressed satisfaction at the compromise reached: ‘The site selected is in every respect a suitable one ... I cannot refrain from congratulating the Council and burgesses that this great desideratum is at length likely to be accomplished ere long.’³⁴ In October that year, the Council confirmed that the Town Clerk could prepare the deed of transfer.³⁵

In the meantime, most lunatics had been moved from the temporary asylum at the gaol to a property at erf 525, Longmarket Street. Purchased by the government at a cost of £1,112, it consisted of ‘about eight-and-a-half acres of ground and a house’.³⁶ Somewhat ironically, this had once been the home of Judge Lushington Phillips.³⁷ Whether it was a significant improvement on the gaol seems doubtful, however: the Colonial Secretary, for instance, was said to have referred to it as ‘that miserable place’.³⁸ There is a photograph of this ‘Old Asylum’ in Hattersley’s *A Camera on Old Natal*, published in 1960, and he described it as a ‘grim-looking building’. Hattersley’s commentary on the photograph notes:

³³ A.F. Hattersley, *A Hospital Century: Grey’s Hospital, Pietermaritzburg, 1855-1955* (Cape Town: A.A. Balkema, 1955), p. 78.

³⁴ PAR PC 3/PMB 1/1/4, Mayor’s Minute for the Corporate Year Ending 31 July 1873.

³⁵ PAR PC 3/PMB 1/1/4, pp. 852 and 856: Minutes, Town Council Meeting, 7 October 1873.

³⁶ Minde, ‘Early Psychiatry in Natal’, p. 287.

³⁷ Union of South Africa, U.G. 31-‘20, *Report of the Commissioner of Mentally Disordered and Defective Persons* (Cape Town: Government Printer, 1920), p. 25. ‘History of Institution’ by Dr. R.S. Sinclair Black, Physician-Superintendent of Pietermaritzburg Mental Hospital.

³⁸ A.F. Hattersley, *A Camera on Old Natal* (Pietermaritzburg: Shooter and Shuter, 1960), p. 59.

Though iron grilles were no longer thought necessary, mechanical restraint by wrist straps and iron handcuffs was still practised in this building. There was no exercise yard, but inmates were sometimes taken for a walk. At night a patrol was organised by John Smithwick, the male attendant, to prevent escapes.³⁹

John Smithwick had formerly been a sergeant in the 75th Regiment. He was appointed as Natal's first 'Keeper of Lunatics' from February 1875, thus reinforcing the notion of the custodial, rather than the therapeutic, role played by asylums at this time. He was 'assisted' by his wife, 'four Coolie servants', (later dismissed) and 'two native assistants, four male guards and one native female guard.'⁴⁰

Dr. Charles Gordon, District Surgeon, was the 'medical man most closely associated with the old asylum'.⁴¹ Reporting in January 1875 on the deaths of three 'inmates', Gordon's letter to the Attorney General shows that African, as well as white, lunatics were restrained there. He noted, for example, the death of 'a native named August who was insane', and who had been an inmate for 'four years and nine months'. The 'native, "Jas"', had been confined as a lunatic since July 1874, and died there of 'Debility and Diarrhoea' six months later. Between 1864 and 1874, only five Indians were committed to temporary asylums as lunatics, representing a pattern of small numbers of legally-detained insane Indians which would endure over the following decades.

Despite Gordon's long interest in and early commitment to the care of lunatics, and despite the new legislative requirements that certification by two medical professionals was required before the legal detention for lunacy, his 1875 letter shows that these measures were not always observed. He wrote indignantly that

I have also to report that the American, A.M. Gray, who died on 29th

³⁹ Hattersley, *A Camera on Old Natal*, pp. 58-59.

⁴⁰U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p.25, and Fouché, 'Mental Health in Colonial Pietermaritzburg', p. 186.

⁴¹ Minde, 'Early psychiatry in Natal', p.287. For a short biography of Gordon, see Burrows, *History of Medicine in South Africa*, p. 218.

December 1874 does not appear in the List of Lunatics although he died in the Asylum. During the crowded state of the prison, some months ago, he was transferred to the Asylum for additional comfort and improved diet owing to the delicate state of his health. The improved comfort consisted in his 'sleeping' in quarters, which, by the returns just sent in the *Blue Book* publication, allowed little more than 500 cubic feet for each inmate. I can not do less than express my regret that I have any connection with a state of things which is a disgrace to a Christian community ... This inmate suffered from a serious form of epilepsy which afflicted and weakened his intellect. Medical certificates were forwarded to the Resident Magistrate to that effect at the time of his being sent to prison ... He does not appear in the List of Lunatics as no warrant has been granted by the Lieutenant Governor.⁴²

As constrained and as grim as the conditions endured by Gray and the other white inmates of this temporary asylum were, they were probably at least slightly more comfortable than those prescribed for African and Indian lunatics. The *Blue Book of 1870* noted the average amount of 'cubic space available for each patient' was 510 feet, but does not say whether each patient was accorded the same space or facilities. Food rations were stipulated and were differently allocated on the basis of perceived racial taste and need: whites received 12 ounces of meat a day, potatoes, rice, bread, butter, vegetables, sugar, and coffee. Africans and Indians were given meat only on Sundays, Wednesdays and Fridays; on the other days, dinner for Indian inmates was rice, with an eighth of an ounce of curry powder. Africans on the other hand, had only mealies. The diet devised for 'Hottentots' stood somewhere between the provisions for 'Europeans' and for Africans: bread and vegetables were given, but meat was only permitted on Mondays, Wednesdays and Fridays.⁴³ Overall, the food given to early asylum inmates was meagre, and as Gustav Fouché notes, 'these rations were deficient in certain essential vitamins, proteins and minerals. The nutritional status of long-term patients must have been appalling and could have induced pellagra, a condition with known psychiatric complications!'⁴⁴

⁴² PAR AGO 1/8/17 4A/1875, Charles Gordon, District Surgeon, to Attorney General, 6 January 1875.

⁴³ *NBB* 1870, Lunatic Asylum Return, 1870. The dietary scales were 'approved of by C.O. Letter 2115/1870, 28 October 1870.'

⁴⁴ Fouché, 'Mental health in colonial Pietermaritzburg', p.186. The exclamation mark is in the original.

The move to the Town Hill occurred first in 1875, with, at first, the establishment of another temporary asylum on the grounds. According to Burrows, thirty-seven patients were transferred there from the goal (Burrows makes no mention of the Longmarket Street asylum), and ‘a garden was now established ... and intelligent diversions were provided, as well as a padded cell, intended – the official report stated – “for the convenience of the violent inmates”’; the old-fashioned hand locks and straight jacket were locked away.⁴⁵ This temporary asylum marked the beginning of a permanent accommodation of lunatics on the Town Hill.

Basic, cramped, unsanitary, perhaps even brutal, the early provision of asylum for lunatics in Natal held out little prospect of solace from mental illness. Indeed, the primary function was to restrain the dangerous and the destructive. Yet, they were not entirely abandoned or neglected. Indeed, following British precedent, a Board of Management was appointed and entrusted with ‘the proper running’ of the asylum. It consisted of the Colonial Secretary, the Mayor of Pietermaritzburg, and a ‘private citizen’.⁴⁶ Attempts were made to distract and deploy the inmates:

the Colonial Government donated musical instruments (two concertinas), a chess set, a draughts board, 4lbs of marbles and 6 packs of playing cards! Ministers of various denominations were conducting church services on Sundays but the attendance was no more than 6 inmates at a time. White inmates refused to do any physical work.⁴⁷

Charles Gordon, District Surgeon of Pietermaritzburg provided medical services to asylum inmates until the appointment of Hyslop in 1882. Although they apparently no longer exist, Gordon instituted the keeping of patient records – in Case-Books – as early as 1864. Max Minde, chronicler of early psychiatry in South Africa, was, in 1955, given access to two such Case-Books which detailed patient admissions between 1864 and 1884, with notes on some of the patients running through to 1889.

⁴⁵ Burrows, *History of Medicine in South Africa*, pp. 218-219.

⁴⁶ Fouché, ‘Mental Health in Colonial Pietermaritzburg’, p. 186.

⁴⁷ *Ibid.*

Minde reports that: 'On the whole it appears that he tended to label the restless, hyperactive, talkative cases as mania and the quiet ones as dementia.... Out of a total of 180 cases described by Dr. Gordon, he diagnosed 64 as mania and 88 as dementia ...'⁴⁸ These Case-Books appear to have contained the records of both black and white patients. If the extracts provided by Minde are representative, as much attention was given to describing the symptoms of insanity of African as of white patients:

53. Majonda, a tall powerful male native aged about 25 years was admitted on 20th October, 1875 suffering from Dementia. This inmate was a prisoner in the Central Gaol, Pietermaritzburg, where he began, a short time ago to show certain peculiarities indicating insanity. When told to do anything he would laugh in a silly and vacant manner, and when spoken to would answer by entering on a rambling and purposeless conversation. At the same time he began to be dirty in his habits, besmearing the walls of his cell with porridge etc. He has become quarrelsome in his manner without cause and is under the delusion that his head is filled with water.

70. C.S.A., aged 27 years. He suffers from Mania. He has a sullen, suspicious appearance, and believes that people conspire against him. He will not undress himself at night but prefers to sleep with his clothes, boots and spurs on. He is a misanthrope and hates the sound of human voices and the whole human race. His sister stated that he had an idea that Kafirs and others conspired against him, and he believed they affected him by means of electricity.⁴⁹

Gordon's description of 'Majonda' relies on observations of his behaviour rather than the content – as with 'C.S.A.' of his delusions – but given the very limited information available to us, it is impossible to draw conclusions about any broad patterns in either diagnosis or treatment overtly based on perceived racial difference.

Some of the excerpts from the early Case-Books, as quoted by Minde, also give an indication of the kinds of biomedical treatments, palliatives and sedatives employed by Gordon. Even after the advent of moral therapy under Hyslop at the 'new Asylum', these remained stock-in-trade: chloral hydrate, laudanum, opium, and bromide of potassium; wine, port, brandy, quinine, and *cannabis indica*; were all prescribed at various times. African and Indian inmates who became debilitated could be

⁴⁸ Minde, 'Early psychiatry in Natal, p. 288.

⁴⁹ *Ibid.*

temporarily upgraded to a 'European diet', which could also be supplemented with beef tea and beaten eggs. Anorexic patients – male as well as female – were fed 'through the oesophagus tube.'⁵⁰ Bodily conditions such as diarrhoea, dysentery and pthithsis were common, and the death rate remained high – an average of 32 percent of all patients admitted between 1864 and 1884 – a feature of colonial asylums that was unfortunately to persist over the following decades. Nonetheless, over the same time period, of the 245 patient records examined by Minde, he found that 27 percent were 'Discharged. Recovered', and 15 percent 'Discharged Not Improved or Outcome Unknown'.⁵¹ Thus detention as a lunatic – even in the rudimentary temporary facilities that existed in Natal in the 1860s and 1870s – was not necessarily a sentence of a life of confinement within the asylum walls. Even so, roughly a quarter of all patients admitted in the twenty years before the opening of the NGA were not released.

Since the mid-1870s at least, the inadequacies of the temporary asylums were recognized by the government of Natal. In November 1875, for example, the Colonial Secretary wrote to the Government Engineer asking 'what steps have been taken towards the preparation of a Plan for a new Lunatic Asylum, and when I may expect it and the estimate of the cost which was asked for.'⁵² In January 1876, he chivvied the Engineer along again. The response came that 'draft designs for the Asylum have been made, but they are not yet matured. You may expect the detailed drawings about the 1 April next'.⁵³ It took until March, however, for him to write to the Colonial Office in England 'for Plans, estimates etc of the latest and most approved designs for Hospitals and Lunatic Asylums', but they had not arrived by July, by which time Bulwer, the Lieutenant Governor, was urging that the plans and estimates be prepared for

⁵⁰ Minde, 'Early psychiatry in Natal, pp. 289-290.

⁵¹ Minde, 'Early psychiatry in Natal, p. 290.

⁵² PAR CSO 539 1876/96, 'New Lunatic Asylum', Colonial Secretary to the Civil Engineer for the Colony, 11 January 1876.

⁵³ PAR CSO 539 1876/96, 'New Lunatic Asylum', Civil Engineer for the Colony to Colonial Secretary, 12 January 1876.

submission to the Legislative Council. One week afterwards, the Colonial Engineer submitted three different designs – apparently drawn up ‘in his own office’ – for a Lunatic Asylum. He had not, he said had time ‘to prepare detailed estimates, but the approximate cost will be, For No. 1 – £20,000, For Nos. 2 and 3, £15,000 each. Each of these would accommodate about 100 patients, and of course the interior appropriation of the wards can be altered to suit the circumstances. Of the three designs, I prefer No. 1, but I shall be glad if His Excellency will look them over and say which he considers the best.’⁵⁴ In 1877, the sum of £20,000 was duly approved for the first design. The following year, 1878, saw the start of the actual construction of the building, which, though considerably expanded and reconstructed over the following decades, formed the nucleus of the Natal Government Lunatic Asylum. The ‘New Asylum’ was formally opened in February 1880.

The Fools on the Hill: Dr. James Hyslop and the ‘Red House’, 1882-1909

From the late 1870s, Charles Gordon, and his later *locum tenens*, Dr. Charles Ward, advised the government of the necessity of appointing a specialist doctor to head the New Asylum, one that they believed would remove ‘all that impeded progress in the old institution’. They were confident that with the establishment of a permanent, resident medical officer and a ‘new system of superintendence’ there would be ‘no reason why, with the facilities at the command of the Directors, it should not become, in every respect, a Model Asylum for the Insane.’⁵⁵ It took, however, until 1882 for Smithwick and Gordon to be relieved of their charge of the 56 lunatics then at the Town Hill. On 21 June that year, the twenty-six year old James Hyslop, M.B., C.M., (Edinburgh) was appointed as first Resident Surgeon (Later, Medical or Physician

⁵⁴ PAR CSO 539 1876/96, ‘New Lunatic Asylum’, Civil Engineer for the Colony to Colonial Secretary, 18 July 1876.

⁵⁵ NBB 1879, Lunatic Asylum Return. Charles Ward was Acting District Surgeon for Pietermaritzburg in that year.

Superintendent) of the NGA. Hyslop has been described as 'the first incumbent and the maker of Town Hill.'⁵⁶ Graduating at the age of twenty-three with a medical degree from Edinburgh University in 1879, and 'subsequently specialising in mental diseases at Berlin, Vienna, and Munich',⁵⁷ he had served for a short time as Assistant at Morningside Asylum outside Edinburgh, before taking up the appointment at the NGA.

Hyslop became an important figure in Natal's medical circles: President of the Natal Medical Council (established in 1894 in succession to the Medical Committee), and representative of the Council on the Pharmacy Board; first President of the Natal branch of the British Medical Association; and President of the Seventh South African Medical Congress held in Pietermaritzburg in 1905. A member of the Central Vaccine Board, in 1899 he investigated the first authenticated case of plague in the Transvaal, was chairman of the Durban Plague Conference, and Natal delegate to the Conference of South African States and Colonies on plague held in Pretoria. In 1901 Hyslop became a member of the Natal Board of Health, and in 1903 was elected its chairman.⁵⁸

Indeed, Hyslop became 'a Natalian through and through'.⁵⁹ He became an integral part of Pietermaritzburg's elite, being, at various times, President of the Horticultural, the Botanical, and the Natal Societies. He was a passionate landscape gardener – and here his interests meshed with his views on moral therapy for asylum inmates – was a member of the Victoria Club, attended the theatre, and played golf and bridge 'as well

⁵⁶ Burrows, *History of Medicine in South Africa*, p. 219.

⁵⁷ Obituary, *South African Journal of Science* (hereafter *SAJS*), 14 (1917-1918), p. 312.

⁵⁸ Burrows, *A History of Medicine in South Africa*, p. 219. Also, *The Natal Who's Who: An Illustrated Biographical Sketch Book of Natalians* (Durban: The Who's Who Publishing Company, 1906); D. W. Kruger (ed.) *Dictionary of South African Biography*, II (Cape Town and Johannesburg: Tafelberg-Uitgewer Ltd., 1972), p. 325; and Obituary in the *SAJS*, 14 (1917-1918), pp. 312-314.

⁵⁹ Burrows, *A History of Medicine in South Africa*, p. 219.

as a gentleman should.⁶⁰ More than this, he was described as being '*persona grata* in Government circles.⁶¹ In particular, Hyslop enjoyed a close relationship with the colonial military services. In 1886 he became surgeon to the Natal Carbineers Volunteers, and later became Lieutenant Colonel. As O.C. of the Natal Medical Corps during the South African War, he was at the siege of Ladysmith and at Laingsnek. Promoted to Colonel, and in 1901 awarded the D.S.O., Hyslop remained at the head of the Natal Medical Corps and saw active service again during the rebellion of 1906. He also enjoyed considerable prestige throughout the region, being, for instance, the Natal representative on the Council of the University of the Cape of Good Hope. After retirement from the NGA in 1914, he became Assistant Director of Medical Services in Natal until a short time before his death in October 1917.⁶²

His thirty-two year tenure as the central figure in the administration of the NGA did not have a particularly auspicious beginning, however. The site allocated on the Town Hill at that time, largely barren land, without access to running water. According to a brief history of the institution written in 1918, by Dr. Robert Sinclair Black, then Medical Superintendent of the NGA: 'the well only furnished sufficient water for cooking and drinking purposes, that required for washing and bathing having to be carried in buckets from a *spruit* about 350 yards away. Sewage was received into wooden buckets the contents of which were emptied daily in a trench sunk for that purpose in the grounds. Light was supplied by oil lamps.'⁶³ Black recorded that Hyslop was said to have been so 'much disappointed with the primitive arrangements that he seriously considered the advisability of resigning and returning to Scotland.'⁶⁴ The design of the asylum buildings itself did not impress him either. Indeed, some

⁶⁰ Obituary, *SAJS*, 14 (1917-1918), p. 313.

⁶¹ Obituary, *SAJS*, 14 (1917-1918), p. 314.

⁶² Obituary, *SAJS*, 14 (1917-1918) pp. 312-314.

⁶³ U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 25. 'History of Institution' by Dr. R.S. Sinclair Black, Physician-Superintendent of Pietermaritzburg Mental Hospital. This was written in 1918, as Sinclair Black died in 1919.

⁶⁴ *Ibid.*

years later, when asked to comment on the 'general plan' of the NGA, he commented: 'There was a very rough plan originally – a plan which I did not approve of at all, though I was informed it was passed by the English Commissioners of Lunacy.'⁶⁵

Nor did he find the colonial government willing to lay out further funds: without official support, he obtained 'a few barrows and a few spades and set to work laying out the grounds and tree planting. In 1883 over 2,000 trees were planted and a start made with road making.'⁶⁶ Over the next several decades Hyslop oversaw the expansion of the buildings, which became more imposing, combining nineteenth century thinking about asylum construction with the especially aesthetically-pleasing Victorian salmon-pink brick architecture for which Pietermaritzburg became well-known. It was this that gave the asylum the name 'The Red House'.

As the asylum facilities were expanded, they increasingly reflected the social stratifications of late colonial Natal. From the beginning, white and black patients were accommodated in different wards or 'quarters'; later, in separate buildings. In 1891, the imposing and attractive Main Building – which still today acts as the most public face of the hospital – was completed. The front part of the building was 'occupied by Europeans'.⁶⁷ At the beginning of the next decade, the original kitchen was replaced; a 'general bathroom' and laundry were built, and a drawing room, recreation rooms and two new dining rooms – one being for private patients – were added.

Men and women were accommodated in separate wards and wings, but there was no strict segregation of the sexes as appears to have been the case at some other asylums.

⁶⁵ SC. 14-'13, *Report of the Select Committee on Treatment of Lunatics*, May 1913 (Cape Town: Cape Times Limited, Government Printers, 1913), p.51. Evidence of Dr. J. Hyslop, 16 April 1913.

⁶⁶ U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 25.

⁶⁷ U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 26.

Indeed, men and women were encouraged to mix, sharing the dining rooms, recreation facilities, and at the weekly dances. Giving his expert testimony at a Select Committee hearing on 'the treatment of lunacy' to the new Union government in 1913, Hyslop responded most indignantly to the suggestion that there should be separate asylums 'for the different sexes'. Chiming with his convictions about the purposes and ideals of moral therapy, he retorted: 'Certainly not. I would bring the men and women patients together as much as possible for that means that they would have to exercise a certain amount of self control. The other arrangement looks too much like dealing with animals.'⁶⁸

To what extent, if any, black patients were permitted to use the private or recreation facilities, we do not know, but it seems unlikely. African and Indian patients did not sleep in beds, but on mattresses on the floor.⁶⁹ Dietary scales were no longer stipulated in the annual reports after 1891, but the provisions were likely to have been less varied than those received by white patients, more of whom in any case were able to supplement their hospital food with items bought or brought by visiting friends or relatives. In 1904, Hyslop commented on the building then underway – 'the Male side being completely occupied at the end of 1905 and the Female side in 1906'⁷⁰ – to provide 'new quarters for the Native and Indian patients. He explained that although the construction of separate amenities appeared to be costly in terms of the duplication of facilities, in fact, through economies achieved by the deployment of black patients on the estate grounds (which now produced vegetables, milk and eggs, and kept cattle and pigs, as well as having a quarry) this arrangement would ultimately be a beneficial one. For white patients, the assumption was that minimizing contact with 'coloured' patients was in and of itself conducive to their better state of mind.

The building when finished will form a practically separate institution, complete in itself, and while the expense of management will out of necessity be increased, the new conditions ought to be much more satisfactory in every

⁶⁸ *Select Committee, 1913*, p. 54. Evidence of Dr. J. Hyslop, 16 April 1913.

⁶⁹ *Ibid.*

⁷⁰ U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 26.

respect; such an arrangement, while having all the advantages of separate and distinct institutions for Europeans and for coloured patients, admits at the same time of the coloured labour being employed in connection with the garden and grounds, and also for the performance of other necessary works, while the whole is controlled from the centre, with the result that the expense in connection with the administration is considerably less than would be the case had separate institutions for European and coloured patients been established, distinct from, and unconnected with each other.⁷¹

At the same time, the number of private patients was also increasing. At the end of 1904, Hyslop reported that there were seventy 'European private patients, nineteen of whom were paid for at rates varying from £104 to £200 per annum.' He added that this was a 'very high proportion', especially of the white women patients at the NGA, of whom just over fifty percent were privately paid for, while this was the case for only nineteen percent of the men.⁷² When placed alongside the running costs of the NGA, it is noticeable that the income from this source was not inconsiderable: it was £4,488 in 1904, and the total cost to the government of the NGA for that year was given at £14,467. In this same report, Hyslop was able to draw on the figures released from the recent Natal census, which, he interpreted as establishing that the 'proportion of sane to insane in the colony' differed significantly according to race. This, he believed, bore out the 'theory that the more civilized a community, and the more stress to be borne, the more mental breakdowns may be expected.'⁷³ One of the therapeutic options apparently being seriously considered – though details are lacking, unfortunately – was the establishment of 'Seaside House' at Ilovo Beach on the South Coast for the fee-paying patients who would benefit both from the climate and from the private facilities.

Originally intended to accommodate a hundred patients, the NGA was always filled to capacity, often beyond. In 1887, there were 112 patients. Ten years later, there were 263 patients; and in 1909, 589 (see graphs below). Hyslop and his successors

⁷¹ *NBB* 1904, Report of the Medical Superintendent, Natal Government Asylum.

⁷² *Ibid.*

⁷³ *Ibid.*

constantly commented upon the ‘overcrowding’ that was a ‘more or less prevalent condition.’ Some temporary wards were constructed out of wood and iron, at times patients slept in the corridors, and several houses on properties adjoining the asylum estate were purchased, both for private patients and for staff. It was, however, a point of pride for Hyslop, that no-one was turned away, provided they were accompanied by the correct documentation.

Taking advantage of the relatively lax provisions – and applications – of the Natal Lunacy Law of 1868, which, with the exception of a minor amendment in 1891, had not been substantially altered at the time of Union, getting a person committed to the NGA was a relatively straight-forward business. This, Hyslop, commenting in 1913, believed, had had its advantages. One of these was the fact that no-one suspected of being of unsound mind had to languish in a gaol cell for a lengthy period before he or she was admitted to the NGA. He was very, very clear in distinguishing between the gaol and the asylum: ‘I will not allow anyone to name any room in the asylum as a cell.’⁷⁴ He went on to explain that if a person from ‘the remotest part of Zululand’ was be certified by a Magistrate, supported by a single medical certificate, as being of unsound mind, application would be made to send ‘the man [sic] right off to the asylum; the Magistrate has a right to do it. As a general rule, however, he wires me that he has sent off the person, but he does not ask me if I will take the patient in the first instance.’⁷⁵ By mutual, if not strictly legal agreement, if the person was still regarded as being of unsound mind three weeks later, a second ‘certificate [was] ‘furnished and an application is made for the detention’. Hyslop admitted that this left him open to enormous risk as far as being prosecuted for wrongful detention was concerned, but insisted too that he ‘did not know of a single instance of any delay having occurred.’⁷⁶ Suppose, asked his questioner, ‘The place was full? ... You have never refused a patient admission?’ Hyslop responded: ‘We have been full, but we have always had to take patients in. We have passages and we have often people

⁷⁴ *Select Committee, 1913*, p. 45. Evidence of Dr. J. Hyslop, 16 April 1913.

⁷⁵ *Select Committee, 1913*, p. 46. Evidence of Dr. J. Hyslop, 16 April 1913.

⁷⁶ *Select Committee, 1913*, p. 45. Evidence of Dr. J. Hyslop, 16 April 1913.

sleeping in passages.’⁷⁷

One of Hyslop’s first requests of the colonial government of Natal was for additional staff. In his 1882 there were seventy-one patients, and five resident (three males, two female), ‘attendants’ listed as being employed ‘in attendance on the patients’, and what seems like a relatively large number – twenty (all of whom were male) – who were ‘employed as servants, or only partially as attendants’.⁷⁸ The role of the latter is obscure, but they presumably performed the tasks of maintaining the asylum buildings and grounds, as well as in assisting with patients’ bathing, laundry, meals and, if necessary, restraint. One of the early difficulties he faced was securing permanent staff, and within a year of his taking up the post, he had engineered an increase in salary for the two ‘European Male Attendants’; in justification for this, he stressed the importance of paying good salaries ‘to secure the services of the very best attendants, and to induce them to remain in the service, a most important consideration, as frequent changes in the staff are most undesirable.’⁷⁹

Over the following years, Hyslop continually sought to expand and to train staff for different roles. Notions of suitability of gender, race and class were evident in his appointments. For instance, his first annual report expressed his frustration at the refusal of many (white) patients to ‘engage in useful work in the garden and grounds’, and then went on to add that, had he more staff, more particularly a ‘competent European attendant, with some knowledge of gardening’, then both patients and grounds could be better directed.⁸⁰ In 1883 he noted that, in his opinion, the replacing of a ‘St. Helena woman who was formerly employed on the female side of the house’ by ‘European Female Attendant’, had been followed by ‘beneficial results.’⁸¹ In this

⁷⁷ *Select Committee, 1913*, p. 46. Evidence of Dr. J. Hyslop, 16 April 1913.

⁷⁸ *NBB 1882, Lunatic Asylum Return*.

⁷⁹ *NBB 1883, Lunatic Asylum Return*.

⁸⁰ *NBB 1882, Lunatic Asylum Return*.

⁸¹ *NBB 1883, Lunatic Asylum Return*.

report, too, he was highly critical of the African attendants, saying that they were ‘totally unsuited’ for their occupation. Rather than commenting on a lack of training, or inadequacies of supervision, Hyslop highlighted what he believed to be differences in approach to the management of the mad, characterizing the African attendants as having

too much of the convict guard stamp about them to make them useful caretakers of the insane. It is impossible [he went on to add] for them to comprehend the fact that an insane person is not responsible for his actions, and I have reason to believe that, when an opportunity presents itself, they are most harsh in their treatment of the patients....⁸²

Reversing the choices made by Smithwick in the previous decade, Hyslop wanted to employ ‘a few of the better class of Indentured Indians.’⁸³ Later, he was to voice the opinion that ‘the original treatment for keeping down the number of native insane down was by knocking them on the head.’⁸⁴ What authority or experience he based this observation on, we do not know, but clearly, Hyslop had little understanding of or regard for the variety of African therapeutic strategies – by no means all of which were as brutal as this – that existed in Natal and Zululand in the late nineteenth and early twentieth centuries.

Under Hyslop’s guidance, the dominant paradigm of the institution shifted towards a more soundly therapeutic basis. This required the recruitment of suitably trained staff who were experienced in nursing rather than in merely overseeing or restraining patients. But, as with the categorization of patients along racial lines, from the early 1880s, the staff at the NGA also reflected the social composition of much of Natal society: African and Indian workers performed the more menial tasks of cleaning and care-taking of black inmates, and occupied a subordinate status within the asylum hierarchy. Gender hierarchies intertwined in interesting ways with race, however, as there were more white male ‘Attendants’ than were commonly found in general

⁸² *Ibid.*

⁸³ *Ibid.*

⁸⁴ *Select Committee, 1913*, p. 51. Evidence of Dr. J. Hyslop, 16 April 1913.

hospitals, and at the NGA 'Head Attendant Davidson' (who arrived from Scotland relatively soon after Hyslop and who was still at the asylum at the time of Hyslop's death in 1917) enjoyed a position equal to, or perhaps superior to, the Head Matron.⁸⁵ This long history of male mental nursing by both black and white men – albeit under a nomenclature that emphasized a relatively spurious distinction from the services performed by women nurses in asylums – warrants further investigation.

In general, however, little is known about the nursing staff, especially the women. For the white patients, 'European' attendants and nurses were recruited. For this, Hyslop turned to his contacts in Britain since he found it 'impossible' to find suitable nursing and medical staff locally. A commemorative brochure issued in 1986, states that 'in 1889 it was decided to bring a Matron from England to take care of the nursing services at Town Hill Hospital and [in 1893] Miss Stewart joined the staff with 5 experienced nurses from England.'⁸⁶ In that year, the annual report listed seven residential staff employed at the NGA 'in attendance on the patients', and two non-residential who were employed for the same purpose. There were now twenty-two 'servants or partial attendants'.⁸⁷ Matron Annie Stewart served at the NGA until she was obliged to take early retirement in 1911, when she returned to Montrose, Scotland, as she was dying from cancer of the uterus. Before her death, she was thanked for her for 'long and unselfish services rendered to this Institution.'⁸⁸ Her position was taken over by Nurse A.S. Russell, who was Matron until 1930.⁸⁹

The NGA senior nursing staff, then, appear to have found their positions sufficiently

⁸⁵ Obituary, *SAJS*, 14 (1917-1918), p.311.

⁸⁶ 'Town Hill Hospital, 1880-1986', brochure issued by Friends of Town Hill, no author, 1986.

⁸⁷ *NBB* 1890-91, Lunatic Asylum Return.

⁸⁸ NAR CS 994 20796, 'Miss A. Stewart, Matron, NGA'.

⁸⁹ NAR Department of Treasury (hereafter TES) 4014 F21/66/11, 'Mental Hospitals, Staff, PMB Mental Hospital, Town Hill Hospital, 1926-1965. Staff folder 'Miss A. S. Russell, Matron'.

rewarding to remain in them for considerable periods of employment. This may in part have been because, from the mid-1890s, Hyslop had initiated lectures and specialized training for the nurses at the asylum, and this was taken over in the early 1900s by Dr. Pringle. In 1905, 'ten candidates submitted themselves for the Medical Council's Certificate of Competency as Mental Nurses or Attendants on the Insane, all of whom satisfied the Examiners. It is proposed [the report added] to continue these lectures annually, and to require Attendants and Nurses to attend who do not already hold the Medical Certificate or its equivalent.'⁹⁰ By 1911, there were approximately eighteen full-time female nursing (i.e. white, female) staff at the NGA, and plans were drawn up for a substantial nurses' home to accommodate them.⁹¹ Specialist training for black 'attendants', their fitment for the care of black patients, as well as their vital roles as translator–interpreters, was recognised in 1914 when it was proposed that training be implemented for both black male and female mental hospital attendants.⁹²

The increase in the number of professional medico-psychiatric doctors, Western-trained nurses, and of less formally skilled attendants at the asylum was a consequence of the constantly rising numbers of patients and the concomitant escalation in clerical work and correspondence with, first the colonial government, and later the Department of the Interior. The workload involved in the smooth running of an institution with several hundred patients, including provisioning inmates and staff, clinical work and record-keeping, the devising and overseeing of morally formative entertainments and activities, the maintenance of extensive grounds and buildings

⁹⁰NBB 1905, Report of the Medical Superintendent, Natal Government Asylum. 'Certificates of Competence as Midwives, Trained Nurses, and Attendants or Nurses of the Insane' were issued by the Natal Medical Council under the provisions of Section 27 of the Medical and Pharmacy Amendment Act of 1899.

⁹¹NAR, Public Works Department (hereafter PWD) 1815 15/672, 'Natal Asylum, Nurses' Home, 1914'. Dr. D.A. Pringle and Dr. J. Hyslop to Minister of Interior, 25 July and 4 October 1911.

⁹² See Chapter 6. Two important works on the history of nursing in South Africa are S. Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg: University of the Witwatersrand Press, 1994), and C. Burns, 'A man is a clumsy thing who does not know how to handle the sick: Male Nurses in South Africa: A History of Absence', *Journal of Southern African Studies*, 24, 4 (December) 1998.

(which were also meant to keep the asylum as self-sufficient as possible in food), the attendance of criminal trials when a plea of insanity had been submitted, as well as correspondence with the families of patients, and the frequent necessity for drawing up and submitting plans and estimates for extensions and improvements, was formidable. Furthermore, the admission of private patients increased this workload even more. In late 1895, Hyslop noted:

The admissions of private patients and numbers resident are becoming much more numerous than formerly. During the year we admitted patients from the Transvaal, the Orange Free State, and Mashonaland. Of course, as the patients – more especially those being paid for at a high rate of board – increase, the work connected with the administration of the Asylum is added to in a proportionate degree, and the clerical and other work, which must of necessity be got through, prevents me spending as much time among those under my care as I ought and would like to do.⁹³

From the late 1890s, a number of Assistant Medical Officer posts were created to assist in the growing workload. As Hyslop himself became increasingly involved in other affairs – both military and civic, which took him away from Pietermaritzburg for long stretches of time – however, the incumbents were often the *de facto* medical officer and administrator in charge of the NGA. These men – and they were all men at this time – were also connected with the colleagues and the networks which Hyslop maintained in Scotland. For instance, Dr. W.A. Skinner came from the Montrose Royal Asylum to Natal during the years of the South African War. He came with ‘the highest credentials’. He died, unexpectedly, in 1904, upon which Hyslop commented that ‘the Government has lost a most able, zealous and courteous officer and the patients a true and sympathetic friend.’⁹⁴

Pringle, who arrived in Natal from the Royal Asylum, Aberdeen, in 1904 aged thirty, served as Assistant Medical Officer at the NGA from 1904 through to 1913, when he was transferred to the Pretoria Mental Asylum, and it is largely his notes on patients

⁹³ NBB 1895, Asylum Returns: Medical Superintendent’s Report.

⁹⁴ NBB 1904, Report of the Medical Superintendent, Natal Government Asylum.

that appear in the sole surviving (European) Case-Book.⁹⁵ In Hyslop's absences, Pringle assumed a heavy burden of the work load; a situation that led, at times, to his frustration and growing concern that while he was shouldering the major responsibilities for a busy institution, other men – both older and younger than he – were being more rapidly promoted elsewhere in the country.⁹⁶ Dr. Aitken, described as a Junior Assistant Medical Officer, resigned his post in October 1909, and was replaced by Dr. Herbert William Glashan from the Derby Borough Asylum.⁹⁷ It was Glashan who ran the NGA through the period of Hyslop's retirement, and during the years of World War 1 he was listed as 'Acting Physician Superintendent.'⁹⁸ After the war, he was transferred to Fort Beaufort Mental Hospital in the eastern Cape, where he remained until 1931, after which he returned to the Pietermaritzburg Mental Hospital for nearly a decade, coming out of retirement as the need for physicians and doctors during World War 2 created a shortage of medical staff, including psychiatrists.

By 1909, Hyslop presided over an institution that had changed considerably from that which he first encountered on his arrival in the colony in 1882. He was largely responsible for the expansion of the NGA into one of the most substantial asylums in southern Africa. Grounds, staff, amenities, and the prestige of the psychiatric profession had all increased under his remit. Furthermore, his connections with the colonial elites of Natal — what one of his colleagues termed his combination of 'mental and military work'⁹⁹ – as well as his reputation as a 'specialist in mental

⁹⁵ NAR CS 986 20397, 'Dr A. D. Pringle, NGA'. Pringle came on the recommendation from Dr. Clouston of the Royal Edinburgh Asylum, to whom Hyslop had written asking for a replacement for the unfortunate Skinner.

⁹⁶ NAR CS 986 20397, 'Dr A. D. Pringle, NGA'. Pringle to Secretary, Department of the Interior, 14 August 1911. I will pick up the story of the psychiatric profession of South Africa in Chapter 6.

⁹⁷ *NBB* 1909, Annual Report of the Medical Superintendent, Natal Government Asylum.

⁹⁸ NAR Department of Health (hereafter GES) 3050 S 12/145, 'Dr H W Glashan, 1938-1944.' This file gives his date of birth as 9 January 1884.

⁹⁹ Obituary, *SAJS*, 14 (1917-1918), p.312.

diseases', meant that Hyslop received considerable respect, and that his views on a variety of subjects were influential in colonial society. It is difficult to know, however, exactly how Hyslop influenced, directly or otherwise, the practice and theory of psychiatry in southern Africa.

Indeed, we have very little in the way of direct information as to *what* Hyslop's views on mental illness were. He left no private papers, and even the patient records that remain are public records in that they were meant for reading by other doctors, and they are terse and formulaic. Unlike his counterparts at the Cape, many of who shared his social and medical background, Hyslop did not publish widely in the medical journals.¹⁰⁰ His only published scientific paper – which I have not been able to locate – was titled: 'An Investigation into the Anatomy of the Central Nervous System'.¹⁰¹ Hyslop's interest in the organic origins of mental disease may well have been a legacy of the time he spent in Germany and Austria before coming to Natal.¹⁰² At the NGA, he frequently bemoaned the lack of dissection facilities, complaining in 1894 for example, that: 'A *post mortem* room is (also) very much required, the present method of conducting autopsies in a lavatory, where the proper appliances are of course conspicuous by their absence, is neither conducive to efficiency or accuracy; nor is it calculated to stimulate one to enthusiasm in pathological research, although, as a matter of principle, I make a dissection in most cases of death ...'¹⁰³

¹⁰⁰ See S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', Chapter 5, for a detailed discussion of the ways in which Cape colonial psychiatrists such as Dodds (Valkenberg), Greenlees (Grahamstown) and Conry (Fort Beaufort), contributed to the construction of sexist and racist 'scientific' knowledge in the late nineteenth and early twentieth centuries. Their publications in the British medical and psychiatric journals ensured the flow of information to the metropole, and reinforced colonialist discourses and practices.

¹⁰¹ Obituary, *SAJS*, 14 (1917-1918), p.313.

¹⁰² See Chapter 1 of this dissertation for a discussion of the greater emphasis on organic and somatic causes of insanity on Continental Europe in the mid-to late nineteenth century. Also, R. Porter, *The Greatest Benefit to Mankind: A Medical History Of Humanity from Antiquity to the Present* (London: HarperCollins, 1997), p. 509.

¹⁰³ *NBB* 1893-1894, Asylum Return and Statistical Tables, Medical Superintendent's Report. In his 1898 Report, he also called for the colonial government to create a post for a pathologist in Natal.

Four years later, in 1898, his continued interest in dissection and ‘brain pathology’ is clearly stated in his annual report:

A post mortem examination has, as formerly been made in a large proportion of the cases, but unfortunately the means at command do not as yet admit of much more being done in the way of investigating the finer pathological lesions. I trust, however, that it will be possible to do something tangible in this direction before long, as the additions to the Asylum at present contracted for include a post mortem room and laboratory, conveniences which we have not previously possessed. I am in hopes also that it may be found practicable to arrange for the investigation elsewhere of the minute pathological lesions of the brain changes in at least some cases of special interest; such research is becoming, if it has not already become a specialty, with which only a few of those of us engaged in Asylum administration can hope to keep abreast of.¹⁰⁴

He also reported ‘of six months’ leave of absence, which he had spent in Britain, and during which he attended the annual meetings of the Medico-Psychological and British Medical Association. He ‘was also, by the courtesy of the Directors of the Central Laboratory of the Scottish Asylums and the kindness of the Superintendent, permitted to study the latest methods in Brain Pathology. I appreciated this privilege all the more in that it was the first instance of its having been granted to anyone unconnected with Scottish Asylums.’¹⁰⁵ From his visits to ‘some of the most modern British asylums’, he brought back ideas about asylum construction and administration. He closed his report by saying: ‘I feel very strongly that it is most desirable that anyone situated as I happen to be should visit England periodically and at comparatively short intervals, and that it would be to the interest of the Institution were the Government to facilitate such visits as much as possible.’

Medical historian Max Minde, who had access to the early Case-Books kept on patients admitted from 1864 to 1884 (and updated through to 1889), noted a ‘considerable change’ in the diagnoses made by Hyslop in contrast to those of Gordon. According to Minde, Hyslop did not extensively utilize the broad nosological concept of ‘dementia’, and the majority of his cases were diagnosed as either mania or

¹⁰⁴ *NBB* 1898, Report of the Medical Superintendent, Natal Government Asylum.

¹⁰⁵ *Ibid.*

melancholia, 'while in a significant number he did not venture on a diagnosis but used such descriptive terms as "great mental depression", "much enfeebled in mind", "mental exaltation, excitement and enfeeblement of the mind". On the whole he favoured the diagnosis of mania.'¹⁰⁶ The major diagnostic and aetiological classifications utilized at the NGA until 1909 are discussed in the next section of this chapter. Other than when noted in the single European Case-Book, however, no record has survived of which doctor attended any particular patient. Even with the Case-Book we do have, which contains patient records after the appointment of the Assistant Medical Officers, it is often impossible to establish with any certainty which physician wrote the notes. Establishing broad trends in diagnoses is, therefore, all that can be achieved from the records available to us today.

Throughout his tenure at the NGA, Hyslop remained strongly convinced of the benefits of moral therapy. All patients were encouraged to become involved in the gardens and fieldwork, or in the laundry, on the asylum farm, or at the quarry. He once remarked that 'You might as well deprive the inmates of the institution [asylum] of medicine as deprive them of work, and the most suitable work for most is on the land. I regard useful employment for inmates of an asylum as quite as important as medicine.'¹⁰⁷ As already noted, however, from the start, white patients – whatever their actual occupations or 'station in life' – often refused to work on the asylum estate. Furthermore, Hyslop found it extremely difficult to get African women inmates to 'employ themselves usefully'. The solution he found it necessary to use, shows clearly that the reordering of inmates' behaviours through moral therapy could be coercive and distressing. In 1887 he wrote:

For the first time since I came here the Native women have been got to employ themselves usefully. These women have always been a constant source of annoyance, being filthy in their habits, disgusting in their conduct and conversation, and very destructive; so that, though few in number, they give more trouble than all the other patients put together. I had previously been of the opinion that an Airing Court was the only suitable place for them, but as there was little chance of

¹⁰⁶ Minde, 'Early Psychiatry in Natal', p. 289.

¹⁰⁷ *Select Committee, 1913*, p. 42. Evidence of Dr. J. Hyslop, 16 April 1913.

getting one, I early in the year had the best substitute provided which was within my reach. This consisted of a large pit about thirty feet long, fifteen feet wide, and six feet deep. The Native female patients were committed to this primitive Airing Court during the day, and although at first sight it might appear rather a barbarous proceeding, the result fully justified the treatment adopted; ... These women are now daily employed in the garden under the supervision of a Native male attendant, ... None of them would be taken for the same women they were twelve months ago.¹⁰⁸

It is perhaps wise at this point to recall to Edward Shorter's injunctions against selective quotation, for it is easy, certainly from the perspective of the twenty-first century, to focus on the brutality of this form of 'treatment', and to downplay Hyslop's distaste at the measures he had employed.

Indeed, in his medically-informed judgements given on topics and issues not directly connected with the asylum, but for which his expertise and status were regarded as significant, he consistently favoured interpretations that did not reflect overt racial prejudice. For instance, when, in his capacity as Chairman of the Board of Health, he was one of the Commissioners investigating the working conditions on the Reynolds' Brothers Esperanza estate in 1906, he concurred in the majority report that found that the dire conditions on the estate were responsible for high rates of mortality amongst Indians, including as a result of suicide.¹⁰⁹ Moreover, as a recent study by Nafisa Essop Sheik into the medical establishment at the time of the bubonic plague in Natal shows, Hyslop stood firm in refusing to back anti-Indian immigration measures then being called for in the late 1890s by settlers who overtly linked the threat of infectious disease and racial stereotypes.¹¹⁰ Instead, Hyslop's recommendations to the Plague Commissions were grounded in critiques of environmental and sanitary conditions,

¹⁰⁸ *NBB* 1887, Lunatic Asylum Returns.

¹⁰⁹ PAR Indian Immigration (hereafter II) 1/156 3338/1907. See also S. Bhana and A. Bhana, 'An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911', in S. Bhana (ed.) *Essays on Indentured Indians in Natal* (Leeds: Peepal Tree Press, 1990), p. 170, footnote 16.

¹¹⁰ N. Essop Sheik, 'Plague Precautions and Public Politics in Natal, 1896-1903' (unpublished Honours thesis, University of KwaZulu-Natal, 2004); also, PAR Natal Medical Council (hereafter NMC) 1, Minutes of Meeting of 10 March 1899.

rather than abstractions of racialized proclivities for harbouring disease.

Frequently deploring the stigma that continued to exist, especially amongst whites, about having a relative as certified as insane, Hyslop consistently urged the necessity for education as well as for the provision of asylum facilities that would be acceptable to upper-class clients. Nor, when, in 1913, he was asked if he was 'in favour of doing something in the direction of preventing the propogation [sic] of imbeciles and idiots', was he prepared to countenance, in his professional capacity, some of the measures being suggested by some of his more eugenically-minded colleagues. 'I think', he said, 'the only way is to try and get the people to educate themselves properly and to select proper partners when they marry. I would not be prepared to advocate anything further at the present moment – not as a professional man.'¹¹¹

Indeed, as historians of medicine and colonialism are beginning to demonstrate in clearer detail, it is often difficult, and usually not particularly helpful, to advance straight-forward 'doctors-as-agents-of-empire' arguments. Moreover, as Jonathan Sadowsky's study of madness and imperialism in Nigeria shows, therapy and control are not mutually exclusive categories. Furthermore, control should not be seen as:

uni-directional, the result of the conscious intent of sinister doctors ...
The social pathways to asylums are complex, (and) doctors and administrators have complex agendas, and often only act at the end points of paths to treatment initiated by family members and communities.¹¹²

And yet, the passage from Hyslop's report throws up several significant issues. Firstly, we must bear in mind that what we are reading is the *doctor's* text. The actions of the women are interpreted and represented in terms of behaviours and attitudes that confirm his diagnosis of them as mad. Secondly, however, is the acknowledgement that different readings are possible. For example, we should be alert to the possibility

¹¹¹ *Select Committee, 1913*, p. 54. Evidence of Dr. J. Hyslop, 16 April 1913, p. 54. Contrast with NAR, Prime Minister's Office (hereafter PM) 1/1/322 184/2/1913, 'Public Health: Expansion of Asylum Accommodation', Memorandum signed by J.T. Dunston, no date, but presumably 1913. See also Chapter 6.

¹¹² Sadowsky, 'Imperial Bedlam', pp. 4-5.

that ostensibly insane behaviour might, in fact, be a psychologically logical response to situations of great stress. On the other hand, it has also been argued that forms of resistance against oppression have sometimes been designated as madness.¹¹³ Importantly, we also need to try to see such actions from the *patients'* perspectives. Might, for example, these women have been reacting to their incarceration in ways that both protested against, and yet confirmed, the label that Hyslop, the colonial state, and perhaps their own families, had given them? The following section of this chapter turns to focus on the patients at the NGA up to the eve of Union, but it recognizes that the extent to which we can hazard answers to such important questions is severely hampered, both by difficulties of source materials, and of interpretation.

The Fools on the Hill: Patients

Race and Gender in the Admissions, 1864-1909

On 31st December 1909, on the eve of Union, Madeline Anderson was one of nearly six hundred inmates of the NGA. Since 1880, when the permanent asylum opened its doors, some 2,560 people had been admitted, and the NGA had the second highest population of legally-defined and detained mental patients in southern Africa.¹¹⁴ Despite the steadily increasing numbers of admissions and chronic long-term inmates, the percentage of persons admitted always remained a very small fraction of the population of the region as a whole, however. According to the Natal census of 1904,

¹¹³ Elaine Showalter's *Hystories: Hysterical Epidemics and Modern Culture* (London: Picador, 1998), for example, shows some of the different ways in which hysteria has been viewed since the nineteenth century as both an oppressive and a liberating social construction. See the next chapter of this dissertation for a more in-depth discussion of gender and hysteria.

¹¹⁴ In 1910, with 713 patients, only Pretoria had greater numbers of inmates. Valkenberg had 428, Robben Island 455, Grahamstown 403, Port Alfred 283, Fort Beaufort 480, and Bloemfontein 273. U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons for the Union of South Africa*, p.1. The admission figures for Natal given in the statistical tables stretch as far back as 1864, making this probably the largest - in terms of time - set of data relating to patient admissions of any type in colonial southern Africa. Between 1864 and 1909, 2,713 persons were admitted to a variety of institutions for lunatics in Natal.

the population stood at approximately 97,000 whites; 101,000 Indians; and just over 910,000 'Natives'. In 1897, Hyslop gave the incidence of insanity in the Colony as 'one insane person to every 407 of the European population, as against 313 in England. Among the Indians the ratio is one (to) 835, and among the Natives one in 5,952..'¹¹⁵

FIGURE 1: NGA, 1880-1909: Annual Admissions

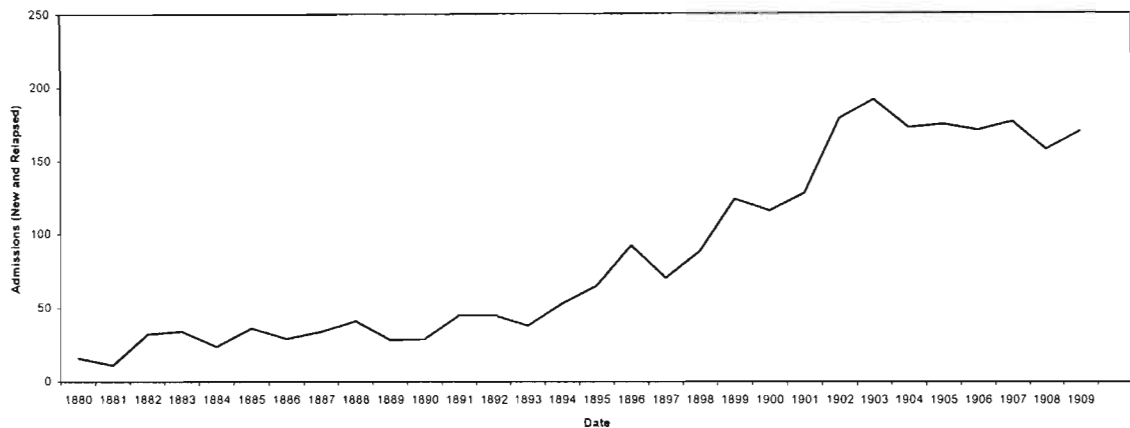
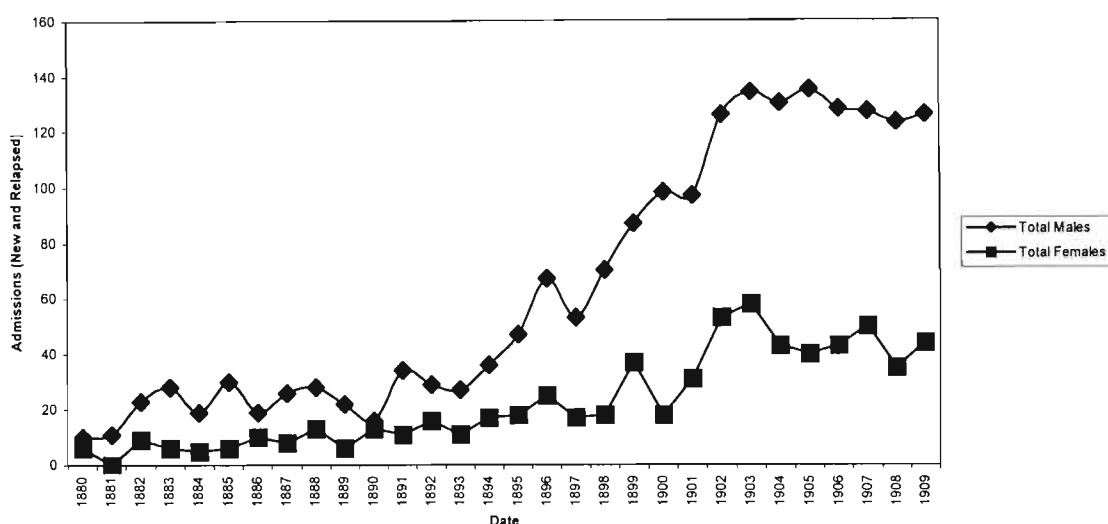


Figure 1 shows the total annual admissions to the NGA between 1880 and 1909.¹¹⁶ Increases in patient numbers can obviously be caused by a variety of factors, including changes to relevant legislation and the creation of expanded facilities for the accommodation of inmates. As we have noted, the NGA did enlarge its facilities several times over the period here under review, but Hyslop never ceased to protest that the accommodation, particularly for black patients, was woefully inadequate. Furthermore, the clearly distinguishable peaks in patient admissions – in the late 1890s and early 1900s - do not follow the increases in accommodation at the NGA particularly closely. Generally, the patterns of admissions by sex and race shadow the broader trends.

¹¹⁵ *NBB* 1897, Asylum Returns.

¹¹⁶ The following figures and tables have been drawn together from the NGA statistical tables published annually in the *Natal Blue Books*. No tables or reports are available for the years of 1906 and 1907, although subsequent reports give some of the relevant figures for these years. It is not clear why these years should be missing from the published record.

FIGURE 2: NGA, 1880-1909: Annual Admissions (Male and Female)



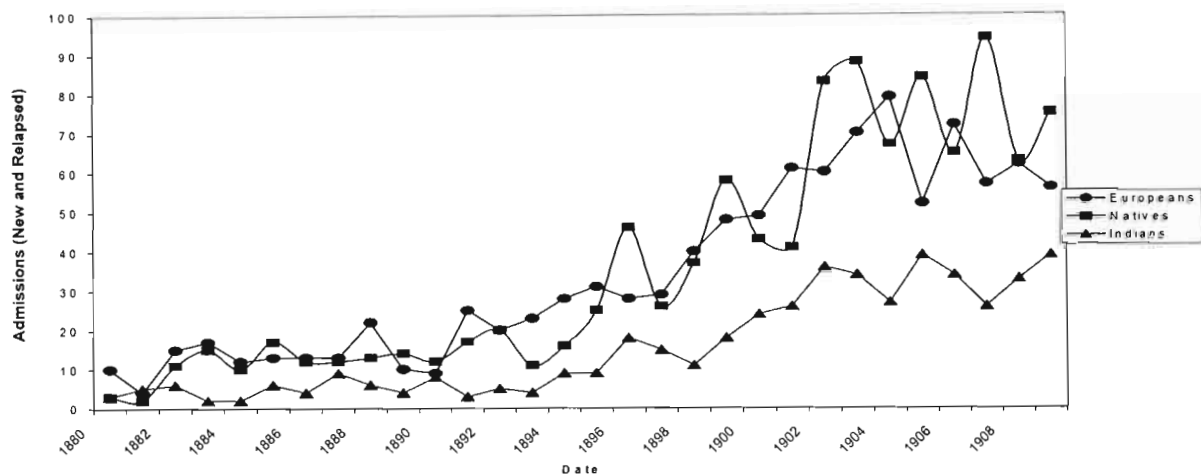
As figure 2 shows, male admissions to the NGA consistently outnumbered those of females. In the *Blue Book* Asylum returns, admission figures stretching as far back as 1864 are given, and they confirm this pattern. Greater numbers of male patients were also found in other colonial asylums. In the case of the European and Indian inmates at the NGA, this was partly a reflection of the higher numbers of men in the region: in 1904, there were 24% more white males than white females, and the demographic imbalance was even greater for Indians, with 46.6% more men than women.¹¹⁷ The number of African women in the NGA, however, was always very low – the highest intake being 26 in 1907 – and never reaching more than a third of African male admissions. Given that the African female population of the region was said to be 18%¹¹⁸ higher than that of African males, this would appear to present us with an anomaly. Only in a handful of cases does the archive provide clues as to the paths by which people came to be admitted in the first instance, and unfortunately, the *Blue Book* statistical returns do not provide information as to the place of origin of the inmates. However, admission rates cannot be directly tied to absolute population figures and a variety of social factors affected the fate of persons who were believed to

¹¹⁷ *Twentieth Century Impressions of Natal: Its People, Commerce, Industries, and Resources* (Natal: Lloyd's Greater British Publishing Company, 1906), p.65.

¹¹⁸ *Ibid.* This refers to both Natal and Zululand.

be insane. In the case of women around the world it has generally been observed that they were more likely to be accommodated within the home for longer – as they could usually continue to perform domestic duties even whilst mentally disturbed or if mentally retarded - than were men. Conversely, men were more likely to be admitted to asylums more quickly. I do not see why this should not also have been the case in southern African. Hyslop's description of African women inmates given above, and his denotation of them as 'very destructive' perhaps hints of the extent to which African women would have to be perceived as being disruptive before they would be admitted to an asylum.

FIGURE 3: NGA, 1880-1909: Annual Admissions (By Race)



Until the mid-1890s, with a few exceptional years, white men formed the single largest category of admissions. After the late 1890s, however, African males consistently formed the largest group. (Figure 3). The reasons for the sharp increase of admissions of African patients after 1897 are unclear: it may be that the annexation of Zululand in that year facilitated the transfer of African 'lunatics' to the NGA, but it is highly likely that socio-economic conditions led to a greater incidence of persons exhibiting psychologically disturbed behaviour.

The late 1890s, as many have attested, were a time of great economic and social hardship and upheaval for many of Natal and Zululand's Africans. Political turmoil was accompanied by a devastating series of natural disasters – plagues of locusts, drought, famine, and an epidemic of rinderpest – which contributed to strains on the

homestead economy. Being further drawn into the market economy, men in particular began to become migrant workers in increasing numbers, while women were placed under great pressure to maintain the homestead and to cultivate sufficient crops for sale to pay taxes.¹¹⁹

That social factors played a role in causing an increase in psychological disturbance is shown clearly in the returns during the early 1900s. Not only were new aetiological categories – such as 'Exigencies and Privations Due to War' discerned – but Hyslop noted that the arrival of refugees from the Transvaal and the Free State had contributed to rising patient numbers at the NGA. In his annual report for 1900 he commented: 'Several of the patients admitted were from the Transvaal, and in some instances their mental illnesses were undoubtedly attributable to anxieties in connection with the war, and to the fact of their having had to leave their homes and relinquish their occupations.'¹²⁰

The vast majority of inmates – of all races and of both sexes – were between the ages of 25 and 45 on admittance.¹²¹ The NGA, however, also usually had a small number of children as patients. Most often, they were young males from 'European' families, and were categorized as 'idiotic', 'epileptic', and later as 'weak-minded'. The surviving Case-Book gives, for instance, the admission notes of Lea Adams, a 'pauper', aged only nine in March 1908, when he was admitted to the asylum because of his 'epileptic form seizures' and his propensity for assaulting his mother and sisters. He was discharged two days after Christmas that year.¹²² Also epileptic was the ten year-

¹¹⁹ J. Lambert, 'From independence to rebellion: African society in crisis, c.1880-1910', in A. Duminy and B. Guest (eds.) *Natal and Zululand From Earliest Times to 1910: A New History* (Pietermaritzburg: University of Natal Press and Shuter and Shooter, 1989). For the impact of the shift from pre-capitalist to capitalist forms of labour and exploitation on African women, see J. Guy, 'Gender oppression in southern Africa's precapitalist societies' and C. Walker, 'Gender and the development of the migrant labour system c.1850-1930', in C. Walker (ed.) *Women and Gender in Southern Africa to 1945* (Cape Town: David Philip, 1990).

¹²⁰ *NBB* 1900, Natal Government Asylum.

¹²¹ The pattern was similar at Valkenberg, where approximately two-thirds of admissions were aged between 25 and 44.

¹²² NGA (European) Patient Case-Book XI, p. 853. Lea Adams, Admission number 2414.

old Elsie May Ingle, who had been transferred from Addington Hospital in Durban, where her constant shrieking had upset the other patients. She was at the asylum for five months.¹²³ Ida Elsie Tollner's father felt he had no choice but to send her to the NGA in mid-1907: generally said to be a gentle girl, the twelve-year old was given to fits and 'temper', and had begun to 'grunt like a goat.' Her father had taken her to a handful of different doctors and purveyors of patent cures, and was now desperate. He wrote to the Medical Superintendent, 'You have my full permission to try any experiment on her.'¹²⁴ Elsie Tollner was still at the NGA in 1919, when her records were transferred to the loose-leaf folder format. Hyslop was never comfortable with the presence of children at the NGA, however, feeling that not only was a life spent growing up at the asylum not good for the children – some of whom, in his opinion, were capable of a little 'teaching...under the care of specially trained nurses' – but that their presence was disruptive for the older patients.¹²⁵ By 1909, there were thirteen patients aged between fifteen and twenty at the NGA; however, there were only two between the ages of ten and fifteen. At the Select Committee hearing in 1913, he expressed the opinion that children who needed such care should be sent to the specialized facility at the Grahamstown asylum that had recently been opened specifically to cater for them.¹²⁶

Of the male patients, nearly two-thirds were single, and just over a half of the women were married. Very similar trends were noted in the Cape, and, again, the demographic imbalance of men over women in the urban areas especially would have influenced this admission pattern. However, world-wide, it has been found that

¹²³ NGA (European) Patient Case-Book XI, p. 637. Elsie Ingle, Admission number 2237.

¹²⁴ NGA (European) Patient Case-Book XI, p. 689. Ida Elsie Tollner, Admission number 2281. Letter from N.M. Tollner to Medical Superintendent, NGA, 12 July 1907.

¹²⁵ *NBB* 1898, Natal Government Asylum.

¹²⁶ *Select Committee, 1913*, p. 53. Evidence of Dr. J. Hyslop, 16 April 1913. See F. Swanson, 'Of Unsound Mind': A History of Three Eastern Cape Mental Institutions, 1875-1910' (unpublished M.A. Thesis, University of Cape Town, 2001), p. 17 for the establishment of the Institute for Imbecile Children at Grahamstown in 1894.

'...while marriage significantly improves the likelihood of men avoiding hospitalisation for mental illness, it may increase the likelihood for women.'¹²⁷ The NGA figures record that 25% of 'Natives' were married. Whether or not the definition of marriage was a legal, Christian marriage is not clear: if so, then it is possible that a significant proportion of these people were drawn from Natal's *amakholwa* population. Of the European patients, women were much more likely to be widowed than were men (7.4% to 2.9%), but the proportions of widowed 'Native' and Indian males and females were approximately the same, at around 3% of the admissions. Roughly 8% of black inmates had 'unknown' marked as their marital status.

'Unknown' was also the most frequently used term in attempts to identify the 'station or occupation' of all women patients. From actors, accountants and acrobats to masseurs, engine drivers and soldiers, the number of categories (nigh on a hundred) listed for white males is indicative of the vastly wider range of social and economic opportunities available to them. Indeed, the NGA inmates reflected the broader socio-economic contours of society in this region in the late nineteenth and early twentieth centuries. The most commonly identified background of insane white men was that of skilled labour, whereas this was so for a mere half a percent of either Africans or Indians males admitted to the NGA until 1909. Instead, 80% of 'Native' and 94% of Indian men were described as 'unskilled labour'. A further 10-15% of black men had 'no occupation, or unknown'. Of the white male inmates, 18% were retailers, traders or clerks; 15% soldiers, sailors or police (these figures increased substantially during the South African War); and 12% were farmers.¹²⁸ In *toto*, women were accorded only sixteen occupations or 'stations' – and that includes the individuality-erasing category of 'Wife of. After 'unknown, not ascertained, no occupation' – which accounted for nearly 50% of all women – the majority of women were apparently kept occupied by 'household and domestic duties'. White women had a slightly greater range of

¹²⁷ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p. 42.

¹²⁸ Again, these figures appear to be in keeping with studies of asylum populations in recently-settled colonies elsewhere in the world, such as Valkenberg in the Cape, and the San Francisco City and County Asylums in the early twentieth century, where the majority of patients came from the working or lower middle-classes. See R.W. Fox, *So Far Disordered in Mind: Insanity*

opportunities for employment beyond the home or the farm, as nurses, teachers, lady's maids, and dressmakers. The figure of 4.4% of 'professional' women is, however, probably inflated by including in this category nurses who had not received any formal training. Four times more Indian than 'Native' women were listed as 'labourers or fieldworkers', and not one Indian female was described as having a profession.

One of the most interesting features of the NGA records is the clear delineation of racial categories. In the Cape statistical returns for this period the only racial or ethnic distinction made is between 'Europeans' and 'Natives'. As Natal had the largest concentration of Indian inhabitants in southern Africa, the NGA profile reflects their position in the Colony. Indian admissions followed the familiar local gender-related pattern, with males outnumbering females: for instance, whereas at the close of 1909 98 Indian males were resident at the NGA, there were only 25 females. Again, this is partly explicable by the higher male Indian population in Natal and the gendered pattern of admissions generally. We know that the conditions under which the majority of indentured Indians were forced to live were injurious to both their physical and their psychological health. In June 1904, the *Indian Opinion* called for a commission of enquiry, claiming that 'suicides among the indentured Indians have become a feature year after year, and we think that the cause ought to be probed to the bottom'.¹²⁹ No such enquiry was held, however.

Prognosis: Recoveries, Discharges and Deaths, 1880-1909

What does seem surprising, at first glance, is that Indian inmates had a higher recovery rate than any other identified category of patients. Figures 4 and 5 outline the prognosis of NGA patients during the period 1880-1909, showing, as a percentage of the admissions, the rates of recovery, discharge, death, and those remaining at the end

in California, 1870-1930 (Berkeley: University of California Press, 1978), pp. 110-117.

¹²⁹ *Indian Opinion*, 4 June 1904, quoted in S. Bhana and B. Pachai (eds.) *A Documentary History of Indian South Africans* (Cape Town and Stanford: David Philip and Hoover Institution Press, 1984), p.20. See chapter 5 of this dissertation for a discussion of Natal Indians, the colonial state, and suicide.

of each year.¹³⁰ Overall, just about 40% of NGA patients were discharged as 'recovered'. This rate was slightly higher (at 45.4%) for Indians, and lowest for Africans (36.7%). There is no great difference between the recovery rates for men and women of any racially-defined group. The recovery figures for the NGA are marginally greater than those of the Valkenberg patients in the period 1891-1920.¹³¹ As will be discussed below, in the case of Indian patients, recovery rates may have been a result of spontaneous remission of the symptoms that had brought about their committal in the first instance, rather than to any treatment received at the NGA.

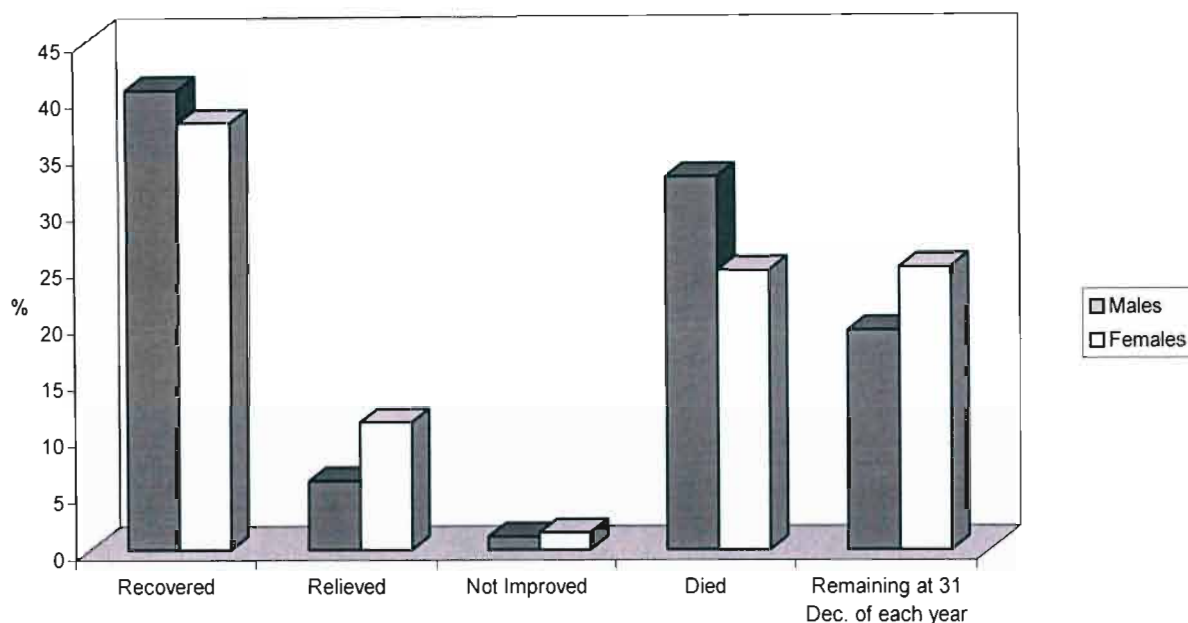
The most striking difference between the NGA and the Valkenberg figures comes in the discharges of patients described as 'not improved'. At Valkenberg, 11.3% of male patients, and 7.5% of female patients were discharged even though they were 'not improved'.¹³² This higher percentage may be related to the fact that two-thirds of admissions to Valkenberg – and until 1916 these were all white persons – were from the Cape Town area and the possibility of patients being released into the care of next of kin or family members was therefore relatively higher than that for African and Indian patients at the NGA.

¹³⁰ 'Patients Discharged' was further divided into patients discharged as 'relieved', as 'recovered', or as 'not improved'. Discharge, therefore, does not necessarily indicate full recovery.

¹³¹ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p. 46.

¹³² *Ibid.*, and Appendix 2, Table 7a.

Figure 4: NGA, 1880-1909: Percentage of Admissions (Male and Female), Relieved, Recovered, Not Improved, Died, or Remaining at 31st December of Each Year

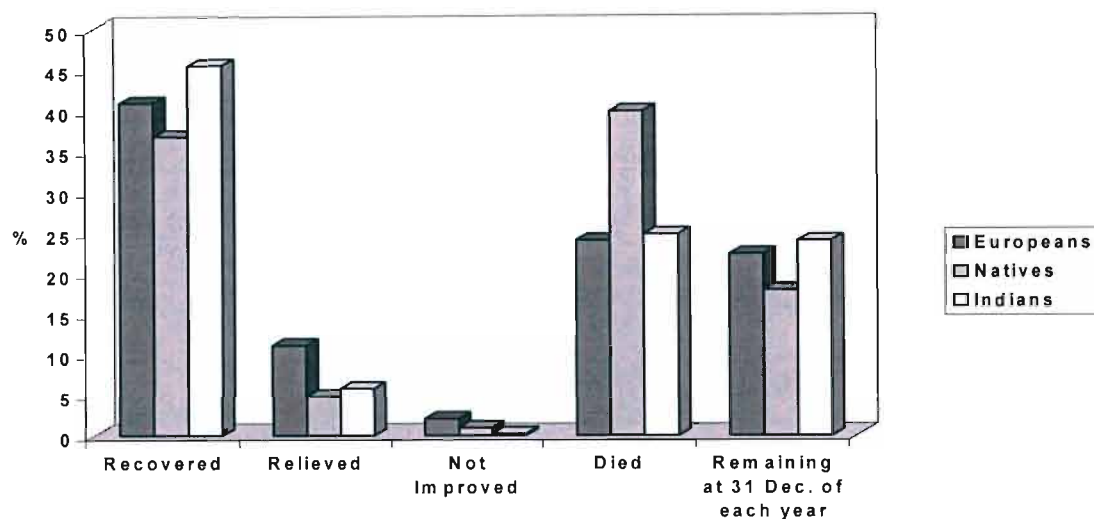


That more women than men remained in the asylum at the end of each year is not surprising. Women were likely to be admitted only when their 'condition' was no longer containable within the domestic sphere. Furthermore, women lived longer than men, and so inevitably represented the greater proportion of long-term chronic patients. The same pattern has been discerned in a wide variety of studies of asylum populations around the world.¹³³ Again, however, Indian NGA inmates present an exception to this general trend: over the period 1880-1909 nearly a quarter of male Indian admissions neither died nor were released and so remained at the asylum at the end of the year, but this was the case for only 10% of Indian female admissions. This can only partly be explained by the fact that Indian women were more likely to die whilst in the NGA than their male counterparts.

¹³³ For example, see Fox's pioneering statistical and cultural study, *So Far Disordered in Mind: Insanity in California, 1870-1930*, pp. 104-135.

If the majority of patients recovered during – or as a result of – their confinement at the NGA, they were nonetheless almost as likely to die. In fact, as Figure 5 shows, in the case of 'Native' patients, especially males, the odds on dying were greater than on recovering. Hyslop made frequent references to the unacceptably high mortality rates amongst black patients.¹³⁴ He acknowledged that overcrowding played a significant role. He was also of the opinion that 'the low vital condition' of 'Native' patients upon admission contributed in no small degree to the mortality rates

Figure 5: NGA, 1880-1909: Percentage of Admissions Recovered, Relieved, Not Improved, Died, or Remaining at 31st December of Each Year



This would appear to support the proposition that African people at this time would only seek admission to facilities such as asylums for themselves or for family members when all other alternatives – indigenous or allopathic, or combinations thereof – had been exhausted. To these factors, however, we should also add that institutional discrimination in the form of distinctly poorer facilities, including the stipulated diet scales, might well have further lowered black inmates' resistance to disease. Until a demographic medical history of Natal in the nineteenth and early twentieth centuries has been compiled, it is difficult to gauge the magnitude of the NGA mortality rates. However, we can get a sense of how high they were by comparing the death rate for white NGA patients in 1904 with that of the 'European'

¹³⁴ *NBB* 1897, Asylum Returns.

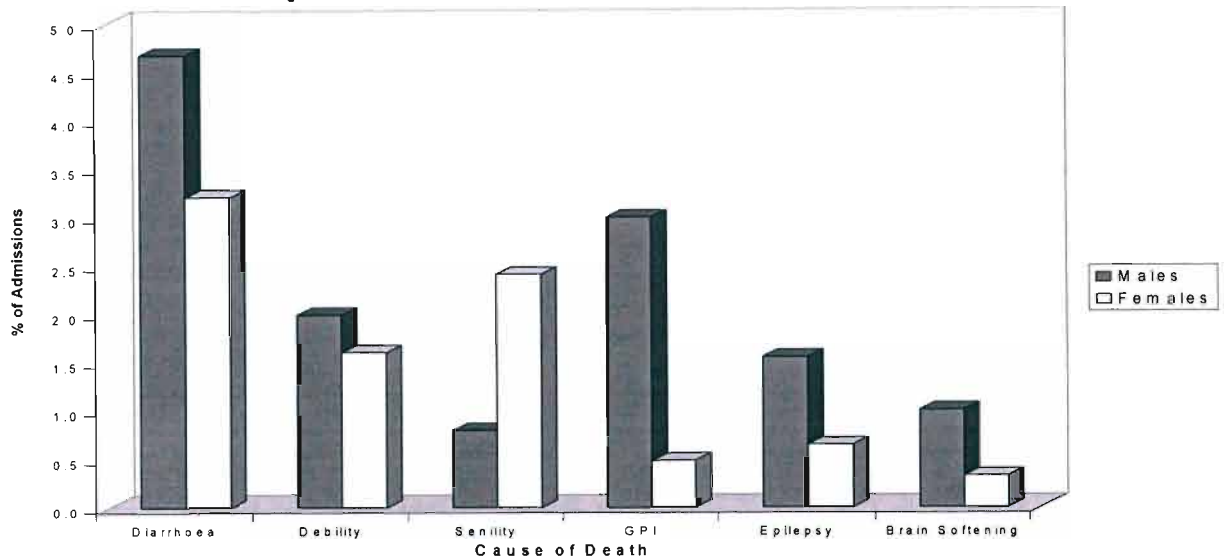
population of Pietermaritzburg as a whole: while 9% of white NGA patients died during that year, the comparative figure for the city as a whole was only 1.4%.¹³⁵

From 1870 onwards the Annual Reports recorded causes of male and female patient deaths in increasingly detailed Obituary Tables. By the 1900s, these tables listed more than twenty causes of death under four major headings (viz. Cerebral and Spinal Diseases, Thoracic Diseases, Abdominal Diseases, and General Diseases) in seventeen age brackets, beginning at 'under 15 years' and running through to '85 and under 90'. The poor conditions of the NGA as a whole and the already debilitated state of many admissions meant that the greatest killers were 'diarrhoea' and 'debility'. Because of the difficulties of tracing trends in the large number of diseases named in the Obituary Tables, I have attempted to extract those causes which were consistently identified over the thirty-four years between 1875 to 1909, and these are shown in Figure 6.¹³⁶ Whereas 'diarrhoea' and 'debility' presumably do not necessarily have any direct relationship with mental illness, the remaining four categories have more traditionally been associated with insanity.

¹³⁵ *Twentieth Century Impressions of Natal*, p. 66. Unfortunately, this source does not give mortality rates for Africans and Indians in the urban areas.

¹³⁶ Causes of death by race are not given in the Statistical Tables. The figures for 1906 and 1907 are missing. Very few women in Natal - or elsewhere - were openly given the diagnosis of GPI. Shorter suggests that this was because of the shame and stigma attached to the disease. He comments that the large number of women who were abandoned and left to die in asylums in the late nineteenth century, may well have been victims of syphilis. There is an account of a young African woman being afflicted by syphilis in Margaret McCord's *The Calling of Katie Makanya* (Cape Town: David Philip, 1995), that tells of how she remained hidden away from the world because the resultant disfigurement.

Figure 6: NGA, 1875-1909. Selected Causes of Death



Given the greater longevity of women it comes as no surprise that more women than men had senility listed as a cause of death. Nor is it unexpected that more men than women died as a result of GPI (General Paralysis of the Insane, the tertiary – and fatal – phase of syphilis). As we shall see when discussing the changing aetiologies of insanity, at least one theorist has suggested that mental illness was on the rise in this period because of the very real increase of infection of syphilis. From the NGA records, I tried to establish whether or not GPI-related deaths rose in Natal over the period under review, but the numbers are too erratic to draw any firm conclusions, there being two in 1876, five in 1887, none in 1894, six in 1904, and two in 1905.

Aetiologies of Mental Illness, 1895-1909

On 21 May 1906, Frank Sullivan, aged 30, was admitted to the NGA. Described as 'noisy, incoherent, delusions' [sic], he had been transferred from the gaol at Umzinto. Although not given a diagnosis at the time, he was thought to be 'A GPI case'¹³⁷. A month later, Frank's brother – a Durban solicitor – wrote to Hyslop, outlining Frank's recent history and explaining how it was that Frank had come to be arrested 'with no boots and no trousers and wet through.':

For about six years he has taken little or no exercise – not engaging in games – going occasionally to a dance.... In 1901 we went to England and lived rather a fast life. I left England in September but he stayed a month or more longer and I believe he drank a good deal after I went. He was employed at my father's store as Manager and after his return it was difficult to get him to walk any distance. I used to go out with him in the evenings but I have since ascertained that he drank more than I knew of. About this time he seemed to be getting slacker and slacker and to have lost all energy. He would go down to the store in a ricksha do a little work and smoke a good many Egyptian cigarettes. My father shortly afterwards went to England and the business was a good deal neglected – my brother used to go out and people used to ask me to "look after" him, but it was no use talking to him. He resented any interference and when my father returned we tried to screen matters a good deal from him by trying to get my brother out of his drinking habits - I used to try to persuade him to come home at ten o'clock (when the bars closed) but he always wanted to go to the Natal Club.¹³⁸

Before long, Frank was asked to leave the family business and then to 'live out'. Frank's father paid for him to be 'kept' at a farm in Fort Nottingham, where he nominally worked as a manager. After being asked to leave this position, Frank moved to his brother-in-law's farm at Nottingham Road, but once again he was asked to move on. In 1905, Frank settled in Pietermaritzburg and attempted to earn his living 'getting goods on approbation and selling same'. After a short while, however, he was on the move again, drifting between temporary jobs and having his living expenses

¹³⁷ NGA (European) Patient Case-Book XI, pp. 433-435. Frank Sullivan, Admission number 2110.

¹³⁸ NGA (European) Patient Case-Book XI, Frank Sullivan. Carbon copy of 'Confidential Report', pinned to p.434, and signed by P. Sullivan, Durban, 19 June 1906.

and steadily increasing debts covered by his father and brother. As time went by he became clearly delusional, placing bids on expensive properties and writing fantastic letters about his plans of making a fortune. In 1906, the year he was admitted to the NGA, he was remanded for medical examination for running 'amok at Harding, frightening the Harding people with tales of (an) alleged ghost - which he chased all over the racecourse with a pack of dogs all one night.' Thereafter, Frank disappeared again, eventually turning up in Umzinto in his sadly dishevelled state.¹³⁹

The notes kept on Frank Sullivan in the Case-Book over the following months until his death in mid-January 1908, charted his steady physical and mental deterioration, the entries becoming increasingly brief and terse. In June 1906, Hyslop noted that Frank's 'deep reflexes have gone... has difficulty articulating test sentences for GP and presents flicker of facial muscle so common in GP.' In March 1907 he was said to be 'tremulous; restless, mischievous'; in May he was 'becoming progressively worse.' By September he had become paralysed, and the entry for 14 January 1908 bears a single word, underlined twice in red ink: 'Died'.

Frank Sullivan's story highlights many of the debates surrounding the reasons for the rising numbers of asylum inmates both in this region and more generally in the late nineteenth and early twentieth centuries. White, male, and single, he was representative of many NGA inmates. His mental illness was real, probably the result of syphilis and the abuse of alcohol. The experiences of his family, of increasing inability to control and care for him, were also not unusual at that time. Indeed, a number of letters preserved in the NGA Case-Book testify to families' increasing desperation and frustration in trying to accommodate the actions of individuals who behaved in a disruptive and unpredictable manner. Often, committal to the NGA came as the *finale* to a period of clearly erratic, even dangerous, behaviour. Until the existence of asylums, such people would usually have been accommodated - not necessarily willingly or happily, to be sure - by their families. In the case of poorer communities, disturbed individuals may have been driven away. Discussing

¹³⁹ *Ibid.*

developments in Europe after the late eighteenth century, Edward Shorter argues that changes in both family structure and attitudes towards the care of the ill made it easier and more acceptable for disruptive - including 'demented elderly' - relatives to be placed in asylums.¹⁴⁰ In addition to this climate of declining tolerance, in the colonial setting, many immigrants simply did not have close relatives, let alone an extended network of kin and acquaintances. In the absence of poor relief structures, the elderly who exhibited signs of mental disturbance were particularly vulnerable and may have been accommodated at the NGA because there were few alternatives available. Hyslop's 1905 Annual Report endorses this view:

There being no Poor Houses, Chronic Sick Hospitals, Epileptic Hospitals, or similar institutions, the sick dependent on the care of the public mostly find their way either to General Hospitals or the Asylum, and many cases which would otherwise be treated elsewhere are, as a matter of expediency, sent to the Asylum, provided, of course, that they can be certified as of unsound mind.¹⁴¹

Significantly, Hyslop also attributed the increase in '...Natives admitted from Zululand who might probably have remained outside the Asylum but for the land in the vicinity of their kraals being taken up by Europeans.'¹⁴² It seems likely that, as the homestead economy began to come under increasing pressure and as African family structures underwent change, some of the people exhibiting signs of mental illness could no longer be contained by conventional methods and therapeutic systems.

Thus, part of the explanation for escalating patient numbers lies in the redistribution of the mentally ill. According to neo-apologists such as Shorter, a '...second major component in the press of bodies was a genuine increase in the rate of mental illness during the nineteenth century. Between 1800 and 1900, the risk grew appreciably that the average person in his or her lifetime would be visited by a major psychiatric

¹⁴⁰ Shorter, *A History of Psychiatry*, p. 50. Here he argues that the family increasingly came to view itself as an emotional unit, rather than being based on ties of property and lineage. The mad could no longer be tolerated as they disrupted the family's definition of itself as a harmonious unit. See also Chapter 1 of this dissertation.

¹⁴¹ *NBB* 1905, Natal Government Asylum.

¹⁴² *Ibid.*

disorder.¹⁴³ At this time there were two major medico-social epidemics that could result in mental illness affecting the populations of Europe and North America: syphilis and alcoholism. Frank Sullivan, in colonial Natal, possibly suffered from both.¹⁴⁴

As Karen Jochelson's study of syphilis in South Africa up to the mid-twentieth century shows, endemic syphilis, which was not sexually transmitted, was in all likelihood, indigenous to the region. She points out that, across the British empire, it was 'traders, sailors, police, soldiers, slaves and migrant workers' who were primarily responsible for introducing sexually-transmitted diseases.¹⁴⁵ Certainly, venereal syphilis was still 'relatively rare' amongst Africans in Natal and the eastern Cape until the late 1800s, and was largely associated with colonists. It was the mineral revolution – more especially following the opening of the Rand in the late 1880s – with the dramatic acceleration of urbanization, prostitution, and the need for African labour that fuelled the transmission of both venereal and endemic syphilis across the country.

The South African War of 1899 to 1902 further accelerated the spread of syphilis, and the military garrison as well as concentration camps in and near Pietermaritzburg, drew prostitutes.¹⁴⁶ It seems safe to assume therefore that the incidence of venereal syphilis was rising in Natal – and later in Zululand – in the late nineteenth and early twentieth centuries. Initially a white problem, the disease would increasingly become

¹⁴³ Shorter, *A History of Psychiatry*, p. 53.

¹⁴⁴ See Shorter, pp. 48-65 for a fuller discussion. Shorter also considers the view that schizophrenia emerged as a new syndrome during this time. Without detailed clinical data, it is impossible for me to trace the evolution of diagnoses of dementia praecox and schizophrenia at the NGA.

¹⁴⁵ K. Jochelson, *The Colour of Disease: Syphilis and Racism in South Africa* (Houndmills, Basingstoke: Palgrave/St. Anthony's College, 2001), Chapter 1, and this quotation is from p. 10. She does not, unfortunately, look at records about the incidence of general paralysis of the insane.

¹⁴⁶ For prostitution, race and the settler community's concerns about infection from venereal disease, see J. Martens, "'Almost a Public Calamity': Prostitutes, "Nurseboys", and Attempts to Control Venereal Diseases in Colonial Natal, 1886-1890', in *South African Historical Journal (SAHJ)*, 45 (2001), pp.27-52.

associated with poor whites and, later, almost exclusively with Africans. The NGA records, however, reflect the earlier phase of this disease, when it was primarily a settler scourge.

Leigh R. Anderson's prodigious doctoral thesis on the relationship between criminal activity and economic trends in Natal in the period between 1860 and the granting of Responsible Government in 1893, links periods of recession with a rise in 'social diseases' such as venereal disease, prostitution and drunkenness.¹⁴⁷ Indeed, it is clear that alcoholism had long been a problem in Natal, especially amongst white men.¹⁴⁸ In the 1870s, *The Colonist* 'claimed that much of the drinking in Maritzburg could be attributed to the fact that fathers in England sent their sons out to Natal because they had become abandoned drunkards at home. Every effort to reclaim them had probably failed and in order to avoid the disgrace of their debauches near to home, they were sent to Natal with little money to drink themselves into the grave, or to be reformed by poverty.'¹⁴⁹ Temporarily deranged drunks were a public nuisance and were often detained in the colony's gaols; and many of those who experienced the horrors of *delirium tremens* were admitted to the NGA. So great did the problem of alcoholism become, that from the 1890s – a decade that began with financial and banking crises that led to a sharp economic depression – it was a matter of public debate, and proposals were put forward for a bill 'for the care, control, and curative treatment of European Inebriates'. In 1914, a retreat for European alcoholics was opened in Pietermaritzburg, but until then, the asylum was the major refuge for ill alcoholics, providing both patients and their families a measure of respite.¹⁵⁰

¹⁴⁷ L.R. Anderson, 'Society, Economy and Criminal Activity in Colonial Natal', 1860-1893' (unpublished Ph.D. dissertation, University of Natal, Durban, 1993), see especially pp. 195, 284, and 331.

¹⁴⁸ I discuss the rise of drunkenness during the economic depression of the 1860s in 'The Impact of the Depression Upon Pietermaritzburg', p. 179. On 27 August 1872, the *Natal Witness* called for the establishment of facilities for 'dipsomaniacs'; Hyslop lent his support to similar calls and petitions on several occasions over the following three decades.

¹⁴⁹ Quoted in Anderson, 'Society, Economy and Criminal Activity in Colonial Natal', 1860-1893', p. 195.

¹⁵⁰ PAR AGO 1/9/19 61A/1900, 'Deputy Mayor, Durban: Difficulties Arising re: Dealing With Inebriates and Other Forms of Madness', 31 October 1900.

Table 1 (below) is a compilation of the NGA statistical tables 'Showing the Probable Cause of Insanity in the Patients Admitted' between 1895 (when these tables made their first appearance) and – excluding 1906 and 1907 – 1909. The greater number of black patients at the NGA than at Valkenberg (and conversely, of white patients at Fort Beaufort) makes it possible to draw a fuller picture than the Cape records allow. Whether calculated as a proportion of the admissions, or of the number of aetiologies assigned for each category of persons, 'intemperance in drink' was the most frequently identified cause of insanity amongst male patients at the NGA.

The overall figure of 7.3%, however, masks significant differences between white, African and Indian men, and it is abundantly clear that alcoholism was a much greater cause of mental illness for white males.¹⁵¹ In Hyslop's opinion, though, while white males' 'over-indulgence in alcohol is perhaps one of the most potent causes of trouble', it was also more likely that male inebriates would find themselves in asylums because 'such excesses are from their very nature more apt to obtrude on the notice of relatives than most other causes.'¹⁵² New patterns of alcohol consumption amongst Africans were also emerging during this time. *Isishimiyana*, which was made from molasses, and which was stronger and more addictive than *utshwala*, was being consumed by increasing numbers of people. Unlike *utshwala*, *isishimiyana* had no customary sanctions guiding its use. The rise of alcohol consumption in this region has been seen as '... both a cause and a symptom of the unravelling social fabric of rural African life in Natal, as women and young men challenged patriarchal authority. ... After 1900, however, alcoholism, which contemporary observers simply called "drunkenness", became more serious than ever.'¹⁵³ How much it contributed to the admission of

¹⁵¹ The figure for Valkenberg (where the vast majority of the patients were white) is 21.8% Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', pp. 106 and 107.

¹⁵² *NBB* 1904, Natal Government Asylum.

¹⁵³ M.R. Mahoney, 'Between the Zulu King and the Great White Chief: Political Culture in a Natal Chiefdom, 1879-1906' (unpublished Ph.D. dissertation, University of California, Los Angeles, 1998), pp. 136 and 171. On p. 82. of *Zulu Medicine and Medicine-Men* (Cape Town: C.Struik, 1966), A.T. Bryant, writing c.1911, described delirium amongst the

African males to the NGA, is, however, not clear.

Overall, 'Previous Attacks' were said to account for 13.6% of admissions, with slightly more women than men being identified in this manner. This category was not used at the blacks-only institution of Fort Beaufort, and Swartz comments that this was perhaps the result of '... an institutional will to forget, or at least to render invisible, the history of black patients' illness, [making] the category irrelevant.'¹⁵⁴ However, Hyslop and the NGA staff did employ it in ascribing aetiologies to the mental illness of 'Native' and Indian patients. The NGA figures bear out the gender stereotype of the time that held that women were more likely to be subject to repeated attacks of mental illness because of their vulnerable nervous systems. Nonetheless, a greater proportion of 'Native' than of 'European' men was held to be insane as a result of prior bouts of madness.

At Valkenberg, 'heredity' was identified as a leading cause (37.8%) of insanity amongst white patients. Feeding off, and into, contemporary social Darwinist beliefs about evolution and degeneracy, the apparent increase in white insanity became a matter of great concern for both psychiatrists and for the colonial state. If we can use the aetiological tables of the NGA as any indication of white fears about racial degeneracy in Natal, then it appears that they were less acute at this time than at the Cape, though it should be noted once again that white women were regarded as being more susceptible to insanity as a result of inheritance than were any other group of inmates.

What stands out most clearly from this table are the enormous difficulties that even 'specialists in mental diseases' at this time had in identifying the causes of insanity. Of the NGA admissions in the period 1895 to 1909, more than half had an 'unknown' cause of illness. It should not surprise us that this was especially the case for black

'isiShimeyana', or treacle-mead drinkers, of Natal. These extreme effects were said to be unknown amongst *utshwala* drinkers.

¹⁵⁴ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p. 108.

inmates. Difficulties of communication across linguistic and cultural chasms meant that Hyslop frequently bemoaned his inability to learn a patient's history, either directly from the patient, or from friends or family. As at Fort Beaufort, fewer categories of causation were used for black patients, however, 'moral' causes were sometimes attributed. The only cause of insanity allocated to blacks and not to whites was 'insangu' (*cannabis*) smoking, and 5% of Indian male admissions were said to be for this reason. The 'Wragg Commission' of 1887 clearly identified 'dakkha' smoking, and not alcohol consumption, as a problem amongst Indian workers: 'The mixture which Indians consume is made up of tobacco, opium, Indian hemp, and brown sugar, and as the fumes from such compounds, when ignited, are not even passed through water ... the habit must be even more injurious.' The report commented that 'every employer ... is familiar with the cataleptic state in which Indians are found from time to time; and such affections as mania, dementia, and melancholy, often terminating in suicide, are events of constant occurrence from indulgence in dakkha-smoking...'¹⁵⁵

The high recovery, after a period of enforced abstinence at the NGA, rate for people suffering from psychoses induced by drug addiction may therefore have had an impact upon the higher recovery rate – as outlined above – for Indian men than for other NGA inmates.

¹⁵⁵ Natal Government Gazette vol. XXXIX No. 2262 Tuesday, September 20 1887, Government Notice No. 430, 1887, *Report of the Commission appointed to inquire into and report upon the Indian Immigration Laws and Regulations of the Colony, and on the general condition of the Indian population of Natal*, Chapter XXVIII, p. 7.

TABLE 1.
SHOWING THE PROBABLE CAUSE OF INSANITY IN THE PATIENTS ADMITTED, 1895-1909

PROBABLE CAUSE.	AETIOLOGY AS A PERCENTAGE OF ADMISSIONS IN CATEGORIES OF RACE AND SEX											
	Male				Female				Total			TOTAL
	E	N	I	Total Male	E	N	I	Total Female	E	N	I	
MORAL:												
Domestic Trouble (incl. Loss of Relatives and Friends)	2.5	0.3	0.3	1.0	7.2	1.1	0.0	4.2	4.2	0.4	0.3	1.8
Adverse Circumstances (including Business Anxieties and Pecuniary Difficulties)	5.4	1.1	1.2	2.6	2.9	0.0	0.0	1.5	4.5	0.9	1.0	2.3
Mental Anxiety (not included in above) and Overwork	1.6	0.1	0.0	0.6	0.7	0.0	0.0	0.4	1.3	0.1	0.0	0.5
Religious Excitement	0.2	0.6	0.9	0.5	0.7	0.0	1.5	0.6	0.4	0.4	1.0	0.5
Love Affairs	0.2	0.0	0.0	0.1	0.7	0.0	0.0	0.4	0.4	0.0	0.0	0.1
Fright and Nervous Shock	0.2	0.0	0.0	0.1	0.7	0.0	0.0	0.4	0.4	0.0	0.0	0.1
PHYSICAL:												
Intemperance in Drink/Alcohol	18.2	1.3	3.1	7.3	2.5	1.6	0.0	1.9	12.7	1.3	2.6	5.9
Intemperance Sexual	0.4	0.0	0.0	0.1	0.4	0.0	0.0	0.2	0.4	0.0	0.0	0.1
Venereal Disease or Syphilis	1.4	0.0	0.3	0.5	0.4	0.0	0.0	0.2	1.0	0.0	0.3	0.4
Self Abuse (Sexual)	1.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.2
Over Exertion	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sunstroke	0.6	0.0	0.6	0.3	0.0	0.0	0.0	0.0	0.4	0.0	0.5	0.2
Accident or Injury	1.4	0.8	0.3	0.9	0.7	0.0	0.0	0.4	1.1	0.7	0.3	0.8
Pregnancy	0.0	0.0	0.0	0.0	0.7	3.3	1.5	1.7	0.3	0.7	0.3	0.4
Change of Life	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.6	0.4	0.0	0.0	0.1
Fevers	0.8	0.0	0.0	0.3	0.7	0.0	0.0	0.4	0.8	0.0	0.0	0.3
Privation and Starvation	0.4	0.3	0.0	0.3	0.7	0.0	0.0	0.4	0.5	0.2	0.0	0.3
Old Age	1.0	0.4	0.3	0.6	3.2	0.5	0.0	1.9	1.8	0.4	0.3	0.9
Other Bodily Diseases and Disorders	3.7	0.6	0.3	1.6	2.5	0.5	2.9	1.9	3.3	0.6	0.8	1.6
Previous Attacks	5.2	6.3	5.0	5.7	11.5	5.4	0.0	7.9	7.4	6.1	4.1	6.3
Heredity	3.3	2.1	1.2	2.3	7.2	2.7	0.0	4.7	4.7	2.2	1.0	2.9
Congenital Defect Ascertained	3.1	1.3	0.3	1.7	4.0	0.0	0.0	2.1	3.4	1.0	0.3	1.8
Parturition and the Puerperal State/Puerperium	0.0	0.0	0.0	0.0	4.0	1.1	1.5	2.6	1.4	0.2	0.3	0.7
Lactation	0.0	0.0	0.0	0.0	0.7	0.0	0.0	0.4	0.3	0.0	0.0	0.1
Uterine and Ovarian Disorders	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Puberty/Adolescence	1.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.6	0.0	0.0	0.2
Epilepsy	2.7	2.8	0.9	2.4	1.4	0.5	0.0	0.9	2.3	2.3	0.8	2.0
Insangu Smoking	0.0	1.5	5.0	1.7	0.0	0.0	0.0	0.0	0.0	1.2	4.1	1.3
Exigencies and Privations Due to War	3.3	0.6	0.9	1.6	2.2	0.0	0.0	1.1	2.9	0.4	0.8	1.4
Other Ascertained Causes (incl. Epilepsy and Insangu Smoking)	1.0	1.0	1.2	1.0	1.4	0.0	0.0	0.8	1.1	0.8	1.0	1.0
Congenital Fright	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Imprisonment	0.0	0.0	0.0	0.0	0.0	0.5	0.0	0.2	0.0	0.1	0.0	0.0
Paralysis	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.2	0.1	0.0	0.0	0.0
Influenza	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Hemiplegia	0.2	0.4	0.0	0.3	0.4	0.0	0.0	0.2	0.3	0.3	0.0	0.2
Infantile Paralysis	0.2	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Brain Tumour	0.2	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.1	0.1	0.0	0.1
Drug Habit	0.4	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.1
Unknown	35.1	62.2	67.6	54.3	35.3	58.7	67.6	47.5	35.1	61.5	67.1	52.6

If causes are calculated as a percentage of assigned aetiologies, rather than of admissions, the discrepancy between psychiatric knowledge about black and white patients at the NGA is even more starkly revealed. While the cause of mental illness was said to be 'unknown' for 37% of whites, this was true for 74% of 'Natives', and 78% of Indians. Black women at the NGA were even more 'alien'. The origins of their madness were largely unknown to western psychiatry: the percentages of 'unknown' being 77% for African women, and a whopping 90% for Indian women. The discursive 'erasure of the indigenous' has been extensively commented upon by Swartz and others, but the almost total lack of knowledge about and understanding of Indians, especially Indian women, in southern African colonial psychiatry has not been yet been explored. Furthermore, approaches such as that of Alexander Butchart which are concerned with the colonial construction of 'the African mind' tend to obliterate gender-related differences. Butchart's all-seeing colonial psychiatric gaze would have us believe that the asylum provided a place where Africans were subject to intense scrutiny, and that in the asylum the African psyche was produced '...as no more than bundles of nerve fibres and neurons'.¹⁵⁶ I would agree that colonial psychiatry as practised by Hyslop and others reinforced contemporary notions about evolution and about the supposed inferiority of blacks in general, but, the overwhelming amount of ignorance about the causes of insanity amongst black people at this time suggests that 'the gaze' was, at most, partially-sighted. Instead of solely scrutinising African minds, colonial psychiatry was probably just as – if not more – concerned with what appeared to be the vulnerability of the white psyche, subject as it was said to be to the stresses and strains of civilised life.

Diagnoses, 1870-1909: Wild women and melancholic men?

The new nosological categories elaborated during the nineteenth and early twentieth centuries are mirrored in the NGA statistical tables after 1894.¹⁵⁷ Until that date, the

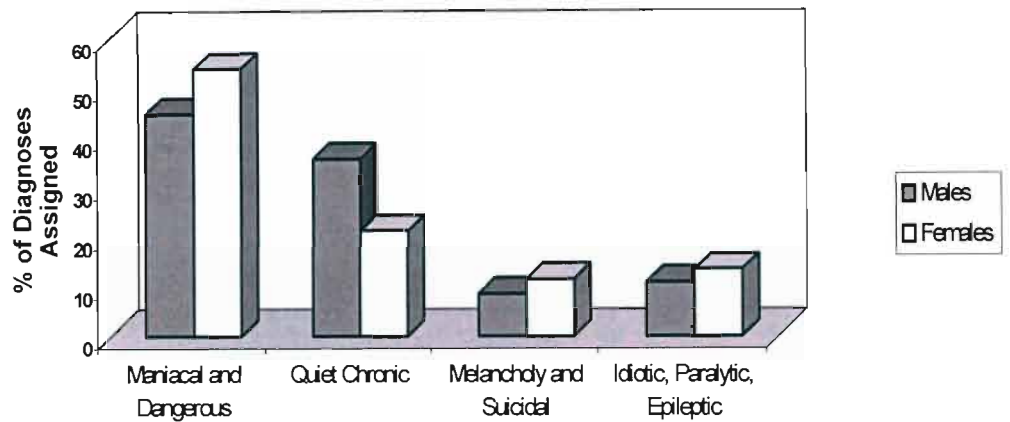
¹⁵⁶ A. Butchart, *The Anatomy of Power: European Constructions of the African Body* (London and New York: Zed Books, 1998), p. 112.

¹⁵⁷ See Shorter, *A History of Psychiatry*, pp. 99-112.

records followed the centuries-old forms of classification of lunacy, and patients were described as 'Maniacal and Dangerous', 'Quiet Chronic', 'Melancholy and Suicidal', or 'Idiotic, Paralytic, Epileptic'. These tables distinguish only between the sexes and not on the basis of race. (Figure 7) At the time, the diagnosis of the majority of inmates as 'Maniacal and Dangerous' was explained in evolutionary terms, by the 'loss of the lower developed strata of the mental organism...among natives of low developed brain-functions'.¹⁵⁸ Today we might interpret this as a result of bias in terms of the 1868 Custody of Lunatics Act. Nonetheless, it seems surprising that such a high percentage of women were so diagnosed. This apparent break with general trends may be because the calculations for this figure are based on the number of diagnoses assigned rather than on admissions: perhaps multiple diagnostic labels were given to women more often than they were to men. Or, perhaps this is another indication that women's behaviour had to be extremely anti-social before they were committed to asylums. Records available to us after 1916 concerning the committal of patients to the asylum – which are considered in more detail in Chapter 4 – tend to bear out this conclusion, though no statistical analysis has been attempted. There is also some corroborating, though anecdotal, evidence from the European Case-Book as well as from occasional court records.

¹⁵⁸ T. D. Greenlees, 'Insanity Among the Natives of South Africa', *Journal of Mental Science*, 41 (January 1895), p72.

Figure 7: Diagnoses, 1870-1894



To give but one illustration of such a ‘wild woman’: in 1884, the Resident Magistrate at Estcourt sought to have Mrs. Emily Elliot Hackett – whom he described as a ‘lady’ – certified as being of ‘unsound mind’. One medical practitioner found her to have a ‘wild, raving appearance’, and to be ‘at times unconscious of my presence; her conduct is disgusting and obscene and violent; her conversation is full of oaths and lewd talk mixed with meaningless songs’.¹⁵⁹ A second certificate noted that her husband had said that she ‘is very violent and has once or twice tried to injure her baby, and that she will destroy everything she can in her attempts to escape.’ Mr. Hackett undertook to pay for his wife’s ‘maintenance at the asylum’.¹⁶⁰

Table 2 gives some idea as to the way in which diagnostic categories became considerably more complex over time. The dates in brackets indicate the category’s first appearance in the NGA nosological tables. The over-arching framework of mania, melancholia and dementia remained in place for some time.¹⁶¹ Mania,

¹⁵⁹ PAR AGO 1/8/31 6B/1883 2978/84, ‘Insanity of Mrs. Emily Hackett’, RM of Estcourt Requests That She May Be Admitted Into The Asylum’, 2 August 1884.

¹⁶⁰ *Ibid.*

¹⁶¹ Attempts to track the rise and fall of various diagnostic categories proved to be immensely complicated, given the ever growing multiplication by division of the old nosological

however, remained the most assigned diagnosis for all patients at the NGA, white women included. More 'Natives' and Indians were said to be 'maniacal' than 'Europeans', and by now more men than women were listed under this category¹⁶². Melancholia formed the second-largest general category, accounting for 29% of female, and 19.9%, of male, diagnoses. In terms of racial distinction under this heading, the NGA statistics are particularly interesting. Melancholia was an unusual diagnosis for black patients in asylums in the Cape. Not once was the category used for African and 'Coloured' inmates of Robben Island's asylum during the period 1872-1888; it was used for only 4% of black diagnoses at the Grahamstown Asylum, and in a mere 3.8% of instances at Fort Beaufort.¹⁶³ Colonial psychiatrists believed that whites were more prone to melancholia because of their supposedly greater intellectual prowess and heightened sensibilities. This was an early form of the conviction so popular in the early to mid-twentieth century that blacks did not – probably could not – suffer from depression. However, the picture for the NGA is more varied, and Indians were almost as likely as whites to be diagnosed as melancholic.

categories, as well as the adoption of new ones. It would seem, however, that the pattern established early on at the NGA continued until 1909 at least.

¹⁶² Swartz explains that, at this time, 'mania' included '... a wide range of behavioural, emotional or cognitive disturbances such as running naked, restlessness, excitability, withdrawal, incoherence, delusions and hallucinations. 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 component of the diagnosis. ... The category dementia ... included senile dementia, and dementia secondary to attacks of insanity, alcohol abuse, epilepsy, or injury to the brain.' S. Swartz, 'Colonialism and the Production of Colonial Psychiatry', pp. 102-3 and 104, footnotes 16 and 24.

¹⁶³ S. Swartz, 'Colonialism and the Production of Colonial Psychiatry', p. 103.

TABLE 2
SHOWING THE FORM OF MENTAL DISORDER IN THE ADMISSIONS,
1895-1909

FORM OF MENTAL DISORDER					
	Male	Female	Europeans	Natives	Indians
Congenital or Infantile Mental Deficiency:					
(a) With Epilepsy	1.1	1.1	2.1	0.7	0.0
(b) Without Epilepsy	2.2	3.2	3.5	2.3	0.9
Epilepsy Acquired	3.5	2.5	3.5	3.8	1.5
General Paralysis of the Insane	2.6	0.0	4.8	0.0	0.3
Moral (Added 1908)	0.0	0.0	0.0	0.0	0.0
Insanity with Grosser Brain Lesions (1908)	0.0	0.0	0.0	0.0	0.0
Acute Delirium (1908)	0.0	0.0	0.0	0.0	0.0
Confusional Insanity (1908)	0.0	0.0	0.0	0.0	0.0
Stupor (1908)	0.1	0.0	0.0	0.0	0.3
Mania:					
Acute	27.2	23.1	15.3	30.8	37.7
Chronic	10.3	9.4	8.3	13.5	6.1
Recurrent	6.7	8.5	8.9	7.3	3.3
A.Potu	3.9	0.9	6.0	0.7	3.0
Puerperal	0.0	2.7	1.5	0.1	0.3
Senile	4.5	5.9	3.9	6.4	3.3
Simple (1904/5)	3.8	3.7	2.7	5.0	3.0
Adolescent (1904/5)	0.7	0.5	0.5	0.8	0.6
Homicidal (1904/5)	0.2	0.0	0.2	0.1	0.3
Recent (1908)	7.0	7.1	4.8	8.3	8.5
Melancholia:					
Acute	12.6	15.1	16.7	9.9	13.7
Chronic	2.7	4.8	4.5	1.8	4.0
Recurrent	1.0	3.7	2.7	0.8	1.5
Puerperal	0.0	1.4	0.6	0.1	0.3
Senile	0.1	0.5	0.2	0.1	0.3
Excited (1904/5)	0.1	0.0	0.0	0.0	0.3
Recent (1908)	3.4	3.7	3.8	1.6	7.0
Alternating Insanity (1908)	0.0	0.5	0.3	0.0	0.0
Delusional Insanity: (1908)	0.0	0.0	0.0	0.0	0.0
(a) Systematised	0.8	0.7	1.4	0.3	0.6
(b) Non-systematised	1.0	0.2	0.3	1.4	0.6
Volitional Insanity: (1908)					
(a) Impulse	0.1	0.0	0.0	0.1	0.0
(b) Obsession	0.1	0.0	0.2	0.0	0.0
(c) Doubt	0.0	0.0	0.0	0.0	0.0
Moral Insanity (1908)	0.0	0.5	0.2	0.1	0.0
Dementia:					
Primary	1.0	1.1	0.3	1.6	1.2
Secondary	5.6	3.4	3.6	6.0	5.8
Senile	1.9	3.2	2.9	1.8	1.8
Organic (i.e., from Tumours, Coarse Brain Disease, &c.,)	1.2	0.0	1.4	0.8	0.0
Not Insane	0.2	0.0	0.3	0.1	0.0

Another category of inmate sometimes noted in the Medical Superintendent's Annual Reports was that of 'criminal patient'. The numbers of persons so detained at the NGA in any one year was usually around a dozen. For instance, in early 1900, there were ten criminal patients at the NGA: two Indian men, four African men, two African women, and one white man and one 'European female'. With the exception of one Indian man (who had attempted to wreck a train) and the 'European male' who had committed assault with intent to cause grievous bodily harm, they had all been found guilty of murder.¹⁶⁴

The single white woman murderer was Emma Lovett, who had been 'confined during His Excellency's pleasure' since 11 November 1894, after drowning her youngest child. Described at the time as 'a dangerous lunatic' who had committed the murder whilst 'in a temporary fit of insanity', Emma Lovett was discharged from the NGA in 1902 after several years of petitioning by her husband and grown-up children.¹⁶⁵ It proved to be a disastrous decision, for the death of her husband in 1908 precipitated another death at her hands, this time of her youngest grandchild. Readmitted to the NGA, she was now given the diagnosis of 'acute melancholia'. Said to be both 'suicidal and homicidal' she was still a patient in 1919. In these eleven years, she was consistently reported to be depressed. In 1917, for instance, her records noted: 'Depressed, depression being due she says to the thought of the two children she killed. She has no recollection of having killed them + cannot understand it as she was always so fond of children. Suffers from periodical attacks of migraine otherwise her health for her age is good + she works well in the laundry.'¹⁶⁶ The final entry we have simply says: '1919 April 24th: Mentally unchanged, periodical attacks of

¹⁶⁴ *NBB* 1900, Natal Government Asylum.

¹⁶⁵ PAR Minister of Justice and Public Works (hereafter MJPW) 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908'.

¹⁶⁶ NGA (European) Patient Case-Book XI, p. 893. Mrs Emma Lovett, Admission number 2433.

depression recur in which she begs to be allowed to expiate her sins. Is always quiet. Slightly depressed. Has taken no more fits.'

Conclusions: Monster Asylums?

By the late nineteenth century, the foundations had been laid in southern African of a form of psychiatry that would largely remain unchallenged until the 1970s. Profoundly shaped by its colonial context, clear distinctions were made between people, not only on the basis of sanity and insanity, normality and abnormality, but also on the grounds of race and sex. Between the 1870s and 1890s, lunatic asylums – many of which are still in use today – were established in all four of the future provinces.¹⁶⁷ Of these, the Natal Government Asylum was the first to be specifically designed and constructed for the institutional care and control of those certified as being insane. Preceded by a number of temporary arrangements – at the colony's gaols and hospitals, and then in makeshift separate housing – lunatics were accommodated on the Town Hill, then on the outskirts of Pietermaritzburg, from 1875. Three years later, the colonial government voted the large sum of £20,000 for the initial phase of construction of the NGA. 1880 marks the date of the first occupation of this institution, which has played a significant role for more than 120 years in the history of the formalized management of the mad from the region.

From 1882 to 1914, the NGA was closely associated with the career of Dr. James Hyslop, whose psychiatric regime was influenced by both biological psychiatry and the precepts of moral management. By the time of Union in 1910, both the profession and practice of western psychiatry had become firmly established in Natal, and Hyslop commanded the respect of his medical peers across South Africa. While practice at the NGA reflected colonial class, gender and race divisions, neither Hyslop nor his

¹⁶⁷ D. Foster and S. Lea, *Perspectives on Mental Handicap in South Africa* (Durban: Butterworths, 1990), p. 28.

successors as Medical Superintendent at the NGA contributed in published form to theoretical explanations of the aetiologies or treatments of insanity.

By the time of Hyslop's retirement in 1914, the institution that he governed for more than thirty years had expanded greatly, and with just under 600 patients in 1910, only the Pretoria asylum accommodated more patients than the NGA. Usually overcrowded, rather than being a single 'Red House' (the local name for the asylum, taken from the Main Building which was constructed in 1891), separate provision was made for the housing of patients according to sex, class and most notably, by race. In effect, and as Hyslop later commented, '...we have three separate institutions – one for Europeans – who pay for their maintenance, or more than pay for their maintenance: one for non-paying European patients; and a third for coloured patients – all within comparatively close proximity and under one administration.'¹⁶⁸

In 1909, another 36 acres of ground was acquired for the asylum, and in 1910 building commenced on new accommodation for both paying patients and the white male staff. This was representative of a new phase of thinking about asylum construction, one which favoured several small 'villas' on a larger hospital estate, with different 'classes' – both in terms of social and psychiatric classifications – of patients accommodated according to their different requirements and to the state's willingness to provide facilities. Testifying before the Select Committee on the Treatment of Lunacy in 1913, this was an arrangement that Hyslop endorsed, believing that a move away from the 'block system', and what one interviewer called 'monster asylums'¹⁶⁹, would increase the therapeutic value of the asylum, especially for the growing numbers of private patients, most – if not all of whom – were white.

Hyslop was definite, however, in his recommendation that every asylum in the country should have a mixture of white and black patients. The presence of the latter was vital,

¹⁶⁸ *Select Committee, 1913*, p. 41. Evidence of Dr. J. Hyslop, 16 April 1913.

¹⁶⁹ *Select Committee, 1913*, p. 13. Evidence of Dr. W. J. Dodds, 14 April 1913. This term was also used by the Chairman of the Select Committee to describe the 'huge asylums' in America and elsewhere that had around 2,000 patients.

he believed, for economic reasons. For it was African and Indian patients who performed much of the labour. By the 1910s, the exploitation of black psychiatric patients as an unpaid labour force on asylum grounds had become well-established, and was factored into the estimates for state expenditure on the provision of mental hospital facilities. By the late nineteenth century, moral therapy was shaped, even perverted, in southern Africa, by race and class.

The growing numbers of private patients would seem to indicate that the asylum was gaining in respectability as a place to which mentally ill whites could be sent. This is not to say that the stigma and shame of having an insane relative had significantly abated by 1910. Indeed, Hyslop emphasized that ‘people’ – meaning whites – ‘are very averse to sending their relatives to an asylum ... it is regarded as a sort of disgrace to have relations in an asylum’.¹⁷⁰ He went on to say, ‘but I fancy the natives are not at all averse to sending theirs and that they, take full advantage of the opportunity of getting rid of the troublesome relatives in this way. I have noticed more especially of late cases are being sent to the asylum which at one time would not have been sent.’¹⁷¹ This is an intriguing statement. A dearth of patient records – especially those of African and Indian patients – unfortunately makes it difficult to corroborate, however. Nonetheless, it does throw an interesting light on the letter from Lubimba kaTeteleku quoted at the beginning of this chapter.¹⁷² If Hyslop’s observation was accurate, then it is entirely possible that Lubimba kaTeteleku was confined as a lunatic at the behest of his family or of influential connections, and therefore differed from the usual African inmates of the NGA and other colonial asylums, the majority of whom, it has been suggested, were detained because they were a threat to the colonial order.

Unfortunately, we do not know if Lubimba kaTeteleku was ever released from the

¹⁷⁰ *Select Committee, 1913*, pp. 52-53. Evidence of Dr. J. Hyslop, 16 April 1913.

¹⁷¹ *Ibid.*

¹⁷² PAR CNC 211 1915/978: ‘Application of Lubimba ka Teteleku who is in the Asylum, Pietermaritzburg to be released and treated by a Native Doctor’, 28 July 1915.

NGA to consult the 'Native Doctor' that he believed would cure him of his sickness. That some record of the fates of David Morrison Jacobs and Madeline Anderson has survived is probably the consequence of both the greater attention paid by professional psychiatrists to white patients at the time, and to the vagaries of luck that has preserved a single Case-Book. The absence of representative records for the greater number of NGA inmates, as well as the deeply complex problems that arise in attempting to interpret both doctors' notes and patient letters, has restricted the extent to which I have been able to construct a social history of the more than 2,000 patients who were admitted to the formal institutions of insanity in colonial Natal.

The brief analysis of the NGA statistics attempted here illustrates many of the methodological and theoretical problems surrounding the study of asylums and of the institutionalisation of insanity. Overall, it would seem that the insane of Natal in the nineteenth and early twentieth centuries were deemed to be so for reasons which were generally recognised elsewhere – in the Cape, at the metropole, and in other recently-settled colonies. Yet the pattern of admissions was at least partly influenced by more regionally-specific factors, including demographic patterns, political and socio-economic events, as well as the actions and attitudes of influential individuals, such as James Hyslop. Where the NGA and practices in Natal and Zululand differed has become visible to us because of the clear distinctions made in the keeping of records about persons designated as belonging to different racial groups. Ironically, this institutionalised discrimination has preserved a fuller picture of possible aetiologies and forms of mental illness in this region than the Cape records permit.

The social profile given here, however, does little to bring to life the experiences of madness of the majority of the NGA patients, let alone their lives spent at that institution. In the now extensive historiography of the institutionalisation in asylums of those said to be insane, many trenchant criticisms have been made of studies that merely re-inscribe the voicelessness of those who were confined as mad, but for the case of the vast majority of those admitted to the NGA, these statistics are all that remain.

After 1909, however, it becomes more difficult to trace the history of this particular institution. While mental matters were given considerable attention by the new state, the statistics that are reproduced in the reports of the Commissioner of Mentally Disordered and Defective Persons (from the 1920s, Commissioner of Mental Hygiene) combine data from the different institutions around the country, and no patient folders or clinical records for the Pietermaritzburg Mental Hospital or Fort Napier exist. These were destroyed because patient confidentiality became a concern from the late 1920s.¹⁷³ We do know that the discrimination between patients on the basis of race that had begun even before Hyslop's time was continued and institutionally entrenched across South Africa. So, too, did the number of asylum inmates continue to increase: at Pietermaritzburg in 1915 they exceeded 700. Urgent and ambitious plans for the purchase of more grounds, and the construction of more facilities were discussed with Dunston and with the Minister of the Interior. These were, however, slowed down by both the shortages of materials during World War 1 and the objections of residents in the residential suburbs that now encircled the asylum grounds.

By 1923, there were 949 mental patients at the Pietermaritzburg Mental Hospital alone. The specter of 'monster asylums' – in terms of the number of patients – loomed. But South African mental hospitals have been regarded as 'monster asylums' in another sense, too. Influenced by Foucauldian analyses of knowledge-power regimes and justifiably outraged by the neglect, and sometimes abuse, of psychiatric patients – especially those who were black – some studies have stressed the racist and oppressive nature of psychiatry in the twentieth century in supporting state policies of racial segregation. They have also described asylums as 'total institutions' that served merely as custodial and disciplinary facilities that were predicated on a body of racialised science that ascribed 'simpler' forms of insanity, lower intelligence, and a

¹⁷³ B.L. Craig's 'The Role of Records and Record-Keeping in the Development of the Modern Hospital in London, England, and Ontario, Canada, c.1890-c.1940' in *Bulletin of the History of Medicine*, 65 (1991), is a very interesting exploration of the changing technologies and discourses of medical record-keeping.

lack of ‘civilised emotions’ to black inmates.¹⁷⁴ In this view, the asylum – or mental hospital in the twentieth century parlance – has retained a central place as a site of social control in a society that moved, apparently inexorably, towards institutionalised racial segregation.

It has, however, also been suggested that this view is one that exaggerates the significance of asylums, especially in the colonial period. It may also be that to focus attention exclusively on the records of the formal institutions of insanity in this period obscures the broader issues of investigating a history of the experience of and responses to mental illness. To privilege the position of the asylum and its psychiatric professionals limits the extent to which we can investigate the ways in which the madness of those who were not legally certified as insane was understood and managed. In Chapter 6, I shall return to the history of the NGA (by then called the Pietermaritzburg Mental Hospital) in the period between Union and the end of World War 1. The following chapters, however, shift the focus of this study beyond the walls of formal institutions. In so doing, they raise questions about the limits to colonial psychiatry, the centrality of the asylum in the care and control of the insane, and the various paths which people in Natal and Zululand could take in the quest for mental health.

¹⁷⁴ See especially F. Swanson, “Of Unsound Mind”, Chapter 5, ‘Total Institutions: A Colonial Legacy’.

Chapter 3

Witches, Spirits, and Hysteria: the Limits of Colonial Psychiatry

Mr Smith was a specialist in mental diseases. But he did not look special: he seemed like any white man, too ordinary to remember. ‘Sit down, Katie,’ he said: ‘I’ve examined your son. He’s had what we call a nervous breakdown. Perhaps he’s been working too hard. What he needs now is plenty of rest and quiet. No excitement of any kind. Nothing to worry him. His condition is a little like what you call –.’ He hesitated and looked at the Doctor.

‘Like *ufufunyane*,’ the Doctor murmured.

‘But he isn’t a girl!’ Katie had to laugh.

‘I didn’t say that’s what it is,’ the Doctor muttered. ‘I said it’s *like* that. A form of hysteria.’

‘Why don’t you put ammonia under his nose? That’s what we do with the young girls.’

Mr Smith just smiled. ‘Ammonia won’t help Livingstone; only time and rest. Take him back to Adams. Don’t press him. Just let him do whatever he wants to. In a few months he should be all right.’

‘But what if he wants to do something crazy?’

*The Calling of Katie Makanya*¹

Expressions of psychological distress

In her poignant account of the madness of her son, Livingstone, Katie Makanya – a staunch Christian, and ‘interpreter, dispenser and loyal assistant’ to the missionary doctor James McCord for the thirty-five years between 1904 and 1939 – reveals something of the anguish of those whose family members became mentally disturbed. When this conversation took place, some time in the 1930s, Livingstone (who had been named for the explorer and medical missionary) was studying at an agricultural college in Natal. A telegram from the Principal of the school told Katie that her son had tried to run away and, on being caught, had become mute and then so violent that it had taken ‘three men to hold him still’. They had had no choice but to lock him up. When she visited her son,

¹ M. McCord, *The Calling of Katie Makanya* (Cape Town and Johannesburg: David Philip, 1995), Chapter 19 ‘Durban, 1930-1939’, p. 231.

Makanya found him polite – but paranoid, believing that attempts were being made to poison him. Clearly delusional, he gripped his mother’s wrists so strongly that his fingernails dug into her skin. He told her: ‘The people here want to kill me because when the government puts me in charge, they know I’ll give them all the sack.’²

Over the next month, Katie and her husband, Ndeya, cared for Livingstone at their home at Adams Mission outside Amanzimtoti. At first, Ndeya refused to believe that his son was ill, but Katie prevailed upon him to humour Livingstone, keeping him quiet, well-fed and busy with chores. After a few days, however, Livingstone was accusing Ndeya of attempting to kill him by poisoning his food. Soon, he made a similar charge against his aunt, Theresa, believing that she would kill Katie too. Every day thereafter, it seemed, Livingstone named another suspected poisoner, and it was clear that Livingstone’s mental state was not improving.

In the months that followed, Katie and Livingstone, disillusioned with the western doctors’ ability to cure insanity, would explore most, if not all, of the healing options that they could find in Natal at that time. Their search for solace through a cure, or at least the alleviation of the worst of Livingstone’s symptoms, took them first to ‘the church of the faith healers’, who had cured a woman Katie knew of a nervous tic. Then they turned to a Zanzibari healer on the Bluff who frightened Katie as her Christian Indian friends told her that Zanzibaris practised ‘black magic’ (although the ‘educated Hindus’ dismissed them as mere charlatans). Finally, she took a decision that frightened her just as much – to go to a ‘heathen *inyanga*’ who lived ‘beyond Umbumbulu’. Every night, she prayed that Livingstone would be cured. Nothing worked. The faith healers’ service disturbed Livingstone, making him if anything worse. The Zanzibari claimed he had expelled the ‘evil spirit’ from Livingstone’s head by snipping off a lock of his hair and then, whilst muttering indistinct invocations, by tying the lock to a bush outside the courtyard in which he consulted. But this failed to banish the spirit for even as long as the journey

² McCord, *The Calling of Katie Makanya*, p.230. The description of Katie Makanya is taken from the back cover of the book. What follows here is drawn from pp. 230-238.

home to Adams. In deciding to visit the *inyanga*, Katie so departed from her usual disdain for and utter rejection of *izinyangas* and their ‘magic potions’, that she feared to confess it to Ndeya or others lest they think that she too had gone mad. Before she and Livingstone could get to the *inyanga*, however, they were turned away by one of his messengers.

Livingstone became less and less biddable. He would run away from his father’s care and walk eighteen miles through the night to turn up at the doorway of the Berea dispensary in Durban where Katie had returned to work. He told her: ‘No one can harm me. Not even the wizards, because I’m not alone. I have six horse powers in me and I’m strong enough to knock them down.’ Finally, Katie was obliged to bring him back to ‘the Doctor and Mr Smith, and they told her she would have to send him to the insane asylum in Pietermaritzburg.’³ After a stay there of several months, the Superintendent said that Livingstone was much improved and he was released to return home. Sadly, however, his symptoms and violent behaviour – now including smashing and burning possessions and clothing – returned with a vengeance. In a heart-rending passage, Katie Makanya tells how Livingstone also began to turn against her. The family grew afraid of him, and what his madness might lead him to do. And then, without provocation, he physically assaulted his brother: ‘Early the next morning men from the asylum came to take him away.’ Livingstone was eventually moved to an asylum ‘for the incurably insane’ in Bloemfontein. His family never saw him again.

I have recounted the story of Livingstone Makanya at some length because it eloquently illustrates a number of significant issues that I wish to explore further in this and the following chapter. Firstly, a number of different idioms of expression are employed in naming the source of what was apparently generally agreed upon to be a variety of madness: possession by a spirit, named in one instance as *ufufunyane* and in another as an ‘evil spirit’; hysteria; and mental illness. Following from the identification of its source,

³ M. McCord, *The Calling of Katie Makanya*, p. 236.

expert healers prescribed appropriate remedies – prayers and chanting by faith healers, exorcism by the Zanzibari healer, containment in the asylum by the ‘expert in mental diseases.’ The *inyanga* was either frightened by Katie’s association with the influential practitioners of Western missionary biomedicine, or by advance notice of Livingstone’s disturbed state of mind. Had a meeting between the three taken place, the goat that had cost Katie five shillings would most likely have been accepted as part payment, and might have been sacrificed to the *amadhlozi* as a part of the recommended treatment.

Secondly, two of the three sectors of healing of which Leslie Swartz writes – folk and professional – are present in the various attempts that were made to effect a cure. We do not know whether remedies representing the third, or popular, sector were bought, produced or employed by Katie, but they were certainly easily available. Also striking, though not surprising, is the extent of the Makanya family’s attempts to care for Livingstone within their home and within extended family and other social networks. Only when he had become a threat to them, and to himself, did they accede to his removal to the asylum in Pietermaritzburg.

Thirdly, and interestingly, is the association expressed by Katie of the link between a particular form of disturbed behaviour with gender. For Katie Makanya, it was impossible that Livingstone be afflicted with *ufufunyane*, for that was a condition that affected young girls, not boys or men. Furthermore, in his attempts to find a local idiom to explain Livingstone’s condition, James McCord – ‘the Doctor’ – described *ufufunyane* as a kind of hysteria. As noted in Chapter 1, this condition was one that had long been associated with women. While hysteria had largely fallen into disuse in as a diagnostic category in Western psychiatry by the 1930s, this episode shows that it remained in currency, both in popular and in medico-psychiatric parlance, elsewhere. The history of hysteria beyond the West is one that has not yet received great attention, unfortunately, but I would suggest that recent revisionist historiography on the relationships between hysteria, gender and psychological distress that has occupied many scholars from a variety of disciplinary perspectives, may give us insights into the social history of mental illness in Natal and Zululand in the period before 1918.

For while this example is drawn from one African family living in Natal in the years immediately before the outbreak of World War 2, it is, I will argue, one that in many important respects represents the experiences of many of those, white as well as black, who were forced to negotiate, either on their own behalf or for a member of their family, the difficult choices and possibilities that mental illness threw in their paths. In this, the custodial or psychiatric facilities of the Pietermaritzburg Mental Hospital (as the Natal Government Asylum was called from the early twentieth century) were often the last, and certainly not the first, referral. Rather, the search for solace often began beyond the walls of the asylum.

Situated within the three different healing traditions of the peoples of Natal – which can be broadly glossed ‘African’, ‘Indian’ and ‘European’ – succour was sought largely within that paradigm. It is important to emphasize that these were by no means mutually exclusive; nor were they frozen in time. Indeed, the very names (such as *ufufunyane* or *indiki* or hysterical) by which different ailments were called were themselves historically malleable, reflexive of the social conditions and times in which they were forged. Furthermore, *within* each of the therapeutic paradigms there existed a range of options that encompassed Swartz’s ‘sectors’ of healing: There could be religious and faith-based responses to spiritual and mental anguish for whites as there was for many Africans; there could be African quacks and shysters as there were peddlers of bogus cures for nervous strain amongst whites; and, as we have already begun to explore, colonial psychiatric ideas and institutions were becoming influential in the ways that mental illness was conceived and contained by Africans and Indians in Natal before 1918.

What follows demonstrates, however, that the significance of the asylum and its associated understandings of madness were restricted in this period. I focus on the experiences of a small group of women in Zululand, known as the *amandiki*, between 1894 and 1914. These eleven women, aged between fourteen and thirty, were brought before the Resident Magistrate of Eshowe in Zululand in November 1910, and charged

with the crime of witchcraft.⁴ They strongly denied the charge, insisting instead that they were the victims of a new form of spirit possession – called *indiki* – that caused them much physical and mental suffering. But colonial officials were unable to decide whether the *amandiki* were in fact practising witchcraft, were merely fraudsters, or whether they were actually mentally ill – the victims of an 'epidemic' of 'hysterical mania' that was said to have been 'raging' through Zululand since the mid-1890s. While some *amandiki* were released with only a strong warning, others were sentenced to a term of hard labour.

The story of the *amandiki* offers us insights into continuities and changes in the ways that isiZulu-speaking societies perceived both mental illness and healing in this period, as well as into relationships between gender, psychological conflict, hysteria, and changing socio-economic conditions at the time. Indeed, current thinking about the linkages between hysteria, gender and social exclusion opens up the possibility of drawing parallels between the ability of women in the late nineteenth and early twentieth centuries to articulate psychological distress, whether they were in Zululand or in Zurich. It shows, too, that the differing diagnoses for the madness of Livingstone Makanya in the 1930s – spirits, bewitchment, hysteria – drew on models of understanding the origins of psychological suffering that were simultaneously long-established, and of a particular historical juncture. The *ufufunyane* spirits of the 1930s, for instance, were only a recent arrival; other spirits – some associated explicitly with women, others not – had preceded them.

The trial of the *amandiki* also poses something of an alternative view to that put forward by Bob Edgar and Hilary Sapire who, in their powerful telling of the fate of Nontetha Nkwenkwe, seek to demonstrate that by the early 1920s in South Africa 'psychiatric practices were used against Africans perceived to be a danger to the monolithic nature of

⁴ Pietermaritzburg Archives Repository (hereafter PAR), Secretary for Native Affairs (hereafter PAR SNA) I/1/452 4045/1909, Enclosure No.11, 'Copy of Notes of Evidence taken by the Magistrate, Eshowe in Criminal Case Rex vs Nomlenze and Ten Others (Rex 471/1910), Eshowe, 24 November 1910. Including Particulars of Charge Sheet in Summary Case Rex vs Nomlenze and Ten Others'.

white rule.⁵ Nontetha Nkwenkwe was a Xhosa diviner, herbalist, and millenarian prophet in the Eastern Cape, who in the early 1920s, preached 'salvation, ... a synthesis of Christian and Xhosa spirituality and demand[ed] abstinence from alcohol, dances, and other traditional customs', was arrested after encouraging Africans to boycott white churches. She was never formally charged, however, but instead committed to Fort Beaufort Mental Hospital, and, in 1924, transferred to Weskoppies Asylum in Pretoria. Diagnosed by white psychiatrists as 'hysterical', Nontetha was deemed by the Commissioner for Mental Hygiene to be 'a source of disturbance' and 'a danger to the preservation of order'. Nontetha Nkwenkwe died in Weskoppies in 1935.

In their book, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth Century South African Prophet*, Edgar and Sapire contend that, in having Nontetha branded as hysterical and confined in psychiatric hospitals until her death in 1935, the South African state sought 'the imprimatur of expert psychiatric opinion', because, 'combining the authority of "science" and the humanitarian gloss of "medicine", meant that such a decision could be represented in humanitarian rather than custodial terms'. Thus, by the 1920s, South African 'psychiatric institutions and professionals had become inextricably involved'.⁶

There is a strong case to be made for this stance in the tragic experiences of Nontetha Nkwenkwe, but the trial of the *amandiki* demonstrates that, in Natal at least, far from being the handmaiden of the state, up until the eve of World War I, colonial psychiatry and its institutions and practitioners were distant, often irrelevant, to majority of the people in the region. Indeed, colonial confusion about the nature of *indiki* and other

⁵ See review of R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Athens, Ohio and Johannesburg: Ohio University Center for International Studies and Witwatersrand University Press, 1999) by P. Limb, H-Net Book Review, (March, 2000), located at <http://www2.h-net.msu.edu/reviews/showrev.cgi?path=16390953064877>

⁶ R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 2000), pp. 125-126.

spirits, as well as about witchcraft and African healing practices more generally, reflected in part the relative weakness of Western psychiatry as a profession, and in influencing indigenous therapeutic notions of sanity and madness.

Witchcraft or Madness? The ‘*amandiki* nuisance’ of Zululand, 1894-1914

The archival sources concerning the *amandiki* begin in the mid-1890s with a letter from a Norwegian missionary, the Reverend Nils Astrup, stationed close to the border of Zululand, who wrote to Resident Commissioner to alert him of the emergence of a new 'disease'. This disease, called 'Mandike' was said to be extremely 'contagious' and to cause people to:

start up in a rage, declare themselves to be possessed by the ghost of a defunct person, and ask for dogs [sic] flesh or other uncommon kind of food, the person in question menacing that he will kill so-and-so, 'as the body of the spirit who has beset him (or her) was killed in a similar way for a similar reason' if he does not get what he asks for. They sometimes throw themselves in the water and are drowned. The persons thus afflicted will often, it is said, commence to speak in a language thoroughly unknown to them.....

The Natives [of Mozambique and Swaziland] think it to be a possession of evil spirits, and they call their *izinyanga*, and *izangoma* to drive them out by drumming and singing, night and day. The drum is heard for such purpose in the village nearly every night, and the children are attending and singing in a peculiar strain together with the elders through the whole night. I recently have had proofs in Zululand, of native female *Izangoma* (four at a time in one kraal), singing the very melodies, in one night, and attracting the participation of the children.⁷

As Astrup indicated, African people themselves were said to attribute the onset of the 'disease' to a new form of spirit – called *indiki* – possession that had been introduced from 'the North', from regions that are today Mozambique and Swaziland. Those possessed by the *indiki* spirit were later called *indiki* or *amandiki*, even after being 'cured' of the

⁷ PAR SNA I/1/452 4045/1909, Minute Paper 386/'94, 30 November 1894. R2732/94, Copy of letter from the Reverend Nils Astrup, Church of Norway Mission Station, Umtunjamili, to Resident Commissioner, Zululand, dated 17 November 1894. Emphasis in original.

complaint.⁸ The earliest African accounts of the origins of this form of spirit possession told how it was caused by a form of retaliation by 'certain Shangana doctors' who had been the among the victims of a Swazi impi's raid into Gazaland.

Through the magic of these men, a transmigration of their spirits was effected (and that of other victims) into the bodies of the raiders, to the great discomfort of the latter. Much mental and physical suffering ensued... This form of retaliation became a common privilege of every soul whose body had suffered injury, and the number of patients, who were known as 'amandiki' or 'amandawe', increased accordingly. Compensation for the original injury would usually appease the 'spirit'....⁹

Astrup predicted that, 'if not stopped in the beginning, [it] will spread over the whole of Zululand ...'¹⁰ He was correct: *indiki* would spread throughout the region over the next twenty years or so. In some instances, however, its nature would undergo a change. For while initially *indiki* spirits apparently possessed both men and women, the phenomenon became rapidly and almost exclusively associated with women.

In his letter, the missionary had also highlighted the role played by 'native incantators' in 'opening the disease ... through their tricks to get their fee afterwards for curing it'. As the 'indiki nuisance' spread throughout Zululand, several later investigations also drew attention to the influence of 'witchdoctors' and 'the self-interested medicine man' in diagnosing and treating the disease, and in receiving payment for doing so. Even where there was no evidence of this, however, officials and missionaries alike immediately agreed that the *amandiki* were engaging in practices that were closely allied with witchcraft and therefore outlawed under Section 9 of Zululand Proclamation No. II of

⁸ H. Ngubane, *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyuswa-Zulu Thought and Practice* (London: Academic Press, 1977), footnote 1, p.144.

⁹ PAR SNA I/1/452 4045/1909, Minute Paper 386.'94, 30 November 1894. Enclosure No. 3 G, C. G. Jackson, Magistrate, Ndwandwe to District Native Commissioner (DNC), Minute Paper N.D. 8/1910, 'Forwards report on the practice known as "'indiki"', 4 January 1910.

¹⁰ PAR SNA I/1/452 4045/1909, Minute Paper 386.'94, 30 November 1894, Copy of letter from the Reverend Nils Astrup, Church of Norway Mission Station, Umtunjamili, to Resident Commissioner, Zululand, 17 November 1894.

1887.¹¹ This law criminalized both those who were regarded as practising witchcraft *and* those who accused them of doing so, but 'witchcraft' itself was neither described nor defined. There was therefore considerable fluidity and room for interpretation as to what, exactly, constituted 'witchcraft'. And so, while this legislation provided those who sought such an instrument a justification for a punitive reaction to the *indiki* outbreak, it could not provide an answer to colonial ambivalence about the nature of *indiki* possession.

Indeed, in the course of further investigations, uncertainty would continue to be expressed as to whether or not the condition was essentially psychological, medical, or criminal. In the correspondence, the terms used to describe *indiki* reflect confusion as to its nature and origins – and, by implication, the appropriate recourse. Astrup spoke of *indiki* as both 'a disease' and as 'evil'. In twenty years of colonial correspondence concerning the *indiki* epidemic, the terms 'alleged', 'so-called', or 'supposed', disease were used repeatedly. For instance, in 1894, in response to Astrup's letter, the Resident Commissioner issued a Circular ordering the District Surgeons of Zululand to investigate and report on the origins, causes and symptoms of the 'alleged disease'. He also instructed that the legal measures against witchcraft be 'strictly enforced'.¹² In response to the Circular, one or two District Surgeons replied that a few such 'cases' had come to their notice, but that the affliction had proved temporary. The Resident Magistrate (RM) of Nongoma was of the opinion that:

It has occurred to me that the malady may have originated in the excessive use of ardent spirits [i.e. alcohol] by the Natives, along the East Coast, and that those who profess to have been infected by it are simply impostors or so weak-minded as to have fallen victims to a belief in its capability of being communicated from one person to another.¹³

¹¹ Natal Colonial Publications, 6/2/2/1, *Zululand No.II., 1887. Proclamation, Laws and Regulations For the Government of Zululand.*

¹² PAR SNA I/1/452 4045/1909, Minute Paper 386.'94, 30 November 1894. Circular from Resident Commissioner of Zululand to Resident Magistrates Ubombo, Ndwandwe, Hlabisa, Lower Umfolozi and Entonjaneni, 30 November 1894.

¹³ PAR SNA I/1/452 4045/1909, Resident Magistrate, Nongoma to Resident Commissioner for Zululand, 16 December 1894.

James Petrie, District Surgeon at Melmoth, had not encountered any *amandiki* in Zululand, but had been acquainted with the phenomenon whilst resident on the Zanzibar coast. He stated that he believed that:

The subjects of the so called disease are mostly Women and Girls; Boys and men are also affected but not nearly so often.... There is no such disease as Mandike at all; ... it is simply a name for Hysterical feelings and symptoms which are in most cases entirely imaginary, but which may in some cases be associated with real disease of the ordinary types.... These feelings are immensely fostered by the powers of the imagination, by the ignorant sympathy of the relatives &c and by the self interested medicine man.¹⁴

Petrie explained that 'the symptoms generally indicate derangement of the patient's intellect in some way more or less marked. There are however no symptoms peculiar to the disease and the only person who can tell for certain that the patient is afflicted by this disease is the medicine man'. He concluded that the proper enforcement of the 'existing laws against the practise of incantations &c are quite sufficient, if properly enforced to prevent the spread of any such disease through this country....' He noted nonetheless that it 'might be a wise precaution ... to prevent the use of the native drum should its use be spreading in the country.'¹⁵

For the next ten years little or nothing more was heard of the 'amandiki nuisance', but in 1909 a second round of official concern was ignited, sparked once more by missionary concerns. According to the Reverend O. S. Norgaard of the Ulwamba Mission Station in the Lower Umfolozi Division, the 'indiki nuisance' was now prevalent in much of Zululand and there were now specific 'schools' formed to 'initiate pupils'.¹⁶ This time,

¹⁴ PAR SNA I/1/452 4045/1909, Minute Paper ZP NK/R 8/1895, Report of District Surgeon, Melmoth, 12 December 1894.

¹⁵ *Ibid.*

¹⁶ PAR SNA I/1/452 4045/1909, E1176/1910, Enclosure No.1, LU 732/09. From Revd. O S Norgaard, Ulwamba M.S., Biyela, to DNC, Lower Umfolozi, 26 November 1909. Some cases of *indiki* and other forms of possession had been brought to the attention of various RMs in this interim period, and had been dealt with in a variety of ways - stern admonitions, whippings, and, in the case of 'all the girls at Moyeni Mission Station ... [who were said to be] ... suffering from "hysterical fits", having buckets of water thrown over them. The girls soon got over their fits, and

Dick Addison, the District Native Commissioner (DNC), swung into action much more decisively. Within a few weeks of receiving Norgaard's complaint, he referred the matter to the Secretary for Native Affairs (SNA) in Pietermaritzburg. Addison had noted that "Mandiki" ... is gaining ground throughout Zululand and should be stopped at once.' He added that in 'almost every case it is practised as a means of obtaining goats and money from natives. I have also known of cases in which they are consulted as "Izinyanga zokubhula"; as such they were punished under Section 9, Zululand Proclamation 2 of 1887.'¹⁷ The SNA wished to take the matter to the Minister of Law, but needed more details. On 28 December 1909 a series of telegrams to the Resident Magistrates of Zululand were fired off, ordering them to submit reports on the prevalence of *indiki* possession in the areas under their jurisdiction. The majority reported back with admirable speed, but when, by April 1910, the reports from the magistracies of Ubombo and Ingwavuma were still outstanding, Addison pursued them with further telegrams.¹⁸

Once the reports were in, Addison took little time before forwarding them to Pietermaritzburg. In his brief summary of the dozens of pages that had come in by May 1910, Addison identified three damning features of *indiki*. In his view it was a form of 'hysterical mania'; it was 'practised by women, both married and unmarried'; and was 'a fraudulent means of obtaining cattle and money, &c., from the Natives'.¹⁹ He had no hesitation, at this point, in recommending that it be 'put down with a strong hand' and that *indiki* warranted prosecution under the witchcraft legislation.

gave no further trouble.' However, it had not apparently seemed necessary to take these matters above the Magisterial level. See also, Enclosure No.7.'Summary of Magistrates' Replies to S.N.A. Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki.' And, Enclosure No. 3 D, C.C. Foxon, Magistrate of Mtunzini Division to DNC, dated 6 January, 1910.

¹⁷ PAR SNA I/1/452 4045/1909, Minute Paper R1126/1909, From R H Addison, District Native Commissioner, Zululand, to Secretary for Native Affairs, 11 December 1909. 'Izinyanga zokubhula' were diviners, and, as such, outlawed under the Code of 1891.

¹⁸ PAR SNA I/1/452 4045/1909, Minute Paper R1126/1909, Circular DNC No.62/1909, 28 December 1909.

¹⁹ PAR SNA I/1/452 4045/1909, Minute Paper R1128/1909, R H Addison, DNC, to SNA, 15 May 1910.

For James Stuart, then Assistant SNA, there appears to have been some doubt as to whether the actions of the *amandiki* could 'rightly be held to be witchcraft', however, and he referred the matter to the Law Department. Stuart referred to 'The Standard Dictionary', which defined witchcraft as "'The occult practices or powers of witches or wizards especially when regarded as due to dealings with the devil or spirits'". He then expostulated:

The evidence in these papers appears to indicate that the practice is intimately associated with the influence of spirits ... [I]t panders to the worst propensities of the people, notably the unmarried female sex, and so fascinates that, not only are the principal exponents of this form of witchcraft kept from following their normal avocations, but it wields its spell over the circle of their respective relatives, who under a polygamistic system, are sometimes very numerous. They, in their turn, in consequence of the pernicious influence of the 'amandiki' not only fritter away their time, but squander the little wealth they have in satisfying the extortionate demands of those practising the evil arts in question.²⁰

In short, he found that 'steps will have to be taken to correct these superstitious and degrading practices'. Significantly, he added that *indiki* possession was a 'comparatively recent innovation on the habit and customs of the Zulu, and for this reason the older and more experienced section of the population regards it with disfavour if not positive dislike ...' The Resident Magistrate (RM) of Ndwandwe confirmed this, saying: 'The older Natives who regard it with repugnance, would welcome any means by which its spread could be checked'.²¹ From the Ubombo Division, where by 1910 the practice was said to be dying out after being 'most fashionable' among the young women, the RM reported that: 'Kraal-heads do not regard it as seriously as they did when it first appeared, and its professors are officially "discouraged"'.²²

²⁰ PAR SNA I/1/452 4045/1909, Assistant SNA to Secretary, Law Department, 26 May 1910.

²¹ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Minute Paper N.D. 8/1910, Enclosure No. 3 G, C. G. Jackson, Magistrate, Ndwandwe to DNC, 'Forwards report on the practice known as "indiki"', 4 January, 1910. According to Jackson, "ubuNdiki" was 'unknown in Zulu land until after the Zulu War. It is said to have been first started in Swazi land in the time of Mbandeni ...'

²² PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure No. 3 K, 5 April, 1910.

From a number of the magisterial reports it seems that, after the initial outbreak, chiefs had been instructed to quash the practice. Though not very successful in their efforts, they showed little reluctance to do so, and may, in fact, have been the instigators of Norgaard's approach to the DNC. The missionary claimed that he had 'often been asked by Natives, why the Government does not put a stop to this nuisance.'²³ According to A. Boast, Magistrate, Eshowe, during 1909 three of the chiefs in his Division had reported that:

the "amandiki" had started in their wards, and had asked for my advice and assistance ... Two of the Chiefs, viz: – Mgandeni and Sikonyana, asked if they might arrest and send to me any person practicing or pretending to be an "Indiki". I directed the Chiefs to call up their people and warn them that I had authorised them to arrest any person or persons practicing the art, and that I would place them in prison to be examined by the District Surgeon with a view to their being sent to the Asylum. The Chiefs did this and they have since informed me that the threat had the desired effect, and they have heard no more of the practice ...²⁴

It is extremely difficult to know how widespread *indiki* possession actually was. No official figures exist. In 1910, Stuart noted that ' ... although it has not yet made an appearance in Natal, [it] has already assumed extravagant proportions in Zululand'.²⁵ According to the RM of Ndwandwe, "ubuNdiki" had 'spread practically throughout Zululand, and is making headway in Natal',²⁶ and the report from Lower Umfolozi claimed

²³ See Norgaard's letter in PAR SNA I/1/452 4045/1909, Minute Paper E1176/1910, Enclosure No.1, LU 732/09. From Revd. O S Norgaard, Ulwamba M.S., Biyela, to DNC, Lower Umfolozi, 26 November 1909.

²⁴ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure No.3 A (E1572/1909), 1909. Magistrate, Eshowe to D.N.C, Zululand, 29 December 1909.

²⁵ PAR SNA I/1/452 40451909, From Assistant SNA to Secretary, Law Department, 26 May 1910.

²⁶ PAR SNA I/1/452 40451909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure No. 3G. C. G. Jackson, Magistrate Ndwandwe to DNC, Zululand. Minute Paper ND 8/1910. 'Report on the practice known as "indiki".' 4 January 1910.

that ‘... “amandiki” are more or less general everywhere; ... and, as each “indiki” must have 2 or 3 personal attendants, a large number of other persons consequently result.’²⁷

Consulted about the causes of *indiki*, Africans agreed that, like *uthwasa* – the state of spirit possession experienced by those called to the life and role of an *isangoma* (diviner) – *indiki* possession was not induced, and that those afflicted ‘could not help themselves’.²⁸ Instead, the woman began to cry, to beat herself on the chest with her fists. Other symptoms included numbness of limbs and fingers, trembling and twitching of the muscles, a growling or ‘subdued roaring’, an obliviousness of all surroundings.²⁹ This attack would culminate in a fit or with the woman falling into a state of unconsciousness.

The initial explanation for *indiki* had stressed its exogenous nature, as it was said to be due to the ‘spirit of revenge’, the result of possession of men or women by the spirits of foreigners killed in battle or who had died without the customary burial rites being fully performed. By 1910, however, an almost exclusive association of women and *indiki* possession was well established and attested to by both colonial officials and African informants. Furthermore, and in a significant shift of meaning, the possessing *indiki* was now no longer than of an invading alien spirit but was said to be that of a deceased father, brother, or other near male relative.³⁰ While no clear ill-will towards the woman could be

²⁷ PAR SNA I/1/452 40451909, Enclosure 7, ‘Summary of Magistrates’ Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki’. Enclosure J. LU 732/09. Report Magistrate, Lower Umfolozi to DNC, Zululand. 31 January 1910.

²⁸ PAR SNA I/1/452 40451909, Enclosure 7, ‘Summary of Magistrates’ Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki’, Enclosure, 3C, Magistrate, Nkhandla to DNC, Zululand, 31 December 1909.

²⁹ PAR SNA I/1/452 40451909, Enclosure 7, ‘Summary of Magistrates’ Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki’, Enclosure No. 3G. Magistrate Ndwandwe to DNC, Zululand. Minute Paper ND 8/1910. ‘Report on the practice known as “indiki”’, 4 January 1910. In a very full report, Jackson explained that the name “ubuNdiki” ‘is derived from dikiza, which means “to tremble and have muscular twitchings”’.

³⁰ *Ibid.* In some later accounts, after the foreign *indiki* spirit was said to be exorcised from the sufferer, the spirit of a male ancestor was bidden to enter the woman so as to ‘protect [her] from future attacks’. See Edgar and Sapire, *African Apocalypse*, p. 49. My archival sources, however, make no mention of this. Instead, they show the *indiki* as the spirit of a male ancestor.

perceived, she nonetheless sought to have a living male relative perform sacrifices to relieve her of the possession. For one colonial authority at least, this shift in the 'motive power' of *indiki* marked a shift from the desire for revenge to the desire for gain.³¹

Treatment for the woman's condition was received from other *amandiki* in the form of medicines (sometimes administered through the ear), and a specially prepared emetic. What was possibly most disturbing for both homestead chiefs and colonial officials alike was the fact that *amandiki* were beginning to band together in groups of between eight and twenty, who would sometimes 'hang about one kraal for a few days. ... Dancing and making the most horrible rows ... Their noises sometimes last even throughout the night... much to the annoyance of the inmates of the kraal where they happen to be staying.'³² At a gathering of *amandiki*, drums would be beaten, the women would don garments made of red handkerchiefs, and they would begin to dance, this lasting sometimes well into the night. According to Norgaard, in 'many cases, through the wild antics of the dancers, the handkerchiefs fall off, and the ceremony is continued in a nude state.'³³ RM Turnbull of Lower Umfolozi Division was, however, sceptical of Norgaard's claims, pointing out that although the Reverend had informed him that 'such abominable practices take place that he does not like to speak or write about them, [yet] he admits that he has never been present at any such meeting (!)',³⁴

³¹ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure No.3G. Magistrate Ndwandwe to DNC, Zululand. Minute Paper ND 8/1910.

³² PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure 3E, Acting Magistrate Melmoth, Emtonjaneni Division to DNC, Zululand. 4 January 1910.

³³ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure J. LU 732/09. Report Magistrate, Lower Umfolozi to DNC, Zululand. 31 January 1910.

³⁴ *Ibid.* Exclamation in the original.

Either immediately after their first possession or at these 'ceremonies' – the evidence is mixed and contradictory – relatives and homestead heads would be required to present the *amandiki* with gifts and to sacrifice an animal, usually a goat, to drive the possessing spirit away. The slaughtered animal's liver was given to the person who was ill to eat raw. *Amandiki* did not claim the power to divine or to treat other ailments, but they did assert a group identity and exclusivity in treatment. For what colonists saw as exorcism from a cult, and what Africans themselves described as a cure, *amandiki* began to charge a cash fee, ranging from 5/- to £2 to £3. For some Africans and officials they also appear to have developed a menacing and intimidating role, threatening to turn anyone who refused their demands into *amandiki*.

Turnbull was convinced that *indiki* was a form of 'necromancy', spread to a 'gullible public', especially women, through 'hysterical mania' and 'false pretences' by 'mountebank artifices' and 'charlatans'.³⁵ Other RMs referred to the actions of the *amandiki* as a 'separate line in Native doctoring', and those who were afflicted as 'patients'. Nonetheless, the 'disease' was a form of 'mania' with its roots in the power of suggestion, superstition and ignorance.³⁶ Whatever its origins, the RMs were agreed that this was hardly desirable behaviour, least of all by women. Clearly, if they were to be controlled, the practice was to be stopped and an example made. Exacerbated by the description of *indiki* possession as a form of hysteria, however, for some time official responses were marked by confusion as to the consciousness or culpability of the *amandiki*. After studying the reports, the Assistant Secretary of the Law Department, for instance, was unable to commit himself as to whether *amandiki* could be found guilty of witchcraft. Commenting that some of the reports 'seem to indicate that this practice is in many cases not distinguishable from the practice of witchcraft'. He nonetheless insisted that '[I]t would ... depend on the facts in any particular case whether the charge can be

³⁵ *Ibid.*

³⁶ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure 31a, Acting Magistrate, Ingwavuma Division to DNC, Zululand, 18 April 1910.

proved or not.³⁷ A week later Stuart prodded him again, asking if: 'Were those who are in the habit of practising in the way described in these papers charged under [Section 9 of the Zululand Proclamation of 1887] would your Department be prepared to prosecute?'³⁸ Once more, the legal position was restated: 'It is impossible to speak generally with regard to the institution of criminal proceedings. The facts of a specific case should be submitted to the Clerk of the Peace of the District with a request to forward them to the Attorney General for his opinion.'³⁹

Accordingly, following instructions from Stuart, Addison asked his RMs to start looking for *amandiki* in their division so that a 'suitable test case' could be brought to book.⁴⁰ The matter, it should be noted, was no longer deemed to be one for the expertise of the local District Surgeons. Nor was the 1868 Natal Lunacy Act invoked. Instead, rising manfully to their task, the various police divisions of the Native Police sent out search parties in pursuit of *amandiki*. In November 1910, they were successful in bringing eleven women to trial before A Boast, the RM of the Eshowe district of Zululand.

Thus, the (archival) story culminates in late November 1910 with the trial of eleven women for the crime of witchcraft.⁴¹ Yet, in this, the case of 'Rex vs. Nomlenze and Ten Others', the same problem that had vexed other colonial officials, European missionaries, and possibly some African men, ever since the outbreak of this 'epidemic' in the mid-

³⁷ PAR SNA I/1/452 4045/1909, Assistant Secretary, Law Department to Assistant SNA, 8 June 1910.

³⁸ PAR SNA I/1/452 4045/1909, Stuart, for Acting Under Secretary for Native Affairs to Secretary, Law Department, 13 June 1910.

³⁹ PAR SNA I/1/452 4045/1909, Assistant Secretary, Law Department to Acting SNA, 14 June 1910.

⁴⁰ PAR SNA I/1/452 4045/1909, Series of telegrams to the RMs of Zululand over the period 20 June 1910 to 8 September 1910.

⁴¹ PAR SNA I/1/452 4045/1909, Enclosure No.11, 'Copy of Notes of Evidence taken by the Magistrate, Eshowe in Criminal Case Rex vs Nomlenze and Ten Others (Rex 471/1910), Eshowe, 24 November 1910. Including Particulars of Charge Sheet in Summary Case Rex vs Nomlenze and Ten Others'.

1890s continued to be a complicating factor. Were Nomlenze and her co-accused – all women aged between fourteen and thirty – practising witchcraft; or were they simply frauds extorting gifts and sacrifices under false pretences; or were they, in fact, the victims of a form of mental illness? The accused freely admitted to being *amandiki*, but repeatedly denied that they were practising witchcraft. They insisted, instead, that they were the victims of 'a distinct disease over which the patient has no control, until the spirit within [her] is appeased'.⁴² The oldest woman accused, Uzitshukanisile Mafu, listed as 'wife of Masara', for instance, stated: 'I admit that I am an Indiki'. I do not know how it came.' Cross-examined, she reiterated: 'I do not know what it is'. The only other married woman on trial, the twenty-eight year old, Nomdeni Mhlongo, 'wife of Mlanduli', was similarly adamant: 'I have a disease in my body, it is in the form of pains on my shoulders. When I take the medicine it goes away.' All of the women emphasized their feelings of powerlessness, and of illness. Mankonai's testimony underscores the seriousness of the *indiki* possession. She told the court that:

When I first got ill all the medicine men failed to cure me. Then I went out with the spirit of my late uncle to [co-accused] Tukutela who took me to get some medicine which I used to make myself sick. I then returned to my home with Tukutela and my father killed a goat for me because I had recovered from death.⁴³

She insisted that Tukutela had not been paid anything for her help. For the investigating officer, Henry Nevill, the trial revealed clearly the extent to which 'Ubundiki' had 'gained a great hold' on the 'female native population', but he could not identify or

⁴² PAR SNA I/1/452 4045/1909, Enclosure No. 10, Minute Paper E1163/1910. 'Practice of Ubundiki by women and men who congregate for the purpose at a certain place not far from Mr J Louw's Store Eshowe Division', H. Nevill, Sergeant, Native Police to District Officer, Native Police, Eshowe. 29 November 1910.

⁴³ PAR SNA I/1/452 4045/1909, Enclosure No.11, 'Copy of Notes of Evidence taken by the Magistrate, Eshowe in Criminal Case Rex vs Nomlenze and Ten Others (Rex 471/1910), Eshowe, 24 November 1910. Including Particulars of Charge Sheet in Summary Case Rex vs Nomlenze and Ten Others'. Testimony of Mankonai Mhlalose (aged eighteen), daughter of Mzwili, and presumably sister of the fourteen year-old Nonhlanhla Mhlalose.

understand 'what the motive is ... as those that have been brought up appear to have made no monetary gain'⁴⁴ Nor was Boast able to pass judgement.

The case was then referred on to the DNC, from Addison to the Acting Under Secretary for Native Affairs, and then on to the Attorney General himself. Addison now revised his earlier conviction, finding that the acts committed by the *amandiki* did not constitute a crime under the existing legislation. Stuart was inclined to concur.⁴⁵ Thus, officialdom could not decide what form of witchcraft was being practised. Nor could it be determined, exactly, these women were guilty of, and, after being issued with a 'stern warning', the women were released. The ambivalence felt by colonists and lawmakers towards the motivations of the *amandiki* is reflected in this opinion of J M Bird, Attorney General of Natal: 'If these woman [sic] are genuinely subject to a form of hysteria or the like, so that they cannot help themselves, they could not of course be charged criminally....' However, he went on to add:

[P]erhaps this condition may be self-induced, through giving way to superstitious ideas. But in so far as they may be capable of controlling their acts (and many a person is capable of resisting superstitious impulses even though he believes himself he cannot) these practices seem to come very close ... to witchcraft.

The women pretend to have been brought under the influence of a spirit and indulge in practices which cannot, I imagine, but be detrimental not only to their own physical and mental condition, but to that of all who are drawn into their company. In some cases, though apparently not in the present, there may be an element of cheating, people being induced to make presents, but however that may be, if punishment is likely to bring such women to their senses one should be cautious in dismissing the idea that there is anything criminal in such conduct.⁴⁶

⁴⁴ PAR SNA I/1/452 4045/1909, Enclosure No. 10, 'Practice of Ubundiki by women and men who congregate for the purpose at a certain place not far from Mr J Louw's Store Eshowe Division', H. Nevill, Sergeant, Native Police to District Officer, Native Police, Eshowe, 29 November 1910.

⁴⁵ PAR SNA I/1/452 4045/1909, DNC, Zululand to Under PAR SNA 24 December 1910 and Acting Under SNA to Attorney General, 28 December 1910. It seems that James Stuart was Acting SNA at this time: Arthur Shepstone resumed this position in January 1911.

⁴⁶ PAR SNA I/1/452 4045/1909, J.M. Bird, Attorney General, to Acting Under Secretary for Native Affairs. 31 December 1910.

Arthur Shepstone, Acting Under Secretary of Native Affairs from January 1911, was less ambivalent, however, and soon the police search for *amandiki* was on again. In 1911 and 1912, several more women were brought to the Eshowe court and were charged with witchcraft. In each case the verdict was guilty. The sentences ranged from fines of £1 to £2, to three months hard labour.⁴⁷ Whilst the Chief Native Commissioner would later claim that the effect of these sentences had been 'marvellous as 'Ubundiki' lost its devotees in the Division in question'⁴⁸, in January 1914 yet another missionary was complaining to the Magistrate – of Mtunzini this time – that 'ubundiki' was on the increase once more. The hapless official complained that 'I have done all I can to stop it here but it still continues. I do not see how it can be stopped.'⁴⁹ Intriguingly, however, his is the last archival record of the *amandiki*, though all the papers concerned with the phenomenon were gathered together some time in 1914.

⁴⁷ PAR Chief Native Commissioner (hereafter CNC) 157 1914/139, Native Affairs Department. CNC, Natal, to Magistrate, Mtunzini Division, 14 February 1914. Here the CNC refers to a 'second batch' of women who had been brought before the RM of Eshowe. My searches have shown that three or four more trials under the Section 9 of Zululand Proclamation No. II of 1887 were held in this District between 1910 and 1914. Although *indiki* is not specified, it seems likely that the accused - all but two of whom were women - were involved in the same practices as Nomlenze and her co-accused. See Durban Archives Repository, 1/ESH, vol. 1/2/1/1/1/6, Criminal Record Book, 1908-1912. Cases No. 98/1912 Rex vs Zondelia Nxumalo and Nomqamu Ndhlovu, 10 April 1911; No. 287/1911 Rex vs. Nomhosi Ntuli, 30 August 1911; No.29/1912 Rex vs. Simitini Tshandu and Mtani Xulu, 7 February 1912; No. 31/1912 Rex vs. Nkombosi Thandu, Mgainga Sibisi, and Ntoni Ntuli, 9 February 1912. Unfortunately, I have not been able to track down further details of this second 'batch' of women. Nor am I likely to: criminal records from this period have been 'scrutinized', and appear to have been destroyed in their entirety. The reasons for the authorities' new-found firmness of will in sentencing remains therefore unclear.

⁴⁸ PAR CNC 157 1914/139, Native Affairs Department. CNC, Natal, to Magistrate, Mtunzini Division, 14 February 1914.

⁴⁹ PAR CNC 157 1914/139, Native Affairs Department. Minute DD: 1.13/14. C. C. Foxon, Magistrate, Mtunzini Division to CNC, Natal. 27 January 1914.

Healing and Conflict: *Indiki*, spirits and witches

In recent times a variety of interpretations of *indiki* have been put forward by a number of anthropologists, ethnographers, psychologists, and historians. Many of these have been framed in terms of accounts of beliefs surrounding spirit possession. Eager to understand the *amandiki* as a psychological response to the enormous social pressures experienced by African women at this time, explanations have followed a number of related themes. The anthropologist, Harriet Ngubane, sees *indiki* possession as 'closely related to [an] extreme form of depression or nervous breakdown which may be coupled with hysteria and suicidal tendencies'⁵⁰. Patrick Harries explains the practice in Mozambique as the expression of women's 'libidinal and aggressive sentiments' in the face of the extended absence of men on migrant labour contracts.⁵¹ Most recently, Sean Hanretta has suggested that *indiki* may have been part of a nineteenth century process by Zulu women to claim dominance as *izangoma*, or diviners.⁵²

To an extent, these views all cast *indiki* possession in terms of a protest – albeit an unconscious one – by women, and this will be an important issue in my discussion, too. However, I would argue that understanding a form of spirit possession such as that of the *amandiki* of Zululand – that of the social history of mental health in southern Africa in the late nineteenth and early twentieth centuries – enables us to both draw on insights from a variety of disciplinary paradigms, and to resist the separation of mind, body and spirit that is the legacy of Western biomedical models of illness. Furthermore, by widening our frames of reference to situate the *amandiki* within the study of the women and hysteria elsewhere in the world, we are compellingly reminded of the need to pay

⁵⁰ Ngubane, *Body and Mind in Zulu Medicine*, p. 149.

⁵¹ P. Harries, *Work, Culture and Identity: Migrant Labourers in Mozambique and South Africa, c.1860-1910* (Johannesburg: Witwatersrand University Press, 1994), p. 165.

⁵² S. Hanretta, 'Women, Marginality and the Zulu State: Women's Institutions and Power in the Early Nineteenth Century', *Journal of African History*, 39 (1998), pp. 389-415, especially pp. 410-415.

close attention to the particular contexts in which gender shapes both consciousness, and the ability to articulate what today might be termed psychological distress. In this light, *indiki* and other forms of spirit possession can be seen not as madness, but rather as attempts to assuage social and psychological stress that could not be expressed in other ways.

As briefly outlined in Chapter 1, in south-eastern Africa in the late nineteenth and early twentieth centuries, there were various causes of 'disturbance' of the head or body that were also regarded as being forms of insanity. Some originated in natural disturbances; others were the consequence of a failure to perform rituals, especially those that purified the person or which acknowledged ancestors at important times; yet others were the direct result of malicious intent on the part of *abathakathi*, or witches. Treatments varied accordingly – *umkhuhlane* illnesses, or those believed to 'just happen', could be tended to by either *izinyanga* or *izangoma* – and combined medicines and behavioural therapies. For instance, in his *Zulu Medicine and Medicine-Men*, missionary and ethnographer A. T. Bryant was of the opinion that 'native doctors have an inkling of the curative effect of "shock" on certain nervous and muscular diseases'. He goes on to describe how:

A native is reported as 'unable' to move his limbs – perhaps from paralysis of some kind. The doctor orders him to be placed amid a heap of dry faggots completely encircling him, and perhaps a foot or more high, at a foot's distance. The sticks are then set on fire, and the patient, 'unable to move', is compelled to see and feel the nerve-disturbing flames arise on every side around him. Water medicated with *iCimamlilo* and similar herbs is constantly sprinkled by the doctor on the firebrands nearest the patient, so as to control the flames and prevent burning. This sprinkling also further creates an amount of steam about the patient scarcely less dreaded than the fire. At length the fire burns itself out; the sufferer is removed 'much exhausted', but sometimes quite recovered.... [I]n the case of epilepsy the patient was ordered to supplement the medical treatment by plunging, at a certain hour, into a particular pool – everywhere known to be especially infested with crocodiles, and reputedly also with pythons – in one of the rivers in further Zululand. The object of this, it seems to me, could have been nothing other than to cause a vitalising shock to the brain and nerves.⁵³

⁵³ A.T. Bryant, *Zulu Medicine And Medicine-Men* (Cape Town: C. Struik, 1966), pp. 69-70. This book is based on an earlier publication in the *Annals of the Natal Government Museum*, vol. II (1909).

Insanity could also be treated by *'ipungula* or steaming [which] involved enclosing a patient in a large skin, blanket or grass mat while they crouched over a pot of medicines caused to boil by the insertion of red-hot stones. Afterwards the doctor sprinkled the patient with the same water while it was still very hot.'⁵⁴

Medicines (though this term may be misleading as they were not necessarily administered to the 'patient') included animal fats, roots of the *uKhathwa* herb, the *umMbehezi* tree, or the *amaPhofu* bush, or the poisonous bulb of the forest climber *inGcolo* (*Scilla rigidifolia*) boiled in water. Parts of the plants *uBhubhubhu* (*Helinus ovata*), *umHlonishwa* (*Psoralea pinnata*), and the fleshy stalks of *uZililo* (*Stapelia gerradi*), *iLabetheka* (*Hypoxis latifolia*), and *inDawoluthi emnyama* (*Belamcanda punctata*) were used specifically in the treatment of insanity or hysteria.⁵⁵

In researching mental afflictions in Natal and Zululand in the late nineteenth and early twentieth centuries, I have not come upon accounts of illnesses that were said to affect men only.⁵⁶ As with Western conceptions of hysteria and madness, however, some kinds of insanity did take on specifically female associations. For instance, *umhayizo*, or the distressing condition in which young women found themselves after being targeted by love medicines, was caused by the 'throwing' of such charms, usually from a distance, as in the following account: '... a man who tied medicine to a cow's tail to make a girl love him. The cow whisked her tail in the direction of the girl's kraal. The charm flew through the air and smote the maiden's heart, whereupon she became very sick, but capitulated at

⁵⁴ K.E. Flint, 'Negotiating a Hybrid Medical Culture: African Healers in Southeastern Africa from the 1820s to the 1940s' (unpublished PhD dissertation, University of California, Los Angeles, 2001), p. 79; references are to Bryant's *A Zulu-English Dictionary*, p. 517, and his *Zulu Medicine and Medicine Men*, p. 22.

⁵⁵ Bryant, *Zulu Medicine And Medicine-Men*, pp. 86-115.

⁵⁶ Absalom Vilazaki's *Zulu Transformations: A Study of the Dynamics of Social Change* (Pietermaritzburg: University of Natal Press, 1962), pp. 50-51, relates that his research had shown that a young man who failed to secure a lover was 'cursed with a social stigma which, in its effects, is worse than an organic disease. Young men usually break down under its strain and may even get afflicted with *ufufunyane* (hysteria) or behave as if they are mentally deranged.' I shall comment on the plasticity of terms such as *ufufunyane* below.

last and loved him.⁵⁷ Anthropologist Fiona Scorgie has shown that today *umhayizo* can be ameliorated by a number of different healers – Zionist faith healers, self-appointed exorcists, and *izinyanga* – but according to A. T. Bryant, in the nineteenth and early twentieth centuries, *umhayizo* could only be cured by administering, as an antidote, the same plant that had caused the *ihabiya* in the first instance. Since only the man who had 'thrown' the charm in the first instance was aware of its composition, 'he alone [would] be cognisant of the proper remedy'.⁵⁸

The composition of these medicines has long been of interest in Natal. For example, The Collector, compiled in 1911 and 1912 by the Reverend W. Wanger of the Roman Catholic Mission at Mariannhill, with contributions by a number of African commentators, devotes several pages to love charms. Generally, they were combinations of 'all kinds of animal fats, flesh or excrements, plant-roots, and European chemicals and minerals, from load-stone to washing soda.'⁵⁹ Such love charms included *iHlali*, a herb 'whose roots are mixed with the flesh of a kingfisher (*isivuba*)'; '*umDakawendhlovu*: Gall-bladder or soft pellet found in an elephants [sic] gall-bladder, a very strong medicine to attract and charm girls.'⁶⁰ Some ingredients were bought from 'Arab traders' in the towns and were put together to produce 'love medicine of any kind smeared or spotted on the forehead etc., by a young man and supposed to mysteriously draw the girls.'⁶¹ Other

⁵⁷ PAR Accession A4/59, M. G. Fannin (A. Cowles), 'A Love Tragedy' in *Flash Lights into Zulu Homes* [n.d.], pp. 10-12.

⁵⁸ Bryant, *Zulu Medicine*, p.71. See J. Parle and F. Scorgie, 'Bewitching Zulu Women: *Umhayizo*, Gender and Witchcraft in Natal', unpublished paper presented at the African Studies Association conference, Houston, Texas, USA, November 2001, pp.19-20.

⁵⁹ Campbell Collections (hereafter CC), Durban: *The Collector*, Rev. W. Wanger (ed.), Printed as MSS at Mariannhill, No. 1 (June 1911), p.41: 313.

⁶⁰ CC *The Collector*, (April 1911), p. 13: 138, 141, and 144.

⁶¹ CC *The Collector*, (April 1911), p.13: 142 and 145.

concoctions produced *iHabiya*, which was 'used by young men to cause a girl to *hayiza*, i.e. to throw her into fits of shouting hysteria in which she repeatedly cries out *hayi! hayi!* or *hiya! hiya!*' Once the *ihabiya* had ensured the desired result, the man would turn to *ukubetelela* medicines, which fixed' the affections of the girl. According to A. Lassak, writing in *The Collector*, 'Take of the *imBambela* (cuttle-fish), *uManaye* (plant), *uNginakile* (plant), *uZilio* (plant), *amafuta engwe* (leopard's fat) and *uLukuningomile* (plant) each a part and mix with the spittle of any particular girl and your own; place all carefully covered up, beneath a projecting rock in some precipice, and the girl is "fixed" firmly to you against all comers!'⁶²

The *amandiki* were clear about the origins of their suffering, and the methods they employed to rid themselves of the spirits that troubled them represent both ritualized forms of healing and self-administered medications. The role of spirit possession 'cults' has been of central importance to studies of healing around the world for some considerable time.⁶³ Recent Africanist anthropological scholarship has, however, been highly critical of an earlier paradigm that saw spirit possession as an 'idiom of sickness or ... as an index for social conflict or as a means to generate power'.⁶⁴ In this view, 'women's preponderance in possession activities cross-culturally' was explained by 'their

⁶² CC *The Collector*, (April 1911), p.13: 149.

⁶³ Especially influential have been the works of I. M. Lewis, particularly his *Ecstatic Religion: An Anthropological Study of Spirit Possession and Shamanism* (Baltimore, Md: Penguin Books, 1971).

⁶⁴ H. Behrend and U. Luig (eds.). *Spirit Possession, Modernity and Power in Africa* (Oxford: James Currey, 1999), p.xiv.

⁶⁴ See Behrend and Luig, 'Introduction', for an overview of this anthropological shift. Fiona Scorgie has drawn my attention to the many difficulties and dangers of attempting to interpret spirit possession, and I have learnt a great deal from our discussions. The works of Janice Boddy are especially helpful in reviewing these issues. See especially her *Wombs and Alien Spirits: Women, Men, and the Zār Cult in Northern Sudan* (Madison: University of Wisconsin Press, 1989) and 'Spirit Possession Revisited: Beyond Instrumentality', *Annual Review of Anthropology*, 23, (1994), pp. 407-434.

subordinate status in contrast to men, who occupy formal positions of power'.⁶⁵ Such a limited and reductionist understanding of spirit possession can be seen as having strong echoes of a long colonialist tradition that dismissed all talk of spirits as mischievous, if not symptomatic of a widespread psychopathology amongst Africans. Instead, a range of rich ethnographic accounts now demonstrates clearly the enormous diversity of spirit possession on the continent, both in the past and today, that reveals the ever-dynamic phenomena as simultaneously '... more and less than healing, art, entertainment, social critique, profession, fashion and ethnography'.⁶⁶ Rather than a 'safety valve' for the frustrations of the oppressed, spirit possession ceremonies and cults become a space for the creation and assertion of alternative – and powerful – identities and meanings, where gender roles are often redefined, even subverted. Moving the study of the experiences and multiple meanings of spirit possession in present day KwaZulu-Natal beyond the instrumentalism of earlier ethnographies is an exciting project for future scholarship from a variety of disciplines.⁶⁷ To this end, and in order to reflect the very diversity of spirits, it is necessary that such studies heed the call made by Janice Boddy and others that possession is examined 'on its own terms in the societies where it is found'. Particular manifestations must be situated 'in wider historical and social contexts, describing how it acts as a prism through which naturalized constructs (e.g. of person, of gender, or body) are refracted or undone.'⁶⁸ It is with this in mind that I would suggest that both the

⁶⁵ L.A. Sharp, 'The Power of Possession In Northwest Madagascar: Contesting Colonial and National Hegemonies', in Behrend and Luig (eds). *Spirit Possession, Modernity and Power in Africa*, p. 4.

⁶⁶ Behrend and Luig (eds). *Spirit Possession, Modernity and Power in Africa*, pp. xiv-xv. Also quoted by M. Engelke, Review Article 'The Idiom of Spirit: Possession and *Ngoma* in Africa' *African Affairs*, 100 (2001), pp.143-150. This quotation is from p. 144.

⁶⁷ A way is shown in the study of contemporary Hindu goddess worship in Natal that considers how possession by female deities can be an empowering experience for women. See A. Diesel, 'The Veneration of the Goddess as an Empowering Symbol for Both Hindu and Contemporary Feminist Women: With Special Reference to the Worship of the Hindu Amman Goddesses in KwaZulu-Natal', (unpublished Ph.D thesis, University of Natal, Pietermaritzburg, 1998), and 'The Empowering Image of the Divine Mother: a South African Hindu Woman Worshipping the Goddess', *Journal of Contemporary Religion*, 13, 1 (1998), pp. 73-90.

⁶⁸ Boddy, 'Spirit Possession Revisited', p. 408.

specifics of the *amandiki* experience, and the wider context in which they occurred, appear to reinforce the view that some (not necessarily all) forms of spirit possession are an idiom for the expression of anxieties and hostilities towards the strong by the less powerful.

A similar view has been taken in an account of the way in which possession, including *indiki*, cults proliferated in Mozambique in the late 1800s. The historian Patrick Harries writes of these as being 'clearly similar to ... the hysteria epidemics sweeping through much of the industrialized world in the late nineteenth century', and as a 'social conduit for tensions'.⁶⁹ He explains that, throughout this time, gender roles were subject to great change, and strain, as men became drawn into migrant labour. Women were under vastly increased pressure to perform domestic and agricultural labour. Anxiety about cash remittances from absent husbands, the pressures to produce a cash crop to pay taxes and for the purchase of commodities, as well as a variety of environmental and natural hazards and disasters, combined to intensify social and economic strains being experienced by many African women at this time. In addition, for Harries, in the absence of men, women were 'forced into sexual asceticism' and were unable to 'express their powerful libidinal and aggressive sentiments'. The psychological pressures experienced by women were exacerbated as:

concepts of female worth, defined both subjectively and objectively, suffered a relative decline and patriarchal authority was increased, at a time when women were required to shoulder a heavier load within the domestic economy.... [F]eelings of aggression harboured by women had to be suppressed. Women were trapped within a culture that, in a contradictory manner, required both obedience and a commanding strength.⁷⁰

What the *amandiki* of Zululand identified as the cause of their trouble however was not the absence of men, but the presence of male spirits. Furthermore, the view of the aetiology of hysteria in female sexual disturbance and denial is one that may be seen as

⁶⁹ Harries, *Work, Culture and Identity*, pp. 164-166.

⁷⁰ Harries, *Work, Culture and Identity*, pp.164-5.

problematic in a number of respects.⁷¹ Nonetheless, it remains helpful to recognize that, as the very idiom of possession suggests, transformative states allowed women to express some of the thoughts and feelings not admissible either to others, or to their own consciousness.

According to a number of scholars, membership of particular possession cults or 'guilds', 'provided women and disadvantaged males with an alternative political structure that was, at once, a mutual aid group and an arena for individual advancement.'⁷² This was certainly borne out in the situation of female *isangoma*. Ceremonies where the spirit took control of participants also allowed the possessed (woman) to *become* a (male) spirit, who is permitted to speak and act in ways that would, under usual circumstances, earn sanction if not retribution. The *amandiki* often spoke in a deep voice, demanded contributions from relatives, and would occasionally 'strike people "without reprisal"'.⁷³ All these acts and behaviours became possible only because of the acknowledgement by the other actors that it was the *indiki* that was in control. Spirit possession thus could be both a medium of protest, and a means of exercising emotional control, often with the family or homestead. Ultimately, however, while the spirit possession guilds permitted marginalized women some space for expression and a measure of freedom of action,

⁷¹ Not least because, as many studies have shown, men's migrancy often had ambivalent implications, including enhancing economic and sexual autonomy for some African women. See C. Walker (ed.). *Women and Gender in Southern Africa to 1945* (Cape Town: David Philip, 1990), pp. 17-21. Moreover, there have been many critiques, both from within and from outside psychoanalytic theory, of Freud's association between female sexuality and hysteria. A brief account of this vast field can be found in the 'Introduction' to E. Wright (ed.) *Feminism and Psychoanalysis: A Critical Dictionary* (Oxford: Blackwells, 1992). I will consider some recent feminist and social revisionist interpretations of hysteria below. For an introduction to recent thinking on the causes and meanings of hysteria by discourse theorists, psycholinguists, and psychoanalysts, such as Lacan, Cixous, and Kristeva, see E. Ragland-Sullivan, 'Hysteria' in Wright (ed.) *Feminism and Psychoanalysis*, pp. 163-166. She explains that, Lacan, for example, while elaborating on Freud's work, locates the cause of hysteria not within women's sexuality or psyche *per se*, but in questions of gender, identification, and language.

⁷² Edgar and Sapire, *African Apocalypse*, p. 50.

⁷³ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure 3 IA, Acting Magistrate, Ingwavuma to DNC, Zululand, 18 April, 1910.

because they did not overtly challenge the basic structure of society, they could not lead to any significant change in the position of subordinate women.

New forms of spirit possession associated with affliction reflected changing 'cultural expressions and treatments of behavioral and affective disorders'⁷⁴, that were responsive to changing social pressures. They offered a 'means of handling the psychic traumas of a rapidly changing way of life, and ... displayed an eclecticism that reflected widened intellectual and experiential horizons of their participants'.⁷⁵ Relying on Ngubane's 1977 study, most of the explanations for the rapid rise of *indiki* possession stress the role of alien spirits 'invading' Zululand as a result of the rise of labour migrancy from the late nineteenth century. In this guise, the replacement of the intrusive spirit by that of an ancestral male is seen to restore social harmony.⁷⁶ It would seem to me, however, that the mutation in the nature of *indiki* possession – as it became associated not with foreigners and threats to Zulu societies from outside, but almost exclusively with young women and possession by the spirit of an immediate male ancestor – reflected gender and generational conflicts *within* Zulu social formations.

As Leith Mullings has noted in her study of psychological and ritual therapies in Ghana:

in all societies the ability to manipulate healing can be used to reinforce selected social relations, classes, and ideologies.... Therapies may align themselves with the interests of specific classes and groups of a given society, may mediate and reinforce certain ideological elements. They are created within a given social order, but also reproduce that order. An essential issue is which set of values is being transmitted and in whose interests.... What becomes important, particularly in light of the critique of biomedicine and the reevaluation of indigenous therapies, is to trace the way in which psychotherapeutic systems are linked to the structure of a given type of society.⁷⁷

⁷⁴ Edgar and Sapire, *African Apocalypse*, p. 48.

⁷⁵ *Ibid.*

⁷⁶ Edgar and Sapire, *African Apocalypse*, p.49; and, Ngubane, *Body and Mind in Zulu Medicine*, pp. 142-150.

⁷⁷ L. Mullings, *Therapy, Ideology, and Social Change: Mental Health in Urban Ghana* (Berkeley and Los Angeles: University of California Press, 1984), pp. 1 and 3.

Central to the structure of African societies and the homestead mode of production was the control of women's bodies, of their productive and reproductive abilities. As this system, and the politics that it sustained, came under great pressure in the 1800s and 1900s from colonial land invasion, ecological disasters, and overpopulation, women's agricultural and domestic contributions to the homestead economy would become essential for continued survival.⁷⁸ Homesteads and households are not, however, inherently harmonious units. Rather, they are frequently characterized by tension, by conflicting interests, and shifting alliances, that flow around the axes of gender and generations.

Struggles between men and women, and particularly fathers and sons, within family units have only recently become an explicit focus in studies of the links between political culture and protest, and gender and generational conflicts, in Natal and Zululand in the nineteenth and twentieth centuries.⁷⁹ Increasingly, it is being shown that both political and homestead dynamics were being shaped, and disrupted, by struggles over attempts to

⁷⁸ For a review of the literature on the importance of women and gender in southern Africa, see T. V. McClendon, *Genders and Generations Apart: Labor Tenants and Customary Law in Segregation-Era South Africa, 1920s to 1940s* (Portsmouth: Heinemann, 2002). The cornerstone contributions in the South African historiography are B. Bozzoli, 'Marxism, Feminism, and Southern African Studies', *Journal of Southern African Studies*, 9, 2 (1983), pp.127-156, and J. Guy, 'Gender Oppression in Southern Africa's Precapitalist Societies', in Walker (ed.) *Women and Gender in Southern Africa to 1945*.

⁷⁹ See especially, B. Carton, *Blood From Your Children: The Colonial Origins of Generational Conflict in South Africa* (Pietermaritzburg: University of Natal Press, 2000); M. R. Mahoney, 'Between the Zulu King and the Great White Chief: Political Culture in a Natal Chiefdom, 1879-1906' (unpublished Ph.D. dissertation, University of California, Los Angeles, 1998); and McClendon, *Genders and Generations Apart*. M.R. Mahoney and J. Parle, 'An Ambiguous Sexual Revolution? Sexual Change and Intra-generational Conflict in Colonial Natal' (unpublished paper presented at the 'Sex and Secrecy' conference, at the University of the Witwatersrand, hosted by WISER and IASSCS in June 2003, considers sexual violence and power struggles between young women and men. Here it is also tempting to refer to Helen Bradford's inspired feminist re-readings of the prophecies of Nongqawuse that reveal possible instances of incest and sexual abuse that occurred within Xhosa society as patriarchal structures came under increasing pressure. H. Bradford, 'Women, Gender, and Colonialism: Rethinking the History of the British Cape Colony and Its Frontier Zones, c.1806-1870', *Journal of African History*, 27 (1996), pp. 351-370.

maintain – and to contest – patriarchal authority. From the mid-1800s, however, the power and control of male chiefs, elders and homestead heads in Natal and Zululand came under threat from a number of sources. In an uneasy and ambivalent relationship with colonial authorities under the Shepstonian system of indirect rule, African males sought to shore up their wavering influence over male youth, wives, and young women. Younger men asserted their growing independence, especially through seeking paid employment in the urban areas and on the mines at the Rand, while both young men and women found that the colonial legal system afforded them opportunities for challenging patriarchal authority.

Chiefs' and parental control was also challenged through greater freedom of association amongst younger persons, especially at beer drinking ceremonies and gatherings. Indeed, in the testimony recorded at the trial of 'Nomlenze and Ten Others', all of the accused, including the fourteen year-old Nonhlanhla, stated: 'I was at Nhlenhle's kraal, but I did not do anything beyond drink beer. I went home when the sun was going down.'⁸⁰

It is not surprising then, that older people and, in particular, male African homestead heads, were not prepared to observe the usual rituals of appeasement and propitiation that were made in the case of *uthwasa* possession or to accept that *amandiki* should be accorded positions of power and respect.⁸¹ Instead, they were perceived by many Africans, as well as Europeans, as a nuisance. Even as Africans recognised that the women were not practising witchcraft, but were suffering from a form of disease, there was no recognized existing remedy or ritual that succeeded in preventing *indiki* from spreading throughout Zululand. Furthermore, the act of women taking at least some of

⁸⁰ PAR SNA I/1/452 4045/1909, Enclosure No.11, 'Copy of Notes of Evidence taken by the Magistrate, Eshowe in Criminal Case Rex vs Nomlenze and Ten Others (Rex 471/1910), Eshowe, 24 November 1910. Including Particulars of Charge Sheet in Summary Case Rex vs Nomlenze and Ten Others'.

⁸¹ I disagree with Sean Hanretta that *indiki* possession can be seen as synonymous with *uthwasa*. See Hanretta, 'Women, Marginality and the Zulu State', pp.410-415.

the responsibility for healing into their own hands may have been perceived to undermine patriarchal authority. So, too, would the growing popularity of cash payment for cures.

Thus, in the early decades of the twentieth century, African psychological healing systems were in a state of flux. Reflecting the many and severe strains being experienced by indigenous societies, they mirrored some of the causes of those strains, and allowed a limited means of protesting them. Colonial expansion and capitalist encroachment wreaked havoc with existing familial and kinship groupings and undermined 'traditional' – and here I do not wish to imply unchanging or inflexible – methods of relieving individual and social stress. Yet, as 'new afflictions emerged, so too did healers who specialized in their treatment, giving rise to new guilds and cults in town and countryside'.⁸² Not only did the *amandiki* claim exclusive purview over treatment for this particular form of spirit possession, but African herbalists also began to claim expertise in treating forms of madness and possession.⁸³ A significant alternative to possession cults was the solace sought and found through Christianity, particularly for women, in the independent African churches.⁸⁴

What the experiences of the *amandiki* show, however, is that colonial psychiatry had limited influence in this period. Though a number of RMs threatened removal to 'the Asylum', it seems that no *amandiki* were institutionalized under the provisions of the Natal Custody of Lunatics Act of 1868. As we saw in the previous chapter, male African

⁸² Edgar and Sapire, *African Apocalypse*, p.51.

⁸³ *Ibid.* See also C. Burns, 'Louisa Mvemve: A Woman's Advice to the Public on the Cure of Various Diseases', *Kronos: Journal of Cape History*, 23 (1996), pp.108-134, and K.E. Flint, 'Competition, Race and Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century', *Social History of Medicine*, 14, 2 (August 2001), pp.199-221. As Burns and Flint show, African herbalists did not necessarily restrict their cures to Africans only: there was a market for their medicines amongst whites and Indians, too. See also the next chapter of this dissertation.

⁸⁴ I shall return to this point below. For a recent account of African peoples' participation in and shaping of Christianity in this region, see M. R. Mahoney, 'The Millennium Comes to Mapumulo: Popular Christianity in Rural Natal, 1866-1906', *Journal of Southern African Studies*, 25, 3 (September 1999), pp.375-391.

inmates at the Natal Government Asylum had outnumbered whites from the mid-1890s, but the number of African women so institutionalized in the period up to 1910 was always very small. The highest number of 'Native' women – 26 – admitted to the Asylum as 'lunatics' in any one year was in 1907. (In that year, there were 18 'European' and six 'Indian' new women patients, and in all, a total of 177 'new or relapsed' patient admissions, of whom 94 were recorded as being 'Natives'.) In the vast majority of these cases, the cause of their madness was deemed to be 'Unknown'. Where aetiology could be ascribed, it was most commonly said to be the result of pregnancy or parturition. This gendered pattern of colonial asylum populations was not unusual. The reasons for this are complex, and have usually been explained in terms of the greater proximity of African men 'to European worlds through migrant labour, and thus the higher visibility to Europeans of aberrant behaviours'.⁸⁵ It has been suggested that only when African women became 'destitutes and vagrants' because indigenous therapies had failed, or kinship networks were unable to control or care for them, that they commonly came to the attention of the white authorities.⁸⁶ Should, in the opinion of the magistrate, their mental state be in doubt, they could be committed to an asylum.

In the case of the *amandiki*, however, being brought to the attention of state authorities did not lead to their incarceration at the Natal Government Asylum in Pietermaritzburg. Instead, as we have seen, the claim that spirits possessed them was interpreted as witchcraft. As Megan Vaughan has shown, while there was no clearly thought-out policy towards insanity on the part of colonialists, there was nonetheless a general acceptance that all Africans were essentially irrational, and that African belief in witchcraft was

⁸⁵ Edgar and Sapire, *African Apocalypse*, p. 38. This question has been explored by many writers on colonial asylums in Southern Africa. See especially, L. Jackson, 'Gendered Disorder in Colonial Zimbabwe: Case Analyses of African Female Inmates at the Ingutsheni Mental Hospital'. Collected Seminar Papers on The Societies of Southern Africa in the 19th and 20th Centuries, 19, 45 (October 1991 - June 1992), University of London, Institute of Commonwealth Studies.

⁸⁶ Edgar and Sapire, *African Apocalypse*, p. 39.

merely an extension of this. Bryant, for example, believed that 'native witch-doctors are always afflicted [with a] physical or mental affection.'⁸⁷

Vaughan points out that in Nyasaland (as in Natal and Zululand) colonial authorities simultaneously recognized 'witchcraft' as both a source and a cause of mental illness. Yet, 'while the Lunacy Legislation was being enacted in order to bring ... the supposed benefits of European psychiatry, so attempts were also being made to curtail the activities of the "witch"'.⁸⁸ In deciding which cases were to be tried under the witchcraft ordinances, and which were suitable for committal under the Lunacy Legislation, authorities were, to some degree, dependent on the definitions of the society with which they were dealing. Apparently, some relatively more powerful Africans sometimes used appeal to the lunacy laws to have those who had become troublesome, or against whom they bore grudges, presented to the RM as 'insane'.⁸⁹ Magistrate Boast did not consult 'Native Assessors', but the consistent insistence of Magistrates' reports on *indiki*, the testimony of members of the Native Police, and the *amandiki* themselves, that *indiki* possession was a form of disease – and not witchcraft – perhaps carried some weight in the trial of Nomlenze and her co-accused.

As Tim Lane shows, the colonial position on witchcraft was fraught with problems and contradictions. Colonial law conflated the roles of those whose function it was to detect

⁸⁷ Bryant, *Zulu Medicine and Medicine-Men*, p.71. I find it an interesting irony that Bryant, a Catholic priest, could so subsume the mysticism and spiritual dimensions of his own ministry and religion beneath the veil of normality that they disappear in his observations of African healers and diviners. 'Hysteria' of course had a scientific ring to it, though it had been disappearing as a phenomenon and diagnosis in Europe since the late 1800s. More on this below.

⁸⁸ M. Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Period', *Journal of Southern African Studies*, 9, 2 (April 1983), pp. 219 and 234.

⁸⁹ Vaughan, 'Idioms of Madness', p. 237. Of course, a common explanation for the existence of witchcraft practices - both past and present - is that they are another means of channelling social and individual stresses and conflicts, and of bringing a moral economy into being. I do not explore this literature here because all the African participants in this *amandiki* episode denied that witchcraft was being practiced.

witches – including *izinyanga* and *izangoma* – and those who actually perpetrated witchcraft, or *uthakathi*. As Lane comments:

This simple but alarming elision formed the basis of all witchcraft eradication efforts.... The authorities had to take a very narrow reading of the social context.... To go any farther than this, to establish a set of objective criteria – facts! – by which a person was proven to be a witch-doctor would come too closely to having to admit that there existed such a thing as ‘witchcraft’ which these ‘witchdoctors’ either combated or practiced themselves.... It is well known that British colonial law is riddled with mental gymnastics designed to achieve the cultural transformation of the civilizing mission.⁹⁰

What seems particularly unusual in this case is the role that the state took in initiating proceedings against the *amandiki* under the Witchcraft Ordinance. Most witchcraft cases originated from Africans themselves.⁹¹ However, as has been shown elsewhere in southern Africa, because those who made accusations of witchcraft were criminalized, in the view of many African men, colonial courts were seen to favour ‘women and witches’.⁹² Possibly, the *amandiki*'s ‘disease’ was not just a new medicalized metaphor for the expression of mental suffering, but it may also have been a means of escaping official sanctions against those who made witchcraft accusations.

The Natal Code of Native Law of 1891 had recognized the distinction between *izinyanga* and *izangoma*, and provided for the licensing of the former as herbalists or ‘native doctors’. Licensing of *izinyanga* began in Zululand in 1895, and was usually restricted to older men. Women were generally denied licences.⁹³ The association of men with herbalism/healing medicine and of women with sorcery, witchcraft, and spirit possession

⁹⁰ T. Lane, ‘The Bones and the Law: Witchcraft Suppression in Early Twentieth Century Northern Transvaal, 1900-1925’, p. 17. Paper presented at the Joint Berkeley-Stanford Center for African Studies Annual Spring Conference, ‘Southern Africa in Perspective’, 25 April 1998.

⁹¹ Lane, ‘The Bones and the Law’, p. 8.

⁹² A.R. Booth, ‘“European Courts Protect Women and Witches”: Colonial Law Courts as Redistributors of Power in Swaziland, 1920-1950’, *Journal of Southern African Studies*, 18, 2 (June 1992), pp. 253-275.

⁹³ Flint, ‘Competition, Race and Professionalization’, pp. 205-6.

was one that was shared by both Africans and Europeans. Hanretta suggests that it was only in the mid-nineteenth century that this separation of healing functions occurred in Zululand.⁹⁴ While the legal acknowledgement of *izinyanga* possibly rested on the observable similarities between their herbal treatments and biomedicine, it was commonly believed by colonists that *izangoma* were wicked, mentally ill, or both. The form of their mental illness, according to Bryant, was hysteria. Thus, Western traditions that associated women and hysteria, and a failure to understand different forms of African healing therapies, led to the trial of 'Nomlenze and Ten Others' in Eshowe in 1910. However, a court case about witchcraft was complicated by the intrusion of a late nineteenth century medical, psychiatric discourse that, while still emphasizing the links between women and hysteria, also insisted on the inability of the insane to control their actions.

Hysteria proved, therefore, to be a complicating factor in colonial responses to the '*amandiki* nuisance' of 1894 to 1914. In the next section, I would like to show that hysteria may also be used as means of illuminating the actions of the *amandiki*, as well as in placing them in the wider context of women, hysteria, and protest elsewhere in the world.

Madness, hysterical women, and protest

As both description of the *amandiki's* behaviour and as an explanation of its origins, many colonial officials, (including District Surgeons) and missionaries drew on the popular (and medical) concept of the relationship between women and 'hysteria'. As Bryant explained: 'Hysteria is very common among native girls.' He added that '... in the majority of cases it is the result of a mental disorder, and although not necessarily caused by any physical derangement, is often sympathetically aroused, through the nerves, at those times when the sexual functions are most active, as is evidenced by the fact of hysteria occurring so frequently around the menstrual period. The Africans being a

⁹⁴ Hanretta, 'Women, Marginality and the Zulu State', p. 391.

race of strong emotions, both sexually and sentimentally, we should almost expect hysteria to be rife among them.⁹⁵

For the RM of Ndwandwe, C. G. Jackson, 'that the symptoms attendant on the novitiate are simply a form of hysteria there can be little doubt; – and a form well-known to the medical profession in females of civilised communities.'⁹⁶ This reference to female hysteria elsewhere in the world has been picked up by Patrick Harries. In an important – but unfortunately undeveloped – insight, Harries likens 'the etiology of spirit possession in southern Mozambique' to 'accounts of hysteria in Europe'. Quoting Jan Goldstein, Harries goes on to say that hysteria was 'a protest' ... 'made in the flamboyant yet encoded language of the body by women who had so thoroughly accepted [the] value system that they could neither admit their discontent to themselves nor narrow it in the more readily comprehensible language of words.'⁹⁷ Thus, the *amandiki* of Mozambique and of Zululand in the late nineteenth and early twentieth centuries made recourse to the same coded means of expression of conflict and aggression as women in contemporary Europe.

Hysteria has an enormous historiography that has charted its rise and fall as both a phenomenon and as a diagnostic category in the West. Shaking hysteria loose of its close coupling with Freud in the popular imagination, revisionist interpretations come from a number of disciplines, and hysteria is now widely regarded a universal human response to emotional conflict that cannot be expressed freely, perhaps not even consciously. As its foremost social historian, Mark Micale, explains, hysteria is not a single, unified, or

⁹⁵ Bryant, *Zulu Medicine and Medicine-Men*, p. 70.

⁹⁶ PAR SNA I/1/452 4045/1909, Enclosure 7, 'Summary of Magistrates' Replies to SNA Circular No. 53, 1909, & DNC Circular No. 62, 1909: Ndiki', Enclosure No. 3 G, C. G. Jackson, Magistrate, Ndwandwe to DNC, Minute Paper N.D. 8/1910, 'Forwards report on the practice known as "indiki"', 4 January 1910.

⁹⁷ Harries, *Work, Culture and Identity*, p.165. And J. Goldstein, 'The Hysterical Diagnosis and the Politics of Anticlericalism in Late Nineteenth-century France', *Journal of Modern History*, 5, 4 (1982), p.212.

consistent disorder, and its meaning and presentation have changed across time.⁹⁸ In the nineteenth century, for example, hysteria was regarded as an affliction of the body that affected the mind; today this has been reversed, and hysterics are people whose unconscious minds produce symptoms and maladies that appear to be 'real' diseases.⁹⁹

Albeit under different names, and with different manifestations, hysteria appears to exist around the world and in most cultures.¹⁰⁰ Crucially, it is a mimetic disorder, mimicking culturally acceptable expressions of distress. What may be regarded as an acceptable disease in one society may not be in another, and 'symptom pools' – a repertoire of culturally acceptable and recognizable ailments and behaviours – also change over time in response to cultural idioms and social pressures. Those who are subject to feelings of anxiety, distress, and conflict, search for the cause of their dis-ease, ultimately finding answers within the dominant cultural paradigms of illness and healing, whether medical, spiritual, or supernatural (including witchcraft), or in a combination of such frameworks.

In the West, hysteria has increasingly come to be expressed and understood in medical terms. In the nineteenth century, real biological and neurological disorders that resulted from infections, inherited birth defects, alcoholism, and syphilis provided a template for the mimetic hysterical afflictions of limps, paralyses, and aphasia. By 1900, hysteria – now explained in terms of hereditary weaknesses and cultural decay – had reached its zenith in Western Europe and the United States. Soon afterwards, hysterical afflictions appeared to be on the wane. Micale explains that this was because behaviours that had formerly been diagnosed as hysterical were now reclassified as being of organic origin, or

⁹⁸ See M. S. Micale, 'On The "Disappearance of Hysteria": Notes on the Clinical Deconstruction of a Diagnosis', *Isis*, 84 (1993), pp. 496-526; and *Approaching Hysteria* (Princeton: Princeton University Press, 1994); S. L. Gilman, H. King, R. Porter, G.S. Rousseau, and E. Showalter, *Hysteria Beyond Freud* (Berkeley: University of California Press, 1993); and E. Showalter, *Hystories: Hysterical Epidemics and Modern Culture* (London: Picador, 1998).

⁹⁹ This section is drawn largely from Chapter 2 of Showalter's *Hystories*.

¹⁰⁰ See, for example, B-Y Ng, 'Hysteria: A Cross-Cultural Comparison of its Origins and History', *History of Psychiatry*, x (1999), pp.287-301 for a history of hysteria in China.

were explained by the emerging field of psychoanalysis.¹⁰¹ By the 1970s, it was difficult to find a diagnosis of hysteria. In the twentieth century, however, hysteria had not disappeared: instead, symptoms assumed new forms, ones more reflective of the times. In medical and psychiatric discourse they are now cast in the terminology of neurological impairments or as somatization, conversion, or associative identity disorders.¹⁰² They may also be experienced as illnesses that have no clear organic origin, and, in the wider sphere, as social panics that may rapidly assume epidemic proportions. Most recently, Elaine Showalter has engagingly, albeit controversially, argued that hysteria is alive and well in the twenty-first century, and is manifesting itself in new epidemics such as Gulf War and chronic fatigue syndromes, and belief in alien abduction. Whether or not Showalter is accurate on all counts, what is useful for our purposes is the way that she shows how hysterical symptoms acquire their own dynamic and momentum, gathering attention and adherents.

As sketched out in Chapter 1, hysteria has long been associated with women and their supposedly wandering wombs. By the 1800s, however, women's greater propensity for hysterical symptoms and attacks was explained in terms of their nervous systems, which were said to be weaker and more prone to stress and breakdown, particularly during different phases of the reproductive cycle, than those of men. Women's hysterical symptoms could be manifested in convulsive attacks, choking sensations, and random pains. Certain 'races', too, were believed to be more susceptible to hysteria, and Africans, it was theorized, had 'low developed brain-functions'.¹⁰³ And so, in Zululand in the late nineteenth and early twentieth centuries, patriarchal European beliefs about both women and Africans combined to suggest to colonial authorities that hysteria was especially common among African women.

¹⁰¹ Micale, 'On The "Disappearance of Hysteria"', p. 504.

¹⁰² Showalter, *Hystories*, p.17.

¹⁰³ T. D. Greenlees, 'Insanity Among the Natives of South Africa', *Journal of Mental Science*, 41 (January, 1895), p. 72.

For feminist scholars writing in the 1970s and 1980s:

women's hysteria was the consequence of nineteenth century women's lack of a public voice to articulate their economic and sexual oppression, and their symptoms – mutism, paralysis, self-starvation, spasmodic seizures – seemed like bodily metaphors for the silence, immobility, denial of appetite, and hyperfemininity imposed on them by their societies.¹⁰⁴

Strikingly, however, these forms of hysterical protest were not a conscious form of proto-feminism, and were ultimately conservative, serving only to underscore the belief that all women were fundamentally irrational, if not 'mad'.

In showing how the symptoms of African lunatics reflected the realities of power relations in colonial Nigeria, Jonathan Sadowsky has eloquently reminded us that, no matter what the causes of mental illness, 'the specific content of the symptoms retains significance'.¹⁰⁵ He correctly cautions, however, against attempts to establish an uncomplicated relationship between protest, resistance, and the specificities of the 'lunatics' symptoms'. A similar caution needs to be exercised in considering a possible relationship between women's spirit possession cults in Zululand and overt protest of any kind. Nonetheless, it seems to me that the observation that hysteria served as an outlet for *gendered* social conflicts is what is most significant in the case of the *amandiki*. For the latter the local African 'symptom pool' permitted women to express their conflicts through spirit possession, pains in the chest and shoulders, bellowing like a bull, frenzied activity, and uncharacteristically assertive – if not aggressive – behaviour. The form of the possessing spirit, a close male ancestor, was expressed at a time when patriarchy was under threat and women were simultaneously experiencing the possibility of greater autonomy and increased responsibilities.

¹⁰⁴ Showalter, *Hystories*, pp. 54-5.

¹⁰⁵ J. Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley and Los Angeles: University of California Press, 1999), p. 76.

The 'accommodation of patriarchies'¹⁰⁶ that developed in Natal and Zululand ironically offered African women significant, albeit limited, opportunities to exercise independent agency in seeking protection from abusive or unwanted fathers and husbands. Both black and white patriarchs sought to prevent the movement of women from the land to the urban areas. Yet, girls and women could – and did – flee to cities and to mission stations to escape undesirable marriages, and in some cases, they initiated divorce proceedings in colonial courts. It is also through these court records that historians have occasional glimpses of intra-family and homestead dynamics.

By the second decade of the twentieth century, some African women were openly and coherently protesting against oppressive political and economic conditions. Nonetheless, it is unusual to find any testimony at all by African women in Zululand in this period, least of all of the tensions and troubles that beset them within the domestic arena.¹⁰⁷ In this light, the testimony by Nomlenze and her co-accused requires close attention. While a few women did not identify 'their *indiki*', all echoed the words of the twenty-eight year old Nomdeni: 'I have a disease in my body, it is in the form of pains on my shoulders. When I take the medicine it goes away.' Others could name the spirit who caused them pain. For Ungiqondile, aged nineteen, the *indiki* was 'in the form of my late father, Mzwakali'. Tukutela's *indiki* was 'my grandfather, Mjosi', and that of Mankonai, her

¹⁰⁶ The phrase is Jeff Guy's from his 'An Accommodation of Patriarchs: Theophilus Shepstone and the Foundations of the System of Native Administration in Natal', paper presented to the Masculinities in Southern Africa Colloquium, University of Natal, Durban, 2-4 July 1997.

¹⁰⁷ A number of significant texts about the lives of African women do exist - see the discussion by Liz Gunner in her 'Let all the stories be told': *Zulu Woman, Words and Silence*, Afterword to Rebecca Hourwich Reyher, *Zulu Woman: The Life Story of Christina Sibiyi*, with a Historical Introduction by M. Wright and Literary Afterword by E. Gunner (Pietermaritzburg: University of Natal Press, 1999), pp. 199-213. In a co-authored paper with anthropologist Fiona Scorgie on *umhayizo*, I have attempted to explore another instance of the linkages between gender and hysteria in Natal over the past century. We note that it is surely significant that, although women use love medicines today – as they have in the past – to secure the attentions of a suitor, they and the medicines that they have knowledge of possess nothing like the power (often at least implicitly violent) that the love charms employed by young men are said to have. Nor can women induce in men anything like the kinds of loss of control or hysterical behaviours so characteristic of women's experiences of *umhayizo*. See Parle and Scorgie, 'Bewitching Zulu Women'.

‘late uncle’.¹⁰⁸ This is a significantly different aetiology than the possession by restless or invading spirits from beyond Zululand’s borders, and it strongly implies a different cause for this new manifestation of *indiki*, one whose roots lay in more local dynamics and conflicts. We do not know why the same term was used for an apparently new phenomenon. Perhaps the appropriation of a powerful concept such as *indiki* – that had hitherto signified violence, invasion, upheaval, and wrongs that had not been assuaged – tells us something of the strength of that which sought to be expressed through the idiom of painful possession by a close male relative.

What this was must necessarily remain a matter of speculation: both because of the distance of time, and because, if, as feminist scholars have suggested, women in a patriarchal society are denied access to the public domain, and if they are unable to speak out about the pressures and conflicts that they experience, then the search for ‘protest’ (however defined) in public domain activities will be largely frustrated. Furthermore, if women are unable to appeal to anything other than a further patriarchal authority – and if they are unable to express these strains even to themselves – then their expressions of psychological distress in the form of socially-sanctioned outlets, such as *indiki* possession or ‘hysteria’, become significant channels of powerful emotions.

Hysteria posed a particularly thorny problem for law courts, however. The M’Naghten rule, accepted by British and US courts after 1843, freed the defendant from responsibility if she or he could not distinguish right from wrong. However, a problem lay in establishing criminal responsibility in the situation of persons who did appear to be able to make this distinction, but who nonetheless claimed to be *unable* to control their actions.¹⁰⁹ By the mid-nineteenth century, psychiatrists were being recognized as the

¹⁰⁸ PAR SNA vol. I/1/452, 4045/1909: Enclosure No.11, ‘Copy of Notes of Evidence taken by the Magistrate, Eshowe in Criminal Case Rex vs Nomlenze and Ten Others (Rex 471/1910), Eshowe, 24 November 1910. Including Particulars of Charge Sheet in Summary Case Rex vs Nomlenze and Ten Others’.

¹⁰⁹ N. Dain, ‘Psychiatry and Anti-Psychiatry in the United States’ in M. S. Micale and R. Porter (eds). *Discovering The History of Psychiatry* (Oxford: Oxford University Press, 1994), p. 422.

appropriate experts on insanity, though they did not gain this status without considerable reluctance on the part of some judiciaries. Psychiatrists were divided on whether hysterics – those whose madness could not, despite their best efforts, be traced to a specific and localized organic cause – were truly mentally ill. As hysteria increasingly came to assume its modern form, that of somatic expressions of mental conflicts, the questions of suggestibility and culpability became even more complex. The details of the *amandiki* case that came before Resident Magistrate Boast, the SNA, and finally the Attorney General of Natal, reflected these ambiguities. It is notable, however, that no psychiatric opinion appears to have been sought from James Hyslop, Medical Superintendent of the Natal Government Asylum (NGA), who was certainly *persona grata* in colonial circles. Favouring Nomlenze and her co-accused, however, the English legal system had long held that 'in criminal cases where there was no evil intent, there could be no blame and therefore no crime or punishment', and this was the opinion reflected in J. M. Bird's review of the 'Nomlenze' case.

Further insights about the ways in which hysterical panics spread and become epidemics may also help to explain the '*amandiki* nuisance'. Hysterical syndromes develop in defined communities that are undergoing social, political, or economic stresses, and take their shape through interaction with 'social forces such as religious beliefs, political agendas and rumour panics'. They result in mass hysteria 'when, because of panic and fear, people simultaneously contract physical or mental symptoms without any organic cause.'¹¹⁰ Mass hysteria is contagious, spreading from one afflicted person to another, but episodes are usually abrupt and brief. The response and reaction of authorities is crucial, and may further fuel the development of the epidemic. Ironically therefore, through their recognition of *indiki* possession, both African men and colonial authorities may have unwittingly prolonged its existence.

¹¹⁰ Showalter, *Hystories*, pp. 21-22.

The changing nature of hysteria might also help to explain why it was that, after 1912 or so, the epidemic appeared to die down. But *indiki* did not disappear. In the 1950s, the psychologist S. G. Lee was writing about *indiki* after researching fits of 'crying and hysteria' amongst Zulu women in Nqutu in northern Natal.¹¹¹ Harriet Ngubane's study in the 1970s devotes considerable attention to interpreting *indiki* possession in terms of 'psychogenic disorders' that resulted from the socio-economic changes that were due to industrialization and urbanization.¹¹² Yet, reflecting the plasticity and responsiveness of both hysteria and spirit possession, over time *indiki* has acquired new forms of expression and behaviours, and new explanations for its origins. According to one of Lee's informants, for example, the *indiki* had come into Zululand 'after Dinuzulu's return from overseas', and was later revived during the influenza epidemic of 1918, and that of malaria in 1933. Interestingly, she told Lee that '*amandiki* sit like men.'¹¹³

Markedly new forms of spirit possession also emerged. Bryant and Ngubane date the emergence of *ufufunyane* as some time later than that of *indiki*, probably from the late 1920s and 1930s.¹¹⁴ *Ufufunyane* acquired some of the characteristics of *indiki*, but there were many significant differences: *ufufunyane* was believed to be caused by sorcery, and sufferers were said to be 'possessed by a horde of spirits of different racial groups. Usually there may be thousands of Indians or Whites, some hundreds of Sotho or Zulu spirits'. For Ngubane, 'the thousands of spirits of various races that were believed to possess an *ufufunyane* sufferer' and that showed their presence by violent aggression,

¹¹¹ S.G. Lee, 'Spirit Mediumship Among the Zulu' in John Beattie and John Middleton (eds). *Spirit Mediumship and Society in Africa* (London: Routledge and Kegan Paul, 1969), pp. 128-155.

¹¹² Ngubane, *Body and Mind in Zulu Medicine*, p. 144.

¹¹³ Lee, 'Spirit Mediumship', pp. 131 and 133.

¹¹⁴ Ngubane, *Body and Mind in Zulu Medicine*, p.144. Some late twentieth century manifestations of *ufufunyane* among Xhosa-speaking people in the Eastern Cape are discussed by F. S. Edwards, 'Amafufunyana Spirit Possession: A Report on Some Recent Developments', *Religion in Southern Africa*, 5, 2 (July 1984), pp.3-16.

hysteria or threat of suicide, indicated the social disorder which had led to many forms of social deprivation of the indigenous peoples of South Africa. She also notes that 'whereas *indiki* which is not so good is treated with red and white symbols ... *ufufunyane* which is thoroughly bad is treated with black and white medication.'¹¹⁵ *Ufufunyane* possession was not associated with cult membership or with any healing powers. And, as we saw at the start of this chapter, for some people, such as Katie Makhanya, *ufufunyane* was exclusively a female malady. For others, it was associated with demon possession.

Ufufunyane was described in terms of demons as early as the 1920s. In an account of what sounds very much like a form of hysteria, the staunch Christian, Paulina Nomguqo Dlamini recounted:

The sorcerer will, for instance, take used oil from a motor car and add it to his *muthi*. With this he will implant in a person the characteristics of a motor car. A person possessed by these demons will then imitate the movements and noises of a motor car. We observed this phenomenon in the case of one of our church elders, Hemeliyothi Ntenga, when he was treated with *fufunyane* while he had a haemorrhage of the lungs.¹¹⁶

Organized religion offers, of course, another outlet for people's psychological strains and tensions. From the start of mission activity in Zululand, Christianity was more attractive to women and children than it was to men. This may well have been because missions offered a refuge for women who were fleeing from unwanted marriages or from overbearing African patriarchal control.¹¹⁷ By the early 1900s, a variety of forms of Christian worship, including a number of independent African churches, existed in the region. At a time of 'social dislocation, despair, violence, and alcoholism' many Africans were attracted by the promise of salvation.¹¹⁸ Through Christianity, the metaphor of demons

¹¹⁵ Ngubane, *Body and Mind in Zulu Medicine*, pp.144-146.

¹¹⁶ *Paulina Dlamini: Servant of Two Kings*, Compiled by H. Filter; Edited and Translated by S. Bourquin (Durban and Pietermaritzburg: Killie Campbell Africana Library and University of Natal Press, 1986), p. 96.

¹¹⁷ Mahoney, 'The Millennium Comes to Mapumulo', p. 379.

¹¹⁸ Mahoney, 'The Millennium Comes to Mapumulo', p.387.

mixed with older idioms of spirit possession to produce new explanations for social and personal distress and misfortune. Worship and demon exorcism ceremonies, which could be powerfully cathartic experiences, were sometimes characterized by behaviours – such as wailing or physical convulsions – that in other contexts might have been interpreted as hysteria. Thus, by 1914, rather than *indiki* disappearing, the personal and social conflicts that it had given expression, were being channelled in different, though not dissimilar, ways.

Conclusions: the possession of multiple meanings

In concluding this discussion on the *amandiki*, it is noteworthy that *indiki* possession has meant different things to different people at different times. Since the ‘epidemic’ of *indiki* possession from the mid 1890s to the eve of World War I, the spirits have become less precisely identified than those named by the *amandiki* of Zululand. In later times they have once more become random spirits, capable of causing a range of symptoms.¹¹⁹ Sometimes, *indiki* is regarded as overlapping with *ukuthwasa*, sometimes not. Even where their source is unknown, however, *indiki* spirits continue to possess powerful currency in south-eastern Africa today. Discussions about what *indiki* is, what causes it, and what may cure it, reflect a variety of opinions whose diversity is testimony to its complicated and shifting nature, and whose ‘accuracy’ may reflect only one of a variety of meanings across both time and space. A similar observation is made by Leslie Swartz who notes that forms of possession such as *ufufunyane* are used and understood in different ways by different informants. In an insight that can usefully be applied to *indiki*, he comments that: ‘In this context, *amafufunyana* emerges less as a discrete diagnostic entity with attached symptoms than as a construction or explanatory model, which

¹¹⁹ See, for example, Dr I. Friedman, ‘Achieving Partnerships with Traditional Healers/Isangomas’, *Traditional Healers*, 37 (October 1998), located at <http://www.hst.org.za/update/37/policy4.htm>. Friedman draws heavily – as do Edgar and Sapire, and Leslie Swartz in his *Culture and Mental Health: A Southern African View* (Cape Town: Oxford University Press, 1998) – on Ngubane’s 1977 study of the nature of *indiki* possession.

patients use to make sense of their experience. It is a ready-made, socially sanctioned model, by which experiences of inner conflict can be incorporated.’ In other words, possession states which are experienced as a disruptive, harmful and distressing phenomenon, are less a ‘set of symptoms’, than ‘a way of understanding and negotiating illness.’¹²⁰ He adds that the proliferation of multiple meanings of these states can be seen as analogous to the ways that ‘nerves’ and ‘stress’ have been invoked in different times and places. They are also strongly reminiscent of the ways in which hysterical symptoms have both become reinvented and have continued to reflect social and individual tensions and conflicts.

Rather than reflecting a single, constant, meaning, it seems helpful, therefore, to see the actions of the *amandiki* in late nineteenth and early twentieth century Zululand as attempts to achieve a state of mental health in ways that should be seen in the context of existing African healing practices. These were themselves undergoing change as the result of social disruption and conflict, as well as through the processes of eclecticism that characterize all healing systems. In Zululand, homesteads and polities were wracked by gender and generational turmoil, and women had limited outlets for expressions of psychological distress. *Indiki* and other forms of spirit possession, which might also be seen as forms of hysteria, provided a socially acceptable form of articulating personal and wider pressures. They also reflected the tensions within Zulu societies. In contrast to the close association posited between the state and colonial psychiatry in the case of the Xhosa prophet Nontetha Nkwenkwe in the early 1920s, however, colonialist confusion over whether the actions of the Zululand *amandiki* constituted ‘witchcraft’ or ‘hysteria’, reflected important areas of indeterminacy in both Western law and psychiatry.

By the 1930s, at the time of Katie Makanya’s quest for a cure for the insanity that beset her son, Livingstone, and which eventually saw him taken away under restraint, probably

¹²⁰ Swartz, *Culture and Mental Health*, p. 163. A further illustration of this point may be drawn from Rian Malan’s *My Traitor’s Heart* - the subtitle of which is ‘Blood and Bad Dreams: A South African Explores the Madness in His Country, His Tribe, and Himself’ – (London: Vintage, 1990), p.211, where *ufufunyane*, *umhayizo* and *indiki* possession appear to be conflated.

to spend the rest of his life in a mental hospital, descriptions of *ufufunyane* had acquired an association with gender much in the way that *indiki* had two or three decades before. Today, *ufufunyane* is generally understood to cover a range of mental and psychological disturbances associated with ‘stress’, or which are not easily explained in terms of any particularly identifiable cause.¹²¹ The search for the alleviation of suffering from such causes still reflects the plurality of options that were open to Katie Makanya, however. Generally speaking, mental hospitals and professional psychiatric treatments for mental illness have not been a first option, but, for all but a few, have remained a last resort, after other strategies to contain or cure distressing and destructive states of mind have failed. Certainly, and as the next chapter will show, in the period before World War 1 – if not beyond – this was as true for whites in this region as it was for Africans and Indians.

¹²¹ See the article ‘Smothered screams in “tranquil” villages’, *Mail and Guardian*, 5 November 2003. The author of the article, L. Kriel, quotes Professor Dan Mkize, Head of the Nelson R. Mandela School of Medicine, as saying: ‘The *amafufunyani* [screaming] syndrome describes a grab-bag of symptoms covering everything from depression to panic disorders through schizophrenia to epilepsy ...’

Chapter 4

In Their Own Hands: The Search for Solace Beyond the Asylum Walls

July 12 1907, Lorats Station
Lindley Dist
O.R.C.

To the Medical Superintendent, PM Burg.
Dear Sir,

I beg to enclose cheque £4.7.3 which include 0/7 balance owed on June account.

Please address your letters here and not Stanger. I shall be pleased to hear from you as soon as you are in the position to give me your Candid Opinion about my little daughter. She has seen nearly every doctor in Natal, and it is surprising how much they differ in their opinion and treatment. The child promised well until the day she was vaccinated. The doctor who vaccinated her alluded to me he was wrong in vaccinating her at the time she was cutting her eye teeth and that she had had a nervous shock but would recover in time.

Her arm was swollen from the fingers to the shoulder. She then nearly died of convulsions and was not expected by the doctor to live through it.

Later on fits periodically occurred sometimes over three hours in them. Trench's Epileptic Medicine completely checked and stopped them for two years and the year after the treatment these fits although not severe appear to be returning. She is constipated after taking Treats which she swallow in large lumps whenever she gets the opportunity.

Within the last year or so the shape of her mouth appears to be protruding.

The servant girl may have let her fall on the spinal core as she had the habit of carrying the child on her back.

She is very gentle and kind to very small children, is no trouble when kept under the same person and influence, dislikes strangers. On neither side of her family can we trace a similar affliction. She lost her mother when she was about eighteen months old. You have my full permission to try any experiment on her.

The doctor stated it was owing to a certain part of her throat and gave her some extract from the throat of a goat to cause an artificial growth to take the part of the natural one. We had to stop this medicine as she began to grunt like a goat and her temper and fits were not improved. Another doctor said the moisture from the throat had been disconnected from the brain. A third doctor said it was a clot of blood in the brain.

However I would be glad to receive your opinion when I pass through PM Burg and will call and see you, but hope to hear from you before then
I remain, Yours faithfully

W.M. Tollner Jnr¹

¹ Natal Government Asylum (NGA) (European) Patient Case-Book XI, p.689. Ida Elsie Tollner, Admission number, 2281. Letter pinned to p. 690 from W. M. Tollner to Medical Superintendent, Pietermaritzburg, 12 July 1907.

The search for solace

At the beginning of the twentieth century, when W.M. Tollner was searching throughout Natal for a successful treatment for his twelve-year old daughter, Ida Elsie, western psychiatry was, arguably, at its nadir. The overcrowding of asylums had put paid to the therapeutic benefits of moral management, and there had been few, if any, significant breakthroughs in the curative capabilities of asylum doctors.² In general, psychiatrists too – whether in the United States, Britain, or in the Cape – did not enjoy great respect among their medical peers.³ In Natal, the prestige and influential connections of James Hyslop preserved something an aura of modern scientific progress and practice, and the Natal Government Asylum (NGA) had become something of a showpiece for those who wished to promote the colony. Nonetheless, as noted in Chapter 2, Hyslop himself often lamented the suspicion with which the asylum was regarded, and was of the firm opinion that if only the mentally ill sought treatment at an asylum earlier, then they would have a greater chance of recovery. In 1913 he told the Select Committee on the Treatment of Lunatics that ‘Unfortunately it is a fact that most people will not yet regard mental disease in the same light as they do bodily disease. They are, however, becoming more educated in the matter.’⁴ On being questioned as to whether he would favour the concentration of different ‘classes’ of patients in specialist facilities around the country, Hyslop responded positively, mentioning in particular the ‘Institute at Grahamstown for imbecile children.’

² E. Shorter, *A History of Psychiatry: A History of Psychiatry from the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p.66 and 190.

³ S. Marks, ‘“Every Facility That Modern Science and Enlightened Humanity Have Devised”: Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910’ in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), p. 283.

⁴ SC. 14-’13, *Report of the Select Committee on Treatment of Lunatics*, May 1913 (Cape Town: Cape Times Limited, Government Printers, 1913), p. 44. Evidence of Dr. J. Hyslop, 16 April 1913.

Ironically, and sadly, however, the stigma of association with mental disability is one that, some theorists have suggested, increased rather than diminished with the increasing provision of institutional care in the nineteenth and early twentieth centuries as it resulted in a ‘distancing of idiots and imbeciles from the community.’⁵ Moreover, in southern Africa, as elsewhere, the increased professional attention given to mental deficiency in the early decades of the twentieth century accompanied growing fears of criminality, racial degeneration, and apparent threats posed to social and racial orders by the ‘feeble-minded’. As has been shown by scholars such as Linda Chisholm and Saul Dubow, in these concerns became directly linked to eugenic programmes that were strongly backed by the recommendations of some of South Africa’s psychiatric profession, most notably Dr J. T. Dunston.⁶

Yet, as the letter that opens this chapter shows, in the late nineteenth and early twentieth centuries not all families were quick to send their mentally afflicted children, or other relatives, to the asylum. Ida Elsie Tollner was admitted to the NGA in May or June 1907, and was still a patient there in 1919, when the extant records end. She was described as ‘ruddy and healthy’, without delusions ‘except those of a child’. Her diagnosis – of ‘imbecility’ – was clearly stated in her patient notes, but her father’s letter to the Medical Superintendent of the NGA drew attention to the ‘surprising’ variety of opinions he’d been given by medical doctors.⁷ It also shows that a range of different treatments had been attempted in the years before he had her committed as a patient. Some of the

⁵ A. Digby, ‘Contexts and Perspectives’, in A. Digby and D. Wright (eds.) *From Idiocy to Mental Deficiency: Historical Perspectives on People with Learning Disabilities* (London: Routledge, 1996), p.2.

⁶ *Ibid.* See also S. Dubow, *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995), Chapter 5, esp. pp. 147-160; and L. Chisholm, ‘Reformatories and Industrial Schools in South Africa: A Study in Class, Colour and Gender, 1882-1939 (PhD dissertation, University of the Witwatersrand, 1989).

⁷ NGA, (European) Patient Case-Book XI, p. 689. Ida Elsie Tollner, Admission number 2281.

recommended treatments seem, today, to be most unlikely: the extract of the throat of a goat rings more of folk remedy than it does of biomedicine, but Tollner seems to have had little hesitancy about giving these details, and it was only when all else had failed that he took his daughter to the NGA in the hope that some other option – even untried and experimental – might succeed.

The story of Ida Elsie Tollner, in as much as we know it, serves as one further illustration of the limits to the efficacy and reach of western psychiatry in the nineteenth and early twentieth centuries. As for Katie and Livingstone Makanya, psychiatry and its doctors and institutions, represented neither the most immediate nor necessarily the most successful option in a search for solace. Instead, a variety of therapeutic – and custodial – alternatives for the ‘care, treatment and control’ of those whose lives were affected by insanity or ‘mental deficiency’ were usually explored before the process of committal as a mental patient was initiated. In writings on the history of healing in this region, most scholars have focused on the most formalized practitioners that existed in Natal and Zululand at this time – professional healers and caretakers such as asylum doctors, and ‘folk healers’ who, through specialized training as *izinyanga* or *izangoma*, were regarded by themselves and, to a large extent, their peers, as being specially fitted for the task of ministering to those unsound of mind. Yet, in many instances, as for Elsie Ida Tollner, approaches to such healers or caretakers came as the culmination of months, sometimes years, of attempts to contain – if not cure – behaviours and beliefs that could become increasingly disturbing for both those who experienced them subjectively, and for the families, employers or authorities with whom they came into contact. Only as a last resort was a mentally disturbed person removed to the realm of professional treatment.

This chapter explores – in broad outline – some of the steps that preceded, and strategies employed in avoiding or delaying, such a move. It suggests that even after the opening of the NGA in the early 1880s and the expansion of its facilities over the following decades,

what Lynette Jackson has referred to as ‘the paths to the asylum’⁸ were seldom straight or, even once followed, impossible of retracing. Rather, committal to the NGA represented only one option amongst many. Before this step – which carried the weight of social stigma for many – was taken, responses to mental disorder could include seclusion within the home, care and restraint by relatives or within the wider community, self-administered remedies (sometimes ordered through the mail), semi-professional doctoring, private nursing, and consultations with a panoply of healers that ran the gamut from hypnotists and naturopaths to ‘mental scientists’ and spiritual healers. Another alternative, where the affected person was deemed to be harmless, or where there was simply no family or welfare safety net, was simple abandonment. All of these will be touched on in this chapter, though a fuller history of medical pluralism – especially amongst the region’s white and Indian inhabitants – awaits its historian.

My sources for this section are drawn from official government documents about the state’s response to the mentally ill whose illness was brought into the public domain, as well as state reactions to the burgeoning number of self-appointed ‘healers of the mind’ that were practising at this time. Another important source is the archived ‘Reception Orders’ that, following the Mental Disorders Act of 1916, explicitly document the grounds upon which applications were made to have a person declared ‘mentally disordered or defective’.⁹ Details noted in this remarkable set of documents show that, by

⁸ L. Jackson, ‘Gendered Disorder in Colonial Zimbabwe: Case Analyses of African Female Inmates at the Ingutsheni Mental Hospital’. Collected Seminar Papers on The Societies of Southern Africa in the 19th and 20th Centuries, 19, 45 (October 1991 - June 1992), University of London, Institute of Commonwealth Studies.

⁹ Systematic documentation pertaining to the medical and legal grounds for the admission of mental patients after the passage of the Mental Disorders Act of 1916 has been preserved at the Pietermaritzburg Archives Repository, in the Registrar of the Supreme Court collection. These ‘Reception Orders’ were also backdated to include persons present at the NGA in November 1916, when the Act was passed. See S. Swartz, ‘Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920’ (PhD dissertation, University of Cape Town, 1996), esp. Chapter 4, ‘The Official Certificates and Forms: Categories of Lunacy Administration in the Cape’, for a discourse analysis of the Summary Reception and Reception Orders required by law (in Natal after 1916).

World War 1, although Natal had the highest ratio of white patients to ‘general population’ in the Union,¹⁰ even for whites, prior to (and sometimes after) admission to the Pietermaritzburg Mental Hospital (as the NGA was now known) much management of the mad occurred within the home, or through an extended network of relatives, private boarding houses, nursing homes and sanatoria, public hospitals and, in the case of dangerous or destructive persons, in gaols.

For those who were prepared to accept and could afford them – usually white, middle class Natalians – such resources had multiplied in the wake of increasing urbanization and the commercialization of nursing care. Generally-speaking, there were probably fewer such options for Africans and Indians within the province, but the expanding road, rail and postal infrastructure in South Africa also created new opportunities for healing entrepreneurs of all kinds, including African and Indian purveyors of cures, as well as bringing perhaps a greater range of direct choice for consumers. During the first two decades of the twentieth century, however, biomedical professionals – including psychiatrists – sought to narrow these parallel paths to mental health, bringing about a regulation of the facilities and practitioners that were legally permitted. I turn to this process, and its significance for the history of mental illness and mental health more fully in the final chapter of this thesis.

Many of the following accounts, drawn from the ‘Reception Orders’ preserved in the records of the Registrar of the Supreme Court at Pietermaritzburg, focus on those individuals admitted to the NGA between November 1916 and January 1917. To undertake a detailed analysis of the hundreds of admissions over the years 1917 and 1918 would be a mammoth undertaking. These two-dozen or so that I have touched on here

¹⁰ National Archives Repository, Pretoria (NAR), Prime Minister’s Office (hereafter PM) 1/1/322 184/2/1913, ‘Public Health: Extension of Lunatic and Leper Asylums’, Memorandum from Dr. J.T. Dunston and Mr. P. Eagle to Acting Secretary for the Interior, 22 December 1912, p. 8.

seem, however, to reflect the point I wish to make here – that families and sometimes authorities sought alternatives to immediate committal, but that committal to an asylum followed more quickly for the more marginalized of Natal's subjects.

A word of caution, however: while the 'Reception Orders' do offer us fascinating glimpses into the social history of the quest for mental health after 1916, they remain of limited utility for the historian. This is for two main reasons: firstly, as with doctors' records (see Chapter 2), they represent a formulaic translation of the ambiguous and often conflicting presentation of chaotic behaviours and experiences into a coherent and self-justifying legalistic discourse intended to reinforce the authority of magistrates, judges and psychiatrists. They are not transparent windows on the past. However, my concern – unlike Sally Swartz, who has also analysed the Reception Orders of patients in the Valkenberg series – is less with the ways that the documentation framed patients in terms of a psychopathological discourse and thus enhanced the power of psychiatrists, but with reading between the lines of the certificates to glimpse the manoeuvres that preceded the point of apprehension and certification.

Perhaps more significantly, for my exploration of the quest for mental health as well as institutionally-recognized mental illness, is that, since the Reception Orders are records that chart eventual committals, they do not testify to the doubtless existence of the many who were successfully treated outside the walls of the asylum, or who spontaneously recovered before they got there, or whose suffering was borne in private. Nor do they tell us about those who were inadvertently or forcibly hidden from public view, although they do point to the number of those whose suffering led them to seek its resolution through suicide. And unfortunately, they do not reveal much about the ubiquitous, but scarcely visible to the historical record, practices of daily and propitiatory healing rituals, prayers, supplications to deities, sacrifices, friendships, support structures, and personal strategies for survival that form the heart of the negotiation of relief from mental illness: such a fascinating and important history remains to be investigated.

Care in the community

Given the relatively small numbers of persons committed to asylums in South Africa by World War I,¹¹ the enduring vitality of African and Indian forms of healing throughout the twentieth century, and the continued existence of popular and faith-based sources of solace for all peoples, questions can be raised about the emphasis given by scholars to the place of the asylum and the profession of psychiatry in the nineteenth and early twentieth centuries, especially in this region. Indeed, recent historical writing about the role of ‘care in the community’ in the management of madness in Britain and beyond has de-centered the asylum as the primary locale of care and control for the mentally ill both in the nineteenth and the twentieth centuries. In his comprehensive history of insanity in South Carolina from the 1820s to 1920, for instance, Peter McCandless, recounts how the opening of the state Lunatic Asylum in 1828 had ‘little immediate impact on the circumstances of most of the insane ... Distrust of asylums, reluctance to part from a loved one, fear of exposing a family disgrace, inability or unwillingness to bear the expense, the advice of physicians – all kept down asylum admissions.’¹² Similarly, historians Peter Bartlett and David Wright have recently explained:

¹¹ The census of 1911 recorded a total of 7,485 registered ‘insane or imbecile’ persons in the Union of South Africa. Of these, 4,484 were ‘Coloured and Native insane’ and the remaining 3,001 were ‘whites’. However, the total number of such persons accommodated in Mental Hospitals was only 2,314; the remainder, presumably, being cared for, or detained, in public hospitals and gaols, as well as in private homes and nursing facilities. See NAR PM, 1/1/322 184/2/1913. ‘Public Health: Extension of Lunatic and Leper Asylums’, Memorandum from Dr. J.T. Dunston to Secretary for the Interior, 18 February 1913. According to the Union Government – UG ‘31, *Report of the Commissioner of Mentally Disordered and Defective Persons for the Union of South Africa* (Pretoria: Government Printers, 1920), p. 32 - on 31 December 1918, there were 5,421 patients in South African Mental Hospitals. Of these, Pietermaritzburg had 797 patients (355 ‘European’; 294 ‘Native’; 31 ‘Coloured’; and 117 ‘Asiatic’). At the same date, in the Union, 66 persons were detained in ‘In Licensed Houses and Single Care’. This was down from the 1917 figure of 70, but excluded ‘curatory cases’, which were ‘cases placed under curatorship by order of Court other than under provisions of the Mental Disorders Act. In 1918, there were 46 such persons (29 males, 17 females – all ‘European’).

¹² P. McCandless, *Moonlight, Magnolias and Madness: Insanity in South Carolina from the Colonial Period to the Progressive Era* (Chapel Hill and London: University of North Carolina Press, 1996), Part 3: ‘Beyond the Asylum, 1828-1915’. The quotation is from pp.144-145.

(d)uring the so-called ‘asylum era’ ... care outside the walls of the asylum was ... a reality, not only for those suffering from madness who were never admitted at all, but also for those patients who were confined in mental hospitals only for short periods of their illness ... (T)he asylum, though increasingly important in the range of options open to communities did not *replace* the family as the central locus of care of the insane. Rather, the household remained an important locus of care for the insane, and families maintained a central role in the decisions over treatment and supervision. Furthermore, there existed no simple inverse relationship between asylum and community provision since the definition and conceptualisation of ‘asylum’, ‘community’, ‘care’, and, for that matter, ‘insanity’, varied both over time and between regions.¹³

They show convincingly that the family – or an extended network – remained the primary ‘locus of care’ before the admission of a family member to an asylum or to some other curative or custodial facility, but that even following the decision that committal was necessary or desirable, ‘... the family was active in the pattern of confinement. ... Rather than passive recipients of state support [or intervention, one might add] the family is seen as a unit which negotiated with authorities over the conditions and locus of care, often from a position of power’.¹⁴

Families often willingly bore the initial costs of caring for the insane in their midst, as well as initiating the process of exploring therapeutic or welfare alternatives. It was also not infrequent for families to petition for the release of loved ones from asylums and to undertake to care for them thereafter. Of course, it could also be families that kept mentally disturbed relatives locked up, exploited as menial domestic workers, and cruelly treated. For Natal and Zululand, evidence of such stories is hard to come by, but can occasionally be glimpsed in the archival records.¹⁵ Sometimes, it was the family that

¹³ P. Bartlett and D. Wright, ‘Community Care and its Antecedents’, in P. Bartlett and D. Wright (eds.) *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London and New Brunswick, NJ: The Athlone Press, 1999), pp. 1-19. This quotation is excerpted from pp.3-5.

¹⁴ Bartlett and Wright (eds), *Outside the Walls of the Asylum*, p. 8.

sought to have troublesome and volatile charges confined to gaols or public hospitals, but more often than not, it was the *absence* of a family or other forms of social support that led to the visibility to the state of a mentally afflicted person. This chapter underscores the importance of recognizing the continued significance of ‘care in the community’ for the insane, and in so doing to restore a measure of agency to those who were often most directly involved in the process of the management of madness.

Ironically, one strategy employed by families buckling under the stress of catering to the needs of a desperately disturbed, but emotionally and economically valued, relative was to send them away. Before the opening of the NGA, this may have been even more common for Natal’s middle classes than it was in later decades, though the social stigma of confinement was enduring. In 1868 – the same year that the Natal Custody of Lunatics Law was passed – and on the advice of his ‘medical attendant who considers him to require rest and change’, the Auditor of the Colony of Natal, Mr J. Symonds, took six months leave ‘to enable him to proceed to England for the benefit of his health, which he states has suffered from the great pressure of the work of his office’.¹⁶ Just over a month later, W.A. Maclean, the Clerk to the Resident Magistrate of Alfred County was also granted six months leave of absence, on half-pay, ‘under very peculiar circumstances.’¹⁷ Lieutenant Governor Robert Keate reported that ‘Mr. Maclean has fallen into a strange state of mental agitation. In fact I am aware that a short time ago he attempted self-destruction.’ Mclean was obliged to attend a sitting of the Circuit Court in

¹⁵ Writing of his experiences in Zululand in the 1950s, Anthony Barker is less equivocal and describes how, in the absence of adequate facilities or curative options, common it was for Africans with mental or psychiatric problems to be tied up with ‘leather thongs’. Anthony Barker, *Giving and Receiving: An Adventure in African Medical Service* (London: Readers’ Union/The Faith Press, 1961), Chapter 11 ‘Magic and Mental Health’, esp. pp. 117-118.

¹⁶ PAR Government House (hereafter GH) 1216, Copies of Despatches to Secretary of State for the Colonies, 1867-1869, No. 68, p.180. Lieutenant Governor R. Keate to Secretary of State for Colonies, 29 July 1868.

¹⁷ PAR GH 1216, Copies of Despatches to Secretary of State for the Colonies, 1867-1869, No. 81, pp. 241-242. Lieutenant Governor R. Keate to Secretary of State for Colonies, 1 September 1868.

Durban, where the Attorney General came across him and judged him 'quite incapacitated from performing the duties of his office'. Keate reported that, the "'Natal Queen" being on the point of sailing from Durban', Maclean had decided to board her 'for a sea voyage'. Whether or not this was of Maclean's own volition or under the recommendation of his superiors is not clear, but, Keate noted, that he trusted that the voyage would restore Maclean 'to his former health.'¹⁸

That same year, Keate's patience had also been sorely tried by the quixotic Thomas Phipson. Sheriff of Natal between 1853 and 1861, Phipson later held various government offices, and was a journalist, father, failed farmer, essayist, stinging critic of the government, and, according to his biographer, a man who was possibly an alcoholic, and very probably a sufferer of 'manic-depressive disorder'.¹⁹ Phipson's *Memorial* on liberty, 'Vicious Precedent', dated 13 April 1868 and sent to Keate, was adjudged 'disrespectful of the government' by the Secretary of State for the Colonies, but Keate was inclined to temper his reactions after learning that 'Mr. Phipson had suffered at one time from a mental malady, and on this account I was inclined to visit his failings with leniency and to attribute them to a cause for which he deserves commiseration.'²⁰

It seems that Phipson's 'mental malady' had come and gone over the years: 'There were illnesses in 1861 and 1872, and Dr Sutherland, the Surveyor-General, spoke of "several occasions" when he had been granted leave of absence under him. In January 1876 Sutherland had opposed his return to Government Service (to work on a Register of Deeds Index which he had long advocated).' By July 1876, Phipson was engaged in a

¹⁸ *Ibid.*

¹⁹ R.N. Currey (ed.) *Letters and Other Writings of a Natal Sheriff, 1815-1876, Selected and Introduced and Edited by R.N. Currey*, (Cape Town: Oxford University Press, 1968), pp. 22-23.

²⁰ PAR GH 1216, Copies of Despatches to Secretary of State for the Colonies, 1867-1869, No. 109, pp. 268-270. Lieutenant Governor R. Keate to Secretary of State for Colonies, 16 October 1868. Also quoted in Currey (ed.), *Letters and Other Writings of a Natal Sheriff*, p. 126.

public spat with ‘the justices and with the Maritzburg Hunt’. The letters he wrote to the local press were possibly defamatory and could well have led to ‘further persecution.’ He was under strain because of ‘the failure of a coffee crop, in which he had invested too much of his wife’s money ... It was after this that he became depressed, and then violent. His family were forced to put him under restraint in the nearest approach they had to a mental institution, the “lunatic ward” of Maritzburg gaol. Here [on 29 October 1876] he took his own life by hanging himself from the window bars.’²¹

Once he had become violent, Thomas Phipson’s family had had little option but to have him physically restrained under lock and key. Throughout the period of this study, and probably since, this was also the experience of many families, who, typically, for several months – if not years – had tried to care for and control a troubled relative before seeking to have that person committed to the asylum. In 1913, John Lidgett of the Natal Midlands wrote to the Medical Superintendent of the NGA that one of his plantation workers, Johannes Mhlongo, had been ‘consigned to the Asylum by the Magistrate of the Lions River Division at the express request of his relatives who were living in considerable fear of him. Having got him in, nothing will please them but to get him out again although I gather that there is little if any material improvement in his condition.’²² Bennie Mkize, it will be recalled, for some years allowed his brothers to tie him up when it became obvious that he was about to begin the descent into the madness that periodically beset him; but by 1916 his violence was uncontrollable and he was a frightening figure.²³ Similarly, the family of Budu Zungu kaKamuva of Greytown, coped with his violent fits

²¹ Currey, *Letters and Other Writings of a Natal Sheriff*, p. 223.

²² PAR uncatalogued Accession Papers of John Lidgett, Letter Book, October 1911 to February 1914, p. 908. John A Lidgett to Medical Superintendent, Natal Government Asylum, Maritzburg, 9 January 1913. My thanks to Allison Drew for this reference.

²³ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 8/16. ‘Bennie Mkize of Rasmani’s Location, Umzimkulu’, 21 December 1916. See also Chapter 1.

for more than four years, but by the summer of 1916-17, when faced with him threatening his wife and child, they apparently felt they had no alternative but to have him removed from their homestead.²⁴ They took him to the police station in Pietermaritzburg and requested that he be ‘detained in [the Mental] Hospital’.

Reception Orders from late 1916 and early 1917 tell several similar stories, and provide us with a sense of the range of the desperation felt by families when one of them became mad. Duty, love, financial insecurity, bewilderment, and fear are all evident in the various experiences recorded in the clinical and legalistic terminology of these documents. Take the case of the sixty-five year old widow, Magdalena Elizabetha Pretorius of Utrecht, for instance, who had been under both medical care and family supervision for some years before her admission to the ‘Natal Mental Hospital’ in November 1916. In 1901 she had suffered a stroke, which was followed by a second one in 1913, since which she had had ‘strange ideas’. She had also survived cancer of the womb. Her nephew, Jacobus Gerhardus Hattingh, farmer at ‘Annasview’ in the same district, set out the following grounds for his ‘belief’ that Pretorius was ‘mentally disordered or defective’ and was therefore to be committed on the grounds that she was ‘not under proper care, oversight, or control’:

She is under the impression that she is building a Church at Estcourt, she fancies that she is to be married and wanders backwards and forwards to the Dutch Church here during night [sic], she has also been found wandering about in the District during night, also in Utrecht, when spoken to about her doings she becomes violent and she wanted to stab my wife a week ago, when the doors of the house were locked to prevent her going out.²⁵

²⁴ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 18/17. ‘Budu Zungu KaKamuva of Greytown’, 6 January 1917. Both his family and Dr Glashan of the Pietermaritzburg Mental Hospital identified the cause of his disorder as epilepsy, though he himself believed it to be caused by witchcraft. It is interesting to speculate that agreement on the origin of the insanity as being of a ‘natural cause’ (in this case epilepsy) might have been an important factor in motivating African families to bring afflicted persons to western psychiatric facilities, but much more thorough research on this is required.

²⁵ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 4/16. ‘Magdalena Elizabetha Pretorius, of Utrecht’, Widow, 1 December 1916.

Hattingh had been 'advised' to look after his aunt by his uncle – of the same name – who lived in Durban. Prior to her taking up residence with him, however, Magdalena Elizabetha had lived with her sister, Miss Elizabetha Hattingh, at 'The Rest' in Estcourt. It was here that her 'present attack' had begun. Miss Hattingh, the nephew observed, was 'eccentric sometimes'. Between 25 September and 9 November 1916, the physician Emil G. A. Niemeyer of Utrecht saw Pretorius on no fewer than four occasions. He reported that her 'treatment' had comprised being 'Kept as far as possible ... [and] a generous diet ... and Bromides and Paralvehed.' Despite these measures, she grew worse and the final straw came on 17 November when she threatened Mrs. Hattingh and 'servant girls' with a knife.²⁶ In his Physician Superintendent's Report, Dr R. Sinclair Black found the widow Pretorius to be of 'unsound mind', 'disoriented as to place and time', and 'suffering from organic disease of the brain due to apoplectic attacks.'

Similarly, the family of Albert Bell, described as a 'Coloured' handyman from Mount Ayliff, had harboured him over the several months that he had 'been mentally deranged'.²⁷ When, however, he 'got bad and became violent and dangerous and attempted to assault people with stones and endeavoured to run away' his mother and brother sought to have placed in the Mount Ayliff gaol, there being no local hospital. The nearest officially-appointed doctor was Arthur J. H. Thornton, who lived at Kokstad and visited Mount Ayliff once a week. Suggesting a long acquaintance with Bell, Thornton noted that he did not 'appear to recognize me although I am well known to him.'²⁸ Bell was moved directly from the gaol to the Pietermaritzburg Mental Hospital.

²⁶ *Ibid.*

²⁷ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 5/16. 'Albert Bell, of Mount Ayliff', 1 December 1916.

²⁸ *Ibid.*

The seventy-one year old Frederick Larsen, father of the thirty-five year old Johannes of Durban had looked after his son, for 'many years' even though Johannes, who had suffered epileptic seizures since a fall at the age of seventeen, 'had to be kept under watch at all times' and had to be fed, dressed, and washed.²⁹ By November 1916, Frederick Larsen was exhausted: Johannes was suicidal, had taken to wandering, and was turning violent. He threatened his brother with a gun. Although the family was in dire financial straits, Frederick undertook to 'do his best' to find the three shillings a day fee that was charged for private patients at the Mental Hospital.

Also dangerous, both to herself and to others, was Whilimina Bibb, the wife of Thomas, an employee of Lever Brothers in Durban. He cared for her at home as long as he could, but her delusions and destructive behaviour escalated: 'She says that men have connections by electricity with her and people want to kill her. She will not eat her food. Says it is poisoned. Gets out of bed at night and breaks windows trying to get into neighbours [sic] rooms. Threatens to burnt (burn) [sic] the furniture. Says Queen of Holland.'³⁰ She repeated her conviction that she was being sexually interfered with by means of electrical currents and that people were looking through the walls at her to two medical practitioners and to Sinclair Black at the asylum. Perhaps Thomas could not bear to keep her at home any longer, but certainly her smashing of their few sticks of furniture, her beating at the galvanized fence that separated them from their neighbours, and her constant threats to burn the room, to kill other people and herself, must have frightened him.

²⁹ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 10/16. 'Johannes Severin Larsen, of 235 Stamford Hill Road, Durban', 22 December 1916.

³⁰ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 13/16. 'Whilimina Bibb of 82 Brand Road, Durban', 22 December 1916.

What is noteworthy about these, and many other, accounts is the not the hastiness with which the insane were hustled off to the Mental Hospital at Pietermaritzburg, but how long they were kept within a protective setting outside it. Sometimes, however, the state forced a family's hand. For while the brothers of Mpikizana Mkwanazi did not object to his being sent to the 'lunatic asylum', for years they had allowed him to wander at large. Arrested in the Hlabisa District for throwing stones at the horse of Rifleman Wessels, Mkwanazi was naked, without even a penis cover. On questioning by 'Native Constable Samboza', Mkwanazi tried to run away, was then chased and handcuffed, and asked why he had run, according to Samboza, said that: 'he wanted the road going to the LUNATIC ASYLUM [sic]. I then took hold of him and told him that would show him the road to the LUNATIC ASYLUM.'³¹ Mkwanazi resisted arrest 'most strenuously' and tore to pieces the sack and the clothes that were given him to wear in gaol. Initially, 'no one knew him', but further investigations revealed that he was 'about 23', and that his father and mother were both dead. The 'Court Induna' at Hlabisa, Shikana, swore in court that he was of the 'VUKAIBAMBE regiment' and that he was 'born an imbecile, [who] suddenly gets worse and then better. He wanders about he never carries [sic] a stick nor does he wear clothes or a betshu UMUTSHA and has no prepuce cover. He has never done any harm to my knowledge.... He was born an imbecile and ever since he was a child of a few years he has been wandering about the Country'.

Shikana identified Mpikizana Mkwanazi's brothers – one of whom was 'Nsikizana Mkwanazi', a 'kolwa at the Ntondweni Mission Station' – who were summonsed to an enquiry by the Magistrate of Hlabisa. They reiterated Mpikizana's essential harmlessness by stating that he 'was born an idiot and still is one'. They reported that their father, the late Hlati, had 'called in Doctors to try and cure the patient but without success. Native Doctors were called in'. They were equally insistent that they could not control or care

³¹ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 7/16. 'Mpikizana Mkwanazi, native male, son of Hlati, Chief Mtubathuba, Mpungunyoni Tribe, Hlabisa Division', 21 December 1915 [presumably an error, and which should have read 1916].

for Mpikizana, but disagreed as to whether he should be sent to 'a mental hospital'. His full brother, ten years his senior, Qidhlana Mkwanzazi stated: 'I have no means to support my brother ... in a mental Hospital. He is a harmless idiot and I do not see why he should be sent to a Mental Hospital. I am unable to look after him. He cannot be looked after, as he wanders about'. But, his half-brother, Mtshokobezi Mkwanzazi said: 'I have no objection to him being sent to a Mental Hospital'. Eventually, they were prevailed upon to sign a 'Security Bond For Payment of Charge For Maintenance of Mentally Disordered or Defective Person', although this was later cancelled by the Registrar of the Supreme Court as 'not applying to Natives'.

The testimony of Mpikizana's brothers was probably the endorsement that Magistrate Harrington required to have him committed to the asylum and he then telegraphed the Magistrate of Durban, notifying him that ' [Number] 135 Native patient with escort will arrive Durban ... about 5. P.M. Please arrange comfortable accommodation for night proceeding next morning to Mental Maritzburg advising him of hour of arrival if possible,' Harrington took the opportunity also to write to the Physician Superintendent in Pietermaritzburg and saying that Mpikizana's escort was 'a Cousin' and asking '... if possible I should like him to see the Institution and how patients are treated so as to advise friends, as Natives Zulus particularly are very suspicious of our good intentions towards their race and they always imagine we do things to exploit or destroy them.'³² As he himself, acknowledged, however, this reluctance may have had as much to do with the threat of legal responsibility for the costs of their brother's maintenance at the asylum than any blanket rejection of Western psychiatry *per se*.

Access to medical officials to certify a person as being a proper subject for confinement, as well as financial resources, and class and social connections, would all have influenced the path taken to committal at the NGA. In the urban areas, especially in the major towns

³² *Ibid*

of Pietermaritzburg and Durban, this was a relatively easy process; the transportation of the certified person to the NGA could then be speedily, comfortably and, possibly discreetly, arranged. Where doctors had been treating a patient for some time, as Magdalena Elizabeth Pretorius, it could be their recognition that they could do nothing more to alleviate the situation that led to a recommendation to the family that they initiate the certification of insanity. For families who lived some distance from private licensed doctors, it is likely that it took an episode of particularly violent behaviour to precipitate an approach to the local magistrate or police officer for the removal of the person. The decision to transfer the person to the NGA was then, however, taken out of the hands of the family. In either case, the records covered in this section show that, with the possible exception of Mpikizana Mkwanazi, it was an escalation in violence and destructive acts beyond the level with which the family or community had coped for some considerable time that proved to be the decisive factor in having the afflicted person officially designated and detained for being mentally disordered.

‘Dangerous to himself or others?’³³

Mpikizana Mkwanazi came to the attention of the authorities because he threw stones at the horse of a passing policeman. He was then held in a gaol while his mental state was assessed and while attempts were made to find any who could be held responsible for his welfare. Thereafter, and under police guard, he was transferred to a psychiatric facility. His experience of short-term incarceration in a lock-up – rather than a prior admission to a hospital or other nursing facility – was commonly shared by Africans and Indians, and by white males who were drunks, poverty-stricken, or without family ties, or a combination of all three.

³³ On the form ‘Mental S.3: Reception Order’, the third ground on which persons could be certified as being mentally disordered or defective was if he [sic] ‘is of suicidal tendency or in any way dangerous to himself or others’. For a discussion of the Mental Disorders Act of 1916, see Chapter 6.

A number of illustrations of this can be found in the Reception Orders of late 1916 and early 1917. Not surprisingly, sudden outbursts of violence, frenzied behaviours, bizarre hallucinations, and threats to the self and/or to others necessitated the immediate removal of the troublesome person to the nearest place of custody. In November 1916, for example, Nkabenkulu of Jani's Location, Mount Frere, was obliged to have his son, Tshongweni, arrested after the latter, 'for no reason whatsoever' suddenly set fire to both their 'huts'. Approaching the local police, Nkabenkulu explained that for about a year Tshongweni had been acting strangely, sometimes furious and assaulting people, sometimes 'get[ting] better'. In the year that he had been under his father's care, however, he had never attempted arson. But now, he swore in a deposition, Tshongweni had 'gone mad' and was 'of unsound mind'. What he wanted was to have him restrained and then 'he wished to obtain the services of Native Doctors to attend him'. Instead, Native Constable Abel Ngxekana had Tshongweni arrested on a charge of arson, held at Mount Frere gaol for ten days, and then the Acting Resident Magistrate applied for a Reception Order for his removal to Pietermaritzburg, where his continued detention was endorsed after he was diagnosed as suffering from 'involuntary melancholia'.³⁴

The presence of a person in place where they were not legally entitled, or socially expected, to be, could also lead to suspicion of mental instability. For instance, Lokotsi Flanke, described in the paperwork as a 'Basutu', and 'a wanderer', was found on the outskirts of Pietermaritzburg, and was, not unusually, apprehended as a vagrant.³⁵ Something about his inability to 'give a good account of himself', however, prompted the

³⁴ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 16/17, 3 January 1917. 'Tshongweni of Jani's Location, Mount Frere', 8 December 1916.

³⁵ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 6/16. 'Lokotsi Flanke of "Unknown"', 21 December 1916.

arresting officer to refer him to a medical doctor. Still, Flanke remained ‘dull and apathetic, and preserve(d) a stolid silence which nothing (could) break’. Sinclair Black concurred that Flanke ‘appears very depressed’ and notified that he was ‘properly classified as being mentally disordered.’

Sometimes the act of arrest could precipitate a violent reaction. The day after Flanke’s arrest, for instance, one Robert Tabete was arrested in Newcastle on a charge of vagrancy. In the ‘Police Quarters’ he was ‘very violent’, so much so that he was ‘remanded to Gaol, as there being no Police Cells for a week for medical observation’. There he underwent ‘observance and careful watching’, by a white doctor and the gaolers. Their submission to the magistrate read: ‘Dirty in his habits, broke windows of his cell and upset latrine utensils, and put his food basin in sanitary bucket, and tore his clothes. Shouts all day long, some times at night. Very restless and tries to escape from Gaol.’³⁶ It is, of course, possible to read Tabete’s conduct as the enraged – and entirely understandable and justifiable – acts of protest of a man wrongfully arrested and wilfully misunderstood.³⁷ His subordinate race and class position were also further marked in a comment in the Medical Certificate that he ‘... talks at random, and interrupts [the] conversation of white people.’³⁸ And yet, after enquiries were made of his wife – who claimed that he had been ‘queer for some months’ – and after the medical practitioner noted that ‘the patient has a stupid silly look [and is] easily excited, [is] very restless’, the

³⁶ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 12/16. ‘Robert Tabete, of Farm Brackhoek, Newcastle Division,’ 22 December 1916.

³⁷ See James H. Mills, *Madness, Cannabis and Colonialism: The ‘Native-Only’ Lunatic Asylums of British India, 1857-1900* (Houndmills, Basingstoke: Macmillan Press, 2000), esp. Chapter 3 ‘Disciplining Populations: British Admissions to ‘Native-Only Lunatic Asylums’, for a Foucauldian-inspired analysis of vagrancy, the role of the state, as well as of families, in Indian admissions to colonial asylums.

³⁸ PAR RSC 1/27/1, R.S.C.N (M) 12/16, ‘Robert Tabete’. Form ‘Mental S.2: Medical Certificate Under the Mental Disorders Act, 1916’, certified by Reginald T. Vaughan, Registered Medical Practitioner, Newcastle’, 2 December 1916.

charges against Tabete were dropped and ‘... a reception order applied for, as the man is suffering from Mental disorder, and his immediate removal to an Institution is prayed.’³⁹ In addition to the testimony of his wife, what seems to have been the deciding factor in the determination of him as a patient, rather than purely as a prisoner, was the fact that he was ‘dangerous to himself.’

While a term in gaol could be uncomfortable, even brutal, beyond the administering of ‘sedatives and hypnotics’, there was little else that could be done other than to ‘observe and watch’. Dr Daniel Birtwell treated the ‘Basutu’ Izaak Fring, of the South African Railways with potassium bromide, while Fring was detained in the Railway Hospital in Greyville, Durban, following Fring’s apprehension for extreme moods, threats, suicidal intent, and paranoia.⁴⁰ Another person to whom drugs were administered in order to calm him was Frans Semmuli of the South African Medical Corps. The onset of his illness was believed to have occurred during service in East Africa, from where he had been led to the coast ‘by a rope’. Now in Durban, he was given ‘bromides, morphia, and hyoscine’.⁴¹

Admissions of persons feared to be dangerous to themselves or to others came from regional gaols, military barracks, and district hospitals. Edward Bourne Mayes, a platelayer with the South African Railways at Bergville, had, in mid-November 1916, attempted suicide by cutting his throat with a razor. His colleagues had him rushed to Grey’s Hospital in the capital city. The Superintendent there applied for him to be

³⁹ PAR RSC 1/27/1, R.S.C.N (M) 12/16: ‘Robert Tabete’, Form ‘Mental S.1: Application for a Reception Order’, brought by Sergeant T.B. Smith, 2 December 1916.

⁴⁰ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 16/16. ‘Izaak Fring, of South African Railways, Durban’, 27 December 1916.

⁴¹ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 17/17. ‘Frans Semmuli of Drill Hall No. 3, General Hospital, Durban’, 5 January 1917’. Reception Order granted by the Assistant Magistrate at Durban on 25 November 1916. In *A History of Psychiatry*, pp. 190-206, Edward Shorter gives a helpful overview of the efficacy, or otherwise, of early psychiatric drugs.

transferred to the Mental Hospital, and he became the first person to be admitted under the new legislation.⁴² He died there from his wounds a week later. The second admission, Private Walter John Cotton, Special Constable, Enemy Internment Camp, Fort Napier and originally from the Orange Free State, was moved to the Pietermaritzburg Mental Hospital after he had had a number of 'epileptic fits' followed by florid hallucinations. Dr Campbell Watt observed that:

Patient is in an excited state. I found him holding on to the wire gauze screen of the window. He told me he was holding it up as it was falling out thro' the window and several cases of it had been removed. He also said he was taking charge of a coloured woman's child in the cell and that she had taken it away. Then he contradicted himself and said it was among his blankets, and began hunting for it. There were faces [sic] and water on the floor

Corporal F.J. Ball states patient was very excited all night smashed the fixtures of the cell, shouting and making noises and was addressing his wife and children and asking them to open the door, and wandered in his talk. Said he had a train to catch. Complains of an electrical engine burning him. Said he has been hanging curtains and pictures in his cell.⁴³

Campbell Watt determined that Cotton was 'not dangerous' (to others) but that he was a fit candidate for committal. Cotton made a rapid, apparently spontaneous, recovery and was discharged after a fortnight.

In the absence of any of Private Cotton's family in the province, the Medical Officer at Fort Napier had applied for his committal. This was not unusual as at times District Surgeons, police officers, resident magistrates, and medical practitioners applied for Urgency Applications in the case of the need to admit people who were still sometimes referred to as 'dangerous lunatics', or to have the subdued but still disturbed inmates of prisons and hospitals transferred to Pietermaritzburg. The Protector of Indian Immigrants

⁴² PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 1/16, 1 December 1916. 'Edward Bourne Mayes, of "Ebersholt", near Winterton', 18 November 1916.

⁴³ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 2/16, 1 December 1916. 'Walter John Cotton, Special Constable, Fort Napier, Maritzburg, and late of Ficksburg, O.F.S', 10 November, 1916.

also found it necessary, on occasion, to apply for reception orders for mentally disordered Indians, indentured as well as free, who usually had precious little in the way of family or community resources or support. One such unfortunate person was 'Muniammal', an Indian woman found wandering around the countryside in early 1917. On being taken to the Pietermaritzburg Mental Hospital, Dr Sinclair Black recognized her as having been a previous patient there who had 'made a good recovery' from manic-depressive insanity. Piecing together her history after her earlier discharge, it seems that she spent some time at the Durban barracks with her husband, Savariappan, but her state of mind soon began to deteriorate once more. She 'walked naked around the Depot', was 'sulky' and 'restless', and alleged that 'big and small kafirs [sic] annoyed her in her room at night.' Her husband disappeared and then Muniammal also left the barracks. On being apprehended again she was placed in a hospital, where she was 'treated with sedatives and quiet'.⁴⁴ The treatment failed to calm her, however, and there seemed no alternative but the asylum. It seems likely that this would be a pattern throughout her life.

The boundaries between hospital, gaol and asylum were not always clear. Applying to have an 'Adult Indian woman named Ettama' certified, Indian Medical Officer at Stanger, Dr R.H. Creighton, referred to her as 'an inmate under my care'.⁴⁵ She was given potassium bromide. The seventeen year-old Ettama, or 'Ettyammah', had also been in the Stanger gaol, and in both the lock-up and the hospital she was reported to be 'riotous', to be given to tearing her clothes, and to be incoherent and rambling in her speech. Creighton said that he had 'no means of controlling her at the Hospital'. Both the gaoler and the officer-in-charge at the hospital noted too, that Ettyammah refused to eat

⁴⁴ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 36/17, 7 February 1917. 'Muniammal – female No. 103164, of Durban', 22 January 1917.

⁴⁵ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 22/17, 13 January 1917. 'Ettyammah, wife of Sundram Gopaul, of Kearsney, Lower Tugela Division', 29 December 1916.

the food they gave her, but would eat dirt and garbage. According to her husband and her employer she had been deranged for seven months. She was also seven months pregnant, and it was this, Sinclair Black, deduced, that was the cause of her ‘mental disorder (of a hysterical character) associated with pregnancy’. Perhaps it was the – marginally – better diet or the respite from labour on the Kearsney Estate or perhaps it was the adjustments made by her own body, but after being admitted to the Mental Hospital, Etyammah’s condition improved and she became quiet and composed, and the Physician Superintendent hoped to be able to discharge her before her child was born.

By their very nature, mental disturbances and disabilities were difficult to pin down as being definitively within the provenance of the psychiatric profession, or the responsibility of religious or other authorities. While some conditions were medicalized, others were regarded as more appropriately dealt with by civic authorities or agencies. James Hyslop, as noted in an earlier chapter, for example, protested against the use of the NGA as a home for ‘idiots’ and ‘epileptics’; and he frequently remarked that the asylum was an unsatisfactory substitute for family or institutional care for the aged and the indigent.⁴⁶ The colonial government was also leery of diluting the requirements of the Natal Lunacy law that insisted on the presentation of two medical certificates before a person could be committed to an asylum. Requests that the committal procedures be ‘hastened’ came especially from beleaguered police officials who were not infrequently faced with the invidious task of arresting drunks and then having to safeguard the unfortunate person whilst they undergoing the horrors of *delirium tremens*. The exasperation of R. C. Alexander, Superintendent of Police in Durban, is all too clear in a letter he sent to the Town Clerk of Durban on 23 January 1900. In it he complained that ‘for the past fortnight’ he had had ‘to deal with four cases of madness through drink or otherwise, and at the present moment I have a man locked up since Thursday last

⁴⁶ *Natal Blue Book 1898*, Natal Government Asylum.

awaiting an order to remove him to the asylum.’⁴⁷ He regarded ‘Delirium Tremens’ as a ‘very dangerous state of lunacy that requires a guard to watch over [the affected person]’. However, ‘The Police Station is not the proper place for such cases, nor can I afford to lose the services of Constables to watch them: nor can I hold myself responsible for their safety, proper food and medical treatment so necessary in such cases.’ He noted that it could take up to three days to get the necessary certificates filled in and properly sworn. ‘Then I must wait as I am doing now, for the Governor’s authority to send the patient to the asylum. All this time I have a raving lunatic to feed and look after ...’

While Alexander urged the Government to ‘adopt a more simple method of dealing with such cases, especially in Delirium Tremens, that so often occurs in a climate like this ... [And that] ... they should be punished, when recovered, in shape of a fine for the trouble they have given by their conduct’, the Attorney General, the Resident Magistrate of Durban, and the Colonial Secretary were agreed that: ‘The majority of the cases referred to by the Superintendent are probably fit subjects for reception and treatment in a Home for Inebriates – not in a lunatic Asylum.’ The Attorney General stated: ‘I concur in the Magistrate’s opinion and hope that it may be possible to establish a Retreat for such cases in the course of a year or two.’ He added, however: ‘I have no doubt that in case of need [the] process for admission might be [shortened] but I am not prepared to advise the relaxation of the provisions of the Law in so serious a matter as the detention of persons supposed to be of unsound mind.’⁴⁸ In the meantime, troublesome alcoholics who had ‘no relative or guardian in the Colony’ to take care of them, were kept locked up in public gaols or hospitals.

⁴⁷ PAR Colonial Secretary’s Office (hereafter CSO) 1639 1900//725, ‘Mayor, Durban. Forwards copy of Minute From Superintendent With Reference to Present Unsatisfactory Manner of Dealing [With] Cases of Madness Brought to the Police Station’, 29 January 1900, R.C. Alexander, Superintendent of Police, Durban, to the Town Clerk, Durban, 23 January 1900.

⁴⁸ PAR CSO 1639 1900//725 ‘Mayor, Durban. Forwards copy of Minute From Superintendent With Reference to Present Unsatisfactory Manner of Dealing [With] Cases of Madness Brought to the Police Station’, 29 January 1900, Resident Magistrate, Durban to Colonial Secretary, 30 January 1900, and Colonial Secretary to Attorney General, 5 February 1900.

Admission to the Mental Hospital presumably would have been a preferable option to being arrested as a criminal, but it brought with it considerable social prejudice. Leigh Anderson suggests that, from the early 1890s, 'there are signs that people in Natal were beginning to look upon drunkenness as a disease which needed treatment, rather than merely a crime requiring punishment.'⁴⁹ He cites the judgement of a Pietermaritzburg magistrate in August 1892 on a man named 'Andrews', who is referred to as being "'shabby genteel'". Sentenced to a month in gaol for drunkenness, Andrews had received no fewer than twelve previous convictions. The magistrate 'remarked that it was a very painful thing for him to have to punish such a man.... He would have preferred to have had the opportunity of sending persons like Andrews to some place of confinement where diseases of this sort could be treated, but unfortunately no such place existed in the colony.'⁵⁰ The *Natal Witness* had also written of 'the craving for alcohol' as a 'disease ... [that] should be subjected to proper medical diagnosis, and treated like any other ailment which the human frame is subject to.'⁵¹

The Attorney General, Henry Bale, who in 1900, had agreed that drunks should be sent to a Home for Inebriates had himself was at the forefront to establish such a facility for some time. Speaking at a meeting of the General Temperance Council in Durban in 1893, he had made it clear, however, that this was envisaged as a retreat that would be 'confined to the care of white drunkards only ... as yet he had not given any consideration to the coloured races.'⁵² As noted in Chapter 2, a home for European Inebriates was finally opened in Pietermaritzburg in 1914.⁵³

⁴⁹ L. R. Anderson, 'Society, Economy and Criminal Activity in Colonial Natal', 1860-1893' (unpublished PhD dissertation, University of Natal, Durban, 1993), p. 282.

⁵⁰ *Ibid.*, Anderson cites the *Natal Witness* of 20 August 1892 as his source.

⁵¹ *Ibid.*, citing the *Natal Witness* of 10 March 1892.

⁵² Anderson, 'Society, Economy and Criminal Activity in Colonial Natal', p. 283.

Home from home?

'Community care' usually began with monitoring and, if necessary, nursing, within the home. Henry Lovett, husband of the 'criminal lunatic', Emma Lovett, for example, in his one of his many petitions praying for her release from the NGA, recounted how for several months before she murdered their thirteenth and youngest child by drowning, Emma had been 'very ill and at times delirious', and how 'for two or three months previously she had been carefully nursed by myself and my daughters.'⁵⁴ Even after she had spent several years in the asylum, and after Henry's own health had been ruined by a 'paralytic stroke', Emma's husband, daughters and sons continued their campaign to have her discharged into their care, claiming that the Hospital was in fact further harming her state of mind. Henry's sincerity can surely not be questioned when he wrote: 'Although a cripple, if my wife is released, I will take every care of her and will be with her night and day.' Her sister, Mercy Wade, had hosted Emma in her home during the many occasions on which she was granted a day's pass from the asylum, and, in 1900, stated: 'I am quite prepared with the help of her husband and my husband to look after Mrs. Lovett ...'⁵⁵ Eventually, although Emma was discharged on the recognizance of Mercy's husband – a police warder – she was cared for by her daughter, Mrs E.M. Bennett of Verulam. It was here that the second part of the tragedy unfolded in 1908 when Emma caused the death of her granddaughter, Jessie Violet Bennett, by throwing scalding water over her.

⁵³ M. Minde 'History of Mental Health Services in South Africa, Part XI: Services for Alcoholics', in *South African Medical Journal*, .49 (December 1975), p. 2198.

⁵⁴ PAR Minister of Justice and Public Works (hereafter MJPW) 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908', Petition of Henry Lovett, 17 January 1900.

⁵⁵ PAR MJPW 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908', Statement of Mercy Wade, Wife of F. Wade of Pietermaritzburg, Natal Warder', 24 January 1900.

The Lovett family were not rich. Their experience, of nurturing or shielding a mentally disturbed family member through home care (usually, but not invariably by daughters and female kin) and then, if possible, drawing on a network of relatives and paying hosts who acted as guardians – formally or otherwise – to their troubled charges was repeated many times. We have noted that the family of Frank Sullivan, discussed in chapter 2, spent much money and emotional effort in ‘screening’ him, trying to channel his profligate habits and wasteful inclinations into productive endeavours, and when these failed they paid for him to be ‘kept’ on a farm outside the city.⁵⁶ Several further examples demonstrate that the boarding out of troublesome and trying family members was commonplace in colonial Natal: the teenage Eileen Amy Turner, whose mother was herself a voluntary patient at the Pietermaritzburg Mental Hospital in early 1916, was cared for by two aunts, with whom she lived in Port Shepstone. Her legal guardian was her great uncle, William Edward Simons of Florida Road in Durban. Sometime in late 1916, Eileen Amy underwent a change in her ‘general demeanour and character’. She ran around hatless, developed ‘unclean habits’ and imagined that she was responsible for the recruitment of hundreds of troops for the war. She bit and scratched. She ate and slept little. She became a kleptomaniac. The aunts could not control her and had her sent up to William Simons.⁵⁷ He called in two physicians, who had no hesitation in certifying her as requiring admission to the asylum.

Florence Ethel Plowes, who in 1916 at the age of forty-five was certified as being ‘a high grade imbecile’, spent all of her adult life under the care of others. In her twenties, Florence, who was ‘dwarfish’ in appearance, and ‘microcephatic’, was relatively

⁵⁶ See NGA (European) Patient Case Patient Book XI, pp. 433-435. Frank Sullivan, Admission number 2110. Carbon copy of ‘Confidential Report’, pinned to p. 434, and signed by P. Sullivan, Durban, 19 June 1906.

⁵⁷ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 11/16. ‘Eileen Amy Turner, of Port Shepstone’, 22 December 1916.

independent, running errands and commissions in Durban for her mother.⁵⁸ She appeared to regress, however, becoming more 'childish' and 'naughty'. In 1904, her affairs were placed under the curatorship of an attorney, John Jacob Hugman, who became her legal guardian. When Mrs Plowes' health began to fail, Hugman, as he noted in his deposition to the Chief Magistrate of Durban:

placed [Florence] with two ladies at Park Rynie, where she stayed some years until her wilfully defiant behaviour, which is the form of naughtiness which her mental defectiveness takes made them give up the charge, and refuse to reconsider it again (lately). Since then she has been at Malvern, where her custodian soon tired of her. I was not satisfied either.⁵⁹

She was then boarded with an elderly couple 'in the vicinity of Verulam', but that did not work out. Florence was then taken in by her aunt and uncle, but the latter testified that Florence was 'unclean in her habits, spits promiscuously' and that he had frequently witnessed her 'violent fits of temper, she is quite unfit to be left alone or to take care of herself'. By all accounts a difficult person, Florence did not endear herself to her guardians. Nonetheless, Hugman sought once more to have her accommodated outside the asylum. By 1916, his options were limited and he wrote to J.T. Dunston, Commissioner for Mentally Disordered and Defective Persons, in Pretoria, for advice. Dunston could only suggest that he 'try for "single" care in preference to the Mental Hospital'. Hugman's exasperation is clear in his response: 'I have so tried and utterly failed, and if anyone did take her, I feel certain, from my own knowledge of the patient, that I should get notice the very first month, to remove her.'⁶⁰ He concluded that he had 'no alternative but the Mental Hospital.'

⁵⁸ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 37/17. 'Florence Ethel Plowes, of 74 Currie Road, Durban, 7 February 1917', 19 January 1917.

⁵⁹ PAR RSC 1/27/2, R.S.C.N (M) 37/17. 'Florence Ethel Plowes'. Depositions by J.J. Hugman and A.A. Shuter, dated 13 January 1917, and Form 'Mental S. 2. Medical Certificate Under the Mental Disorders Act, 1916' completed by Dr. S.G. Campbell, Musgrave Road, Durban.

⁶⁰ PAR RSC 1/27/2, R.S.C.N (M) 37/17. 'Florence Ethel Plowes'. Deposition by J.J. Hugman, 13 January 1917. Emphasis in original.

From the latter decades of the nineteenth century, come accounts of not only informal surveillance and care-taking within the home by family members, servants and paid ‘minders’, but also the hiring of nurses (professionally qualified or not), and the placing – at a cost – of the mentally disturbed in private nursing or custodial facilities. In the care of the mentally deficient or of persons whose symptoms were generally mild, these ventures offered families a socially acceptable substitute to the asylum. In some instances, patients discharged from the Mental Hospital as ‘not fully recovered’ would be transferred to nursing or private homes. Should their illness flare up again, they were re-admitted.⁶¹ Once more, the Reception Orders from late 1916 and early 1917 provide us with examples of these means of soothing and managing the mad. Olive Maud, wife of Robert Richard Harris of the Eastern and SA Telegraph Company in Durban, spent two months at the Mental Hospital in 1914. In mid-1916 she gave birth, and Robert hired a nurse to take care of both Olive and the baby. But Olive ignored the child and it became apparent that she was suffering a second attack of insanity. She took a ‘dislike to her husband’, struck at both him and the nurse, and crawling on her hands and knees, she ‘made grimaces at the furniture’. But, the ‘careful nursing at home’ proved ‘useless’, and she was found with her ‘fingers round Baby’s throat.’⁶² Her husband undertook to pay for her maintenance at the Pietermaritzburg Mental Hospital.

⁶¹ Far from being a ‘total institution’ with no exits, at the NGA patients judged to be substantially, but not fully, recovered, were permitted to receive visitors and to go into town with them on day passes. This was justified not only on medical grounds, but also, given the pressure on accommodation – an argument made by Emma Lovett’s family - patients were sometimes released into the care of their family or legal guardian. Remission of symptoms was, sadly, not always permanent, and re-admissions were not infrequent. Chapter 2 of this dissertation discusses patient admissions and discharges up to 1910. See PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 14/17. ‘Priscilla Gardner, of Fox Hill, PM Burg’, 30 December 1916, for an example of a woman who had been admitted and released to the care of her husband four times. The distance from the asylum, as well as pass restrictions and financial and class barriers, meant that far fewer African or Indian patients were released into the custody of their families, either temporarily or permanently.

Far from wishing to offload an unwanted and troublesome irritation, the removal to the asylum of patients such as Olive Harris could bring their families further burdens, not least in the loss of their household labour, parenting activities, as well as in a financial sense. Fees for the care (and control) offered by private nursing homes and sanatoria were presumably steep. After his discharge from the Pietermaritzburg Mental Hospital, Brian Vernon Prior, a thirty-two year old 'Merchant', was sent to a Nursing Home in Pinetown. Walter B. North, his uncle, paid for his treatment – rest in bed, and nerve foods – there.⁶³ It was not enough, however, to keep Prior from going mad again. In early November 1916, he was once more 'unduly excitable', exhibiting 'a craze for farming whereas two or three days before he had a craze for the motor business', and 'destroying the garden at the Nursing Home for no reason and replanting the broken plants' upside-down in the soil, saying 'they will come from the heart.' Fearing that he was heading for another manic phase of a condition that had formerly been characterized by violence, North sought to have him returned to Pietermaritzburg as quickly as possible. The Magistrate was of the opinion that 'he should never have come out' of the asylum.

Another option was the Roman Catholic Sanatorium in Loop Street, Pietermaritzburg. It was here that Sidney Davis, 'Licensed Victualler and Caterer' at the capital's Town Hall, who apparently had drunk 'to excess' over many years, and who, believing that he was in military khaki, had taken to wandering around the town in his pyjamas, was admitted in late 1916. For a time before this, however, he had been 'detained in his lodgings'. At the Sanatorium, he received 'general skilled nursing', and was given 'sedatives and rest'; at

⁶² PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 15/16. 'Olive Maud Harris, of 29 Madeline Road, Durban', 23 December 1916.

⁶³ PAR RSC 1/27/1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 3/16. 'Brian Vernon Prior, of Northdene, Natal', 1 December 1916.

some point he was also 'treated' by hypnosis.⁶⁴ He died at the Mental Hospital two days after admission.

In the urban areas, there were several alternative places for the private care of patients. For instance, the suicidal housewife, Aldyth Ruth Mary Clark, whose husband was the Stationmaster at Donnybrook, had first been looked after by her mother, and then spent 'six days at The Health Institute', under the treatment of a Dr. Woods before he judged that the 'sedatives, bromides and Veronal' that he was administering were not helping, and had her transferred to the Mental Hospital.⁶⁵ The Institute may well have been the 'Natal Health Institute: A Real Home For the Suffering, Equipped for the Successful Treatment of the Sick' at 126 Longmarket Street, Pietermaritzburg, whose proprietors took out a full page advertisement in the 1918 *Braby's Natal Directory*, informing the public that it was 'The most up-to-date Hydropathic Institution in Natal'.⁶⁶ 'Special features of the treatment' – administered 'under the personal supervision of C.H. and Mrs Shaw' – included 'Electric Light and Heat Cure, Medical Massage and Health Reform Diet'. A substantial building in one of the best parts of town, the Institute offered accommodation for its patients.

Since 1910, hydrotherapy had also been available at the 'Grand Lilani Hot Sulphur Springs Sanatorium', near Greytown. Chairman of the 'Grand Lilani Syndicate', Dr J.W. Matthews (who supplied Arthur Shepstone with prescriptions for his asthma), wrote to an associate that he had drawn up an advertisement for the Sanatorium, which he intended to

⁶⁴ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 24/17. 'Sidney Davis (Deceased), of Church Street, PMBurg', 13 January 1917.

⁶⁵ PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 32/17. 'Aldyth Ruth Mary Clarke of Donnybrook', 26 January 1917.

⁶⁶ Advertisement for the 'Natal Health Institute', *Braby's Natal Directory*, 1918, p. 938.

‘feed to a news-devouring public in the “sweet bye-and bye”’. In it he extolled the beauty of the scenery, the ‘wonderful powers of the hot mineral spring to be found here ... long known to the Dutch community’; and he compared the ‘healing qualities’, ‘Radio Activity’ and ‘chemical composition’ of the waters to those found at ‘Harrogate and Spas of a similar character’.⁶⁷ Somewhat remote from the urban centres of Natal, and without a ‘decent passable road’ Lilani Hot Springs nonetheless managed to remain open until the 1960s at least.⁶⁸ James Hyslop himself spent six weeks at the ‘Caledon Natural Thermal Waters: Sanatorium and Baths’ in the Cape when he was taken ill on a return journey from Cape Town.⁶⁹

Whereas, no doubt, good general nursing along approved biomedical lines was provided in sanatoria such as that run by the Catholic Church, the existence of private sanatoria

⁶⁷ PAR Chief Native Commissioner (hereafter CNC) 294 1917/2592, ‘Location Leases: Lilane Hot Springs Transfer of Lease to E. L. Matthews’, Letters from J.W. Matthews to Mr. Barnes, 13 April 1910 and to The Colonial Secretary, 8 January 1910. Thanks to Cheryl Stobie for telling me about Lilani.

⁶⁸ In the mid-1920s a bid to take over the lease of Lilane was made by Mr and Mrs C.M. Blaine of the ‘Berea Health Institute’. Their letterhead claimed ‘25 Practical Experience’ and expertise in ‘Massage, Electricity & Hydropathy as given in English, American and Continental Institutes’. Their Institute offered a range of therapies, including ‘High Frequency Currents, Diathermy, D’Arsonal and Oudin Currents, Ultra Violet Rays, Auto Condensation, Vibrotherapy, Ionization Treatment, Electric Light Baths, Swedish Medical Massage, Steam Baths, Sitz and Hip Baths, Galvanic and Faradic Electricity, Water Electric Baths and Various Other Baths for Rheumatism, Paralysis, Indigestion, Nervous Disorders, Liver and Kidney Complaints.’ ‘Maternity Cases’ were ‘received’, there was an ‘up-to-date Operating Room for Doctor’s Use’ and they allowed for ‘Your own Doctor in Attendance’. The Institute accommodated both ‘Indoor and Outdoor Patients’. The letter from C.M Blaine to Wheelwright, Native Affairs Department, dated 3rd March 1926 can be found in CNC 294 1917/2592, ‘Location Leases: Lilane Hot Springs Transfer of Lease to E. L. Matthews’.

⁶⁹ NAR Colonial Secretary (hereafter CS) 994 20795, ‘Dr J. Hyslop, Health. Medical Superintendent, NGA, Natal’, Hyslop to Secretary of the Interior, 10 March 1913. For a lively introduction to the range of hydro and other therapies that were popular at this time, see Chapter 4 ‘Nerve Tonics and Treatments’ in J. Oppenheim, *Shattered Nerves: Doctors, Patients, and Depression in Victorian England* (Bridgewater, New Jersey: Replica, 2000).

and 'Healing Institutes' may also have represented beliefs about healing mental and medical ailments that rejected or supplemented those of professional psychiatry at the time. This seems to be the case with 'The Natural Healing Sanatorium' at Sweetwaters on the outskirts of Pietermaritzburg, which was also known as the 'Sweetwaters International Establishment of the New Science of Healing'.⁷⁰ Its proprietor, 'Professor' August Beissner, ran into trouble with the colony's medical establishment on more than one occasion, however. In February 1907 an enquiry was held into the death of Frederick Charles William Alexander, who had died at the Sanatorium in mid-December 1906 after being resident there for about three months. It was his second stay at the Sanatorium, he having first come to it from Johannesburg where 'medical treatment had done him no good'. The monthly fees for 'board, lodge and treatment' were £10. A post-mortem – conducted by Campbell Watt – revealed that Alexander had had 'an enormously enlarged spleen' and a 'highly cirrhotic' liver, the latter commonly associated with chronic alcoholism, and had 'died from Hepatic Cirrhosis'.⁷¹

Describing his profession as that of a 'Natural Healer', Beissner insisted that he had no suspicions as to 'intemperance' by Alexander and that the diet followed had been one of Alexander's preference, and that this was in accordance with the general 'natural' philosophy of the Sanatorium. In the view of Beissner, Alexander was suffering from 'dropsy and jaundice' and from 'the spleen and a swollen liver'. The treatment regime, administered by Beissner, with assistance from his wife and apparently also from fellow patients, consisted of

cold water hip baths twice or three times a day, for a few days of hip baths only, dieting him on vegetables, grain and fruit. The result was satisfactory. His condition was such that he could walk about and I could administer sun baths. Hip baths were kept up all the time. The sun baths consisted of lying in the sun with a

⁷⁰ P. W. Laidler and M. Gelfand, *South Africa, Its Medical History, 1652-188: A Medical and Social Study* (Cape Town: C. Struik, 1971), p. 348.

⁷¹ PAR Attorney General's Office (hereafter AGO) II/1/9 CPM 149F/1907, 'Death of F C W Alexander of the Natural Healing Sanatorium, Sweetwaters, Pietermaritzburg', 4 February 1907. A number of different spellings of 'Beisener' appear in the documents.

thin muslin green covering with green leaves [described by a patient as ‘banana leaves’] next to the skin. After the sun bath he was put into a hip bath from 5 to 8 minutes. Clay poultices were applied on the lower abdomen whenever it was thought necessary. ... The diet consisted of beans, peas, lentils, rice brown and white, well boiled. Carrots, turnips, green beans, this was in the vegetable time. Fruit: Bananas, pineapples, apples, pears, and other similar fruits, also Graham-bread (unleavened wheaten bread) ... His diet consisted principally of strawberries and canned peaches No medicines whatever were given.⁷²

When it became obvious that Alexander’s condition was terminal, Beissner sent for Campbell Watt, but the latter refused to ‘attend the patient [unless] he was removed to another house’. After a week or so of continued cold compresses to his stomach, Alexander died in the presence of his wife, for whom he had sent for from Johannesburg, and Beissner.

Although Campbell Watt was of the opinion that Alexander had suffered ‘from a disease that was bound to prove fatal’, and that the ‘treatment carried out by Beissner so far as the diet, baths and poultices are concerned did not influence the course of the disease’, he wanted to see Beissner charged with ‘practising as a medical practitioner without a licence.’ In this Minute Paper there is no further documentation to show whether Beissner was fined or in any way penalized, but just a year later he was the target of further accusations, this time specifically of ‘quackery in cases of consumption’.⁷³ Another death had followed a course of ‘Sunbaths’, causing an anguished father to write that ‘this Establishment, ... is run by a man who calls himself Professor Beissner, and it appears that he has a good claim to the title for he professes to cure everything. ... He had my son under him for over nine months presumably seeing him daily – every day he was

⁷² PAR AGO II/1/9 CPM 149F/1907, ‘Death of F C W Alexander of the Natural Healing Sanatorium, Sweetwaters, Pietermaritzburg’, 4 February 1907. Testimony of August Beissner before Acting Magistrate, Umgeni Division, 29 January 1907.

⁷³ PAR Prime Minister’s Office (hereafter PM) 70 1908/78, ‘J.E. Allnat, Siddlesham, Wokingham, England. Re: Death of John Edward Allnat of Consumption at Sweetwaters. That Action Might Be Taken to Restrain a Certain “Professor” From Practising Quackery in Cases of Consumption’, 3 January 1908.

getting worse, and when he was actually dying this Professor was quacking that he was getting better. To my mind it is a clear case of the Confidence Trick with a man's life as the forfeit.⁷⁴ In the following investigation, Inspector Earle wrote to the Permanent Under Secretary in the Law Department: 'As the Law stands it is very difficult to get at these Health Institutes.'⁷⁵ A 'Medical Amendment Bill' was introduced midway through 1908, but it was defeated at its second reading. It was only after World War I that South African biomedical doctors – including psychiatrists – were able to move more successfully to exclude those whom they regarded as quacks. In the meantime, those searching for solace were being solicited by a number of different purveyors of cures, some of which promised a faster, or a more private, solution to their ailments and problems than specialist medical practitioners, or rest cures or special diets, or even recognised African or Indian healers, could provide.

⁷⁴ PAR PM 70 1908/78, 'J.E. Allnat, Siddlesham, Wokingham, England. Re: Death of John Edward Allnat of Consumption at Sweetwaters', J.E. Allnat to The Honourable The Prime Minister of Natal', 3 January 1908. Emphasis in original.

⁷⁵ PAR PM 70 1908/78, 'J.E. Allnat, Siddlesham, Wokingham, England. Re: Death of John Edward Allnat of Consumption at Sweetwaters', D.E. Earle, Inspector, Central Intelligence Office to Permanent Under Secretary, Law Department, 9 March 1908.

**‘Delay breeds ruination... Write immediately and do not be afraid’⁷⁶:
the popular sector and the commercialization of cures**

Treatment by specialists legally recognized or otherwise, was probably just as likely to fail, as it was to succeed. While some forms of mental illness may have improved with care and control, or with intense attention to the individual and to his or her social setting, the increasing numbers of asylum patients as well as the proliferation new healing practices more generally is testimony to the continued search for solace for mental suffering in arenas other than the professional. The *amandiki*'s formation of their own healing groups and rituals, for instance, may in part have been a reflection of the impotence of recognized African therapeutics and health practitioners to respond to the intense social and psychological pressures of the period. It also illustrates the permeability of the boundaries between Swartz's 'three sectors' of mental health therapies and strategies. In the late nineteenth and early twentieth centuries, the distinctions between 'professional', 'folk', and 'popular' healing were arguably less clear-cut than they are today, with African and Indian healers in particular complicating many of these boundaries. So, too, did some who claimed to work within a 'Western' paradigm, whether religious or scientific. How, for example, should we place the 'Mental Scientist' 'Professor Edward Hale', whose advertisement in *The Times of Natal* in May 1901 is reproduced below?⁷⁷

⁷⁶ NAR, Secretary of Native Affairs (hereafter NTS) 6758 62/315. Translation of advertisement "The great chemist of Africans – All Africans buy from Velabahleke at Pretoria -- Medicines of Africa – Manufactured in Africa – Manufactured for Africans – By the People of Africa, At Velabhleke, Pretoria Drug Store Co. Manufacturing Chemists, [obscured] Pretorius Street", annexure to 'Advertisements of Quack Medicines', Senior Inspector, Central Investigation Department, Transvaal Division, to Secretary, Native Affairs Department, Pretoria, 17 November 1928.

⁷⁷ PAR CSO 1675 1901/3585, NP 3459/01, CIC 1667, "Professor Edward Hale" advertises diseases cured by the application of "MIND", 14 May 1901.

**Professor EDWARD HALE,
Mental Scientist**

The Power of Mind over Matter.
Thought is a Creative Power.
The Physician of the 20th Century is
MIND.

Health is more contagious than Disease.
Man is Master of his own Destiny.
Nothing Impossible to the "Mind"
conscious

of its unbounded Power.
Mental Science cures when all else fails.
Advice given which will ensure
Success in Everything!!

CONSULTING HOURS :

From 10 a.m. to 12 noon, and 2:30 to
4:30 pm,

Every Monday, Tuesday, and Thursday
Evening from 8 to 10.

CONSULTING ROOM: No. 17,
Mutual Buildings, Durban.

1565ei-tc

On the urging of Dr Campbell Watt of the Natal Medical Council, the Durban Criminal Investigation Office questioned Hale. The officers had to report, however, that it was unlikely that he could be prosecuted for acting as an unlicensed 'Physician' since: 'He simply contends that sickness is caused by worry etc., and if you leave off thinking about it and don't worry it will cure itself – He attempts to prove this theory by a course of lectures, for which he charges 10/6 a hearing. He does not wish to know the nature of complaint and gives no treatment beyond saying "Don't worry".'⁷⁸

The authority to diagnose, as Karen Flint has pointed out, was of key concern to Natal's emerging white-controlled medical establishment at this time. She notes that, especially

⁷⁸ PAR CSO 1675 1901/3585, NP 3459/01, CIC 1667, "Professor Edward Hale" advertises diseases cured by the application of "MIND". Sergeant Lees-Smith, NP, CIO, Durban, to Sub-Inspector W.E. Earle, CIO, Pietermaritzburg, 14 May 1901

from the 1920s, 'the professionalization of biomedicine in South Africa' was predicated upon claims to 'science' and that not only did this entail a conscious distancing from African diagnosticians and healers, but also that the medical profession '... defined itself in contradistinction to all non-allopathic practitioners or, in their estimation, "quacks", white healers-osteopaths, cancer curers, Christian Scientists ...'⁷⁹ To this end, the various overlapping professional medical associations in Natal – the Natal Medical Committee (from 1856) and later the Natal Medical Council (formed under Act No.35 of 1896), the Pietermaritzburg Medical Society, the Durban Medical Society, and the Natal Branch of the British Medical Association – increasingly sought to rigidify the boundaries of admission to licensed medical practice and to prosecute those, black and white, who were not legally sanctioned as 'physicians' or biomedical practitioners. The day immediately following the instigation of the investigation into Professor Hale, for example, saw Campbell Watt drawing the attention of the Colonial Secretary to another news-clipping from *The Times of Natal*, this time concerning the 'Spiritualist, Mr. Cherigny'. The latter and his wife were involved in an unsavoury court case in Durban where they claimed £300 from 'Jacquelia of Verulam County' for – unfortunately unspecified – conduct against Mrs. Cherigny. Interestingly, it was not so much Cherigny's methods that Campbell Watt objected to – 'when patients came to him he put his wife under hypnotic influence, and ascertained the nature of the illness' – as the fact that he claimed to be a 'Medical Practitioner'.⁸⁰ The Colonial Secretary was urged to ensure that: 'He should be called upon to register himself and take out a license.'

Nor were state officials enamoured of the late nineteenth and early twentieth century upsurge in evangelical, syncretic, and charismatic movements allied with Christianity that laid a special emphasis on the power of healing through faith. On 9 July 1909, *The Times*

⁷⁹ K.E. Flint, 'Negotiating a Hybrid Medical Culture: African Healers in Southeastern Africa from the 1820s to the 1940s' (unpublished PhD dissertation, University of California, Los Angeles, 2001), pp.179-180.

⁸⁰ PAR CSO 1675 1901/3584 'Mr. Cherigny, Spiritualist, Claims to be a Medical Practitioner', D. Campbell Watt, Secretary, Natal Medical Council to Colonial Secretary, 3 May 1901.

of *Natal* carried reports of three different instances of ‘spiritual healing’ that had recently taken place in Johannesburg.⁸¹ The first two concerned members of the Apostolic Church – a Miss Maggie Truter – who refused medical intervention for severe head and ear pain, but who nonetheless recovered through prayer; and ‘a young lady belonging to a good family in Johannesburg’ who was instructed by the Holy Spirit to marry a recently-widowed preacher. It was the third report, however, that particularly caught the attention of Richard Addison, Commissioner for Native Affairs in Zululand: titled ‘A Curious “Knife and Fork”’, it noted:

As a matter of fact the Zion Tabernacle is attracting large crowds to its services and although few serious cases have been submitted to the faith healing test, several deaths have already occurred, which, it is claimed, might have been avoided had medical aid been summoned. ...But perhaps the most grave feature of the spread of the faith is its attitude towards the native races. ...⁸²

It was this latter point that elicited the most critical comment from both the reporter, and from Addison, who recalled that, just the previous year, the ‘Induna Vula brought to my notice that the doctrine of healing by faith had spread to the natives in the Estcourt division.’ He asked the Resident Magistrate of Estcourt to ‘... bring the matters to the notice of Govt if the evil still exists’.

Scholars of religious and cultural innovation in late nineteenth and early twentieth century southern Africa have often drawn our attention to the especial appeal that such movements had for societies and individuals experiencing the traumatic adjustments of the times – war and environmental disasters, displacement from land, the alienation (and excitements) of urbanization and industrialization, the impact of disease epidemics such

⁸¹ ‘Choosing to Die: Spread of “Faith Healing”’; ‘Rand Girl’s Sad Story’; ‘A “Black Peril” Danger’, R668/09, excerpt from *The Times of Natal*, 9 July 1909, included in correspondence in PAR between R. Addison, Commissioner of Native Affairs, Eshowe, Zululand and Secretary for Native Affairs (hereafter SNA) 1/1/440 1909/2567, 10 July 1909.

⁸² PAR SNA 1/1/440 1909/2567, R. Addison, Commissioner of Native Affairs, Eshowe, Zululand and Secretary for Native Affairs, 10 July 1909.

as the Great 'Flu pandemic of 1918-1919, and the manifold cultural collisions, confusions and innovations that accompanied these upheavals.⁸³ In the previous chapter, I suggested that certain forms of spirit possession – such as *indiki* and *ufufunyane* – that emerged at the close of the 1800s, and then underwent various transformations, were reflexive of the fluidity and responsiveness of local idioms of psychological distress. I also noted that some behaviours that might have been classed by psychiatrists as 'hysterical' were embraced as acceptable forms of worship in the syncretic churches of Natal and Zululand. It would be absurd – and far from my intention – to suggest that there is a straight-forward relationship between extreme personal and social suffering and religious beliefs and practices. It is nonetheless the case that religious, spiritual and other movements that explicitly offered healing as a major focus, must have drawn adherents who were searching for solace from ailments whose origin lay in body, mind or spirit.⁸⁴ Such an argument is even more compelling when we recall that it was only 'Western' science that insisted on such a separation. For many inhabitants of Natal and Zululand – Africans, Indians and whites – the hope of healing via faith or through divine grace remained a very real possibility. That specialists appeared to meet their needs should come as no surprise.

⁸³ See R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 2000), Chapters 1, 4, and Conclusion, for a sensitive exploration of the links between Christianity, African agency, and social responses to the exigencies of the period.

⁸⁴ The literature is vast. In addition to *African Apocalypse*, for Natal, see also M. R. Mahoney, 'The Millennium Comes to Mapumulo: Popular Christianity in Rural Natal, 1866-1906', *Journal of Southern African Studies*, 25, 3 (September 1999), pp. 375-391. On the Nazarite (Shembe) Church – so important in this region from 1910 onwards – see 'Introduction: Isaiah Shembe, Place, Power and the Languages of Prophecy', in E. Gunner, *The Man of Heaven and The Beautiful Ones of God: Writings from Ibandla lamaNazaretha, a South African Church* (Leiden, Boston and Köln Brill, 2002). Several very useful essays can be found in R. Elphick and R. Davenport (eds.) *Christianity in South Africa: A Political, Social and Cultural History* (Cape Town: David Philip, 1997). This latter volume provides many insights into the interactions of southern Africa's diverse religious strands with biomedicine, witchcraft, and healing; something which I unfortunately do not have the space to develop further here. More research is needed, too, into Islamic and Hindu interactions and separate areas of concern with relation to healing, broadly defined.

With urbanization and increasing commercialization, especially from the early twentieth century, a wide variety of medications also became available for purchase in the town markets. James McCord reported to Campbell Watt in 1918 that:

[S]ome time ago I examined and invested in some of the native medicine on sale at the Native Market in Durban. Among other medicines, I noticed a piece of crocodile skin, which if put in cough medicines increases their efficacy. The feathers and skin of a vulture as a cure for insanity. Powdered cuttle fish for sore eyes. The powdered dried flesh of a snake as a cure for witchcraft etc. etc. etc....⁸⁵

Also available for purchase would have been substances such caustic soda, 'quicksilver', and 'acid stone', that could be ground into blue or white powders; as well as the flesh and fat of animals, dried insects, and fresh and dried herbs. Given the differing medical epistemologies governing the mixing and administering of ingredients, some of these treatments could prove disastrous to the patient. McCord related that the Reverend Johannes Astrup of Untunjambili Mission Station had written, scathingly, about the case of 'one native boy here who had brain fever when he was about 8 or 9 years of age. The stupid ass of a "doctor" filled his ears with some poisonous stuff which destroyed his ears so that he is as deaf as a door post and partly dumb.'⁸⁶ As with the ingredients required to mix 'love charms' such as those required for the causing of *umhayizo*, these components were sometimes bought directly from itinerant 'Arab' traders who travelled throughout the region.⁸⁷ One such could well have been the 'Free Indian, Seetal', who in 1913 applied through the northern Natal lawyer, William Dalzel Turnbull, to the Chief Native

⁸⁵ PAR Pietermaritzburg Corporation (hereafter PC) 1/PMB 3/1/12/11 30/15, James McCord, 'The Zulu Witch Doctor and Medicine Man', MSS contained in correspondence between Lt Colonel Foxon, Chief Magistrate, Pietermaritzburg and Colonel Campbell Watt, Natal Medical Council, on 'Native Medical Facilities', 27 and 29 April 1918. McCord's memorandum argued the case by the Natal Native Affairs Reform Association to the Natal Medical Council and the state that Africans be trained locally as biomedical practitioners.

⁸⁶ *Ibid.*

⁸⁷ Campbell Collections, Durban, *The Collector*, Rev. W. Wanger (ed.), Printed as MSS at Mariannahill, No. 1 (June 1911), p.13: 142 and 145.

Commissioner for a licence to 'practice as a Native herbalist and doctor'. In his application, Seetal stated that he had 'resided in South Africa since 29th March 1895 and for the greater part of that time amongst natives and has studied the calling of a native doctor and herbalist.'⁸⁸

This direct market in medicines was of concern to government officials, biomedical doctors and also to some Africans. For instance, from Transkei, Johannesburg, and Natal, came similar reports of elder Africans' concerns about the subversive power of love medicines and of the free fraternization of the youth. In Natal the 'selling or administering [of] reputed love philtres' had been criminalized in the 1890s. Nonetheless, between 1899 and 1909 nearly three hundred Africans were arrested for this offence in Natal alone.⁸⁹ This was a separate offence from 'practising as a/or consulting a witch doctor or diviner' or from 'practising as a medicine-man or herbalist without licence', and represents perhaps the emergence of an African 'popular sector' of medicines and remedies in their broad sense. Indeed, in 1911, the chiefs of the Newcastle Division petitioned the local Magistrate on the subject of "Sale Of Love Philtres", expressing 'the wish that the sale of native medicines, by natives (as is now being carried on in nearly every town) be stopped, as they find that both boys and girls are being duped of their earnings by these vendors ...'⁹⁰

⁸⁸ PAR CNC 112 1913/390, 'Application by Free Indian Seetal No.58438 for a licence to practise as a Native herbalist and doctor', 14 March 1913. The CNC was of the opinion that Seetal did not qualify under the Natal Native Law Code of 1891 that allowed for the licensing of herbalists.

⁸⁹ Extracted from tables 'Natives Tried For Offences Committed Under The Code of Native Law', Criminal Statistics of the Colony of Natal, in *Natal Blue Books and Statistical Yearbooks*, 1899-1909.

⁹⁰ PAR CNC 176 1914/1069, 'Representations by Native Chiefs of the Newcastle Division with regard to the sale by Natives in towns of herbs and love philtres', 29 June 1911.

It was not only 'Native markets' that sold cures and medications directly to the public. Chemists supplied formal medical institutions and the general public with an assortment of products. In 1890, the Natal market was already keenly competitive with Wholesale Druggists, Dispensing and Homeopathic Chemists' Reed and Champion; as well as Raw & Co.; the Natal Drug Company; Bentley and Vanderpump, Wholesale and Manufacturing Chemists and Druggists, and Stranack & Williams; all advertising and submitting tenders – as the latter listed – for the provision of: 'Drugs, Chemicals, [and] Druggists' Sundries, Surgical Instruments & Appliances, Glass Apparatus, Patent Medicines, Proprietary Articles, Photographic Goods, Perfumery, Dutch & Homeopathic Medicines, Materials for Aerated Water Manufacturers.'⁹¹

Advertisements in newspaper, journals, as well as word-of-mouth helped to popularize and make widely accessible a range of cures and palliatives for a range of conditions. Some of the most popular tonics and cures on offer included 'Phosferine', punted as 'The Most effectual Remedy for Weakness, Lassitude, Debility, Loss of Appetite, Nervousness, Neuralgia, Toothache and other several Nerve Pains, Rheumatism, and Gout'. It retailed at 1/1½ and 2/9 per bottle. 'Reuter's Life Syrup No.1', by purifying, the blood was said to be a certain cure for 'Weakness, Nervous Debility, Headache, Dyspepsia, Fever and Ague', amongst other complaints. 'Barry's Florida Water' (double strength) was recommended for 'Exhaustion and Weakness'; headaches and 'Fainting Attacks'. Horsford's Acid Phosphate could be taken 'As Food for an Exhausted Brain, In Liver and Kidney Trouble, In Sea-Sickness and Sick Headache, In Dyspepsia, Indigestion and Constipation, In Inebriety, Despondency and cases of Impaired Nerve Function'. All these were advertised for sale by Bentley & Vanderpump, who also promised free to anyone who bought 'Ashton and Parsons' products, a copy of the 216 page 'medical guide', 'Homeopathic Advice', published in both English and Dutch.⁹² Medical journals

⁹¹ PAR Indian Immigration (hereafter II) 1/54 I358/1890, 'Tenders, Drugs, etc., For the Year Ending April 14/91'.

also carried advertisements for medications that could be supplied to both doctors and the general public: 'Guderin', promoted in the *Transvaal Medical Journal* of 1910, for example, was dubbed 'Of unsurpassed effectiveness for Anaemia, Chlorosis, Malaria, Scrofula, Rachitis, Nervousness, Women's Diseases, etc.'⁹³

The advertisement by Bentley and Vanderpump points to a therapeutic tradition so far neglected in this dissertation, that of 'Dutch' or 'Boer' remedies. Edmund Burrows writes, somewhat dismissively, that these were 'an interesting blend of empiricism, rational thought and rank superstition', and included plasters, salves and medicaments that combined herbs, plant extracts, tonics and astringents such as brandy and vinegar, as well as animal fats, oils, and the 'body fluids or excreta of wild animals.'⁹⁴ The medicine given to Ida Elsie Tollner, described at the beginning of this chapter, with its 'extract of the throat of a goat', may have had its origins in Boer medicines and treatments, many of which could also be found in African medicines or therapeutic strategies; for instance, 'steaming' the illness from a person by wrapping them in the skin of an animal and placing them close to or over a fire. The majority of the remedies, however, were derived from herbal infusions or applied as poultices 'Cape' or Boer remedies found increasing respectability after the mid-1800s, and were extensively researched by botanists and doctors, as well as by private peddlers of proprietary medicines. A collection of Cape medicines was sent to the London Exhibition of 1851, and in 1886 'a collection of South African herbal plants' was exhibited at the Colonial and Indian Exhibition.⁹⁵ Dutch remedies were usually self-administered, though some biomedical doctors and pharmacists, such as John W. Akerman, a Pietermaritzburg chemist, also prescribed them

⁹² PAR II 1/54 1358/1890, 'Tenders, Drugs, etc., For the Year Ending April 14/91'. Pamphlet produced by Bentley and Vanderpump, Wholesale and Manufacturing Chemists and Druggists.

⁹³ *The Transvaal Medical Journal*, v, 12 (July 1910), p.iii.

⁹⁴ E.H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town: A.A. Balkema, 1958), p. 192. See pp. 188-194.

⁹⁵ Laidler and Gelfland, *South Africa, Its Medical History*, pp.348-351.

freely.⁹⁶ The entrance of pre-packaged 'Dutch Medicines' into the mainstream of commercially provided medicines came at a time when homeopathic therapies were enjoying great popularity.

An increasingly exploited means of reaching a market was through mail order. 'Professor August Beissner' of the Sweetwaters Natural Healing Institute claimed to have 'treated thousands by letter.'⁹⁷ Also active in South Africa in the first decade of the twentieth century was 'The Eucrazy Company', which laid claim to 'The Only Positive Cure For Drunkenness, Liquor, Tobacco and Drug Habit'. With its South African branch based in Johannesburg, and offices in America, Canada, England and Australia, the company appears to have (if its claims can be believed at all) to have provided a desperately needed service across much of the British colonial world. In a letter to one P.M Nel Esq. of Krantzkop, manager R M. Newton claimed 'we have a record of over three thousand cures during the first year of establishment in our South African branch (having as many letters on file from our clients to prove it) these to be added to the million odd cures which have been effected in other parts of the world during the past thirty years ...'⁹⁸ This was not, however, a random postal appeal. The letter opens by saying:

Once more we take the liberty of writing to you professionally. That there is an urgent need for our services is evident from the fact that our advertisement impressed you sufficiently to induce you to write to us regarding our treatment, and that some of your relations or friends are really in need of the assistance we can render.

We do not wish to annoy or presume upon your valuable time with frequent letters, but out of respect for the interest you have manifested thus far in us and our successful treatment, we write again, at the same time enclosing herewith two more editions of our South African testimonials, as well as a few

⁹⁶ Laidler and Gelfland, *South Africa, Its Medical History*, p. 351.

⁹⁷ Laidler and Gelfland, *South Africa, Its Medical History*, p.348.

⁹⁸ PAR 1/KRK 3/1/5 LKK 1003E/1904, 'The Eucrazy Co..' Davy's Chambers, PO Box 6164, Rissik Street, Johannesburg, to P.M. Nel Esq., Krantzkop, via Greytown, 15 July 1904.

clippings from the daily papers, which, we can assure you, you will find most interesting and instructive.

The sales pitch walks a fine line between alarming a potential client as to the shame attached to having an alcoholic family member and persuading him of the necessity for their treatment – of which unfortunately no details are given. The appeal linked fears of social stigma, moral degeneracy, claims of scientific proof, and urged Nel to respond immediately.

That Alcohol is more of a disease than a voluntary vice, has become a crystallized fact. This will be amply borne out by the enclosed report of a Medical Congress in discussing “Degeneracy the outgrowth of Alcoholism.”

The moral phase of the question will be so familiar to you, that it is not necessary to dwell on the ravages caused by these horrible evils, viz. home and family life ruined – business destroyed – loss of self-respect – integrity most unstable – utter disregard of consequences, only too obvious – and the dread Nemesis stalking the victim until the terrible end comes.

Should you be unfortunate enough to have a member of your family, a relative or friend on the downward grade, do not hesitate to avail yourself of the help we offer you. Delays are dangerous, and time is inexorable – it will wait for no man. Why not to-day in this most serious matter? Tomorrow may be too late.⁹⁹

African herbalists and health practitioners also expanded their commercial activities in the years immediately before the First World War, and deployed the language of biomedical terminology as well as incorporating some of the symbolic and practical tools of ‘western’ medicine and pharmacology. Catherine Burns has written about the remarkable Louisa Mvemve – ‘herbalist, “women’s healer”, fertility expert and chemist’ – who, operating from the Eastern Cape and the Rand, from the second decade of the twentieth century, herself ‘travelled vast distances to set-up dealers networks for her cures in rural parts of the Transkei, Eastern Cape, Transvaal and even Lesotho.’¹⁰⁰ She also patented and packaged her cures as modern medicines. In the 1920s, as Karen Flint

⁹⁹ *Ibid.*

¹⁰⁰ C. Burns, ‘Louisa Mvemve: A Woman’s Advice to the Public on the Cure of Various Diseases’, in *Kronos: Journal of Cape History*, 23, (November 1996), pp. 108-134. Quotation from pp. 108-109.

has shown, there was competition between white chemists and other providers of cures to Africans as well as whites. Some of these were dispensed through the post. Remedies that were advertised included those that promised to cure ‘insanity’, and especially ‘hysteria’ in girls and women. Although dated a full decade after the close of the period focused on in this dissertation, this extract from an advertisement for ‘Medicines of Africa – Manufactured in Africa – Manufactured for Africans – By the People of Africa’ demonstrates very clearly how commercialised remedies reflected both changes and continuities in African medical practice and conceptions of insanity:

THE KEEP QUIET GIRL MIXTURE

Medicines for Hysteria. This medicine helps a girl very much who has been given love charms (or potions) and suffers from hysteria.

Even if the love charm had caused her to be insane. The medicine will immediately give her relief.

Price 4/6, per post 5/6.¹⁰¹

Another advertisement (for ‘Dr Joffres Corrective Mixtures for Females’) from the same proprietors echoes strongly the terminology employed by the Eucrazy Company more than twenty years earlier: ‘Therefore write and explain how you feel. The Basuto Africans say delay breeds ruination. Therefore do not delay. Write immediately and do not be afraid.’¹⁰²

¹⁰¹ NAR NTS 6758 62/315, ‘The great chemist of Africans’.

¹⁰² *Ibid.*

Conclusions: In their own hands

Reframing the history of mental illness in terms of a wider understanding of the search for solace from disorders that could range from mild melancholy and persistent misery, to frightening mood shifts, violence and terrifying hallucinations, as well as congenital ‘conditions’ that resulted in mental retardation (to use a more recent terminology), enables us to shift our focus from the realm of colonial psychiatry, healing specialists – however defined – and asylums, and to ask a set of new questions about the social history of the quest for mental health. How did those most directly affected by a mentally or emotionally disturbed family member respond? What curative or custodial options were available in the context of Natal and Zululand in the late nineteenth and early twentieth centuries: and, to whom? Which was chosen in preference to another, and at what point in the process of managing madness were specialists – ‘traditional’ folk healers, biomedical doctors, faith healers, or providers of various therapies – regarded as being the most appropriate, or needed, resource? What possibilities for self-medication were procurable through the commercial sector?

Above all, we are prompted to reconsider the centrality of a psychiatric profession that was, in the period before 1918, still of limited impact in this region. Not only was the ambit of colonial psychiatry in some senses narrower than it would become in the later twentieth century – with such matters as the state of mind of the *amandiki* being determined by the law courts of Natal and not its doctors – but even by Union in 1910, the majority of people officially registered as being ‘insane or imbecile’ were still to be found in accommodation outside the country’s mental hospitals. As this and the previous chapter have shown, not only did the majority of the people in this region continue to seek healing within the therapeutic paradigm with which they were most familiar, but even for white Natalians, psychiatric medicine and the asylum were usually places of final, and not first, recourse for families struggling to care or control a mentally disturbed person. ‘Care in the community’, nursing homes, self-administered remedies and healing

by other means, were all as, if not more, important in the negotiation of a path to restoring a person's mind and body than the Pietermaritzburg Mental Hospital.

Nonetheless, by World War 1, Physician Superintendents of the country's psychiatric hospitals complained that they were understaffed and over-worked and that they and their staff were themselves under enormous physical and psychological strain.¹⁰³ All the asylums were full to overflowing. This was in part because, in the absence of social welfare institutions that could provide something of a safety net to catch the indigent elderly or neglected disabled before they fell through the social cracks, asylums continued to be one option for the placement of such persons. It was also partly because, despite the stigma attached to having a mad relative, many families – African as well as white – were increasingly calling upon the state to take charge of the troublesome and the disruptive. Indeed, as this chapter has shown with regard to alcoholism, by the late nineteenth century important shifts were underway in the perception of what constituted a psychiatric disorder.

The rise in inmates was also a consequence of the boosting of South Africa's fledgling psychiatric profession by a number of important pieces of legislation in the second and third decades of the twentieth century. The most important of these – which will be discussed in greater depth in Chapter 6 – were the Mental Disorders Act of 1916, and the Medical, Dental and Pharmacy Bill of 1928. The former reworked and expanded the classification of persons who could legally be classified as mentally disordered or defective and the latter Act moved to drastically restrict the room in which healers who were not officially recognised could manoeuvre. However, despite the beginning in 1919, 'in earnest', of what has been described as a process 'to bolster the authority of medical

¹⁰³ One example, amongst several, of such a state of affairs can be seen in a confidential letter from Dr A.D. Pringle, Senior Assistant, Physician Superintendent of the NGA, Pietermaritzburg to the then Colonial Secretary, Shawe, dated 14 August 1911. NAR CS 986 20397, 'Dr. A.D. Pringle'.

knowledge and the right to heal',¹⁰⁴ and despite the steady rise in numbers of psychiatric patients over the following decades, the search for solace in the face of mental suffering continued – as it does today – to take a variety of forms, some more orthodox than others.

Sometimes, a solution to the extremes of personal pain was taken literally in the hands of the afflicted, who turned to suicide as a final resort. In the history of Natal, self-destruction has often been written about in the context of Natal's Indian population, who often had little option but to live in exploitative and extremely harsh conditions. Suicide was a response to, or protest against, an intolerable situation. By contrast, Africans, it has been said, had strong taboos against self-annihilation, and so suicide has been highly unusual. Both views posit a relationship between race, culture and suicide. It is to this discussion, and to the place of suicide in the context of the social history of mental illness and of mental health in Natal, that I turn next.

¹⁰⁴ Burns, 'Louisa Mvemve: A Woman's Advice to the Public', p. 121.

Chapter 5

Death in Black and White: Race, Suicide and the Colonial State

We have given the remarks of the Protector on this painful subject in full, and we cannot help expressing our surprise that it has been dismissed so light-heartedly. Suicides among indentured Indians have become a feature year after year, and we think that the cause ought to be probed to the bottom. And it is hardly an answer coming from the Protector of Indians that he cannot arrive at even a probable cause if those who are supposed to know decline to give any information... There is enough in the Protector's statement to shew that there must be something wrong...¹

Editorial, *Indian Opinion*, 4 June 1904

On Friday before last ... came Gwai-ka-Sobanga to me from the kraal of Mpumpuluza ... a neighbour of Mhlahlo to report to me that a woman – the wife of Mhlahlo – had cut her throat. I accordingly went to see her and found her still alive. I asked her how such an unusual thing had occurred and she told me that her “heart” had directed her to cut her throat and accordingly she did so. I then sent Tribal Constable, Ngcubana, to report to the Magistrate. I asked if she had not quarrelled with her husband that she committed such an act and she repeated: “No, chief, my heart made me do it!”²

Testimony of Chief Manqamu kaSomelomo
Lower Umfolozi Division
23 November 1909

He is very depressed on account of experiencing auditory hallucinations of an abusive character; voices malign him saying he is a German spy. Other virulent abuse is shouted at him and people collect to stare and talk about him. His depression might easily result in suicidal impulses. He requires care in a Mental Hospital.³

Dr Robert Sinclair Black, Physician Superintendent, Mental Hospital,
Pietermaritzburg,
30 March 1917

¹ *Indian Opinion*, 4 June 1904. Quoted in S. Bhana and B. Pachai, *A Documentary History of Indian South Africans* (Cape Town and Johannesburg: David Philip, 1984), pp. 18-20.

² Durban Archives Repository (hereafter DAR) EPI/1 3/2/13 LU 727, 'Medical certificate and Report on Suicide, at Mhlalilo's kraal, Chief Manqamu's ward, Reserve IV, of a native woman, Banonilie Mhlahlo'. Testimony of Chief Manqamu-ka-Somelomo, of the Umbonambi Tribe before Magistrate A.R. R. Turnbull, Lower Umfolozi District, 23 November 1909.

³ Pietermaritzburg Archives Repository (hereafter PAR) Registrar Supreme Court (hereafter RSC) 1/27/3, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 73/17, 'Harold King of D.H. Section, No. 3 General Hospital, Durban', 5 April 1917. Reception Order granted on 22 March 1917. Form Mental S. 9 'Report of District Surgeon or Other Medical Practitioner or Physician Superintendent of Mental Hospital', signed by Dr R. Sinclair Black, 30 March 1917.

‘This painful subject’

Until relatively recently, the act of deliberately attempting to take one’s own life was regarded as primarily a legal, rather than a medical, matter. The move towards the understanding of suicidal behaviours as being rooted in psychological disturbance, or in response to social conditions, or, more recently, in a complex interaction between individual biochemistry and the psycho-social, did not necessarily take place swiftly or uniformly, however.⁴ In Britain, for example, even alongside the growing acceptance of suicide as a mental health ‘problem’, especially in the middle decades of the twentieth century, attempted suicide remained a criminal offence until the early 1960s. This was also the case in southern Africa.⁵ Although, by the nineteenth century, in the West suicide had been widely accepted as being the consequence of insanity – a mind temporarily unbalanced – there remained ambiguity about the most appropriate manner of official responses to suicide, and about the place of medicine, more particularly psychiatry, in restraining or treating those who expressed the will towards self-destruction.⁶

The history of suicide in Natal and Zululand in the period before World War 1 reflects, in part, these different stances. On the one hand, ‘attempting suicide or threatening suicide’ was criminalized, and was punishable by three months’

⁴ Considerable debate has emerged recently in the literature about precise definitions of ‘suicide’ and ‘attempted suicide’, with the latter being particularly problematic. Some of the difficulties arise from the observations that, while on the one hand not all acts of deliberate self-harm are characterized by suicidal ideation – the wish to die – on the other, some highly risky behaviours might be seen as ‘courting death’. For the purposes of my discussion, I shall be relying largely on the official designations of suicide and attempted suicide, and will not speculate beyond these into the realm of individual motivations behind acts that might have incited or invited death, such as ‘suicidal attacks’ during times of military conflict or ‘high risk behaviours’ such as alcoholism or dangerous sporting activities.

⁵ Suicide was decriminalized in Britain by the 1961 Suicide Act, and in South Africa in 1962 by *State vs. Gordon*, and upheld in 1970 in *State vs. Grotjohn*. See J. Burchell and J. Milton, *Principles of Criminal Law*, second edition (Lansdowne: Juta & Co., 1997), p. 471.

⁶ For the secularisation and later medicalisation of suicide in Britain, see M. MacDonald ‘The Medicalisation of Suicide in England: Laymen, Physicians, and Cultural Change, 1500-1870’

imprisonment, sometimes with hard labour. On the other hand, the first clause of the 1868 Natal Custody of Lunatics Act stated that: ‘If any person shall be discovered and apprehended under circumstances denoting derangement of mind, and a purpose of committing suicide...’ then this was sufficient ground on which to have that person confirmed as a lunatic, and confined to any place designated as an asylum.⁷ Nearly a half century later, the Mental Disorders Act of 1916 confirmed ‘... a mentally disordered or defective person shall mean any person who in consequence of mental disorder or disease or permanent defect of reason or mind is incapable of managing himself or his affairs or is in consequence of such disorder or disease or defect a danger to himself or others ...’.⁸ After medical certification by two duly qualified practitioners, a magistrate could issue a Reception Order for the admission of persons to a mental institution. One of the six categories of justification for such detention was if the person was judged to be ‘of suicidal tendency or in any way dangerous to himself [sic] or others.’⁹ Thus, by the twentieth century, in Natal the will to suicide could be regarded as a mental – rather than a moral – failing, and therefore more appropriately the business of ‘medical men’ and those who stated purpose was to console troubled minds, rather than of judges and gaolers.

The three quotations with which I introduce this chapter reflect something of the complicated history of suicide in this region in the decades before World War 1. The first is excerpted from an editorial published in 1904 in *Indian Opinion*, the newspaper begun by Gandhi just one year before, which highlighted the high death rate among Indians in Natal, and drew particular attention to the 31 deaths that had occurred in the previous year as a result of suicide. It openly called upon the colonial government to institute a Commission of Enquiry into ‘this painful subject’. No such

in C. E. Rosenberg and J. Golden (eds.) *Framing Disease: Studies in Cultural History* (New Brunswick, New Jersey: Rutgers University Press, 1992), pp. 85-103.

⁷ Natal Law No. 1(1868), ‘The Custody of Lunatics Law’, Section 1.

⁸ Union of South Africa, Mental Disorders Act, 1916 (Act No.38 of 1916), Introduction, Section 2 (1).

commission into the rate of suicide in colonial Natal was ever held, but since the early twentieth century the history of the relationship between suicide – threatened, attempted and completed – and race and culture (often conflated) is one that has acquired some attention in this region. Most studies have continued to focus on the experiences of people of Indian origin and descent, and it has become almost routine to note the high rate of suicide by indentured workers.

In the past fifty or so years, suicide by South African Indians has also become an important area of study for psychologists and sociologists, who have frequently emphasized two main points: that records reflect Natal's Indian population as having had consistently high suicide rates since the late 1800s; and that self-killing by Africans has, until very recently – perhaps the last twenty years – been extremely unusual.¹⁰ Yet, as the second quotation – from an enquiry by a colonial magistrate into the self-inflicted death of Banonile, a woman said to have been about 'thirty three years of age' – shows, suicide was not unknown amongst Africans. Perhaps it was not the 'taboo surrounded by silence' that many twentieth century anthropologists and social scientists would suggest.¹¹ Furthermore, despite the fact that, since the 1960s, the incidence of suicide amongst whites in this region has exceeded that of Indians, shifting patterns of suicide across racial categories have not been studied – let alone

⁹ Union of South Africa, Mental Disorders Act, 1916 (Act No.38 of 1916), Chapter 1, Section 6 (4 c). See Chapter 6 of this dissertation for a more detailed discussion of this Act.

¹⁰ Sociologist Fatima Meer's *Race and Suicide in South Africa* (London: Routledge and Kegan Paul, 1976) was extremely influential in the study of suicide among Indians in this region from the 1940s to the 1970s. Since the late 1980s, Professor Lourens Schlebusch of the University of Natal's Medical School has organized a series of conferences on suicidology and there is a journal – *Suicidal Behaviour* – that publishes the proceedings. For current studies by psychologists, see A. L. Pillay, 'Family Dynamics and Adolescent Parasuicide: A South African Indian Sample' (PhD. Dissertation, University of Natal, Pietermaritzburg, 1989) and A.J. Hare, 'An investigation into the relationship between suicide intent, attributional style and coping style in a sample of female Indian and Coloured adolescent parasuicides', (unpublished M.Sc. thesis, University of Natal, Pietermaritzburg, 1995).

¹¹ This phrase is from G. Minios, *History of Suicide: Voluntary Death in Western Culture*, Translated by L. G. Cochrane (Baltimore: The Johns Hopkins University Press, 1999), p. 320, but as I hope to show in this chapter, it is one that aptly reflects often-repeated views about African attitudes towards suicide that claim that such acts were virtually non-existent until very recent times.

explained – by historians.¹² We know very little about the incidence of suicide amongst whites in Natal and Zululand in the late nineteenth and early twentieth centuries, but as the quotation from the report by Dr R. Sinclair Black on a South African soldier who had been on active service in the ‘German South West African campaign’ illustrates, by 1917, if not earlier, threats of suicide were also made by whites, and could be a significant factor in deciding whether or not to have a person confined within a mental hospital.

Indeed, examining the (European) patient records that have been preserved in the sole surviving Case-Book from the Natal Government Asylum (NGA) and also looking through the ‘Reception Orders’ of the first admissions to the Pietermaritzburg Mental Hospital, as the NGA was then known, after 1916, one is struck by the frequency with which suicidal behaviours are noted. Of the first nine whites admitted under the Mental Disorders Act of 1916, three were justified on the grounds of suicidal behaviours or threats. Yet, Europeans were seldom charged with the crime of attempting or threatening suicide. This, I would suggest, was in part because, while the penalties for this crime ostensibly applied to all the region’s subjects, race and class – and less overtly, gender – influenced the ways that suicide came to the notice of the state. This in turn had important implications for the recording of suicide statistics, giving us a possibly skewed picture of patterns of suicidal acts at this time. For, as many scholars have reminded us, there is no straightforward correlation

¹² It is beyond the scope of my study to speculate about the persistence of high rates of suicide by Natal Indians between 1918 and the 1960s, and into today. Such a trajectory would be very hard to trace given the multiple variables that would have to be taken into account for such a long stretch of time. Most sources which focus on the more recent period transfer the pressures and conditions experienced by indentured workers to the experiences of Indians in segregationist and apartheid South Africa, explaining the continued high rate of suicide in terms of alienation, racial and economic marginalization, and acculturation in a manner that is not periodized. My argument here is not that Indians in Natal did not have higher rates of suicide than whites or Africans at the time, but that the conditions of their indenture have left us with a particularly clear picture of suicide amongst indentured workers and that suicide became a matter for medical attention for whites sooner than it did for Africans or Indians.

between official statistics and the actual incidence of self-inflicted injuries or death.¹³ The published records in fact give very little information at all about suicide amongst whites, and only slightly more about Africans, who were more likely than either whites or Indians to be charged with attempting or threatening to kill themselves. They do tell us that Indians in Natal had by far the highest recorded rate of *completed* suicides. This picture requires further scrutiny.

There are thus several reasons why suicide should be included in a consideration of the histories of mental illness and mental health in this region. Not the least of these is the prominence of suicide in the social profile of Natal Indians over the past century and more. Such a discussion is even more important when we note that it is largely by examining the history of suicide in Natal and Zululand that it becomes possible to include South African Indians in a consideration of the reach of colonial psychiatric practice and ideas. As pointed out in Chapter 2, Natal's Indian population was under-represented in the number of asylum patients throughout this period, so we have precious little information about their interactions with western psychiatry. Although there are several historical accounts of the state of health, mortality and morbidity amongst indentured Indians, until the studies of anthropologist Hilda Kuper in the mid-twentieth century, our knowledge of Indian therapeutic practices is scanty, at best.¹⁴ Colonial officials, missionaries and biomedical doctors were also largely

¹³ The difficulties of deciding what constitutes 'suicide', and the translation of official data into facts, trends, and patterns, are clearly laid out in J. M. Atkinson, *Discovering Suicide: Studies in the Social Organization of Sudden Death* (London: Macmillan, 1978), and by U. Bille-Brahe, 'Sociology and Suicidal Behaviour' in K. Hawton and K. van Heeringen (eds.), *The International Handbook of Suicide and Attempted Suicide* (Chichester: John Wiley & Sons Ltd., 2000), pp. 194-5, and in the Introduction by Hawton and van Heeringen..

¹⁴ H. Kuper, *Indian People in Natal* (Pietermaritzburg: University of Natal Press, 1960), especially Chapter XIII; for Indian-African interactions in health and healing, see K.E. Flint, 'Competition, Race and Professionalization: African Healers and White Medical Practitioners in Natal, South Africa in the Early Twentieth Century', *Social History of Medicine*, 14, 2 (August 2001), pp.199-221; Marcia Wright has recently begun to explore the history of public health in Natal and is particularly interested in Indian morbidity and mortality, see her work cited later in this chapter. J.B. and P. Brain made early significant contributions in their two papers, 'The health of indentured migrants to Natal, 1860-1911' in the *South African Medical Journal (SAMJ)*, 62, 6 (November 1982), pp. 739-742; and 'Nostalgia and alligator bite: morbidity and mortality among Indian migrants to Natal, 1884-1891' in *SAMJ*, 65, 21 (January 1984), pp. 98-102.

ignorant or dismissive of imported Indian medical, psychological, and spiritual beliefs about illness, disease and well-being, and almost nothing was written about Indians' own attempts to manage bodily or mental health. Thus, unlike the *amandiki*, or Africans experiencing other forms of psychological distress, or 'Zulu medicine' in general, there is no rich history of Indian healing strategies in this area.

The bulk of this chapter, then, is devoted to discussing the significance of suicide amongst what were often known as 'Natal Indians' in the period before 1918. Rather than merely reiterating the distressingly high rate of self-killing, however, I shall attempt to address the question of why so few Indians who finally took their own lives were admitted to the NGA and why their states of mind preceding their death were not regarded as being of concern to the colony's 'mental specialists'. This requires something of an excursion from a sole focus on suicide, to examine the relationship between Natal's Indians, medicine, and the colonial state. While making explicit provision for the medical treatment of ill Indians, on the one hand, the state was also instrumental – through its policy of returning invalidated or insane indentured and some ex-indentured workers to India – in diverting away from the NGA some persons who might otherwise have been committed as lunatics. Records of legal wrangles between the government of Natal and the employers of indentured workers reveal the reluctance of either to bear the costs of treating and accommodating Indians at the colony's asylum.

These two factors may have combined to limit the number of Indian asylum inmates at this time. So, too, may have Indian resistance to western biomedicine, including psychiatry, and its institutions. Such rejection and resistance could have been expressed in a search for solace from psychological and emotional suffering through religious and other channels, through attempts to ignore or obliterate pain through self-administered medications and drugs (such as *cannabis* and opium; included in this category could also be alcohol). And, finally, the death by suicide of several hundred Indians at this time may be regarded as an understandable reaction to their

experiences of alienation and mental anguish resulting from intolerable living and working conditions.

There are also, however, a number of further questions that can be explored when we consider the histories of suicide, mental illness and the role – or limitations of – colonial psychiatry at this time. For instance, the paucity of research into suicide amongst those other than of Indian descent in Natal and Zululand begs the question of whether self-killing amongst these ‘groups’ was really as rare as the figures would suggest. One answer may of course lie in differing rates of suicide amongst three rather different broad ‘cultures’. But this is unlikely to be the whole picture, for, albeit not systematized in the same way as the ample testimony of suicides for Indians, there is sufficient archival evidence to suggest that self-annihilation by both Africans and whites was not entirely taboo, and that the layers of silence that surround its history may in part be attributed to differences in record-keeping as well as to actual practice.

Until the mid-1900s, such records were not a concern of colonial psychiatry, the institutions of which were – as this dissertation has argued – in any case limited in influence throughout Natal and Zululand until the period after World War I. Nor was such data collected through a concern with suicides *per se*. Rather, statistical information about suicide was recorded in a variety of sites, according to concerns on the part of the colonial state about different groups of people in the region, with these groups being demarcated by race. Some of the visibility of Indian suicides may be explained by the greater extent of state surveillance over Indians than over Africans or whites. In the middle sections of this chapter, I therefore consider the means and the will evident on the part of the authorities to note self-inflicted deaths amongst those whom it was unable or unwilling to police quite as closely as it did Natal’s Indian workers.

Similarly, in order to explain the committal rates of persons ‘dangerous to themselves’, I look at the readiness of families, doctors, employers or officials to refer those suspected of being ‘of suicidal tendency’ to the asylum, or other private

institutions as described in the previous chapter. Even into the twentieth century, and after several decades of the existence of the NGA as a flagship institution in southern Africa, considerable stigma was attached to having a relative in a mental hospital.¹⁵ Furthermore, as the case of Thomas Phipson shows, for whites at least, suicide in the family carried a heavy burden of shame. (Phipson, it will be recalled, battled a ‘mental malady’ for many years before hanging himself on the window bars of the ‘Maritzburg gaol in 1876.¹⁶) His biographer goes so far as to say that the relative obscurity of Phipson’s political thought and commentaries in the twentieth century was in part due to ‘... his sensational death, by his own hand, under circumstances of terrible strain, [which] led his family to drop a curtain of silence over his memory – at any rate so far as concerned the world outside.’¹⁷ The decision to report a suicidal death as such, then, or to seek to have a suicidal family member or member of the community removed to a mental institution was therefore not one to be taken lightly. The final section of this chapter – ‘the burden of civilization’ – suggests that such decisions were related to the timing at which the ‘painful subject’ of suicide shifted from being regarded as predominantly a criminal matter, to a mental or medico-psychiatric issue.

¹⁵ National Archives Repository, Pretoria (hereafter NAR) Prime Minister’s Office (hereafter PM) 1/1/322 184/2/1913, ‘Public Health: Extension of Lunatic and Leper Asylums’, Memorandum from Dr. J.T. Dunston to Secretary for the Interior, undated but probably February 1913

¹⁶ See previous chapter and R.N. Currey (ed.) *Letters and Other Writings of a Natal Sheriff, 1815-1876, Selected and Introduced and edited by R.N. Currey*, (Cape Town: Oxford University Press, 1968), p. 223. This is not to suggest that all acts of suicide were the consequence of mental illness. The taking of one’s own life as a rational choice is one that has a long history and can be found in many cultures. For a very accessible and sympathetic overview of the history of suicide, see K. Redfield Jamison, *Night Falls Fast: Understanding Suicide* (London: Picador, 1999).

¹⁷ Currey (ed.), *Letters & other writings of a Natal Sheriff*, p.xiv. Phipson’s death certificate does not note his suicide, even though this was a matter of public knowledge.

Indians, mental illness, and medicine in colonial Natal

By 1904, when the *Indian Opinion* drew attention to the unacceptably high mortality rate amongst Indians in Natal, indentured workers had been coming to the colony for four decades. Rising from a total of 41,142 persons in 1891, the number of Indians grew dramatically in the twenty years that preceded the closing of the bonded labour system, and by the early twentieth century Indians outnumbered whites in the region. In 1911, there were approximately 133,000 Indians resident in Natal and Zululand, of whom nearly 70,000 were classified as ‘free Indians’, being those who had served out their contracts (or their descendants) and who had opted to remain rather than to take up the government-financed return passage to India. At this time, there were nearly 44,000 indentured Indians. The remaining Indians living in the colony – the ‘Passenger Indians’ – numbered just under 20,000 persons, and had come of their own volition to Natal as immigrants.¹⁸

The elevated morbidity and mortality (including as a result of suicide) rates of indentured Indians may be regarded as somewhat ironic given that, of all the people of the region in the late nineteenth and early twentieth centuries, Indians coming to Natal as indentured workers were those who were most thoroughly, even forcibly, brought within the ambit of Western biomedicine.¹⁹ From even before they embarked on their voyage to Natal, indentured workers from India were subject to a level of state-sponsored medical scrutiny and surveillance that exceeded that of whites and Africans. Natal Emigration Agents in India (primarily based in Madras and Calcutta) engaged

Medical officers to check the health of the prospective migrants before they embarked on one of the ships specially chartered to transport them. These had to conform to specifications with respect to size, deck space, water storage, etc., and between 1880 and 1882 each vessel had to be fitted with a Thiers automatic ventilator. Rations and water were carefully controlled. Since the Natal government had to pay the cost of transporting the workers, it was most

¹⁸ U. Dhupelia-Mesthrie, *From Cane Fields to Freedom: A Chronicle of Indian South African Life* (Cape Town: Kwela Books, 2000), p. 13.

¹⁹ Karen Flint first brought this point to my attention.

anxious to ensure that their health was good and that they were capable of manual work when they arrived.²⁰

A long list of undesirable physiological and behavioural defects was issued to the medical officers, instructing that applicants be rejected if they showed signs of contagious disease (including smallpox and syphilis), physical abnormality (including being one-eyed or having enlarged testes), and men who had formerly worked in trades such as shop-keeping or weaving were as unwelcome as beggars or ‘users of opium and ganja’.²¹ On the sea voyage, the ship’s medical officer combined medical and moral oversight and kept a ‘daily record of medical treatment, rations provided, any punishments, and any special weather condition likely to cause sickness. Single men were separated from the women and children, and the medical officer had to see that there was no clandestine intermingling.’²² After landing in Durban, and before they could be allocated to employers, the indentured immigrants were lodged in a depot where they were subjected to another medical examination. In the words of Joy and Peter Brain, anyone found to be seriously unhealthy or undesirable was either successfully treated or returned to India ‘on the next ship.’²³

While the medical screening to which indentured workers were subject was aimed at winnowing out the physically or mentally infirm, the process was by no means infallible. Ailments and illnesses – including mental disturbance or defect – could be hidden or latent, becoming evident only after the worker had been allocated to an employer in Natal. This was a not uncommon source of complaint by employers. For instance, the Commission into Indian Immigration Laws and Regulations (known as the ‘Wragg Commission’) that reported to the government in 1887 agreed with a Mr. Woods of Stockton, near Estcourt, that the workers he had received were ‘worthless’.

²⁰ J.B. Brain and P. Brain, ‘The health of indentured Indian migrants to Natal, 1860-1911’, *SAMJ*, 62, 6 (November 1982), p. 740.

²¹ Brain and Brain, ‘The health of indentured Indian migrants to Natal, 1860-1911’, p.741.

²² *Ibid.*

²³ *Ibid.*

The Commissioners found against an earlier recommendation by the office of the Protector of (Indian) Immigrants that Woods be prohibited from employing any more indentured workers since his harsh treatment of those under his care qualified him as 'not a fit and proper person to employ indentured Indians'.²⁴ The Commissioners instead reported:

We think that undue importance has been attached, by the Deputy Protector and Protector, to the complaints made by the Indians first assigned to Mr. Woods: they were an exceptionally worthless allotment. Mr. Woods describes them thus: "they were all from Calcutta, four men and two women: two of the men were imbeciles, one had his tongue hanging out and his eyeballs revolving like a madman, another was subject to fits and should have been in the asylum, and the other two men confessed to me that they had committed manslaughter in India and were just out of prison, a portion of the sentence of one having been remitted on condition that he emigrated – Kallu was his name. Maddo was the name of the other man. The women were perfectly useless; one, Mattachar, had to be carried from the railway station at Maritzburg to the Town Hill as she could not walk – she was of a weak mind and used to obey calls of nature involuntarily – she is dead. The other woman, Dorgia, after accusing all the white men about the place of raping her, and laying complaints with the Magistrate on charges of rape, which were dismissed, deserted; but not before all the white men, employed by me, left my employ by reason of these accusations ..."²⁵

As the testimony shows, Woods was of the opinion that at least one of his indentured workers should have been 'in the asylum', but he was more concerned to blame the government for having allocated him problematic and unproductive labourers.

Natal Law No. 12 of 1872 had replaced that of the 'Coolie Agent' with the office of the Protector of (Indian) Immigrants. The same law stipulated that medical treatment for indentured workers was to be provided. The districts in which Indians were employed were divided into 'Medical Circles', each with an appointed medical officer whose duty it was to visit the estates and other employers of Indians in the district,

²⁴ Natal Government Gazette (hereafter NGG) XXXIX, 2262, Tuesday, September 20 1887, Government Notice No. 430, 1887, *Report of the Commission appointed to inquire into and report upon the Indian Immigration Laws and Regulations of the Colony, and on the general condition of the Indian population of Natal*, Chapter XXVIII, p. 29. This Commission was commonly referred to as the Wragg Commission.

²⁵ NGG XXXIX, 2262, 'Wragg Commission', Chapter XXVIII, p. 30.

and to ensure the health of Indian employees. After the establishment of the Medical Circles, a number of small hospitals were built specifically for the care and treatment of Indians.²⁶ Employers were required to subsidize the provision of these medical facilities by paying a shilling a week for each indentured labourer. State-appointed doctors were to visit each estate within their 'circle' once a week, and to provide a regular update of data to the Protector on housing, sanitation, water supplies, food rations, the health of workers, and illnesses and injuries. The Protector was also to be notified immediately on the death of an indentured worker, and investigations and autopsies were carried out if any death was deemed to be due to 'unnatural causes'.

While some ailments were dealt with on site, others were referred to the larger hospitals in the towns. Surendra Bhana and Arvinkumar Bhana suggest that the high death rate (including by suicide) of indentured workers on some of the larger, and most exploitative, estates can in part be explained by the reluctance of employers to send seriously ill labourers for medical care until it was too late.²⁷ Some Indians also showed resistance to being administered with 'medicines' (which may have been no more than coloured water, or even comprised harmful substances) by *sirdars* (overseers) or managers.²⁸ While it is possible that some complaints of illness were part of a strategy to avoid heavy work – many employers accused Indian labourers of 'shirking' – being confined to a hospital was not necessarily an attractive option, and being demoted to the 'women's gang' on account of illness could mean a cut in wage, rations, and status.²⁹

²⁶ See M. Palmer, *The History of the Indians in Natal* (Cape Town: Oxford University Press for the University of Natal, 1957), pp. 39-41.

²⁷ S. Bhana and A. Bhana, 'An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911', in S. Bhana (ed.) *Essays on Indentured Indians in Natal* (Leeds: Peepal Tree Press, 1990), pp. 137-187. This quotation is from p.161.

²⁸ *Ibid.*

²⁹ *Ibid.*, and see testimony put forward before the Wragg Commission by, amongst others, Dr. F. W. Greene of the Isipingo Medical Circle, quoted in Y. Meer et al, *Documents of Indentured Labour in Natal, 1851-1917* (Durban: Institute of Black Research, 1980) , pp. 401-403.

Indians who exhibited signs of mental instability or defect were amongst those considered to be ‘untreatable’ and therefore who were repatriated to India. Medical grounds for return to India included ‘blindness, insanity (provided that there was no danger of the patient’s attacking other passengers), senility, leprosy, tertiary syphilis, phthisis, general debility, heart and liver disease, and chronic bronchitis.’³⁰ One such person was Obah (or ‘Hubah’) who in April of 1894 was the subject of some controversy between Louis H. Mason, then Protector of Immigrants, and the Resident Magistrate of Durban, R. Lucas. Remanded in gaol, presumably on a charge of vagrancy, Obah was examined by local doctor Daniel Birtwell, who noted that: ‘This man is an imbecile and has been repeatedly in gaol. He ought to be taken charge of by his friends or sent to the Asylum.’³¹ Indian interpreter, Henry Lewis Paul, added that Obah had appeared before the Court before and that on that occasion had been referred to the Protector. Indeed, earlier medical reports showed that, in 1892, Birtwell had investigated ‘the mental state of the Indian Hubah ...[and said] This man is suffering from partial paralysis of right side [sic]. Evidently a result of brain disease. He answers questions rationally – but he is both physically and mentally weak.’ Birtwell had concluded: ‘He can be released – but should be taken charge of by someone.’³² On this basis, the Resident Magistrate had written to Mason, asking what could be done. Mason, however, found that his hands were tied because Obah was in fact not an indentured labourer, but instead had come from Mauritius and therefore did not fall under his writ. Nonetheless, Obah’s subsequent arrests were taken up by the *Natal Advertiser*, which accused the Protector of callous disregard, and, according to Mason’s indignant retort to the Resident Magistrate had implied

³⁰ Brain and Brain, ‘The health of indentured Indian migrants to Natal, 1860-1911’, p. 742.

³¹ PAR Indian Immigration (hereafter II) vol. 1/73 I474/94, ‘District Surgeon, Durban, Report on the Mental [State] of Obah and Indian Prisoner’, 23 April 1894. Dr. D. Birtwell, District Surgeon, Durban to Resident Magistrate Durban, 21 April 1894.

³² PAR II 1/73 I474/94, ‘District Surgeon, Durban, Report on the Mental [State] of Obah and Indian Prisoner’, 23 April 1894, enclosing 5082/1892, with 2205/94, ‘Dr. D. Birtwell, District Surgeon, Durban to Resident Magistrate Durban, 30 September 1892’.

‘that I kicked him out and that I did not care one rap whether he died or not.’³³ After his 1894 arrest, the matter of Obah’s ‘repatriation’ was speedily sanctioned, he having ‘expressed himself willing and desirous to return to India’.³⁴

Especially noteworthy is the fact that although he was apparently not then or formerly an indentured worker, the colonial state preferred to have the ‘imbecile Obah’ returned to India at its expense rather than to fund his committal to the NGA as a mental patient, evidence that in the case of indentured and ‘free Indians’ who, for reasons of chronic or mental illness, were likely to become a burden to the state, the favoured option was repatriation. In 1902, for instance, Messrs Angus & Co., of Dalton, notified the Resident Magistrate of New Hanover that Shanmugum, who had been indentured to them for four years, had tried to commit suicide.³⁵ Shanmugum was placed in gaol, and then, when it was abundantly clear that he was an ill man, was sent to Pietermaritzburg for admission to a hospital. There, Dr. Currie found that Shanmugum was ‘suffering from disease of the brain and atrophy of both optic nerves and will probably become totally blind’. He was also apparently suffering from syphilis. When Angus & Co. were given Shanmugum’s prognosis, they agreed that he could be repatriated, although they were somewhat reluctant to see this happen, since they were ‘very short of labour’. James A. Polkinghorne, then Protector of Immigrants, arranged for Shanmugum to be on board the ship S.S. “Congella”, which left Durban in August 1902. He also arranged for Shanmugum to be met at the railway station in Durban because he was too blind to find his own way.

³³ PAR II 1/73 I474/94, ‘District Surgeon, Durban, Report on the Mental [State] of Obah and Indian Prisoner’, 23 April 1894’, enclosing 5082/1892, with 2205/94, ‘L. Mason, Protector of Immigrants to Resident Magistrate Durban, 4 October 1892’.

³⁴ PAR II 1/73 I474/94, ‘District Surgeon, Durban, Report on the Mental [State] of Obah and Indian Prisoner’, 23 April 1894. Sub-Inspector, Durban Gaol to Dr. D. Birtwell, District Surgeon, Durban, 30 April 1894.

³⁵ This account of the experiences of Shanmugum has been compiled from correspondence in the PAR file II 1/108 I1025 N.H. 152/020, ‘Magistrate, New Hanover, Indian Shanmugum Indentured to Messrs Angus & Co., Dalton, Attempting to Commit Suicide’, 31 May 1902.

The repatriation of insane or ‘imbecilic’ Indians was a policy that was endorsed by Hyslop, who had told the Wragg Commission: ‘If practicable, I think that arrangements should be made to send back Indian lunatics to India’. He added that he the ‘proportion of Indian lunatics in the Asylum to the population in the Colony is exceedingly small, so far as I am able to judge.’³⁶ Nonetheless, some Indians did, find themselves committed to the asylum as mental patients. As we saw in the previous chapter, a number of Indians found wandering in the veldt or in the towns were arrested and then transferred to Pietermaritzburg, in some instances, having first been treated in a hospital for some time.³⁷ Sometimes, as in the case of ‘the unfortunate woman, Kuppayee (colonial number 36783) of unsound mind’, detention in the NGA was a temporary measure before deportation to India.³⁸ Gaolers and medical attendants at hospitals were, however, often unhappy to have lunatics under their charge. While the authorities dithered for several months as to whether Kuppayee should be repatriated or committed to the NGA, she was kept at the Durban gaol. The Superintendent there complained that she ‘and other lunatics being kept there’ were a disturbance because of their ‘incessantly shouting and bellowing in their usual way, [and] neither [the Head Female warder] nor the convicts can get any proper rest or sleep.’ He concluded: ‘I would most seriously ask that the subject of locating lunatics in this gaol ... may be reconsidered.’³⁹

³⁶ Wragg Commission, 1887, Examination of James Hyslop, Resident Surgeon of Lunatic Asylum, in Meer et al, *Documents of Indentured Labour*, p. 405.

³⁷ See, for instance, the cases Muniammal and Ettyammah, PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 36/17, 7 February 1917: ‘Muniammal – female No. 103164, of Durban’, Reception Order Granted by the Chief Magistrate, Durban, 22 January 1917’ and PAR RSC 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916: R.S.C.N (M) 22/17, 13 January 1917, ‘Ettyammah, wife of Sundram Gopaul, of Kearsney, Lower Tugela Division’, Reception Order Granted by the Magistrate, Stanger, 29 December 1916’, respectively. These two women were discussed in Chapter 4.

³⁸ PAR II 1578/1890, ‘Indian Woman Kuppayee No. 36,783 of unsound mind’, 19 July 1890.

³⁹ *Ibid.*

In the absence of full patient records, it is difficult to establish why some persons suspected of being lunatics were repatriated, and why others were sent to the NGA. One distinction may have been age, and the associated degrees of physical infirmity, with employers and the state hoping that younger persons would regain sufficient health and sanity to be returned to work. Another variable would have been the willingness or otherwise of employers to bear the costs of maintaining indentured workers on their books in the asylum.

Since even before the opening of the NGA in 1880, several employers who had found their workers unsatisfactory on grounds of insanity or imbecility had had them detained in hospitals or Pietermaritzburg's temporary asylum, and some contested the state's attempts to recoup the one shilling a day charge for the upkeep of the patients.⁴⁰ In 1881 the Circuit Court in Durban overturned an earlier judgement in favour of the Protector and against the Natal Land and Colonization Company for the sum of 'twenty-four pounds eighteen shillings ... for the maintenance of an [indentured] Indian named Ramadhin No.13094 in the Lunatic Asylum, Pietermaritzburg from the 18th day of May 1877 to the 27th day of September 1878 at one shilling per diem.'⁴¹ Ramadhin had been committed as a 'dangerous lunatic' and later 'discharged as cured and returned to work.' The Protector had argued that the Natal Land and Colonization Company had contracted to 'provide to and for the said Immigrant good and compatible lodging wholesome and suitable food and proper medical attendance and medicine during the period for which the said contract was made'. The Company countered this, however, by exploiting loopholes in the colony's legislation that meant that '... no provision is made in the said Laws compelling employers of Indian Labourers charged with the commission of Criminal

⁴⁰ For example, PAR Attorney General (hereafter AGO) I/8/21 195A/1879, 'The Keeper of the Lunatic Asylum forwards the Return of Coolie Lunatics in the Asylum'. The correspondence in this file covers the six months between September 1875 and January 1876.

⁴¹ PAR AGO I/8/23 452A/1881, 'Costs/employers Indian Immigrants in Lunatic Asylum', 23 March 1881.

acts or violence in a state of lunacy to pay the cost of their maintenance.⁴² Liability for asylum costs for Indians continued to be contested between employers, the Colonial Treasury, and the Indian Immigration Trust Board. In 1906, the latter body asked Hyslop if he could find a way to reduce the costs of charges for Indians to six pence per day.⁴³ Hyslop declined to do so. Three years later, the Report of the Indian Immigration Commission (also known as the Clayton Commission) protested against the liability of the Trust Board ‘for the cost of removal to and from, and the maintenance in, any lunatic asylum of this colony of any Indian immigrant, reindentured or free, confined therein as an insane person’, arguing that the Board should be divested of such a responsibility for free Indians.⁴⁴

Important too was whether or not insane Indians had family or friends who were willing to care for them. The Protector instigated enquiries into whether relatives could be found in the cases of Obah and Kuppayee cited above: when none could be found, he endorsed their repatriation. Albeit abandoned by her husband, Muniammal clearly had some family ties in Natal, as did Ettyammiah.⁴⁵ Both were sent to the NGA, rather than being returned to India. Even when, from the 1880s, ‘free Indians’ began to outnumber indentured workers substantially, the pattern of small numbers of Indians being admitted as mental patients remained. The Wragg Commission reported in 1887 that Hyslop had said:

the present Indian inmates of the Asylum represent only a small proportion of the insane Indian population of the Colony, and we think that his opinion is well founded. In the locations of free Indians are, probably, many persons

⁴² *Ibid.*

⁴³ PAR II A 2/1/11 IIB 288, ‘Secretary, Indian Immigration Trust Board, asks that the charges for treatment of Indians in the Asylum may be reduced from 1/- to 6d. per day’, 6 July 1906’, James Hyslop, Medical Superintendent to Colonial Secretary, 29 September 1906.

⁴⁴ Document 53, ‘Lunatic Asylum Charges on Indians’, Report of the Indian Immigration Commission, 1909, quoted in Y. Meer et al, *Documents of Indentured Labour*, p. 645.

⁴⁵ It is not clear whether these two women were still under indenture or whether they were ‘free Indians’, though the evidence in their Reception Orders would tend to indicate the former. It was often difficult, in the case of very deranged patients, to establish their legal status.

whose mental condition, if reported and if complaint were made by any relative or other friend, would necessitate removal to the Lunatic Asylum.⁴⁶

Thus, it would seem that Indians themselves resisted the reach of colonial psychiatry.⁴⁷

A number of factors, then, contributed to the small number of Indians committed to the NGA in the period before World War 1. Employer reluctance to refer sick – including mentally ill – workers to doctors or hospitals until it was absolutely necessary to do so, and baulking at cutting profits (or, for some, perhaps the fine line between making any profit at all) by paying for what could be an extended stay at a mental hospital, was one. Another was the state's willingness to repatriate disruptive, diseased and unproductive former workers to India, thus relieving the colony of the burden of welfare provision, including asylum costs, and removing potential patients before the need to commit them became imperative. Yet another was the lack of alacrity with which Indians themselves referred family members to western medical authorities.

All this meant that for Indians, who experienced their lives in Natal at this time as intolerable, the colonial psychiatric establishment was distant, perhaps irrelevant. Despite, too, the provisions of the Natal Custody of Lunatics Act of 1868, reinforced by the Mental Disorders act of 1916, even those Indians who were clearly 'a danger to themselves' as evidenced by threatening or attempting suicide were – at least initially – more likely to find themselves incarcerated in a gaol than transferred to the NGA. In part, this was because suicide had not yet come to be understood as a phenomenon that could be explained or predicted in either sociological or psychological terms, and instead was still primarily attributed to character or moral failure. In Natal, such an understanding was one that served to reinforce the conviction of much of the colonial establishment that it was not the system of indenture, or the political and economic

⁴⁶ 'Wragg Commission' 1887, p. 59.

⁴⁷ See also Brain and Brain, 'Nostalgia and alligator bite', p. 102.

restrictions and pressures placed upon free Indians, that was to blame for the colony's appallingly high suicide rate, but the very character of 'the Indian' himself.

'The result of these enquiries proved beyond doubt that no blame could be attached to anyone but the Indians themselves'⁴⁸: Indian suicide and the state

By the early 1900s, the high incidence of suicide amongst indentured Indians was one that was being taken up by the nascent Natal Indian middle class, such as those who wrote for and read *Indian Opinion*. In its editorial of 4 June 1904, that newspaper noted that, according to the Protector's report for 1903: 'Out of the free Indian population of 51,259, there were 8 suicides. Out of 30,131 indentured Indians, there were 23.'⁴⁹ It went on to add that the highest rate of suicide in the world was to be found in Paris, where 422 suicides per million inhabitants occurred. In Natal, however, calculations revealed that the comparative figure amongst indentured workers was 741 per million. The editorialist commented: 'These figures are sufficient to give cause for very serious reflection'.

In his Annual Report for 1903, the Protector had emphasized that he was obliged to personally investigate suicides 'whenever the evidence tends to show that the fatality in any way resulted from ill-treatment received from an employer or employé [sic].' He reported, too, that of his enquiries into suicidal deaths that year, only one had suggested that fault may have lain with anyone other than the deceased, and that that

⁴⁸ PAR II 8/4, Annual Report of the Protector of Immigrants For The Year Ending June 30, 1894, p. 7. The phrase was repeatedly used in the annual reports after noting the number of Indian suicides for that year.

⁴⁹ *Indian Opinion*, 4 June 1904, quoted in Bhana and Pachai, *A Documentary History of Indian South Africans*, p. 20. The editorial might have been written by Gandhi. According to Joy Brain, 'most of the editorials published between 1903 and 1914 were probably written by him'. See J. Brain, 'Natal's Indians, 1860-1910: From co-operation, through competition, to conflict', in A. Duminy and B. Guest (eds.) *Natal and Zululand From Earliest Times to 1910: A New History* (Pietermaritzburg: University of Natal Press and Shuter and Shooter, 1989), p. 263.

enquiry had been ultimately unnecessary, the man having 'really committed suicide because the work on a Sugar Estate was uncongenial to him.'⁵⁰ Other cases investigated by him that year were due, in his opinion, to a woman's regret at marrying a man of a lower caste, and to a man hanging himself after attempting to murder his wife. He was, however, at a loss to explain why 'a free Indian boy of 9 years of age, while tending cattle belonging to his father's Indian employer might kill himself', describing it as 'a mystery yet to be explained.' The *Indian Opinion*, however, effectively accused the colonial government, including the Protector, of a genuine lack of interest in establishing the root cause of the 'staggering figures': 'There is a homely English proverb,' it went on to say, 'Where there's a will, there's a way', and if the Protector would only feel as we feel, having the powers of an autocrat, he should have not the slightest difficulty in tracing the cause....'⁵¹

This cause, the writer went on to suggest, lay not in mysteries but in the sharp discrepancy between the number of suicides by free and indentured Indians, and suggested that the explanation for the excessive number of self-inflicted deaths of indentured workers on the estates could be found in the conditions they experienced there. The editorial urged:

We think that the information given in the report on the subject is exceedingly meagre. There should be a statement shewing which estate shews the highest number, and there should be a summary at least of the nature of the evidence given, etc, at the magisterial enquiries. We do not wish to draw any conclusions against these employers from these staggering figures, but we do plead for a thorough enquiry, alike in the interests of the Indians as of the employers, and we consider that nothing short of an impartial commission to investigate the cause would meet the ends of justice. And an ideal commission ought to include medical men of good standing, a nominee of the Immigration Board, the Protector, and, if it is not a sacrilege to make the suggestion, an Indian of standing in the Colony. Such a commission cannot but result in arriving at the truth. The greater the light thrown on the subject, the better it would be for all concerned, and we hope that the remarks we have ventured to offer will be favourably considered by the authorities.⁵²

⁵⁰ PAR Natal Colonial Publications (hereafter NCP) 8/1/10/5/9, Report of the Protector of Immigrants For The Year 1903, p .9.

⁵¹ *Indian Opinion*, 4 June 1904.

⁵² *Ibid.*

In 1906, there was further comment by the same newspaper on the topic; this time the tone was more direct:

Such frightful mortality from self-immolation, being almost three times as great amongst indentured Indians as amongst free Indians says very little in favour of the treatment that is meted out to Indians on the estates. Again, we find that, as against one free woman who committed suicide, there were three indentured women, or, if we correct the figures, there are six times as many suicides amongst indentured women as amongst free women. Can there be any occult reasons for this astonishing discrepancy? Is *all* well on the estates?⁵³

Although both these reports singled out the Protector of Immigrants for criticism, virtually accusing him of a cover-up, correspondence between Polkinghorne and the Colonial Secretary's Office shows that the Protector was himself sincerely concerned with the suicide statistics, but his efforts to establish, with any degree of certainty, where the blame lay were frustrated. In 1904 or 1905 – the documentation is unclear as to the exact date – Polkinghorne had written to the Attorney General suggesting that 'the Deputy Protector might assist in the enquiries' by Magistrates into unnatural and accidental deaths. The Attorney General was not at all amenable to this 'improper suggestion', and told the Colonial Secretary:

I object to his taking part in enquiries and matters which solely concern my department and the respective Magistrates holding such enquiries. ...The Protector is fully aware that every care and attention has been given to such cases, and as his suggestion and remarks infer that his presence or that of the Deputy would have brought about a result different to that recorded in each case then I entirely repudiate such inference, which is uncalled for. ... I have at all times been anxious to assist the Protector, and co-operate with him, but he must not presume to cast reflections on the manner in which my department discharges its duties, any attempt on his part to do so will be resented.⁵⁴

Two years later, in 1906, Polkinghorne was once more writing to the Colonial Secretary that 'the suicides are excessive' and, referring to the Attorney General's

⁵³ 'Second Thoughts on the Protector's Report', *Indian Opinion*, 15 September 1906, together with correspondence between James A Polkinghorne, Protector of Indian Immigrants and the Colonial Secretary, 8 October 1906, in PAR II I/146 3491/1906. Emphasis in the original.

⁵⁴ PAR II I/130 I2409/04, 'Attorney-General to Protector, 5 November 1904', Copy of Attorney General's Minute to Colonial Secretary, 4 April 1904.

resistance to any perceived interference in the judicial process by his office, he added: 'All that can be done now is for me to read through the depositions and if there are any suspicious circumstances then to make further enquiries.'⁵⁵ By now he was unequivocal in identifying 'treatment by the Employer [as] a contributory factor' in the case of at least three of the twenty suicides that were officially recorded for 1905, and ended his report with a request for a greater supervisory powers for his office, stating that this would 'probably tend to lessen the suicides among Indentured Indians in this Colony.'⁵⁶

As Polkinghorne and several subsequent commentators have pointed out, the epidemic of suicide that he was witnessing in Natal in the early twentieth century gave the colony the dubious distinction of having one of the highest rates of self-killing by indentured workers in the British empire. He himself noted that the local rates were higher in Mauritius, Fiji, and Jamaica, but lower than those in Demarara. This stands in contrast, however, to the figures quoted by Surendra Bhana and Arvinkumar Bhana, who have produced probably the thorough study of suicide amongst Natal's indentured Indians to date. They state that Natal's rate 'far [exceeded] the rates in other British colonies', being second only to that of indentured workers in Fiji.⁵⁷

No matter which ranked first in the statistical stakes, the figures for Natal alone are indeed startlingly high. The statistical tables that established deaths as unnatural, as suicidal or accidental, initially detailed only indentured Indian labourers, noting the (first) name, official number, sex, age, and cause of death. The earliest entry for suicide was in 1880. In surveying the records of the Protector, as well as these tables, for the 36 years between 1875 and 1911, Bhana and Bhana identified 363 deaths by

⁵⁵ PAR II I/146 3491/1906, Polkinghorne to Colonial Secretary, 8 October 1906.

⁵⁶ *Ibid.*

⁵⁷ Bhana and Bhana, 'An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911', p. 137 and Table 6 'Comparative Statistics on Suicide in British Colonies (1900-1903)', on p. 151.

suicide by indentured Indians. (See Table below.) They also note, however, that because of discrepancies between the Protector's records and their own archival searches – which revealed some 'individual suicide reports' of persons not listed by the official records – 'it is doubtful that the actual number of suicides will ever be known'. For instance, they found that a further 44 Indians who had killed themselves might also have been indentured workers, though their status was not clearly marked in the records.⁵⁸ By my own calculations, in Natal's published colonial records, between 1880 and 1916, the deaths of more than 670 Indians were officially recorded as being the consequence of intentional suicide.⁵⁹ Indeed, it is likely that the actual number of suicides was somewhat higher than the officially sanctioned figures portray, since difficulties of determining intent led then, as now, to an inability on occasion to assign a definite verdict. In 1885, for example, at least six deaths – two from burns, two from drowning, one by gun-shot and another by swallowing poison – could have been intentional.⁶⁰ Even so, the number of Indian suicides as a proportion of deaths recorded as being due to 'unnatural circumstances' is astonishingly high, ranging in the years between 1880 and 1906, from eight to more than 50 per cent. On average, a quarter of deaths of Indians in Natal of other than natural causes in these years were self-inflicted.

Separate statistical tables for suicides, clearly distinguishing them from other categories of unnatural deaths, began to appear in the late 1890s, and contained the usual information of name, number, age, and method. This tracking of the suicide

⁵⁸ Bhana and Bhana, 'An Exploration', p. 139. In the Protector's records, some years gave different tables for 'free' and indentured Indians, but this was not always the case.

⁵⁹ These, and the following, figures have been extrapolated from the Annual Reports of the Protector of Immigrants, found variously in PAR II 8/3 - 8/5 and NCP 8/1/10/5/1 - 8/1/10/5/11. From 1907, the category 'unnatural deaths' disappears and suicide becomes just one category amongst dozens of causes of death. There are occasional discrepancies between the tabulated statistics and the Protector's written report. In some years – but not all – free Indians are listed separately.

⁶⁰ PAR II 8/3, Annual Report of the Protector of Immigrants for the Year 1885, pp. 21-24. Annexure A Deaths of Indian Immigrants From Other Than Natural Causes, Natal, 1885. Hereafter, 'Report of the Protector of Immigrants'.

statistics as a specific concern coincided – and probably reflected – the fact that Indian suicides had started increasing in the early 1890s. ‘The average number between 1890 and 1900 was 13; and between 1900 and 1910, it stood at 34 per year.’⁶¹ The extent of the problem is further highlighted by the fact that in 1907 – when the highest number, 41, of completed suicides were recorded – twelve Indians were also arrested and charged with the crime of attempting or threatening suicide.⁶² These latter records were noted not in the Protector’s Reports, however, but in the colony’s criminal statistics under ‘Crimes and Offences Tried By Magistrates.’ Between 1906 and 1909, 45 Indians were tried for this offence, of whom only six were acquitted.⁶³

⁶¹ Bhana and Bhana, ‘An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911’, p. 139.

⁶² PAR NCP 7/3/14, *Colony of Natal, Statistical Yearbook For the Year 1907*, pp. 228-229, Part X - Law, Crime, Taxation, Ec., ‘Crimes and Offences Tried By Magistrates During 1907. Of these twelve, seven were convicted, one acquitted, and the remaining four were ‘otherwise disposed of’.

⁶³ PAR NCP 7/3/13-7/3/16, *Colony of Natal Statistical Yearbooks, 1906-1909*, ‘Crimes and Offences Tried By Magistrates’.

TABLE 3: INDIAN SUICIDES, 1880-1916 ⁶⁴			
Year	Sex		Total
	Male	Female	
1880	1		1
1881			
1882	4		4
1883	3		3
1884	9		9
1885	13		13
1886	4		4
1887	1	2	3
1888	7	1	8
1889	9		9
1890	11	2	13
1891	10		10
1892	2		2
1893	21	1	22
1894	16	2	18
1895	24		24
1896	15	1	16
1897	15	3	18
1898	12	2	14
1899	24	2	26
1900	11	2	13
1901	26	2	28
1902	23	4	27
1903			26
1904			20
1905	31	4	35
1906	39	1	40
1907			41
1908			32
1909			34
1910			24
1911			23
1912			36
1913			18
1914			21
1915			14
1916			22
TOTAL			671

⁶⁴ Extrapolated from the Annual Reports of the Protector of Immigrants, found variously in PAR II 8/3 - 8/5 and NCP 8/1/10/5/1 - 8/1/10/5/11.

Of the officially recorded suicides of Indians, the overwhelming majority were men between the ages of 20 and 40, though suicide by hanging was recorded for the deaths of persons as young as ten-and-a-half and twelve.⁶⁵ In the years that deaths were categorized by sex, only 29 women were identified as having committed suicide. In these tables, the most commonly used method by both sexes was hanging, which probably reflected both the availability of means and preference. Other forms of self-destruction involved gun-shots, stabbing and cutting (usually of the throat), burning, and drowning, and later, as Natal's transport infrastructure expanded, by intentionally lying in front of an oncoming train.

The sex of those who were charged with attempting to kill themselves was not recorded in the criminal statistics, and according to the records of the Protector, the number of Indian women who died intentionally was relatively low, 29 in all between 1880 and 1916.⁶⁶ What is interesting, however, is that a reading of the statistics on the causes of deaths of Indian women in this period shows very clearly that the mortality rate from 'unnatural causes' of Indian women was far, far higher than the official figures on suicide indicate. In the 24-year stretch from 1882 to 1906, at least 120 women over the age of 16 perished directly or indirectly as a result of 'burns', which were usually described, especially from the late 1890s, as being 'accidental'. In 1903,

⁶⁵ PAR II 8/4, Report of the Protector of Immigrants For The Year Ended 31 December, 1902. p 20. Annexure A lists the death of by 'suicidal hanging' of Ammany, female aged 12; in the same year Beni, a 16 year-old male was 'Found dead on railway line; suicide.' The death of the ten-and-a-half year old Kupusami in the previous year from asphyxia may have been accidental or suicidal, the verdict was unclear. The category 'child' is one that would probably not have been given to the thirteen-and-a-half year-old Manga who hanged herself in the same year. See II 8/4, Report of the Protector of Immigrants For The Year 1901, pp. 13 and 26.

⁶⁶ It is interesting to note that by 1940, data collected by sociologist Fatima Meer indicates that suicide incidence was more-or-less equal amongst Indian men and women in Natal, and that nearly 70% of Indian women's suicides were as a result of 'burning'. Less than 10% of Indian male suicides employed this method. See F. Meer, *Race and Suicide in South Africa*, pp. 277-278. Table 45: 'Distribution of Suicide By Method Used, Race and Sex, Durban, 1940-1960'. Table 46 on pp. 279-280 shows that by 1970 burning was less frequently recorded as a method of self-killing, but it nonetheless remained the single largest category of method for Indian women. It was also the most common means of suicide for African women at the time of Meer's study.

for example, while there were no official figures for female Indian suicides, 10 women died from 'burns'.⁶⁷ The year 1906 is the last for which I could find the manner of unnatural death categorized by sex: in this year, only one Indian female aged 16 was recorded as having died from hanging herself, but 16 women – the majority in their twenties and thirties – died from burns.⁶⁸ When female suicides were recorded they were almost invariably the consequence of hanging or drowning, but the historic association between Indian women and burning as a means of taking their own lives – in private acts of suicide as well as in the more public instance of *sati* – is suggestive of the intentional self-destruction by Indian women going unrecognised or unrecorded by colonial officials.⁶⁹ In other words, it is possible that at least some of the Natal Indian women who died as a result of 'burns and shock' up to 1916 did not do so entirely accidentally.

Beyond the bald stating of numbers, the first official comment on suicide by Natal Indians appears in 1886, when the Protector noted that of the deaths of 392 Indians that year, (nearly half of these were of children under ten years of age), 45 were from 'unnatural causes', and there had been a 'marked decrease' of suicides, with the number dropping to six from seventeen in the previous year. He made no further comment. In 1894 the Protector stated that the majority of the 16 male suicides that

⁶⁷ PAR NCP 8/1/10/5/9, Report of the Protector of Indian Immigrants For The Year Ending 31 December 1903, pp. 17-18.

⁶⁸ PAR II 8/5, Report of the Protector of Indian Immigrants For the Year Ending 31 December 1906, pp. 19-21.

⁶⁹ A large number of works, from a variety of disciplinary perspectives, have examined the discursive power of representations of *sati* in both the nineteenth and twentieth centuries. While most commentators agree that the actual incidence of *sati* has been small since it was legally outlawed in 1829, there is some debate as to whether *sati* constitutes suicide or a form of martyrdom. *Sati* was a central element in colonial and Indian male (re)constructions of gender and nationalist identities. This was clearly not the case in colonial Natal. Amongst many others, see: M. Sinha, 'Gender in the Critiques of Colonialism and Nationalism: Locating the "Indian Woman"', in J. Wallach Scott (ed.) *Feminism and History* (Oxford: Oxford University Press, 1996), pp. 477-504; J.S. Hawley (ed.) *Sati, The Blessing and The Curse: The Burning of Wives in India* (Oxford: Oxford University Press, 1994); and R. S. Rajan (ed.) *Real and Imagined Women: Gender, Culture and Postcolonialism* (London: Routledge, 1993). My argument – which I acknowledge as tentative – concerns suicide, however, rather than *sati*.

had occurred in the previous year-and-a-half were 'new or comparatively new arrivals in the Colony.'⁷⁰ This pattern was confirmed the following year. It may be no coincidence that it was recently arrived indentured labourers who also laid the greatest number of complaints of assault and mistreatment against Indian and European overseers.⁷¹ In one such case, eight complainants were arrested having failed to appear at the Divisional Court, 'several' of them then 'made a pretence ... to commit suicide by hanging'.⁷² The tree branch being 'too low to suspend them', they subsequently submitted to arrest without the need for handcuffs. After serving a sentence for contempt of court, these men were returned to the employer to whom they had been indentured and thereafter 'very few complaints' were made.

From the mid 1890s, the Protector's Reports noted a number of suicides by 'Free Indians'. In contrast to the indentured labourers, these tended to have been in the Colony for some considerable time: in 1895, for instance, the two 'Free Indian' suicides noted – Seopaul, aged 30 and Chengadoo, aged 42 – had been in Natal for more than a decade. Once more, despite a magisterial enquiry into each case, 'no reliable evidence or satisfactory information of any kind could be obtained to account in any way whatever for the real cause of these unsatisfactory deaths.'⁷³ In 1896 there were four suicides of 'Free Indians' recorded; in 1897, four; and in 1898, six; and in 1903, eight. The numbers continued to grow slowly and in 1912, for the first time, suicides by 'Free Indians' outnumbered those of indentured Indian labourers 19 to 17.

This increasingly detailed information about Indian suicides at this time stands in contrast to the situation regarding data on Africans and whites, about whom, especially during the war years of 1899 to 1902 little was recorded. For Indians in

⁷⁰ PAR II 8/4, Report of the Protector of Immigrants For The Year Ending 30 June 1894, p. 12.

⁷¹ PAR NCP 8/1/10/5/6, Report of the Protector of Immigrants For The Year 1896, pp. 7-8.

⁷² PAR NCP 8/1/10/5/6, Report of the Protector of Immigrants For The Year 1896, p. 8.

⁷³ PAR II 8/4, Report of the Protector of Immigrants For The Year Ended 30 June, 1895, p. 11.

Natal, however, the year 1903 was to bring the escalating rate of suicide into the public domain. In that year the overall death rate for Natal's Indians was at its highest recorded incidence in nearly 30 years. This was attributed to an epidemic of plague and an increase in phthisis amongst those employed at the collieries. However, there appeared to be no clear reason why there should have been 31 suicides, including eight who were no longer indentured.⁷⁴

It was after the release of this report that the issue was taken up in *Indian Opinion*, which drew specific attention to the economic climate of Natal. It noted that indentured Indian labour in Natal was coming under increasing pressure. While the official position was that, on completion of their contract, many Indians had sufficient savings to return to India with the prospect of a 'decent living', this was hardly the case and that, in fact, many workers were obliged to renew their indentures. In the face of growing demand from Natal employers, the rights of indentured workers to lay a complaint against employers were being compromised by the requirement that they acquire a pass from the magistrate of the division. This, plus the number of claims of assault and other forms of mistreatment, belied somewhat the oft-repeated assurance that relations between employer and Indian employee were good and Indians were well-treated. But it was the Protector's remarks on suicide, 'this painful subject', that earned perhaps the most stinging response.⁷⁵ Their call for a commission of enquiry was, however, and as we have already noted, in vain.

The social and economic pressures experienced by indentured Indians in the late nineteenth and early twentieth centuries, as identified by *Indian Opinion*, have formed the basis for more recent explanations for the high rates of self-killing at the time. For, as a number of detailed histories have shown, the experience of indentured workers in Natal was notably harsh. Under the terms of their contract, substantial powers of

⁷⁴ PAR NCP 8/1/10/5/9, Report of the Protector of Immigrants For the Year 1903, p. 9.

⁷⁵ *Indian Opinion*, 4 June 1904. Quoted in S. Bhana and B. Pachai, *A Documentary History of Indian South Africans*, pp. 18-20.

control were granted to employers.⁷⁶ Capitalist owners of sugar plantations and mines sought to ensure profits by minimising production costs, and it was not uncommon for the conditions of the indenture to be flouted by employers. On the large estates especially, the picture of indentured life that emerges from the documentary evidence is one of frequent brutality, over-work, squalid housing, poverty and malnourishment. Alcoholism and excessive use of cannabis were common. It had proved difficult to persuade Indian women to emigrate to Natal, and the resulting imbalance in the ratio of males to females combined with the strictures of life on the estates and mines to render a reasonably settled family life practically impossible to create or sustain in the early years.⁷⁷ Indeed, the situation in Natal only exacerbated the vulnerability of Indian women within wider patriarchal structures, often leaving them the victims of violence at the hands of men, and neglected by employers and authorities.

It is against this background that scholars Surendra Bhana and Arvinkumar Bhana argue that ‘the high incidence [of suicide between 1875 and 1911] is attributable to the conditions under which indentured Indians lived and laboured.’⁷⁸ Drawing on insights that flow from Durkheim’s seminal study of suicide from the late nineteenth century, they add: ‘The narrow confines of an estate constituted a mini-laboratory in which alienation and acculturation co-existed.’⁷⁹ Over-work and employer cruelty,

⁷⁶ B. Freund, *Insiders and Outsiders: The Indian Working Class of Durban, 1910-1990* (Pietermaritzburg: University of Natal Press, 1995), p. 2.

⁷⁷ For a focus on indentured Indian women in Natal, see J. Beall, ‘Women Under Indenture in Natal’ in Bhana and Bhana, *Essays on Indentured Indians in Natal*; and her chapter ‘Women in Indentured Labour in Colonial Natal, 1860-1911’ in C. Walker (ed.) *Women and Gender in Southern Africa to 1945* (Cape Town: David Philip, 1990).

⁷⁸ Bhana and Bhana, ‘An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911’, p. 137.

⁷⁹ Bhana and Bhana, ‘An Exploration of the Psycho-Historical Circumstances Surrounding Suicide Among Indentured Indians, 1875-1911’ explain that Hinduism – which was the religion of the vast majority of indentured Indians – generally condemned suicide, but there were special circumstances where it was considered acceptable. These included *sati* – the self-immolation of widows – and ‘in some instances, persons afflicted with incurable diseases could terminate their lives under strict rules.’ They comment: ‘Nevertheless, whereas for the Muslim, Islam took an unequivocal stand, for the Hindu there was ambiguity if only because

illness, lack of family support, and grinding poverty with few options for relief, all combined with religious ambiguity on the issue of self-killing and an overwhelming sense of despair to lead to an understandable phenomenon that was rooted in both psychological and material circumstances.

This is not a line of argument from which I would wish to dissent. Indeed, the economic and political context of Natal at this time does much to account for the increasing incidence of self-inflicted deaths by indentured Indians, as well as amongst some who had recently qualified for the status of 'free Indians'. As the table above shows, suicides began to rise consistently from the early 1890s, peaked later that decade, and again in 1905, 1906 and 1907. This coincides with the granting of Responsible Government status to Natal in 1893 which, as Marcia Wright has pointed out, was accompanied by a 'profound shift in policy', which was characterized by 'highly purposeful animosity directed against Indians.'⁸⁰

On the one hand, both the colonial authorities and employers – experiencing a labour shortage as Africans withdrew their labour during the South African War – were acutely conscious of their reliance on indentured labour. In 1901, for instance, it was publicly recognized that: 'if by any reason Indians were unhappily withdrawn from the Colony, or even their introduction discontinued for a short time, the whole of the industries of the country would at once be simply paralyzed. Not only would this be the case in regard to any private enterprise, but every public institution in the Colony would suffer more or less.'⁸¹ Accordingly, the importation of indentured workers

Hinduism condoned suicide under special circumstances.' See their discussion on pp. 156-157.

⁸⁰ M. Wright, 'Public Health among the Lineaments of the Colonial State in Natal, 1901-1910', unpublished seminar paper presented at WISER, University of the Witwatersrand, June 2003, p. 3.

⁸¹ PAR II 8/4, Report of the Protector of Immigrants For the Year 1901, p. 19.

continued to increase: in 1904, for instance, the incoming number stood at 7,046, and in 1906 at nearly 10,500.⁸²

On the other hand, the Census of 1904 confirmed what whites had feared for some time, that demographically, Indians outnumbered white colonists in Natal. Moreover, whites were increasingly resenting of commercial competition from free Indians, who, by this time, significantly outnumbered indentured workers. This led to the introduction of a number of financial and legal restrictions on the trading and residential rights of Natal's Indians: in 1895 the notorious Act 17 levied a £3 licence fee on all ex-indentured workers and all children of persons whose indenture had commenced before 1896; in 1896 Indians were excluded from the Natal franchise; and in 1897, the Dealers' Licences Act (Natal) limited the activities of traders and any Indians wishing to come to the colony were obliged to undertake tests of their facility with the English language.⁸³ In 1901, it was stipulated that women were also liable for the £3 fee, even though their wages under indenture were set at half that of a man's; and from 1903, the act was extended to apply to boys over the age of 16 and to girls over 13.

According to Wright: 'The 1895 Act, which became operative in July 1896, had a delayed impact, affecting those who concluded their indentures in 1901 and after... From 1903, following the full effect of this punitive legislation and the deepening of economic recession, the life-chances of ex-indentured women, above all, became exceedingly harsh.'⁸⁴ She goes on to contrast the lack of room to manoeuvre experienced by the 'New Act' (i.e. post-1895) immigrants, as compared to the 'Old Act' indentured workers, who, although they had in many instances no doubt endured harsh working conditions, had not had to carry the burden of a hefty licence fee.

⁸² Wright, 'Public Health among the Lineaments', pp. 7-8.

⁸³ See Brain, 'Natal's Indians, 1860-1910' in Duminy and Guest (eds.) *Natal and Zululand From Earliest Times to 1910: A New History*, pp. 261-263.

⁸⁴ Wright, 'Public Health among the Lineaments', pp. 3-4.

Indeed, the £3 fee was particularly effective in ensuring that many workers were unable to establish themselves as independent agriculturalists, market gardeners, or traders, and the rate of both re-indenture and of those electing to return to India, rose. Uma Dhupelia-Mesthrie states that, by 1913, more than 65% of the indentured workforce was on their second or third contracts, and between 1902 and 1913 32,506 Indians took up the free return passage to India.⁸⁵

Some suicides occurred just as workers were about to re-indenture.⁸⁶ Henry S. L. Polak, editor of *Indian Opinion* on the eve of Union, vividly portrayed the increased immiseration of Indians in the colony, linking ‘the state of squalor in which those people are compelled to live who just manage to scrape together the annual tax’ and a number of diseases exacerbated by poverty, such as malaria, hook-worm, tuberculosis, and dysentery. In his impassioned – but ignored – submission to the Clayton Commission of 1909, he drew a direct line between the £3 tax and ‘the depression caused by these diseases that the greater number of suicides amongst the “free” Indian population is due.’⁸⁷ Marshalling an impressive array of comparative statistics, Polak urged the Commission to take the suicide rates seriously. He compared the rates amongst ‘covenanted workers’ in Natal to those for India as a whole (fourteen times higher), and to free Indians in Natal (between two and five times higher). Attempting to drive his point home, he highlighted too the contrast between the number of suicides per indentured Indians – 585 per million – to that amongst whites in the Colony – 168 per million – and in Johannesburg, 370 per million. ‘Again and again’, he said, ‘the Indian communal leaders’ have ‘sought an explanation for these figures, but none has been forthcoming. Again and again an

⁸⁵ Dhupelia-Mesthrie, *From Cane Fields to Freedom*, p. 16.

⁸⁶ See, for example, the case of Gajadher in PAR II 1/124 138/04, 3 January 1904. He had also attempted to kill his wife.

⁸⁷ PAR Colonial Secretary’s Office (hereafter CSO) 2783, unnumbered eleven page typed document ‘Indian Indentured Immigration into Natal, signed by H. S.L Polak, placed with the testimonies before the (Clayton) Commission into Indian Immigration into Natal, 1909. Polak gives no indication of the sources of his figures on suicides by whites in South Africa. My thanks to Marcia Wright for this reference, as well as several other primary sources quoted in this chapter.

inquiry has been pressed for, but without avail. It is submitted the Commission should give the figures supplied the closest examination ...'⁸⁸ As with the previous calls for in 1904 and 1906, however, Polak's plea fell on deaf ears.

All this suggests a general context for the increase in suicide amongst indentured workers from the 1890s and through the first decade of the next century.⁸⁹ On the larger estates in particular, the need to maximize worker productivity would have been even greater during these years, with a concomitant possibility that the pressures under which Indian workers lived and laboured would have intensified. Without a detailed analysis of the place of employment of the indentured workers who committed suicide between 1880 and 1916 (and this information was not systematically captured in the Protector's Reports), it is not possible to establish with any certainty the extent to which the upsurge in self-destruction at this time was shared across both large and small-scale employers of indentured Indians.

Snippets of surviving archival evidence show that threats of suicide were sometimes made by Indians in an effort to lever for themselves a better form of employment. Khem Karan, for example, who began his indenture in March 1894, repeatedly protested that he had been abducted in Calcutta, and brought to Natal under false pretences. On arrival, he had been assigned to a sugar estate, where he was 'put to separate mealies at the Mill'. There he insisted that he was inappropriately employed since 'I was a shopkeeper in India. I have never done any work but shopkeeping. I was sent to this Colony against my wish. ... I told my Master that I could not do field work ... If I am made to work in the fields with the hoe or any other work about the

⁸⁸ PAR CSO 2783, Polak, 'Indian Indentured Immigration into Natal', 1909, pp. 4-5.

⁸⁹ The indenture system was abolished in 1911 - largely at the behest of the Indian government., and the £3 tax dropped in 1914, but thereafter - with the Immigration Act of 1913 and repatriation schemes from 1914 in particular - the state actively sought to limit opportunities for Natal's Indians. See Brain, 'Natal's Indians, 1860-1910' in Duminy and Guest (eds.) *Natal and Zululand From Earliest Times to 1910: A New History*, pp. 268-270.

Estate I must either take my life or die.’⁹⁰ His threats were apparently taken seriously, for Khem Karan was transferred to ‘Gakool as storekeeper in Durban’, but he found him to be ‘utterly useless’, and after a week Gakool asked the Protector to take him off his hands. Mason stated that he was ‘confident that [Khem Karan] will commit suicide if compelled to work as a labourer’, and instructed that he be repatriated to India.⁹¹

It is possible that employers who could afford to employ only one or two workers, or in times when there were not enough Indians available to meet demand, that threats of suicide were more effective as a strategy for getting better conditions. This may have been the case for Mohan, indentured to Dr. Mary Hannan of Pietermaritzburg in the early 1900s. To Hannan’s exasperation, Mohan stated that he was a ‘Brahmin ... and could not be asked to do work unless he likes’.⁹² Mohan demanded pay for working on Sundays, was ‘insolent’, and frequently truant. After an altercation with Hannan, he threatened to ‘cut his throat and then there will be an end of his work’. She claimed that she did not believe ‘for a moment’ that he ‘will or would do so’, but she sent him to ‘the Indian Hospital at Maritzburg’ even though she believed he was malingering. Hannan then approached the Natal Government Railways to ‘take him over’, but only if she could ‘get a substitute’. She could not, she insisted, do without a servant for she ‘had suffered too much since [she] came to Natal for lack of servants not to be really alive to the truth of the proverb that “Half a loaf is better than no bread.”’⁹³ Whether or not Mohan preferred employment at the Railways, he was too valuable as a worker

⁹⁰ PAR II 1/74 1823/94, ‘Khem Karan No. 54751 indentured to Mrs Cheron, states that he was a shopkeeper in India and if compelled to do fieldwork must commit suicide’, 13 July 1874. Statement of Khem Karan before Louis H. Mason, Protector of Immigrants, 13 June 1894.

⁹¹ PAR II 1/74, 1823/94, ‘Khem Karan No. 54751 indentured to Mrs Cheron’, Protector of Immigrants to Secretary, Trust Board, 17 December 1894.

⁹² PAR II 1/127 1093/04, ‘Dr Mary Hannan reports that her indentured Indian Mohan No. 103529 threatens to commit suicide’, 20 May 1904.

⁹³ PAR II 1/127 1093/04, ‘Dr Mary Hannan reports that her indentured Indian Mohan No. 103529 threatens to commit suicide’, letters to the Protector of Indian Immigrants from Dr. Mary Hannan, Pietermaritzburg, 5 May, 18 May, and 25 September 1904.

to be packed off to gaol to serve three months imprisonment for his threat to cut his throat. We do not know, however, whether he ever carried out this threat.

As Bhana and Bhana's study indicates, it is likely that the largest number of suicides occurred on the biggest estates.⁹⁴ They focus on the Reynolds Estates at Umzinto and Esperanza on the south coast, which, in 1906, came under the scrutiny of a Commission of Enquiry into the treatment of indentured Indians. These estates had also been examined, and found wanting, by Louis Mason, the Protector, in 1886, but had been exonerated by the Wragg Commission. In 1893, Louis Mason, attempted to investigate the circumstances behind twelve suicides that had occurred on the Reynolds Brothers' estates in the previous year, but, in the presence of the managing director, Charles P. Reynolds, no worker had been prepared to lodge a complaint. Nor did a number of magisterial enquiries manage to elicit anything other than the verdict that 'no reasonable grounds' could be established for these deaths.⁹⁵

Mason's successor, Polkinghorne, continued to keep the estates under observation and in 1906 the Commission heard evidence of the debilitating conditions under which the indentured workers lived, and how their morale had been undermined by a poor diet, harsh labour regime and inadequate medical support. Dr Rouillard, who was responsible for the medical needs of the Reynolds' indentured workers, however, reneged on his earlier support for Polkinghorne, and the Protector was unable to make his accusations of ill-treatment stick. Nonetheless, the Commission had a salutary effect on the Reynolds' company, and worker conditions began to improve. Interestingly, one of the Commissioners of 1906 was James Hyslop, who was commissioner by virtue of his position as Chairman of the Board of Health⁹⁶: although he endorsed the majority report – which indicted the Reynolds – he left no

⁹⁴ Bhana and Bhana, 'An Exploration', pp. 141-148.

⁹⁵ Bhana and Bhana, 'An Exploration', pp. 141-143, and also P. R. Warhurst, 'Obstructing the Protector' in *Journal of Natal and Zulu History*, VII (1984), pp. 31-40.

⁹⁶ PAR II 1/156 3338/1907; also Bhana and Bhana, 'An Exploration', footnote 16, p. 170.

recorded observations on the state of mind of the Indian workers on these, or any other, estates.

From the mid-1880s, then, the Protector of Immigrants made it his business to attempt to establish the cause of suicides amongst indentured Indians. In this, both Mason and Polkinghorne were largely unsuccessful. As with the instances of 'obstructing the Protector' by the Reynolds Brothers cited above, they were often frustrated in their efforts to interview workers without the inhibiting presence of employers or overseers. Local doctors (who were in any case paid by the capitalist-dominated Indian Immigration Trust Board) and magistrates were not infrequently reluctant to testify about oppressive work conditions and the abuses of discipline, of which there is abundant evidence.⁹⁷ Nor could workers who wished to lay complaints do so without first having to acquire a pass from their employer.

In the early 1900s, the Protector's office gained an ally in the form of the newly-constituted Department of Health, more particularly in the person of Dr. Ernest Hill, the colony's first appointed chief Health Officer. Hill, who occupied this position from 1901 to 1911, did not usurp the Protector's role in inspecting estates, but rather they worked together to 'command expensive improvements in the habitations and thus the health of indentured workers.'⁹⁸ As Marcia Wright has shown, in this, they faced resistance from some settlers, including some members of the Indian Immigration Trust Board, although by the eve of Union, this was lessening, as evidenced in the support given to the Health Department by at least one of the major employers of indentured workers, the Tongaat Sugar Estates.⁹⁹ Hill was not successful, however, in securing governmental backing for his efforts to overhaul the colony's laws on the registration of births, deaths, and marriages. In 1906, he submitted a draft bill that would have required the universal registration of births and

⁹⁷ See Warhurst, 'Obstructing the Protector', pp. 36-38.

⁹⁸ Wright, 'Public Health among the Lineaments', p.13.

⁹⁹ Wright, 'Public Health among the Lineaments', pp. 13-20.

deaths in Natal, and which would facilitate ‘the improvement of the Public Health’ because of the ‘Vital Statistics ... which form the only basis from which the well-being of the people can be ascertained, and from which can be deduced the necessity of measures, and the nature of the measures necessary to ameliorate evil conditions which are remediable.’¹⁰⁰ The Board of Health, with James Hyslop as its Chairman, endorsed the Bill as a ‘much needed improvement.’¹⁰¹ However, it was not favourably received by the Colonial Secretary, and the colony was left with a system that did not capture this data for Africans who were not married under Christian rites, or for immigrant (free and ‘Passenger’) Indians, or for the inhabitants of Zululand.

Wright has argued that Hill drew on the ‘vital statistics’ to which he did have access – those for whites and for indentured Indians – as the basis for a remarkable statistical analysis and comparison of mortality figures in which he ‘contended that the marked differences were attributable primarily to disparities in wealth and social conditions, and only very secondarily to intrinsic physical or racial attributes.’¹⁰² She concludes that although Hill made no direct comments on the policies of the Colony of Natal, from the perspective of the twenty-first century, ‘the findings were devastating’. Thus, the ‘vital statistics’ of the colonial state, of which the figures enumerating the incidence of suicide among indentured Indian workers, could be used to challenge prevailing racial orthodoxies and could ultimately be mustered in arguments in favour of public health that led to improvements in the living and working conditions of what were arguably the most exploited labourers in the region.

The significance of the statistics concerning suicides collected by the Protector of Immigrants, is perhaps more difficult to establish. Indeed, despite a large and detailed

¹⁰⁰ PAR Department of Public Health (hereafter DPH) 24 75/1906, 26 September 1906. Ernest Hill, ‘Memorandum by the Health Officer for the Colony on the scope of Draft Bill for Registration of Marriages, Births, Deaths & Still Births’.

¹⁰¹ DPH 24 75/1906, 26 September 1906. James Hyslop, Chairman, Board of Health to Colonial Secretary, 28 December 1906.

¹⁰² Wright, ‘Public Health among the Lineaments’, p. 22.

body of facts and knowledge, carefully amassed and tabulated by colonial authorities, from District Surgeons to Resident Magistrates and the officials of the Protector, the underlying motives for Indian suicides remained a mystery. Hindered by estate owners and others in his efforts to get testimony from indentured workers about specific complaints that they might have, the Protector also found it near impossible to establish the state of mind of the victims of suicide immediately prior to their final act, even when he could interview with freedom the surviving family members or colleagues of an Indian who had killed him or herself. In the official annual reports, the testimony of witnesses to suicide or of family members was seldom noted, but it does seem that when questioned they, too, were often at a loss to explain the reasons for the suicide, or they declined to do so.¹⁰³ Most usually, investigators were met with the sort of response that was given by Chella Muthu in November 1893 to Mason, who was investigating the suicide of Apparoo (colonial number: 51622), both of whom were indentured to the Natal Government Railways. He said:

We lived in the same hut. ... On Monday 30th October we went to work as usual I to the coal gang and deceased to the (wheel) machine shop. I returned home on Monday evening. Deceased did not come home that night but I thought nothing of that as he was in the habit of coming home late at 9 or 10 o'clock.

Deceased used to drink at night but not to excess. He was not ill and I know of no reason why he should have committed suicide. He has never complained to me of any ill treatment.¹⁰⁴

In 1906, the Protector investigated twenty suicides. In his opinion, the causes 'in so far as can be ascertained' were depression (6), nostalgia (5), various (2) and unknown (7). While he identified the employer as a 'contributory factor' in three of the cases, he also thought that an epidemic of 'Malarial Fever' might have been the cause of several suicides.¹⁰⁵

¹⁰³ PAR NCP 8/1/10/5/9, Report of the Protector of Immigrants For The Year 1903, p. 9.

¹⁰⁴ PAR II 1/71 1413/1893, 'Deposition of Chella Muthu before Louis H Mason, J.P', 9 November 1893.

¹⁰⁵ PAR II I/146 3491/1906, James A Polkinghorne, Protector of Indian Immigrants to the Colonial Secretary, 8 October 1906.

Blaming excessive consumption of alcohol, or abuse of cannabis, for suicides went at least as far back as the mid-1880s. Testifying before the Wragg Commission, Dr. Richmond R. Allen of Pietermaritzburg stated:

I have had a large number of suicides in my circle. I attribute them to smoking dakkha [cannabis] and to drink. I would strongly recommend that the smoking of dakkha be made penal, as it is in Mauritius; it has led to much misery and insanity. I do not think that the Indians are as intemperate as they used to be, nor do I think that the effects of liquor are so bad as those of dakkha; but I would certainly prohibit the sale of intoxicating liquors to Indians. ... I have had four cases of lunacy, which I attributed to dakkha-smoking: these men were transferred to the Government Lunatic Asylum¹⁰⁶

Nor were Mason and Polkinghorne immune from the tendency to place the blame for disease, illness, and suicide on the proclivities of the persons concerned, rather than on the conditions of their lives under indenture or, as free Indians, often in grinding poverty. For instance, in 1886, despite the deaths of 153 children under the age of ten, and 45 unnatural deaths of adults, the Protector stated:

There is not, I believe, a Colony having Indian immigrants as part of its population that can show such favourable statistics, taken as a whole, of births and deaths, as can Natal. There can be no doubt of the suitability of this climate for Indians, and this is proved by the favourable reports of the physical condition of Indians who, after completing their term of residence in Natal, return to their native country, as furnished from time to time by the authorities in India.¹⁰⁷

Indeed, it appears to have been something of an article of faith that indentured labour in Natal was actually good for the health of Indians. The Annual Report of 1894 noted that, the 'average mortality of Coolies' was significantly lower than in other British colonies with comparable Indian populations.¹⁰⁸ In general, the Reports echoed the sentiment most baldly expressed in 1891: 'There can be no question about it. Natal is

¹⁰⁶ 'Wragg Commission', 1887, Chapter XLIII, pp. 1577-1691. Quotation from p. 1579.

¹⁰⁷ PAR NCP 8/1/10/5/3, Report of the Protector of Immigrants For the Year 1886, p. 9.

¹⁰⁸ PAR II 8/4, Report of the Protector of Immigrants For the Year Ending 30 June 1894, p. 26, gives the following data: '*Average Mortality of Coolies*. In British Guiana, during 1892 and 1893, 26.9 per 1,000. In Mauritius, during last 4 years, 29.2 per 1,000. In Surinam, during last 16 years, 23.7 per 1,000. In Natal, during last 5 years, 16.2 per 1,000.'

a perfect Paradise for these people, and they know it.¹⁰⁹ Instead, by implication – and sometimes by accusation – illness and mortality represented as being in some way the fault of the individual. According to the Report of 1902, for instance, the increased death rate was attributed to '... Pneumonia, which may be accounted for by the cold weather lasting two months longer than usual, and the preference of the Indian for working in as few clothes as possible.'¹¹⁰

In a variety of contexts, Indian women were often portrayed as particularly resistant or neglectful of measures that would ensure the good health of themselves, Indian men, and children. For instance, the spread of venereal diseases was, said to be due to 'the rooted objection evinced by Indian females to undergo a proper medical examination.'¹¹¹ The high number of children dying year after year as a result of burns was put down to 'the absence or insufficiency of precautions taken by the mothers when leaving their children alone in the house with a fire burning.'¹¹² The pressures experienced by Indian women as workers, house-keepers, wives and mothers in the straits of poverty and poor living conditions went unrecognised, with the implication being that they were simply neglectful. When the number of young children dying of 'want of nourishment' and 'cold' was noted, it was frequently followed by the comment that Indian women 'failed' to provide sufficient 'warm and suitable clothing for [the] cold winter months, and to pay greater attention to careful nursing and nourishment ... '¹¹³

Similarly, explanations for suicides were sometimes provided by recourse to 'the character or temperament of some Indians ... as this ... is such that quite trivial circumstances are sufficient to cause them to threaten to take their lives – a threat too

¹⁰⁹ PAR NCP 8/1/10/5/4, Report of the Protector of Immigrants For the Year 1891, p. 16.

¹¹⁰ PAR II 8/4, Report of the Protector of Immigrants For The Year 1902, p. 14.

¹¹¹ PAR NCP 8/1/10/5/3, Report of the Protector of Immigrants For the Year 1886, p. 13.

¹¹² PAR NCP 8/1/10/5/3, Report of the Protector of Immigrants For the Year 1886, p. 9.

¹¹³ PAR NCP 8/1/10/5/4, Report of the Protector of Immigrants For the Year 1891, p. 16.

often put into execution'. Even the 'many suicides of the beggar class' were ultimately responsible for own demise as

such men will not accept work although they might readily obtain it, and seem to prefer the unsettled life, with its attendant miseries of begging. Eventually apparently, they tire of the existence they have made so little effort to render useful or happy, and put an end to it in some isolated bush or deserted hut.¹¹⁴

As with the reception by employers of workers' complaints of ill-treatment, the causes of Indian suicides were not infrequently regarded as being 'frivolous' and inexplicable. In 1900, commenting on the 13 suicides that had occurred during the previous year, the Protector, opined: '(T)he majority of the suicides that take place amongst the Indian population here are attributable, directly or indirectly, to jealousy, domestic troubles, or disappointments of some or other kind.'¹¹⁵ The death by his own hand of a 'Hindoo (caste *Ahir*)' after being prevented from marrying 'a girl who is a Mohammedan' despite their being 'an illicit connection' between them was merely 'a somewhat extraordinary case'.¹¹⁶ The apparent suicides of two very young persons – Kupusami, a boy aged ten-and-a-half, and Manga, a 'female' of thirteen-and-a-half – were dispassionately described, with Kupusami's hanging being termed possibly 'accidental', and Manga's 'strangulation while hanging' being attributed to shame after her relatives had heard Manga's husband 'accuse her of intimacy with a native'.¹¹⁷

Unfortunately, by locating the impulse to suicidal acts within the individual or the innate nature of 'the Indian', self-destruction by Indians could not be framed in terms that took colonial complicity in exploitation, alienation and oppression into account. Instead, race served as a self-evident explanation for behaviours and acts that might otherwise have required closer investigation of and intervention by the state. What form that intervention might have taken in the context of the times is, however, a matter of some contention, since views about the causes of and appropriate response

¹¹⁴ PAR NCP 8/1/10/5/3, Report of the Protector of Immigrants For the Year 1886, p. 10.

¹¹⁵ PAR NCP 8/1/10/5/8, Report of the Protector of Immigrants For The Year 1900, p. 11.

¹¹⁶ PAR NCP 8/1/10/5/3, Report of the Protector of Immigrants For the Year 1886, p. 10.

¹¹⁷ PAR II 8/4, Report of the Protector of Immigrants For The Year 1901, pp. 13 and 26.

to suicide still occupied an indeterminate position between criminality, morality and mental derangement. In Natal and Zululand before 1918, suicidal acts by Indians received no special comment from the colony's emerging psychiatric profession. Suicide, among Indians at least, had not yet become an issue of 'mental health'. Instead, it could be perceived of as being primarily the result of Indians' personal failure in the face of circumstances that were trying, but not unbearable; this was the view of many whites. Or – as for the editorialists of *Indian Opinion* – the high incidence of self-killing could be regarded as a tragic response to inescapably overbearing conditions that robbed workers of hope and dignity. In either case, the abundant evidence of suicide by Natal Indians at this time stands in notable contrast to the dearth of information that we have about acts of self-destruction amongst Africans or by the colony's white population. Was this because suicide was indeed a rare occurrence in blacks and whites, or because the records that have come down to us have omitted or obscured the histories of people in this region who were not of Indian origin or descent, but who nonetheless resorted to suicide?

'A taboo surrounded by silence'¹¹⁸: Suicide amongst Africans in Natal and Zululand

In studies of suicide in Africa as a whole, it is commonplace to note that the available statistics are sketchy and therefore unreliable. In addition to this statistical blank a wide variety of sources – literary, anthropological, medical, psychiatric, and anecdotal – have combined to form the conventional view that suicide amongst black Africans has always been rare, and that cultural and social taboos against self-destruction are particularly strong amongst Africans. Indeed, it is the conviction that these strictures are now falling apart as Africans become more and more 'Westernized' that underpins many of the current explanations for rising suicide rates. For some societies and at some times this may be true. However, I would argue that if the prominence of suicide in the records of Natal in the late nineteenth and early twentieth centuries can,

¹¹⁸ Minios, *History of Suicide: Voluntary Death in Western Culture*, p. 320.

at least in part, be explained by the state's concern with and surveillance of indentured Indians, then the corollary is the dearth of information that we have about self-killing by both Africans and Europeans in Natal and the neighbouring territory of Zululand at this time. In the case of Africans, this was the consequence of two things: an inability to police or survey the African subjects of Natal, much less Zululand; and a legalistic, rather than a psychiatric or medical, concern with suicide at this time.

With the failure of the Health Officer's draft Bill on 'vital statistics' in 1906, the colonial state remained severely hampered in its ability to gather information on its subjects. As late as 1908, there was no provision at all for the registration of births and deaths in Zululand.¹¹⁹ In the following year, Ernest Hill expanded on his frustration with the existing inadequate laws governing births, deaths and marriages in Natal. He pointed out that:

The present Laws allow thirty days' notice for the registration of a death, and require that, if a body be buried without an order from the Registrar, notice shall be given to him of such a burial, but only within two months. No medical certificate of cause of death is demanded. ... It is obviously plain that these lax provisions will admit of a person dying of violence, poison, or any other cause, and being buried without an inquiry... The sections [of the current legislation pertaining to the registration of deaths] are, in fact, farcical....¹²⁰

These problems were even more marked when it came to recording deaths amongst Africans. The retention of a measure of autonomy by African workers and producers into the early twentieth century, the limited nature of colonial infrastructures, and the space for manoeuvring by Africans within the system of indirect rule, meant that colonial officials were in large part reliant on the co-operation of chiefs and headmen in notifying them of unnatural deaths. In Natal, chiefs were, on pain of a fine, required to report such deaths to the local Resident Magistrate, and in some instances heavy fines were imposed when it became apparent that they had failed to do so. For instance, when in 1876 in the Magisterial District of Ladysmith, 'Mabala's daughter'

¹¹⁹ PAR NCP 8/2/9, Colony of Natal, Report of the Health Officer For The Year Ended 31 December, 1908, p. 29.

¹²⁰ PAR NCP 8/1/12/4/2, Colony of Natal, Report of the Health Officer For The Year Ended 31 December, 1909, pp.1-3.

killed herself before her wedding ceremony, it was not the matter of her suicide that earned the ire of the Secretary for Native Affairs, but the failure of the (unnamed) chief, his induna, Beje, and the official witness who would have attended the wedding, to report the death. They were fined £25, £10, and £5, respectively.¹²¹

Given the unevenness of the legislation – which Hill noted required that ‘deaths in one place [had to be registered] in 30 days, and in another, the production of a certificate of registration [was required] at the time of burial’– there could be no systematic, coordinated effort to gather or compile data on the causes of death, including suicide, among Africans as there was for Indians in the region. Indeed, Hill recognized that ‘in a sparsely populated country there is a limit to practicability’ and that under his proposed Bill Medical Certificates detailing deaths should be furnished to a Registrar within 48 hours if the person had died within a twelve mile radius of a magistrate, but the permitted period was extended to seven days for those outside this reach.¹²² Even so, the process of reporting and registering a death would be laborious, and it seems safe to surmise that the colonial authorities were not informed of many incidents of voluntary death that Africans themselves had recognized as such.

Thus, in the annual statistics and reports of District Surgeons and Resident Magistrates, appeared only occasional and random recordings of post-mortems undertaken on African suicides. Unlike the occurrence of suicide amongst Indians, most self-inflicted deaths by Africans did not receive particular attention from either the state nor from Africans themselves. This does not mean, however, that suicide was especially rare: in fact, the very lack of commentary on a relationship between suicide and ‘the African’ tends to underline the unremarkable nature of its occurrence. This impression is borne out through a reading of the magisterial and medical inquests that can be found scattered through the colonial archives. These reports attest that Africans

¹²¹ PAR 1/LDS 3/3/4 H16/1876, Secretary for Native Affairs to Resident Magistrate, Ladysmith, 18 February 1876.

¹²² PAR NCP 8/1/12/4/2, Colony of Natal, Report of the Health Officer For The Year Ended 31 December, 1909, pp.4 and 5.

who attempted or completed suicide came from varied backgrounds, and apparently took their lives for a variety of reasons. A few examples will suffice: Chief Manqamu of the 'Mbonambi tribe' was arrested after setting fire to his hut and apparently threatening to commit suicide by drowning himself in the sea.¹²³ In 1909, 'kraal head, Mqatshelwa Nqaiyana, in the Lower Umfolozi' region, reported to the Resident Magistrate that one of his wives, the 35 year-old Xotshwasi, had hanged herself from a tree, the morning after refusing to 'sleep in my hut'.¹²⁴ 'Mavili, of the kraal of Chief Ngokwana' in Zululand hanged himself after murdering his wife, Nogusa, in early 1915.¹²⁵

As much as these testimonies give us a glimpse into African suicides in this region at the time, we can be sure that there were very many more, and that, as not all deaths that were agreed by witnesses and the authorities to have been self-inflicted were recorded as so being, these are now not easy to find amongst the official records. Serendipitously, in a search of a single box in the remaining records of Lower Umfolozi, for example, I came upon two very probable suicidal deaths that had not been specifically noted as such. In May 1909 a young woman named Nqobokazana died as a result of stabbing herself with an assegai; and six months later, Banonile, wife of Mhlanhlo, died in a similar way, insisting as she died that '... her "heart" had directed her to cut her throat and accordingly she did so'.¹²⁶ Banonile's death was – as shown at the beginning of this chapter – reported to A.R.M. Turnbull, Resident Magistrate of the Lower Umfolozi Division, by Chief Manqamu kaSomelomo. Although no medical doctor, let alone psychiatrist, Turnbull pronounced: 'I am of

¹²³ Durban Archives Repository (hereafter DAR) 1/EPI 3/2/7, LU 154/1902, 'Depositions charging Manqamu (lately Regent of the Mbonambi tribe) with the crimes or offences of Incendiarism and Attempted Suicide, while in a state of temporary Insanity', 10 March 1902.

¹²⁴ DAR EPI/1 3/2/13 LU 197/09, 'Death of Xotshwana', 19 April 1909.

¹²⁵ PAR, Chief Native Commissioner (hereafter CNC) 191 1915/16, Magistrate, Mtunzini Division to District Native Commissioner, Zululand, 2 January 1915.

¹²⁶ DAR, EPI/1 3/2/13 198/1909, 'Death of Nqobokazana by stabbing herself with an assegai', 26 May 1909, and LU 727 'Medical certificate and Report on Suicide, at Mhlalilo's kraal, Chief Manqamu's ward, Reserve IV, of a native woman, Banonilie Mhlahlo', 23 November 1909.

opinion that deceased must have been suffering from puerperal fever and consequent hysterical mania to have acted as she did.'¹²⁷

After the death by hanging of Xotshwasi, her husband, step-son, and the Chief Wife all testified that they 'could not account for her actions'. This was a constant refrain in recorded testimony. Officials did not, however, make overt connections between suicides by Africans and race. When Bafikile kaMpepo, wife of Putili kaNomageja, was found, hanging by her neck, Resident Magistrate Turnbull decided that, despite discrepancies in the testimonies of various witnesses, including that of her husband, her suicide had little or nothing to do with a row she had had with Putili or the favour he had shown to another woman. Instead, he expressed the verdict that: 'the mere fact of her adorning herself with her beadwork before committing suicide indicates that she must have been of a jealous and selfish disposition, and ... her whole action was premeditated. In the opinion of the court, temporary insanity cannot be advanced.'¹²⁸ His chauvinism has been shared by many commentators on female suicide the world over, but his comments are not racialized.

Nor were African suicides uniquely driven by the need for 'revenge': instead, the testimonies often reveal a history of troubled behaviour and relationships, sometimes accompanied by an apparent abuse of alcohol, and intra-familial interactions fraught with tensions and violence, especially between husbands and wives, and brothers and sisters. 'Look at this gun, and look at me for the last time, see how I finish myself off', said Umkonjiswa after repeatedly beating his sister and threatening to kill her, and

¹²⁷ DAR, EPI/1 3/2/13 LU 727, 'Medical certificate and Report on Suicide, at Mhlalilo's kraal, Chief Manqamu's ward, Reserve IV, of a native woman, Banonilie Mhlahlo', 23 November 1909.

¹²⁸ DAR, 1/EPI 3//2/4 LU 381/1897, 'Depositions with regard to the suicide of one Bafikile ka Mpepo, a native woman, the wife of Putili ka Nomageja, of the chief Bejane's tribe', 16 July 1897.

shortly before stepping outside their hut and fatally shooting himself in the face.¹²⁹ Often, the ultimate act of suicide seemed to have been precipitated by an argument like many others. And, as with suicides anywhere, both officials and those closest to the deceased were usually unable to comprehend the final thoughts and actions of the suicidal person.¹³⁰

Until 1916, British law required that attempted suicides be imprisoned, although this did not always happen in practice.¹³¹ Given the limited reach of the colonial state, especially outside the urban areas, the reporting of attempted suicide or threats to do so by Africans would have required, in most instances, a determination by one or other party to bring the issue to the attention of the authorities. As Africans used the colonial law courts to settle conflicts in a variety of ways, such as disputes between husbands and wives, and fathers and sons, so too could the threat of suicide be used as a weapon in inter-personal conflicts. In the case of Regina vs. Usipuga in the late 1880s, the accused's husband, Mapiti, brought her threat of suicide to the attention of the Magistrate at Polela, asking that she be taken into 'proper custody'.¹³² Despite finding Mapiti's claims 'very much exaggerated', Usipuga was fined 30/- and required

¹²⁹ PAR, Secretary for Native Affairs (hereafter SNA) I/1/170 1893/55, 'Suicide of Native Umkonjiswa of the kraal of Matumba, Xolo Tribe', Testimony of Ulutshintshi before Resident Magistrate, Lower Umzimkulu, 9 May 1893. Revenge as a primary motive for African suicide was posited by M.D.W. Jeffreys, "'Samsonic' Suicide or Suicide of Revenge among Africans', in *African Studies*, xi, 3 (1952), pp. 118-122. Quoted in P. Bohannan (ed), *African Homicide and Suicide* (New York: Atheneum, 1967).

¹³⁰ For comparisons with suicide today see, for example, the compassionate and erudite survey of suicide, both past and present in K. Redfield Jamison, *Night Falls Fast*. On p.198 she sums up much of her discussion with the following: 'For some, suicide is a sudden act. For others, it is a long-considered decision based on cumulative despair or dire circumstance. And for many, it is both: a brash moment of action taken during a span of settled and suicidal hopelessness.'

¹³¹ According to G. Evans and N.L. Farberow, *The Encyclopedia of Suicide* (New York: Facts on File, 1988), pp. 22-23, after 1916, the person was placed in the custody of relatives or friends. Natal followed British precedent. In Natal and Zululand, too, magistrates did not always insist on the incarceration of those who had been found guilty on such a charge. Chief Manqamu, for instance, was released into the custody of family in 1902.

¹³² PAR I/HWK 3/1/3 R214/1886, 'Regina vs. Usipuga Charged with attempting to Commit Suicide and Assaulting Her Child', 25 September 1886.

to put up a surety of £5. Afterwards, she disappeared. An abusive relationship marked by beatings and sexual jealousy brought the suicidal threats of Umlizana to the court of the Resident Magistrate of Lion's River in 1883.¹³³ Charged with 'Wrongfully and unlawfully [attempting] to commit suicide, to the evil example of all others in like cases offending, and in Breach of the Peace', Umlizana continued to insist that 'if he is set at liberty he will assuredly commit suicide if his wife continues to refuse to cohabit with him.'

In the magistrates' courts of Natal and Zululand, every year between 1895 and 1909, at least a dozen such cases were heard. During 1903, 36 Africans – 29 from Natal and seven from Zululand – were tried for attempting to commit suicide. In the following year, of the 52 formal charges on the grounds of attempted suicide heard by magistrates, 37 were of Africans.¹³⁴ During 1904, there were 11 cases of attempted murder, and 18 of culpable homicide, making the number of persons charged with trying to kill themselves greater than those tried for killing others.

Statistical records of African suicides suggest that the act was still largely viewed in terms of criminality at this time, and threatening or attempting self-murder was, in the main, regarded by the state as a threat to public order rather than as a medical or psychiatric problem. Furthermore, in the great majority of cases – more than eighty percent – when Africans were charged with attempting suicide, a criminal conviction was recorded. For whites charged with the same crime, approximately fifty percent were convicted, and the remainder were either acquitted outright, or 'otherwise disposed of'. What this suggests is that it was very seldom that Africans expressing suicidal intentions were transferred to the Asylum. In part, this may have been because western medical practitioners and officials failed to recognize in Africans

¹³³ PAR 1/HWK 3/1/1 194/1883, 'Deposition of Nomahlazi Regarding the Attempt by Her Husband, Umlizana, To Commit Suicide', 28 August 1883.

¹³⁴ Figures extrapolated from PAR NCP 7/3/2 - 7/3/16, *Colony of Natal, Statistical Yearbooks*, 1895-1909, 'Return of Crimes and Offences Tried By the Magistrates During the Year', and NCP 8/2/1 - 8/2/6, *Blue Book on Native Affairs*, Bound Departmental Reports, 1899-1905, 'Summary of Crimes and Offences Committed By Natives and Tried in the Courts of Magistrates For the Year'.

states of mind that might have precipitated suicide. Indeed, the lack of suicide was taken as evidence that – as orthodox ethno-psychiatry would so strongly emphasize until the 1960s – Africans did not experience depression, shame or guilt, and instead, turned aggressive feelings outwards in violent acts against others.¹³⁵ In contrast to a racialized discourse about Indians and self-killing, it was therefore an apparent *absence* of suicide amongst Africans that would be taken up as a marker of racial difference. This absence was to some extent the consequence of the concerns of colonial record-keeping.

From scattered inquests and testimonies preserved in the archival records of colonial Natal, as well as in criminal statistics, however, it is clear that Africans could become suicidal, and sometimes carried out their intentions. We know, for instance, between January and April 1905, of the 42 enquiries that were made into suicides, 12 were by Indians, 14 by whites, and 16 by Africans.¹³⁶ In addition, the surviving committal papers (the ‘Reception Orders’) of the Pietermaritzburg Mental Hospital from 1916, show that if Africans thought to be ‘dangerous to self or to others’ came to the attention of the state, some were committed as mental patients. In some of these cases, it was public acts of aggression or oddity that brought them to the notice of the authorities. In other cases, it was families who initiated the process of committal. In either instance, however, these persons were, by and large, those who exhibited

¹³⁵ See Introduction to this dissertation; and J. C. Carothers, *The African Mind in Health and Disease: A Study in Ethnopsychiatry*, WHO Monograph Series No.17 (Geneva: World Health Organization, 1953), and S. Fernando, *Mental Health, Race and Culture* (Houndmills, Basingstoke and London: Macmillan and MIND Publications, 1991), esp. pp. 40-50; L. Swartz, *Culture and Mental Health: A southern African View* (Cape Town: Oxford University Press Southern Africa, 1998), Chapter 5; J. McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995); and J. McCulloch, 'Depressive Illness in Colonial Africa; 1920 to 1960', paper presented at the conference 'Colonialism and Public Health in the Tropics, June 18-19 1999 : York University, Canada. My thanks to Professor McCulloch for a draft copy of his paper. For literary representations of African taboos against suicide, we can note that in Chinua Achebe's *Things Fall Apart*, Okonkwo's suicide takes place within a society that regards suicide as an abomination.

¹³⁶ PAR II 1/130 I2409/04, 'Attorney-General to Protector, 5 November 1904', Copy of Attorney General's Minute to Colonial Secretary, 4 April 1904.

alarming, manic, and violent behaviour. Treatment or confinement in a psychiatric facility for Africans who were quiet, withdrawn, melancholic and suicidal, was probably far less likely to occur at this time given both the very real threat of criminal censure and the then lack of understanding of suicide as a biomedical issue on the part of either Africans themselves or by professional psychiatrists. Not until a mind shift occurred would self-destruction be brought within the realm of professional Western psychiatry. This shift was beginning in Natal and Zululand only in the early twentieth century, and it did so first for the white inhabitants of the region, for whom the 'burdens of civilization' appeared to pose a particular threat.

'The Burden of Civilization': Suicide and Whiteness

Until the early 1900s, suicides amongst Natal's white inhabitants were only occasionally noted in the criminal records, and it was not until after the establishment of the office of Public Health, in 1901, that a formal channel was created for the compilation of statistics about 'European' self-inflicted deaths. This distinction is significant in that it highlights the difference between the ways in which self-killing by Indians, Africans and whites was regarded and recorded at the time: for whites, it seems, suicide openly came into public view only once it had become the concern of medical authorities.

From newspapers, anecdotal, and secondary sources, we know that there were instances of whites deliberately taking their own lives well before this, however. For instance, social historian, Alan F. Hattersley tells the story of Gabriel Eaglestone, stone carver and builder, who came to Natal in 1850: 'Eaglestone ...was responsible for the stone-work of the new (1860) Victoria Bridge [in Pietermaritzburg]. He was deaf and suffered from persecution mania. Invited with his family to attend the opening ceremony in January 1860, he angrily refused to allow his wife and daughter to be present, fearing some dreadful calamity. Within a month his body had been

recovered from the Umsindusi [River]' apparently the result of suicide.¹³⁷ Thomas Phipson, Sheriff of Natal, was perhaps the most prominent of the early white suicides, and the shame of him hanging himself in the 'Maritzburg gaol for his family has been touched on already in this chapter. His death certificate did not indicate that he had brought about his own death. Nor did that of the thirty-year old James Kerr who, in October 1906, threw himself over the Howick Falls, which has subsequently become a notorious spot for suicide. Signed by the local undertaker, Kerr's death certificate stated that he had died from 'injury to brain hastened by asphyxia from drowning'.¹³⁸ Kerr had recently tried to update his Will in favour of his former landlady's daughter.

No enquiry into Kerr's death was noted in his estate papers, but records of enquiries into suicidal deaths of whites can be found scattered throughout the archival collections of government departments during this period. In fact, many of them show how suicides were thoroughly investigated, with testimony about the actions and mood of the deceased prior to the suspicious death being sought from a number of possible witnesses, as well as the results of post-mortems by District Surgeons. However, in the 33 year-period 1870 to 1903, I was only able to find two instances where completed suicides by Europeans had been noted in the published records of any kind in the colony; these being three such deaths in 1873 and one in 1897, and they were noted merely in passing in District Surgeon's annual reports. By 1904 at least, figures detailing 'cases of suicide amongst Europeans' were collected by the Department of Public Health: in October that year, for example, P. Murison, Medical Officer of Health for the Durban municipal area wrote to the Protector of Indian Immigrants that there had been nineteen suicides by whites 'during the Municipal

¹³⁷ A.F Hattersley, *A Camera on Old Natal* (Pietermaritzburg: Shuter & Shooter, 1960), pp. 30-31.

¹³⁸ PAR Master of the Supreme Court (hereafter) MSCE XXVIII 28/77, 'Intestate Estate of James Kerr, 1906-1908'. Kerr's death occurred on 27 October 1906 and the death certificate was signed on 2 November 1906. In a supplement to the *Natal Witness* on Howick in February 2003, Kerr was said to be the first recorded suicide at Howick Falls.

Year ending 31st July, 1904'.¹³⁹ However, in contrast to the exhaustive enumeration of Indian suicide statistics, even after European suicide statistics were collected, there was no attempt to portray European suicides as problematic, let alone explicable in terms of racial characteristics.

It was in the Health Officer Reports after 1904, that European suicides were collated and enumerated for the first time. These show us that figures and patterns remain fairly stable over the six years for which we have data, with absolute numbers fluctuating between twelve and seventeen, with death inflicted by shooting the most common method of suicide, followed by the (presumed) self-administering of poison.¹⁴⁰ These figures are suggestive of gendered patterns of self-murder, in that historically, men have been more likely to use more 'violent' – though not necessarily less painful – methods of self-destruction such as shooting or stabbing, whereas poison has been more closely associated with self-killing by women – but we cannot know this for sure as the sex of the suicides was not recorded.

Thus, when, in the early twentieth century, European self-killing was brought to light as a statistical category, it was done in a medical, rather than a solely criminal, context. Nonetheless, attempting or threatening suicide remained a criminal offence. Prior to 1906, this crime was noted only erratically, and therefore it is only with the systematic delineation of these figures by race in the *Statistical Yearbooks* after 1906 that we can get a sense of any regular occurrence. Of the twenty people charged with this crime between 1906 and 1909, ten were convicted and sentenced to a prison

¹³⁹ PAR II 1/130 I2409/04, 'Attorney-General to Protector, 5 November 1904', P. Murison, Durban Corporation, Public Health Department, Durban to The Protector of Indian Immigrants, 25 October 1904. Also quoted in Brain and Brain, 'Nostalgia and alligator bite, p. 102, fn 50: it is not clear from this letter whether these suicides all occurred in the Durban municipal area – as Brain and Brain have interpreted it – or whether they reflect the numbers for Natal as a whole.

¹⁴⁰ Figures extrapolated from Table III 'Showing Detailed Causes of Death - Europeans Only' in the Reports of the Health Officer for the Colony for the Years 1904-1909 in PAR NCP 8/2/5-8/2/9 and 8/1/12/4/2. For gendered patterns of suicide method, see Redfield Jamison, *Night Falls Fast*, Chapter 5.

sentence, in some cases with hard labour, while five were acquitted, and the remaining 'otherwise disposed of'.¹⁴¹

It may, of course, be that relatively few Europeans actually attempted or achieved suicide in Natal during this period, but it is also likely that its incidence was under-reported. At a time when suicide was not only an offence, but also carried substantial social censure, District Surgeons, Magistrates, and police probably shared a reluctance to stigmatize colonists with the shame of a verdict of suicidal death. The attitude of the Chief Commissioner of Police of Natal towards criminality amongst different races is indicative of the social penalties that would accrue to a European who was charged with attempting suicide:

The criminal population may be said to consist of casual offenders and habitual criminals, and I venture to suggest that the mode of prison treatment should be different for each class. The casual offenders may also be divided into two classes – those who repent and those who do not. The latter will probably soon pass through the hands of the Police again, and eventually be numbered with the habitual criminals, but to the former, especially in European cases, where repentance may be considered sincere, a helping hand should be extended. There is this difference between European and Native offenders – that to the European imprisonment generally means ruin, whereas the social position of the Native is in no way affected thereby, nor does it detract from his value as a labourer. In a small community like ours, a European finds it difficult to hide his identity, and no matter how desirous he may be of earning an honest livelihood after release from prison, he finds himself unable to obtain remunerative employment, and consequently lapses again into crime.¹⁴²

By the late nineteenth century, statistics on suicide rates were becoming a central part of investigations into self-killing in the metropolitan West. This was gradually accompanied by a shift of attitude away from viewing suicide as a religious and criminal problem to one that should be explained by social or psychiatric factors. Public opinion, in Natal too, was shifting in the direction of finding the punishment of

¹⁴¹ PAR NCP 7/3/12-7/3/16, *Colony of Natal, Statistical Yearbooks, 1905-1909, Magistrates' Courts: Crimes and Offences Tried By the Magistrates'*.

¹⁴² PAR NCP 7/4/2, Bound Departmental Reports, Part V - Judicial. Annual Report of the Criminal Investigation Officer For The Year Ended December 31, 1895, p. E1.

suicidal people inappropriate: one W. Stobie, writing to the *Natal Mercury* in 1905, for example, expressed the sentiment that the sentence of two months' hard labour meted out by the 'First Criminal Magistrate of Durban' to Herman Rode, who had pleaded guilty to attempting suicide by 'drinking a quantity of morphia at the Bluff' was 'outrageous' and 'cruel ... and for no fault committed towards anyone but himself'.¹⁴³ Rode had told the Magistrate that 'he was out of employment for some time, and he thought the best thing he could do was to commit suicide', but this clearly failed to move the official, who reportedly asked Rode 'what the country would come to if every person who could not find employment committed suicide, and said that the accused's action was that of a coward.'¹⁴⁴

Rode's experience points to how class was likely to have played a role in bringing whites who threatened or attempted suicide to the attention of the authorities. Where families of sufficient means – and with good connections – were concerned, covering up self-destructive acts as accidental was possible. So, too, was care or confinement in the home, especially for those expressing the wish to die but who were not noticeably violent. Women, especially, could be restrained at home with less risk of incurring curiosity or censure. As Africans were able to withhold information about self-inflicted deaths from magistrates, upper class white Natalians, including doctors and officials, were likely to have withheld reporting threatened or attempted suicides and to have closed ranks to avoid the stigma of suicide and madness tainting their carefully preserved class and ethnic identity.

This class cohesion is described in Robert Morrell's discussion of the social history of settler masculinity in Natal. Morrell describes how, in the process of his research –

¹⁴³ PAR CSO 1801 1905/9421, 'W. Stobie, Durban. Forwards Cutting From The "Mercury" Relative To H. Rode Who Was Charged With Attempting To Commit Suicide, Before The First Criminal Magistrate, Durban,' 1 December 1905. W. Stobie, Durban to Colonial Secretary, Pietermaritzburg, n.d., received Colonial Office 1 December 1905. Rode had made his suicide attempt on 18 November 1905, and the *Natal Mercury* item, dated 30 November 1905, was titled "A Rash Act".

¹⁴⁴ PAR CSO 1801, 1905/9421, 'W. Stobie, Durban. Forwards Cutting From The "Mercury" Relative To H. Rode', "A Rash Act", *Natal Mercury*, 30 November 1905.

conducted in the late 1980s and early 1990s – the descendants of Natal’s white ruling class had erased the memories of ancestral misfits:

The major mechanism by which the [Old Natal Families] presented unity was to silence dissident voices and deny their existence. This involved withdrawing of economic support and social recognition, seeking and using legislative power to isolate and marginalize and, subsequently, to tamper with the historical record to make ‘blobs of shame’ disappear.¹⁴⁵

Included in the ‘misfits’ about whom Morrell writes were the those who transgressed social norms through miscegenation, the unlucky and unsuccessful, as well as the ‘feeble-minded’. It does not seem to be too much of a stretch of the imagination to include the suicidal. The silence of the historical record on the incidence of suicide amongst ‘European’ Natalians becomes understandable, then, in terms of the social shame and taint of mental instability which it carried.

Class would also have played a part in the strategies employed by families to soothe and dissuade the suicidal amongst them. Many of the facilities described in the previous chapter – private nursing homes and sanatoria in particular – combined aspects of both the custodial and the curative and would have been seen as more desirable options than physical restraint in a gaol. This latter fate was more likely to be the lot of the person without property of family willing to take him, or her, in. A further alternative was, of course, the asylum.

Indeed, attempting suicide was one of the major reasons why committals were precipitated: of the 251 admissions recorded in the European Case-Book between 1904 and 1908, more than 40 persons were identified as being ‘suicidal’.¹⁴⁶ Many of these – more than half at least – were admitted as private patients. Unfortunately, we lack information about who was instrumental in having these patients certified or under which section of Law No. 1 of 1868 they were committed to the NGA.

¹⁴⁵ R. Morrell, *From Boys to Men: Settler Masculinity in Colonial Natal, 1880-1920* (Pretoria: UNISA Press, 2001), p. 254.

¹⁴⁶ Natal Government Asylum (hereafter) NGA (European) Patient Case-Book XI. This is a conservative estimate as I have not included those who were said to be ‘probably suicidal’.

However, even the skimpy notes that we have, indicate that most private suicidal patients had first been treated at home, but that when their disturbed states of mind became dangerous, they were moved to the asylum. Either because of independent financial means or because, notwithstanding the social embarrassment of having a family member there, families were prepared to pay for their maintenance at the NGA, a significant number of white patients were admitted because they exhibited suicidal tendencies. Once more, a few examples illustrate the general points made, that whites who attempted or threatened suicide were transferred to the asylum if it was no longer possible to restrain them in private accommodation, and that in many cases the costs of maintaining these patients were charged to their families or to their own account. For instance, the 39-year old Mrs Roxburgh, admitted in April 1905, had refused food for some months after both her husband and her child had died, but it was when she took to wandering about and became suicidal, that she was committed to the NGA, where she died in June that year.¹⁴⁷ In 1906, Edward Pickering became troubled by suicidal thoughts, prompted by money troubles, but he 'could find no comfort in Religion', and he became 'intolerant to friends'. Attended by two doctors he had nonetheless tried twice to kill himself before his committal. Said to be 'a thin frail old man', he died in the asylum barely two months later.¹⁴⁸

Both Roxburgh and Pickering were 'Private First Class' patients. The morphine addict, Dr Butterfield, had admitted himself as a voluntary patient when his 'drug habit' had rendered him suicidal. He was at the NGA for only two months before his discharge.¹⁴⁹ Charles Crabbe, described as 'very suicidal' was also a voluntary patient. The victim of 'years of melancholy' and of insomnia, Crabbe had been in and out of asylums in England before coming to Natal.¹⁵⁰ Also 'extremely suicidal' was

¹⁴⁷ NGA (European) Patient Case-Book XI, p.161. Mrs Alice Roxburgh: Admission number 1919.

¹⁴⁸ NGA (European) Patient Case-Book XI, p.373. Edward Pickering: Admission number 2084.

¹⁴⁹ NGA (European) Patient Case-Book XI, p.685. Dr. Butterfield: Admission number 2275.

¹⁵⁰ NGA (European) Patient Case-Book XI, p.437. Charles Crabbe: Admission number 2112.

the 41 year-old publican, Charles Harmsworth: his symptoms were noted as 'Undecided, sleepless, and complains of dominant thoughts urging him to commit suicide. Erotic. Carries a bottle of Laudanum about with him.' Harmsworth had been treated at home by Drs Dumas and Murray Gray before coming to the NGA.¹⁵¹ It was four years before he was discharged.

Finally, suicidal thoughts and even attempts were not unheard of amongst patients themselves, perhaps the most poignant example being that of Emma Lovett whose discharge Hyslop was, in early 1897, on the verge of authorizing. So improved had Hyslop believed her to be, that he said, 'I have for some time been prepared to certify her as being of sound mind', and she was permitted to help the nursing staff in their duties. However, while cleaning the operating surgery, Lovett 'secreted a small bottle containing poison' which, it was later established, was acetic acid, and swallowed it down.¹⁵² Her suicide attempt was unsuccessful, but Hyslop was forced to change his opinion about her suitability for discharge and Emma Lovett's bid for release into the recognizance of her family was delayed for another five years.

It may be that the survival of the European Patient Case-Book with details about white patients from the early 1900s, as well as the richly informative Reception Orders from 1916 onwards, has skewed the evidence available to us by making visible records of white self-destruction in the context of colonial psychiatry, in a way that obscures a similar incidence amongst Africans or Indians. This seems unlikely to be the whole picture, however. Rather, the NGA offered an alternative, which, while continuing to carry negative social connotations for white Natalians, could be regarded as far less shameful and more humane than the incarceration of the suicidal in a gaol. Particularly in cases where the deranged could be accommodated as private patients, in comfortable surroundings and supported by additional nursing care and

¹⁵¹ NGA, (European) Patient Case-Book XI, p.429. Charles Harmsworth: Admission number 2109.

¹⁵² PAR Minister of Justice and Public Works (hereafter) MJPW 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908,' James Hyslop, Medical Superintendent to Colonial Secretary, 10 February 1897.

other luxuries paid for by their families, the stigma of suicide began to lessen, or at least began to be regarded as far more appropriately the domain of the doctor than of the magistrate.

This shift towards a more sympathetic response to self-destruction appears to have taken place first for whites: Indians, as we have noted, were often dismissed as frivolous in their suicidal acts – or they were deported if they bungled a suicide attempt – while African suicide went under-reported; where it was threatened, it was not infrequently punished by a term in gaol, with hard labour. Furthermore, the War of 1914 to 1918, meant a rise in the number of soldiers who needed to be transferred to a psychiatric facility, and Pietermaritzburg received a number of traumatized military men, such as Harold King, transferred from No. 3 General Hospital in Durban in April 1917.¹⁵³ King had been involved in the campaign in German East Africa, where, after ‘he was lost in the bush for 5 days,’ he was treated at a military hospital at Dar-es-Salaam. Transferred to his home-town of Durban, King was by turns violent, paranoid, and suicidal, and the Union Defence Force undertook to pay for the costs of his maintenance at the Pietermaritzburg Mental Hospital.¹⁵⁴

That attitudes towards suicide amongst whites remained ambivalent, however, can be seen in the existence of European suicide figures in both the criminal and the medical statistical tables of Natal. Another factor which fuelled split-feelings about white

¹⁵³ PAR RSC 1/27/3, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 73/17, ‘Harold King of D.H. Section, No. 3 General Hospital, Durban’, 5 April 1917.’ Reception Order granted on 22 March 1917. Form Mental S. 9 ‘Report of District Surgeon or Other Medical Practitioner or Physician Superintendent of Mental Hospital’, signed by Dr R. Sinclair Black, 30 March 1917.

¹⁵⁴ At the end of 1918, there were 58 persons identified as ‘Soldiers’ who were patients at the country’s various Mental Hospitals, 29 of whom were classified ‘European’, 23 as ‘Native’, and 6 as ‘Coloured’. U.G. 31-’20, *Report of the Commissioner of Mentally Disordered and Defective Persons for the Union of South Africa* (Pretoria: Government Printer, 1920), ‘Occupation of Patients – Direct Admissions, 1918’ p.47. Unfortunately, it is not possible to establish how many were at each hospital, but in relation to other listed categories of occupation, that of soldier is relatively high. By comparison: police (7), storekeeper (28), clerk (19), farming (93), and unknown (68).

suicide was related to the growing fears that whites, as members of the more 'advanced race' were more susceptible to insanity and to 'nervous breakdown' because of the stresses and strains of 'civilization'.¹⁵⁵ In the climate of a scientific racism based on social Darwinist principles that was increasingly forming the basis of state and institutional research in southern Africa at this time, suicide amongst whites could therefore occupy the paradoxical positions of signalling a source of shame and weakness, as well as being a sign of greater sensitivity and intelligence.

Conclusions: Death in black and white

Suicide had been of concern to colonial authorities since at least the 1868 Natal Custody of Lunatics Law, which created the legal grounds for the certification and confinement of persons believed to be 'dangerous to themselves or to others'. Early measures for restraining the suicidal, however, were restricted to locking them in gaol, as occurred with the Sheriff of Natal, Thomas Phipson, in 1876. After the opening of a temporary lunatic asylum in the mid-1870s, suicidal persons could be kept there rather than in the gaol proper. There was little to distinguish these two facilities, however. From the 1880s, the Natal Government Asylum offered (presumably) a more desirable alternative for the care and confinement of the mentally ill, including those who expressed the wish to end their own lives. Throughout the late nineteenth and early twentieth centuries, however, suicide continued to be regarded primarily as a legal, rather than a medical, matter. This had implications for the way in which those who attempted, but failed to achieve, suicide were treated. For some who came to the attention of the state, a punitive, rather than a psychiatric response, was meted out, with the hapless survivors being sentenced as criminals and receiving a gaol sentence, sometimes with hard labour.

¹⁵⁵ See S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape' (unpublished PhD. Thesis, University of Cape Town, 1996), pp.113-116, and Saul Dubow *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995), esp. Chapters 5 and 6.

What determined whether or not a suicidal person – either before or after the act – came to the attention of the authorities, however, was mediated by social position, as profoundly shaped by class and race. For instance, the category of suicides about which we know the most, those by indentured Indians, first came to light through with the increasingly detailed recording of 'unnatural deaths' amongst the bonded workers of Natal, especially from the 1880s when there was a need to ensure a steady supply of labour for Natal's economic expansion. The records of the Protector of Immigrants highlighted, in black and white, the scandalously high rate of suicide amongst indentured workers. An emerging Indian middle-class called repeatedly for an enquiry into the 'painful subject' of Indian suicides, but was ignored by the government of the Colony, which, after 1893, showed increasing hostility towards the continued presence of 'free Indians' in Natal and Zululand, and which, through its taxation policies, intensified the economic conditions which, so Henry Polak, insisted, contributed directly to Indian suicides. The Protector was also hobbled in his attempts to discern the causes of the epidemic of self-killing. Even where the context seemed clear – the oppressive and highly exploitive conditions under which many indentured workers lived and laboured – explanations for suicide continued to reflect a discourse of blame rooted in the supposed character of 'the Indian'. Nor were those Indians who showed suicidal intent usually removed to the NGA: instead, some of those who attempted suicide, and many of those regarded as 'imbecilic' or insane were repatriated to India. Employers also balked at paying for the asylum fees. In any case, Indians themselves showed a reluctance to be hospital, including asylum, subjects, and in many cases preferred to manage insanity and illness themselves. One option, albeit a drastic one, in the face of psychological strain and suffering was suicide.

We have far less data about African suicides. This has usually been seen as a reflection of a virtual absence of such acts by Africans in Natal and Zululand – as well as elsewhere in Africa – at this time. Certainly, the colonial state was not concerned to document self-destruction by Africans in the same way that it did for Indian workers. Nor could it. Archival records suggest that self-murder by Africans did occur, but that

the state lacked both the mechanisms and the will to track patterns of African suicide. Individual threats or acts of self-killing became visible largely in magistrates' courts that tried the survivors of suicide attempts, or those accused by others of threatening to do so. The majority of those tried for this crime were convicted, and presumably punished, but few were certified as being of unsound mind. On the other hand, the limited information about African committals to the NGA that characterizes most of the half-century covered by this dissertation begins to be supplemented by the fuller records available to us from the Reception Orders that had to be filed under the Mental Disorders Act of 1916, and these do show that African families were beginning to utilize the NGA as a place of restraint for the mentally disturbed and dangerous individuals who threatened them. Suicidal Africans could, of course, be dangerous and it was they – rather than the suicidal or melancholic or depressed – who were confined as psychiatric patients.

We have the least statistical information of all about white suicides, which began to be systematically recorded only after mortality figures were compiled by the Department of Public Health in the early 1900s. Yet, the patient records of the NGA demonstrate vividly that many European inhabitants of Natal and Zululand attempted to take their own lives. Mostly, these records reflect the experiences of those who threatened but did not complete suicide: we have no reliable way of estimating how many suicides by whites were certified as being natural or accidental deaths, but the shame and stigma attached to both insanity and to suicide at this time strongly suggest that white Natalians, especially those belonging to the upper ranks of settler society, would have been reluctant to bring self-inflicted deaths (let alone threats of suicide) to the notice of the authorities. At a time when race, heredity, and the dangers of degeneration were entering popular and scientific thought and practice, the burdens of civilization that whites believed they carried appeared to make them even more vulnerable to nervous strain and possible collapse, including suicide. Upper class white patients could afford – and received – more sympathetic responses to their suicidal impulses. Poorer class white patients, however, were viewed with increasing suspicion along with the perceived threat they supposedly posed to ‘the white race’

through ‘the propagation of the unfit’ by the ‘feeble-minded’ and those who ‘spread insanity by being discharged unrecovered’.¹⁵⁶

The psychiatric profession in South Africa was attentive to these fears, and responded, in the years immediately before and after World War 1, by making determined efforts to distinguish between different ‘classes’ of patients, and in so doing to provide what it claimed would be more appropriate diagnosis and care. Special attention was to be paid to the categorization of persons of unsound mind, and to the physical accommodation that was needed to treat the ‘mentally afflicted on modern lines’.¹⁵⁷ The new legislation of 1916 provided for greater differentiation of categories of mental disorder. Dr J T Dunston, who was influential in the drafting of the new provisions, was keenly aware of the ‘stigma which unfortunately an ignorant and indiscriminating public opinion attaches to treatment at [an Asylum]’ and wished to create a new set of distinctions between patients who had different prognoses, housing the merely ‘neurasthenic’ and the those who were likely to recover separately from the incurable.¹⁵⁸ This would require the ambitious expansion of the existing asylum facilities and the construction of several new mental hospitals. By 1914, the Pietermaritzburg Mental Hospital looked to build new wards, an admission block, and also – so its new management urged – to purchase new lands adjoining the asylum estate. With the second-highest number of mental patients in the country, the Pietermaritzburg Mental Hospital remained an important institution in the Union’s mental health service, but, since the opening of Valkenberg in Cape Town in 1891, Natal could no longer boast its leadership in asylum construction. The shifting political centre of gravity to Pretoria also now meant that jostling for the allocation of

¹⁵⁶ NAR PM 1/1/322 184/2/1913, ‘Public Health: Expansion of Asylum Accommodation’, Memorandum – presumably authored by J. T. Dunston – to the Acting Secretary for the Interior, Pretoria, 22 December 1912, p. 12.

¹⁵⁷ NAR PM 1/1/322 184/2/1913, ‘Public Health: Expansion of Asylum Accommodation’, ‘Minute by the Minister of the Interior giving an estimate of the requirements necessary to enable Lunatic and Leper Asylum accommodation in the Union to be placed in a reasonably sound position, 1 April 1913, p. 1.

¹⁵⁸ NAR PM 1/1/322 184/2/1913, ‘Public Health: Expansion of Asylum Accommodation’, Memorandum signed by J.T. Dunston, no date, but presumably 1913.

much-needed funds had to take place in an arena wider than that of Natal. By this time, too, the asylum was no longer regarded by many of Pietermaritzburg's white citizens as an asset, but rather as a threat to the social order that was solidifying along lines of class and race.

Chapter 6

‘The A-Z of Mental Disease and Asylum Administration’: the Pietermaritzburg Mental Hospital and Psychiatry in South Africa, 1910-1918

To: H.B. Shawe, Acting Under Secretary, Department of Interior

‘... I think I have learned mental disease and Asylum administration from A to Z here.’

Dr. D. A Pringle
Govt. Asylum
Maritzburg
Natal
14.8.1911¹

In late April 1913, on the return journey from Cape Town where he had given testimony before a Parliamentary Select Committee as well as attending a meeting of the Council of the University of the Cape of Good Hope, Dr. James Hyslop, Medical Superintendent of the Natal Government Asylum since 1882, was taken ill. On 2 May, Hyslop was obliged to write to the Minister of the Interior from the Caledon Sanatorium, where he had been advised to remain for at least six weeks.² He wrote, too, to Dr Archibald Douglas Pringle who had for some time been the Acting Superintendent in Pietermaritzburg. Pringle had served at the Natal Government Asylum (NGA) since his arrival from Britain in 1904, and by 1913, held the post of First Assistant Medical Officer.

¹ National Archives Repository (hereafter NAR) Pretoria, Colonial Secretary (hereafter CS) 986 20397, Dr A. D. Pringle, NGA. Dr A. D. Pringle to Acting Under Secretary, Department of the Interior, 14 August 1911.

² NAR CS 994 20795, Dr. J. Hyslop, Health. Medical Superintendent, NGA, Natal. Hyslop to Secretary for Interior, 2 May 1913.

The Parliamentary Select Committee which Hyslop attended had been appointed to 'enquire into the adequacy or otherwise of the provision in the various Provinces of the Union for the accommodation and treatment of persons of unsound mind', and it called for evidence from the country's leading psychiatric experts as well as from District Surgeons, magistrates, and from the Minister of the Interior. It allowed for an extensive airing of the problems that beset the country's asylums and various views on how these might be remedied. Some of the recommendations made at the Select Committee hearings would form the basis for South Africa's 'asylum administration' and lunacy legislation, as some medical and legal practitioners still termed it, for the next half a century. It seems, then an appropriate focus for the beginning of this chapter, which turns once more to the formal, professional, sector of psychiatry, focusing on the years between the formation of the Union of South Africa in 1910, and the end of World War 1.

With some justification it might be said that, by 1920, South African psychiatry – although still bearing the imprint of its nineteenth century origins – had taken on a different orientation, one that was more carefully directed in the interests of a state that was increasingly concerned to systematize the segregation of its citizens and its subjects. In this, the boundaries of race, gender and class continued to be potentially threatened by those who exhibited insanity or idiocy (a concept and a category that was now more broadly understood to include the 'feeble-minded'); and policing the racial borders acquired, if anything, an even greater urgency.

By the laying down of the first lunacy legislation of the region and the construction of a number of asylums, the nineteenth century had seen the institutionalisation of insanity in the four colonies that would later become the Union of South Africa. The following century would see the professionalization of a psychiatry that, in large part and in keeping with developments in the West – in the USA as much as in Europe – allied itself with a scientific and popularist enthusiasm for eugenics, and for the wider application of notions of mental aptitude or inferiority. Although the number of formal practitioners was never

large, psychiatry would also broaden its base far beyond its nineteenth century institutional setting of the asylum, and its practitioners could, by the late 1920s and 1930s, be found in universities and schools; as physicians they had been drafted into the armed forces during World War I. Thereafter, psychiatrists and psychologists were also advisors on educational policies to the state, as well as monitors of intelligence testing; as private practitioners they could be found engaged in psychoanalysis, and in the treatment of individual patients. In Europe and North America, so too in South Africa, doctors, psychiatrists and law-makers shifted away from focusing on fears about the increase of madness, to a concern with 'mental hygiene' as a vital strand in the struggle to preserve racial purity. In South Africa, these fears contributed, both directly and indirectly, to the elaboration and implementation of segregationist legislation.³ They also led, as Sally Swartz notes, and in contrast to the nineteenth century, to a relative lack of attention to the 'institutionalised insane' until the treatment revolutions – most notably the convulsive therapies – of the 1930s.⁴

This chapter will attempt to show that the period between Union and 1918 was something of a transitional phase: the separate colonial administrations of individual asylums, whose practices and guiding principles were shaped by local factors and personalities whose most direct linkages were often to Britain rather than with other Southern African psychiatrists or institutions, gave way to a national system of mental hospitals, administered from Pretoria. This period saw, too, the reorientation of the medico-scientific basis of psychiatry that heralded what may be regarded as a new phase in South African psychiatry, one that, as Shula Marks has commented, saw a shift from universalism to a 'particularist vision of

³ The general South African picture - of the eugenics and mental hygiene movements, concerns about degeneration, poor 'whiteism', the 'feeble-minded' and racial purity - is well covered in chapters 4, 5 and 6 of Saul Dubow's *Scientific Racism in Modern South Africa* (Cambridge: Cambridge University Press, 1995). A helpful overview of the increasingly intertwined nature of science and politics, from the early twentieth century, remains P. Rich, 'Race, Science, and the Legitimization of White Supremacy in South Africa, 1902-1940', *The International Journal of African Historical Studies*, 23, 4 (1990), pp. 665-686.

⁴ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920' (Ph.D. thesis, University of Cape Town, 1996), pp. 31-32.

the world which came to characterise care in South Africa's psychiatric institutions for much of the twentieth century.'⁵

In the main, the profession of psychiatry in South Africa would become more closely allied with segregationist policies based on perceived racial differences, and would play a greater role than it had before in the genesis of such views. The paucity of records makes it difficult to discern, however, the extent to which Natal, and in particular the psychiatrists associated with the Pietermaritzburg Mental Hospital (and, after 1927, Fort Napier), contributed to and participated in this move to a psychiatry explicitly shaped by scientific racism. Patients' experiences are even more opaque: abandoning the old Case-Book format of record-keeping, after 1919, patient records were transferred to loose-leaf sheets and folders. These were destroyed in accordance with state regulations dating from the late 1920s, a practice that coincided with professional medicine's increasing concern for patient confidentiality.

More than patient records were deliberately destroyed, however: so, too, were most staff files, correspondence, and miscellaneous records that had previously been held by the colonial government, and from 1910 by the Department of the Interior.⁶ The annual Medical Superintendent's reports, previously published in full in the colonial Blue Books also disappeared from view, the Secretary for the Interior deciding that, in interests of economy, they should not be printed after 1910. Excerpts from these reports were included in the Reports of the Commissioner of Mentally Disordered and Defective Persons after World War 1, but they were perfunctory, and moreover, were vetted first by the Commissioner. With the transfer of responsibility for the country's asylums to Pretoria, it

⁵ S. Marks, "Every Facility That Modern Science and Enlightened Humanity Have Devised": Race and progress in a colonial hospital, Valkenberg Mental Asylum, Cape Colony, 1894-1910' in J. Melling and B. Forsythe (eds.) *Insanity, Institutions and Society, 1800-1914: A Social History of Madness in Comparative Perspective* (London: Routledge, 1999), p. 286.

⁶ NAR Director of Archives (ARH) 14 C11/13/17, Destruction of Records, Department of the Interior, Mental Hospital, Pietermaritzburg, 1928-1938.

becomes considerably more difficult to trace the history of the formal practices of Natal psychiatry, which in any case became less autonomous and more directly controlled by the national state.

What the surviving records – as well as other evidence gleaned from local, Pietermaritzburg sources such as municipal records and newspapers – do tell us, though, is that, the decade after Union saw a relative decline in importance of the Pietermaritzburg Mental Hospital (as the NGA was now known) *vis-à-vis* other asylums in the country. While its patient numbers continued to escalate – in 1910 there were 619; by 1918 there were 797 – and more lands were acquired for new buildings and for the asylum farm, the professional staff complement remained small, and was overworked and frequently demoralized. Located at some distance from the Rand, the political and economic nub of the new country, Natal's 'mental services' and its psychiatrists no longer occupied the position of prestige enjoyed by and under James Hyslop. Moreover, the majority of patients accommodated at the Pietermaritzburg Mental Hospital were black – African, Indian and Coloured – and the over-riding interest of the emerging national South African psychiatric profession and scientific practice lay in a concern for whites. The continued accommodation of several hundred black patients, as well as black staff who worked at the asylum, also had begun – by the years of World War 1 – to arouse the resentment and animosity of a number of white Pietermaritzburg residents, who fused fear of the insane inmates, racial stereotypes, and avaricious interests in the, by now extensive and economically-desirable, lands that the Mental Hospital occupied at the heart of the city. While the asylum had always been regarded with ambivalence, by 1918, the mad in the city's midst were regarded as a nuisance at best, and a danger, at worst. It is this story – one of expansion yet also of contraction – that this chapter seeks to trace. In so doing, it is necessary to place the history of the Pietermaritzburg Mental Hospital against the backdrop of national, as well as more local, dynamics.

The Select Committee of the Treatment of Lunatics that met in April 1913 was the first step in the establishment of the national South African psychiatric system that would increasingly shape the fortunes of individual mental hospitals. The Committee took evidence from the Medical Superintendents at the country's asylums, with Dr. William J. Dodds, Medical Superintendent of Valkenberg and Inspector of Asylums, representing the five Cape institutions. Dodds and Hyslop were then the country's most eminent specialists in mental matters, and represented an older generation of psychiatry. They had both trained in Edinburgh in the 1870s, and their psycho-medical principles were rooted in the precepts of moral management. Both had had considerable experience of managing asylums in South Africa. (Dr. Thomas D. Greenlees, who had been Medical Superintendent of Grahamstown Asylum since 1890, was also an Edinburgh graduate, and had taken early retirement in 1907.) Both Hyslop and Dodds retired in 1914.⁷

Whereas Hyslop expressed himself relatively satisfied – for the moment – with the asylum facilities at Pietermaritzburg, for white patients in particular, Dodds was despondent about the situation in the Cape. For years he had been decrying the unsuitable and unsanitary state of affairs at Robben Island, Grahamstown, Port Alfred, and Fort Beaufort. Even Valkenberg, the flagship asylum of the 1890s, was in dire need of extension and upgrading. He told the Committee that 'practically nothing was done here [in the Cape] from 1905 until 1911 ... From 1905 the years had been simply black years. It is impossible almost to speak of the difficulties from 1905.'⁸ Reluctant to endorse the continued use of Robben Island for lunatics, he admitted that 'I have been a good deal responsible myself for the flimsy character of the buildings erected there, wood and iron, as I have always looked forward to the day when the patients would be leaving it.' Fort Beaufort and Port Alfred were both unsuitable in construction – having been formerly barracks – and were

⁷ E. H. Burrows, *A History of Medicine in South Africa up to the end of the Nineteenth Century* (Cape Town: A.A. Balkema, 1958), pp. 219 (Hyslop); 343 (Greenlees); and 345 (Dodds).

⁸ SC. 14-'13, *Report of the Select Committee on Treatment of Lunatics, May 1913* (Cape Town: Cape Times Limited, Government Printers, 1913), pp. 3-4. Evidence of Dr. W.J. Dodds, 14 April 1913.

unhygienic and unsightly; Grahamstown Asylum, which from 1908 had been reserved for white patients, was in need of considerable expenditure. All were overcrowded.

In their testimonies, both Dodds and Hyslop stressed the necessity of keeping the number of asylum patients relatively small so that the Medical Superintendent, or his Assistants, could oversee the care and treatment of patients with a degree of personal involvement. Dodds in particular expressed his dislike of huge asylums, mentioning that some in the USA and in Europe housed several thousand patients: 'Economy is not,' he said, 'I hope, to be the only consideration. As a medical superintendent, I have a perfect horror of those monster places.' He reiterated the point: 'Personally, I should not like to see anything in the shape of a monster asylum. Have dotted about the country asylums of moderate size. The nearer you get asylums to the homes of people the better for everybody, the better certainly for the patients. ... It is most advisable from every point of view.'⁹ Dodds conceded that Valkenberg could be expanded to accommodate eight hundred patients, but he did not want to push the numbers higher, calling attention to the benefits to be had from 'the individualism of the treatment.'¹⁰ He also wanted to retain that asylum for white patients and for a new facility to be erected on the mainland for black lunatics.

Hyslop was interviewed two days later. On the matter of the number of patients which any one institution should accommodate, his views were similar to those of Dodds: 'I do not think I would recommend more than 1,500 patients in all in any institution. With regard to the economical aspect I daresay a larger institution is more economical to run than a smaller institution, but there are other considerations than economy ... I do not think anyone can properly supervise more than a certain number of patients.'¹¹ These views were somewhat at odds with those of Dr. Eric Swift, who had been Medical Superintendent of

⁹ *Select Committee, 1913*, pp. 10 and 15. Evidence of Dr. W.J. Dodds, 14 April 1913.

¹⁰ *Select Committee, 1913*, p. 14. Evidence of Dr. W.J. Dodds, 14 April 1913.

¹¹ *Select Committee, 1913*, pp. 42-43. Evidence of Dr. J. Hyslop, 16 April 1913.

the Bloemfontein Asylum since 1905.¹² Swift favoured larger institutions – of between 1,500 and 2,000 – on the grounds that this facilitated the classification of patients (which was believed to be vital for a correct diagnosis and therefore treatment), as well as efficiency and economy.

At the Select Committee hearings, and in correspondence and direct consultation with the Department of the Interior, the most influential voice of all was that of Dr. John Thomas Dunston. In several important ways, Dunston represented a new generation of psychiatric thinking and practice in southern Africa. He was one of two appointments from Britain in 1906 – the second was Dr. Harry Egerton Brown – to head up the Pretoria Asylum. This was the old *Krankzinnigengesticht* of the former South African Republic. As Hilary Sapire and Bob Edgar explain, this lunatic asylum was the subject of a ‘minor scandal’ during the South African War of 1899-1902. The occupying British administration found conditions there ‘abominable’; they took over the running of the asylum, and under Milner’s reconstruction programme following the war, the buildings were torn down and, by 1907, in their place stood ‘bow-windowed, red-brick Edwardian buildings ... Based on the architectural principles of Menston Hospital in Yorkshire (and making no concessions to local climatic conditions, such as providing verandahs or shelters from the fierce highveld sun), it was planned to accommodate 450 patients.’¹³ For a time known simply as the Pretoria Asylum, it later became known as Weskoppies. It was to this mental hospital that the Xhosa woman prophet, Nontetha Nkwenkwe, was transferred from Fort Beaufort in 1924, and where she died eleven years later.

¹² *Select Committee, 1913*, p. 20. Evidence of Dr. E. W. D. Swift, 15 April 1913. Swift had had short periods of service at Valkenberg and Robben Island, as well as at the London County Council Asylum at Hanwell and the Exeter Asylum.

¹³ R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 2000), pp. 64-65.

Dunston's career has attracted some attention from historians, and he is rightly regarded as a key figure in the history of South African psychiatry, being highly influential in the drafting of the Mental Disorders Act of 1916; as the Commissioner, first of Mental Disordered and Defective Persons, and then, from 1922, of Mental Hygiene; and the first professor of psychiatry at the University of the Witwatersrand. Primarily concerned with the mental state of whites – particularly the 'feeble-minded' – he also promoted strongly pro-eugenicist policies.¹⁴ If his published beliefs about the relative mental abilities of whites and Africans echoed those expressed by Greenlees in the late nineteenth century, the language and the tools that Dunston employed to establish this were however those of the early twentieth. As his testimony to the 1913 Select Committee made clear, he regarded the entire 'asylum system' that the Union had inherited as hopelessly antiquated, and in need of rethinking and reorganizing. Nothing short of an 'organized system for providing for the care of the insane throughout the Union' would do.¹⁵ His sense of urgency is palpable even in the transcript of the Committee hearings: 'The scheme should be carried out at once. If we cannot place the asylums on a sound basis at once we cannot go on. The whole scheme is equally urgent.'¹⁶

Dunston's recommendations for the immediate expenditure required on the Pietermaritzburg Mental Hospital were perhaps the most modest of all for, in his opinion, the 'needs in Natal are not so pressing as they are in other parts of the Union'. Ironically, perhaps, Hyslop's success meant that under the new Union dispensation, the needs of Natal's 'asylum service' were relatively neglected. Certainly, this was the perception of some of Hyslop's successors who, especially during World War 1 and in its immediate aftermath, struggled to cope with rising patient numbers, financial cut-backs, stalled

¹⁴ Edgar and Sapire, *African Apocalypse*, pp. 154-155; and Saul Dubow, *Scientific Racism in Modern South Africa*, pp. 147-149, 151, 173, and 233.

¹⁵ *Select Committee, 1913*, p. 22. Evidence of Dr. E.W.D. Swift, 15 April 1913. The phrase is Swift's, but it echoes the sentiments most forcefully and comprehensively expressed by Dunston.

¹⁶ *Select Committee, 1913*, p. 68. Evidence of Dr. John T. Dunston, 18 April 1913.

additions to building plans and extensions, as well as increasing hostility from the rate-paying citizens of the city of Pietermaritzburg. Somewhat remote from the centre of financial and political power on the Rand, where the Pretoria Asylum was also becoming known as a place of psychiatric innovation, the Pietermaritzburg Mental Hospital and the profession of psychiatry in Natal were, by 1918, inextricably – though not necessarily always advantageously – linked to a broader national network of personnel, policies and political agendas.

‘The whole scheme is inter-dependent – no part can be done without another’: from lunacy to mental disorders, the establishment of a South African asylum system

In 1909, James Hyslop had concluded his final published Medical Superintendent’s Annual Report for the government of the Colony of Natal by noting that: ‘Important changes, will, in all probability, be effected in connection, not only with this Asylum, but also with other Asylums in South Africa as a result of the Act of Union... It is to be hoped that one of the effects of the contemplated change will be uniformity in Asylum administration, and an Asylum Service for the Union of South Africa’.¹⁷ He went on to say that he was ‘fully anticipating that such changes will be of material benefit to those for whom the Institutions are provided, as well as to those who have to do their working and administration...’ Earlier in his report, he had lamented the pressure that he had been under for some years from the colonial treasury to cut down ‘expenditure to the lowest possible limit’. This, he added, had some been ‘at the expense of perhaps more important considerations’. By the time of his retirement, in 1914, a national asylum system was in the process of formation, but there had been very few material benefits. Indeed, in the early years of the Union, the situation at most asylums in the country was, if anything, to deteriorate.

¹⁷ *Natal Blue Book, 1909*: Annual Report of the Medical Superintendent, Natal Government Asylum.

Indeed, the overcrowding that characterized all South African asylums by the late nineteenth century intensified in the early 1900s. In 1913, Edmond Gorges, Secretary for the Interior, admitted that 'ever since the first day of Union' his department had 'come up against this question of over-crowding in lunatic asylums.'¹⁸ He added that 'because of that want of accommodation ... we have been at our wit's end.'¹⁹ The measures taken over the previous few years had been piecemeal, however, he conceded, and although £144,000 had been spent on asylum accommodation since Union - £28,000 on Pretoria, £13,000 on Valkenberg, £4,500 on Fort Beaufort, and £22,000 for 'a new paying patients' block at Maritzburg' - it was still necessary to 'tackle the matter in a comprehensive way, and deal with the whole thing in one scheme.'²⁰ This, he said, had 'come together in the last nine months', as a result of the reports made to him by a Committee, consisting of Dunston and Mr. P. Eagle, Chief Architect of the Public Works Department, who had visited every asylum and associated institution in the country.

It was not this report that led to the appointment of the Select Committee by the Union Parliament, however. Instead, it took a scandal in the press in early 1913 that made the state of the country's asylums a matter of public concern. The scandal followed on the reporting of the case of a Mr. Auliff who had been forced to spend more than a month in the Wale Street gaol because there was no place for him at any Cape asylum. Auliff had been arrested on a 'trivial matter' and detained for observation. After a month had passed, however, he was found to be 'not insane', and the criminal charge was dropped. Although Auliff subsequently disappeared from view, George Blackstone Williams, Resident Magistrate of Cape Town, reported that several other instances of a similar nature had occurred and that the discharged persons had been aggrieved, as they were 'not a prisoner'

¹⁸ *Select Committee, 1913*, p. 141. Evidence of Mr. E.H. L Gorges, 25 April 1913.

¹⁹ *Select Committee, 1913*, p. 142.

²⁰ *Ibid.*

but had been ‘confined in a place which is associated with prisoners!’²¹ Williams told the Commissioners that in the first quarter of 1913 his office had dealt with sixteen lunacy cases and that in six of these cases ‘there was delay in getting accommodation’:

In one case I find that a lunatic was detained at the Woodstock Police Station, according to my information, for five days: one lunatic was detained for 21 days in his or her residence and another at the Wale Street Police Station for ten days; another apparently at his or her residence for 42 days; another for 39 days and one for 18 days. One of these cases I may say came from the country and the patient was not at her own residence. We had to find accommodation for her for several days and to pay a woman 7s. 6d. per day to look after her. ... I understand one man was detained at the Wale Street Police Station who was not only mentally weak but also physically.²²

Not only had the asylums been overcrowded for some time, recent changes in legislation had put them under even greater pressure. The new Prisons Law (no.13 of 1911), had stipulated that persons suspected of being insane could only be held in a police cell if there were no near state-aided hospital or asylum. While the principles behind this measure met with general approval, it was repeatedly stated that, without adequate asylum accommodation, there remained little choice but to restrain lunatic ‘suspects’ in gaols. In 1911 there had been 781 ‘suspected lunatics’ held in various gaols around South Africa; the majority had eventually been certified, but many had had to remain in the gaol for several months until a vacancy opened in an asylum.²³ In 1912 the Act was implemented more rigorously, and the number had been reduced to 487, 21 of whom remained in prison at the end of that year. The Secretary for Justice and Director of Prisons told the Committee: ‘We have had cases of men who have recovered from their temporary insanity making the bitterest complaints at being confined with criminals, when they were not criminals themselves.’²⁴ The situation was at its most acute in the country areas where there were no

²¹ *Select Committee, 1913*, p. 81. Evidence of Mr. George B. Williams, 21 April 1913.

²² *Ibid.*

²³ *Select Committee, 1913*, pp. 105-106. Evidence of Mr. J. de Villiers Roos, 22 April 1913.

²⁴ *Ibid.*

public hospitals or special cells attached to the gaols and where suspected lunatics had to be held in ordinary cells. Nor were hospitals in the larger urban centres necessarily prepared or equipped to take in lunatics who were likely to be noisy or dangerous, or both.

The pressure on the Medical Superintendents to take in more patients increased. Swift at Bloemfontein reported that he had had to turn away at least a dozen patients in as many months because of the lack of accommodation. He noted: 'By shifting the beds closer together you can make more accommodation in spite of hygienic principles. We have patients sleeping in corridors and tents'.²⁵ Swift noted too that as there were no 'chronic sick hospitals' or 'institutes for imbeciles' in the Free State, and such persons had to be cared for by friends or family. He also voiced the opinion – shared by all who testified – that the lack of places at the asylum and the consequent delay in admissions meant that incidence of mental diseases was actually increasing, and that there 'were more confirmed lunatics now than would otherwise have been the case ... [because] many cases are kept outside which would probably have got better earlier if they had received proper treatment'.²⁶

Measures designed to cut costs were achieved particularly at the expense of African, Indian and Coloured patients. James Hyslop, for instance, told the Committee that although the colonial government had, in the early 1900s, funded 'very excellent accommodation' for black patients, they were again facing 'excessive overcrowding on the native male side more particularly' and that not only did the lack of 'proper accommodation' increase the death rate, it also would 'militate against the recovery rate'. In 1913, there was space for 212 African and Indian patients in Pietermaritzburg, but the actual number was 352, 'with the result' Hyslop admitted 'I fear that the health of the patients is very much

²⁵ *Select Committee, 1913*, p. 21. Evidence of Dr. E.W.D. Swift, 15 April 1913.

²⁶ *Select Committee, 1913*, p. 22. Evidence of Dr. E.W.D. Swift, 15 April 1913.

endangered.²⁷ Indeed, whilst in Cape Town, Hyslop had received a ‘very alarming’ telegram from Pringle, stating that the death rate amongst ‘coloured’ patients was rising ‘very much indeed – to an extent that mere overcrowding will I fear not explain.’ He went on to add that he had already forwarded to the Department of the Interior documents requesting an increase in ‘coloured’ accommodation – by which he meant black – and that although sufficient for the moment, he anticipated the need for more space for white patients, and more land for the asylum farm and estate in the near future.²⁸

Even when vacancies did open up in asylums, the incompatibility of the lunacy legislation of the four provinces meant that it was not possible to move patients outside their region of origin. For example, in some cases, certified lunatics from the eastern Cape border were sent to Cape Town rather than to the much closer Pietermaritzburg, which, Dodds pointed out was ‘cruel’, not only because of the distances involved, but because patients were moved far from their families.²⁹ This was finally remedied in 1914 with the Lunacy and Leprosy Laws Amendment Act (no. 14 of 1914), which left, for the meantime, provincial legislation intact but did facilitate the transfer of lunatics between the former colonies. Dodds and Swift were agreed that the more centrally located Bloemfontein could take in patients from the northern Cape. Pietermaritzburg, it was recommended, could increase its intake from the eastern Cape and other ‘Native territories’.

The centralizing practices of the new state were resented and resisted by some doctors and magistrates, especially those who worked in rural areas who found the new regulations

²⁷ *Select Committee, 1913*, p. 40. Evidence of Dr. J. Hyslop, 14 April 1913.

²⁸ *Select Committee, 1913*, pp. 46-47. Evidence of Dr. J. Hyslop, 14 April 1913. Hyslop and others giving evidence at the Select Committee adopted the terminology of the Cape, and referred to Africans and Indians as ‘coloured’. He made it clear, however, that there were few ‘Coloureds’ at the NGA and that, by the use of the term, he meant African and Indian.

²⁹ *Select Committee, 1913*, p. 11. Evidence of Dr. W. J. Dodds, 14 April 1913.

cumbersome and counter-productive.³⁰ From the Cape, for example, came complaints that the coordination of administration had complicated and lengthened the process of certification. Under the terms of the Cape Lunacy Law of 1891, as well as Medical Certificates signed by doctors, Resident Magistrates were required to submit 'Reception Orders', or in the case of those deemed to be lunatic, but not dangerously so, 'Summary Reception Orders'. Swartz explains: These Reception Orders were valid for a month, whereafter application for further detention under the Act was made by forwarding the Medical Certificates, depositions, and Reception Orders 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'.³¹ Magistrate Gie, from Paarl, pointed out that 'when a lunatic has been in an asylum the medical officer in charge, has within ten days of the issue of the summary reception order to certify to the condition of the man, and to send the certificate to a Judge.' But, he added: 'I consider that this ten days is too short a time because in that case the papers have to go to Pretoria and back again.' Moreover, only once this certification had been processed, could he apply to the Secretary for the Interior to establish whether there was a vacancy, and if so, where.³² Once again, because of the lack of asylum accommodation, this period of waiting for the Judge's Order could be spent in a gaol rather than at the asylum. Gie had no hospital or special cells at his disposal, and it was his usual practice to persuade the afflicted person's family or friends to continue to look after them in the home, or, if the person was dangerous, he might appoint a guard to oversee the person. He did whatever he could, he said, to keep respectable people – 'educated Coloureds' as well as whites – from the stigma of being detained in a gaol.

³⁰ For a rather different example – though one that might shed some light on the potential frictions between the bureaucratic interests of the modernizing state and those of individual doctors, including psychiatrists, during the 1910 to 1920 period – see R. Cooter 'Malingering in Modernity: Psychological Scripts and Adversarial Encounters During the First World War', in R. Cooter, M. Harrison and S. Sturdy (eds.) *War, Medicine and Modernity* (Stroud: Sutton, 1998).

³¹ Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', pp. 82-83.

³² *Select Committee, 1913*, p. 100. Evidence of Mr. J. C. Gie, 21 April 1913.

The situation at the Cape was more complicated than in the other provinces. Gorges, Secretary for the Interior, explained that this was because of the overcrowding at the asylums in that region had meant that it had become necessary to 'control the admissions'. Magistrates applied to one asylum, or to all; or they delayed too long in making an application, thus confining lunatics to a gaol illegally. From 1910, such decisions were made in Pretoria. Furthermore, not only did a vacancy have to be identified, but, increasingly, race determined where a certified lunatic would be sent: Valkenberg and Grahamstown were for white patients; until it was closed down in 1920/1, the Robben Island asylum housed black patients; Fort Beaufort was reserved for black inmates; only chronic, long-term patients were sent to Port Alfred. A few long-term patients remained at the Old Somerset Hospital in Cape Town, but this was never legally identified as an asylum. Gorges denied that the committal process was complicated by being centralized in the Transvaal, however, pointing out that it took just as long for a telegram to cross Cape Town as it did the country, and instead stated that any delays were due to 'lack of accommodation, entirely'.³³ It had become the practice for every asylum in the country to telegraph what Gorges referred to as 'the state of affairs' to his office every Monday morning. 'If they have a vacancy by a death or a discharge they can telegraph to us as well', he noted.³⁴

In the other provinces, direct admission to the asylum was far more straightforward. In Natal, for instance, as Hyslop told the Select Committee, if a Magistrate had a person under his charge whom a Medical Officer had certified as a lunatic, he could telegram the Asylum and inform the Medical Superintendent that he was having the lunatic person brought up to Pietermaritzburg. It was courteous, but not necessary, to ask whether there was a vacancy. Hyslop underlined the fact that, simple as the provisions of the 1868 Act were, they enabled the expeditious transfer of lunatics from gaol to asylum. The Act

³³ *Select Committee, 1913*, p. 134. Evidence of Mr. E. H. L Gorges, 25 April 1913.

³⁴ *Select Committee, 1913*, p. 147. Evidence of Mr. E. H. L Gorges, 25 April 1913.

stipulated no specific period which a person could be detained and a rule of thumb practice had developed whereby a maximum of three weeks' observation at the asylum was permitted. Within that time Hyslop or his representative sent his report to the Department of the Interior. Hyslop admitted that this 'simple procedure' did not establish legal safeguards for the patient and also meant that he had 'to take a great deal of responsibility. I might find myself in the Law Courts at any time', he noted:

The Cape and the Transvaal have most excellent laws which I often envy them having, but on the other hand I don't know whether under those laws we could deal so simply and expeditiously with patients as we do in Natal. The Colonial Secretary and the Medical Superintendent of Asylum [sic] in Natal have in the past taken considerable responsibility under that law, or rather under regulations passed under the law. I act strictly according to the letter of the regulations.³⁵

Not only had, he insisted, there never been a delay in admitting a patient – provided that they were accompanied by the correct medical certificate – but no patient had ever been turned away; nor had he, in thirty years of practice, found any trouble with the system or once been challenged in a court of law.³⁶

Committal procedures were similarly straightforward in the Free State and the Transvaal, but in the latter province, a clause in the existing legislation (Transvaal Proclamation 36 of 1902, section 6) allowed policemen to have persons apprehended and detained on the suspicion of being a lunatic, and held without any warrant or certificate. The Minister of Justice admitted that this led to abuses:

At Johannesburg a member of one of the biggest clubs in South Africa was sent to gaol by his friends through the aid of a policeman, and the next morning his friends telephoned to the gaol asking that he should be well looked after, but they did not want his care until certified. We also had another case where a woman suffering from puerperal fever was sent to gaol from a maternity hospital, and patients in public hospitals have also been threatened that a policeman would be sent for to haul them off to a gaol, and the threat has been carried out.³⁷

³⁵ *Select Committee, 1913*, p. 49. Evidence of Dr. J. Hyslop, 14 April 1913.

³⁶ *Select Committee, 1913*, pp. 46 and 49. Evidence of Dr. J. Hyslop, 14 April 1913.

He believed that Africans in the Transvaal utilized this method of getting 'rid of their obligations by calling in an officer of the law for the removal of a native who is a supposed lunatic, to gaol.'³⁸ Bypassing the medical certification process was not only faster it was also cheaper. He agreed wholeheartedly that there should be more safeguards to protect the rights of the person apprehended for no other reason than suspicion of lunacy.

If the Select Committee participants were unanimous in their concern for the overcrowded state of the existing asylums and with the numbers of lunatics over-long detained in the country's gaols, there was alarm too, at the undoubted number of insane persons who were not under any form of legal restraint. They were keenly aware of the failure of their profession – and its institutions – to break down the resistance of many to bringing the mentally ill to the attention of psychiatrists or to have them admitted to an asylum. Hyslop believed that there was greater resistance among whites than amongst Africans, and said that although whites were

very averse to sending their relatives to an asylum [but] I fancy the natives are not at all averse to sending theirs and that they take full advantage of the opportunity if getting rid of the troublesome relatives in this way. I have noticed more especially of late cases are being sent to the asylum which at one time would not have been sent. We discharge a good many of these people.³⁹

Hyslop's reference to the role of African families in initiating the committal procedure can be seen as support for the argument made earlier in this dissertation about the limited reach of colonial psychiatry and the use made of colonial institutions, including asylums, by some Africans as a strategy for responding to a need to cope with the insane. Whether Hyslop's suspicions about the sending of relatives for confinement on spurious grounds were accurate or not is hard to establish, however.

³⁷ *Select Committee, 1913*, p. 107. Evidence of Mr. J. de Villiers Roos, 22 April 1913.

³⁸ *Select Committee, 1913*, pp. 108-109. Evidence of Mr. J. de Villiers Roos, 22 April 1913.

As mentioned in Chapter 2, Hyslop – along with his professional colleagues – was of the opinion that whites were more vulnerable than other races to mental breakdown and therefore that insanity would not be as notable feature of African societies. Asked if ‘the ratio of insanity among the natives [is] as high as among the whites?’ he responded ‘No, not nearly as high.’⁴⁰ In this, the opinions expressed by Dodds and Hyslop were very similar. Dodds had told the Committee that ‘there was a certain feeling among country people against sending the insane into hospital asylums. They kept the patients on the farms.’⁴¹ He believed that attitudes – and clearly he was speaking of whites – were changing to favour a more positive view of asylums. Of ‘natives’, Dodds had to admit that he did not know much about them, but that there was a comparatively small number of insane in proportion to the population. This was to be expected, however, he said because ‘(y)ou cannot expect in a race like the natives that you can have anything like the same amount, or proportion of insane as among civilized people.’⁴²

The figures reproduced in the appendices to the Select Committee report appeared to have provided corroborating evidence for these views about the differing rates of mental illness amongst different races, as well as proof of the urgency for increased accommodation for whites in the country’s asylums. They showed, for example, that in Natal in the 1911 Census there had been 181 white males noted as being insane (140 of whom were in the asylum). This calculated to 34.2 per 10,000 of the white men in Natal. For black men, however, the comparable figures stood at 686 ‘total insane’ (278 in the asylum) or only 13.9 per 10,000 total black males. The discrepancy between white and black women was even more stark: 115 white women were listed among the ‘total insane’ (110 at the NGA) or 25.2 per 10,000 population; and 245 black women (83 at the asylum), making only 4.2

³⁹ *Select Committee, 1913*, p. 52. Evidence of Dr. J. Hyslop, 16 April 1913.

⁴⁰ *Ibid.*

⁴¹ *Select Committee, 1913*, p. 8. Evidence of Dr. William J. Dodds, 14 April 1913.

⁴² *Ibid.*

per 10,000 population.⁴³ From the perspective of nearly a century later, these figures are not so much noteworthy for what they may appear to say about racial propensities towards madness, but for showing that the majority of black persons – no distinction was made in the Tables between Africans and Indians – entered in the 1911 Census (presumably by family members) as being lunatics or idiots were still outside the formal institution of insanity, the NGA, after Union.

It was in the Cape where the most alarm was felt: the 1904 census had showed that only 40 percent of the ‘registered insane’ were actually in an asylum. The 1911 Union census showed that the figure now stood at 47 percent. Dunston was quick to insist that this did not necessarily mean that madness was on the increase in the Cape, but that such an impression was caused by the lack of asylum accommodation there.⁴⁴ Understanding and predicting population trends in the Union was, he pointed out, fundamentally important in planning the number, form, and location of the country’s asylums over the next ten years, and beyond. He explained, for instance, that in looking at the admission patterns across the country, it had appeared as if the

admission rate to asylums in the Transvaal and the Free State was going up by leaps and bounds. We could not understand this until we studied the census figures. In them we found that the population of the Cape and Natal had remained practically stationary, whereas the population of the Free State had increased by something like 300,000 between 1904 and 1911, and the population [in the Transvaal] had increased by 140,000 in the same period. We at once saw that the difficulty of our problem was largely solved by the distribution of the population and the rate of increase in the various parts of the Union⁴⁵

Dunston and Eagle’s ‘scheme’ – as they termed it – required the provision of large-scale asylum accommodation at the centres of economic and demographic expansion, especially on the Rand, and at Bloemfontein, which was noted as being particularly accessible by rail.

⁴³ *Select Committee, 1913*, p. xix. Appendices: Tables G ‘Showing Proportion of Registered Population and Total Insane to Total Population, Europeans’, and H ‘Showing Proportion of Registered Population and Total Insane to Total Population, Coloureds’.

⁴⁴ *Select Committee, 1913*, p. 62. Evidence of Dr. J.T. Dunston, 18 April 1913.

Extensions to the asylum there, it was proposed, would be the first step in the reorganization of the country's asylum system, for it would enable the Port Alfred and Robben Island asylums to be closed down. In addition, they proposed the construction at Bloemfontein of an asylum specifically to detain the criminally insane. Dunston went on to propose the other alterations that were urgently required: additional accommodation, drainage and extensions to Valkenberg; a new asylum adjoining the Valkenberg estate for coloured patients; the overhaul and upgrading of Grahamstown as well as the closure of the public road that ran through its grounds; an altogether new asylum for Africans at Fort Beaufort; additional villa accommodation for white patients in Pretoria, as well as new stores rooms, kitchen and workshops; 'some reconstruction' and some new accommodation for whites at Pietermaritzburg, as well as 'considerable' extra room for Indian and African patients, and more grounds.⁴⁶

Pressed by the Committee to prioritise, Dunston reiterated that 'The whole of the proposals contained in the reports form one complete scheme to provide moderate sized asylums in accessible centres of the Union, sufficient beds for our immediate needs, and allowing for the time that will be taken in the building.'⁴⁷ Asked if it was absolutely necessary that the whole of the scheme could be adopted, he replied: 'Yes. So far we have not the bed rock to work upon and I am stating the very minimum requirements. ... The whole scheme is equally urgent.' He estimated the cost of the scheme at £305,000 as being 'very cheap.'⁴⁸

There was little in this with which Hyslop or Dodds disagreed. They both wished for more accommodation, upgraded kitchens, store-rooms, and extensive grounds for the privacy and recreation of their patients. Dodds was adamant that Valkenberg should remain an institution that catered only for white patients, and he justified this in part because the

⁴⁵ *Select Committee, 1913*, p. 66. Evidence of Dr. J. T. Dunston, 18 April 1913.

⁴⁶ *Select Committee, 1913*, p. 65. Evidence of Dr. J. T. Dunston, 18 April 1913.

⁴⁷ *Ibid.*

presence of black patients meant that whites refused to work, lessening the therapeutic regime of the asylum estate. He favoured the total abandonment of the Robben Island, Fort Beaufort and Port Alfred asylums. He agreed that the duplication of asylums – separate institutions for blacks and whites in Cape Town, for instance – would lead to some increase of costs, but Dodds pointed to the necessity of keeping patients separated, not only because of the difficulties in getting whites to work, but also because although ‘European’ patients themselves might not have objected to mixing with coloured patients, he observed that their friends did: ‘I think anybody with higher feelings would’, he said.⁴⁹

It was never envisaged that any new facilities for black patients would be equivalent to those of whites, however. Hyslop favoured the retention of a certain number of black patients at Pietermaritzburg – in an institution with a maximum of 1,500 patients, he wanted about 600 or 700 Europeans – as, he argued, this enabled him to run the Natal Asylum fairly economically. As pointed out in Chapter 2, by 1913, there were effectively three separate institutions on the same grounds, one for private fee-paying whites, another for state-funded whites, and a third for black patients. The accommodation provided for the latter was inferior to that provided for whites, whether fee-paying or not, with more black patients per building or ward and sleeping on concrete floors. Hyslop was of the opinion that further economies could be achieved by reducing the cubic space allocated per black patient ‘by means of ventilation’. He elaborated:

For instance in a building we put up a short time ago we have windows which practically can always be left open, but in bad weather they are closed of course. We arrange this by means of very strong steel wire netting, which as regards the Native patients, is not at all objectionable, but which one would not use in connection with buildings for Europeans themselves as thereby too much of a feeling of restraint might be engendered.⁵⁰

⁴⁸ *Select Committee, 1913*, p. 71. Evidence of Dr. J. T. Dunston, 18 April 1913.

⁴⁹ *Select Committee, 1913*, p. 13. Evidence of Dr. W. J. Dodds, 14 April 1913.

⁵⁰ *Select Committee, 1913*, p. 40. Evidence of Dr. J. Hyslop, 16 April 1913.

As we have already noted, dietary scales and access to recreational facilities had been differently allocated from even before the opening of the Natal Government Asylum in 1880. Hyslop no doubt shared the views of Greenlees, Dodds and Dunston in believing Africans and Indians to be mentally inferior to whites, but he made no argument in favour of the establishment of a totally separate mental institution for African and Indian patients; nor were his motives entirely mercenary. For example, although he admitted that speaking in terms of ‘spare beds’ for African patients could only be done figuratively, since ‘we do not use beds for them at all’, he insisted that some spare capacity for Africans was desirable, since it was ‘not fair either to the patients or the institution that there should be overcrowding which causes a great deal of trouble.’⁵¹

For several years, Hyslop had overseen the development of private facilities for white, fee-paying patients and he was keen to see private patients from other provinces sent to Pietermaritzburg. Similarly, he favoured the transferral of ‘imbecile’ children to Grahamstown, which had opened a specialist institution there in the 1890s (see Chapter 2). Yet he was also in agreement that the location of his asylum meant that it was logical that Africans from the eastern Cape, as well as Zululand and Basutoland, be moved there. Furthermore, he was not in agreement with Dodds – let alone Dunston – on the issue of the role of psychiatry or its professionals in ‘preventing the propogation [sic] of imbeciles and idiots’. While Dodds had expressed support for more state intervention in such matters – saying that the ‘feeble-minded should also come under the state’ – Hyslop was considerably more hesitant, and indicated that his reluctance to ‘do something in the direction of preventing [their] propogation’ [sic] stemmed precisely from his professional status and convictions.⁵² He restricted his opinions of the issue to the observation that education could help people to choose their partners more wisely. He was also deeply concerned that the continuing stigma attached to asylums: ‘Many people’, he observed,

⁵¹ *Select Committee, 1913*, p. 51. Evidence of Dr. J. Hyslop, 16 April 1913.

⁵² *Select Committee, 1913*, p.54. Evidence of Dr. J. Hyslop, 16 April 1913.

‘have a great objection to being treated in an asylum and anything which would get over that aversion should be aimed at. ...Unfortunately it is a fact that most people will not yet regard mental disease in the same light as they do bodily disease.’ He was somewhat sanguine about the future, however, noting that ‘They are, however, becoming educated in the matter.’⁵³

Lessening this stigma, getting those suspected of insanity or feeble-mindedness admitted into a suitable institution speedily, correctly classifying the different mental disorders – and thereby increasing the possibilities of a favourable prognosis for some patients - as well as economies of scale were all factored into the scheme put forward by Dunston, and strongly endorsed by Swift. Dunston’s plan did not only envisage the integration of the Union’s asylum system in terms of a national network of facilities that would cater for different races and ‘classes’ of patients, it was also structured so as to eliminate the bottlenecks that were occurring as asylums became congested with chronic patients. In other words, patients were not only to be distributed more efficiently around the country, but also within the institutions themselves. Whereas Dodds and Hyslop feared that large-scale asylums would be so bloated that, to use Dodds’ phrase, ‘the individualism of treatment’ would be compromised, Dunston and Swift would argue that this could be better achieved in bigger establishments, albeit those based on the ‘villa’ system of design rather than the older ‘block’ system, of which the early buildings at Pietermaritzburg and Valkenberg are good examples.

From the late 1800s, but more particularly after 1904 when Kraepelin’s *Lectures on Clinical Psychiatry* appeared in English, classification had become widely regarded as the essential foundation of successful psychiatric practice. Classifying the type and the associated degree of mental illness was the key in predicting outcomes, as Edward Shorter

⁵³ *Select Committee, 1913*, pp. 43-44. Evidence of Dr. J. Hyslop, 16 April 1913.

puts it.⁵⁴ As Sally Swartz notes, South African psychiatrists had become aware of debates about classification through a series of articles published in the *Journal of Mental Science* between 1899 and 1909. By the time that Dunston arrived in South Africa, the new diagnostic categories described by Kraepelin were being implemented and detailed in the changing format of the statistical tables used in the Cape annual asylum reports.⁵⁵ Under Dunston's direction, the systematised classification of patients would come to form the basis of an asylum system designed to cater for the needs of the whole Union. In this, he showed scant regard for the therapeutic needs of black patients. As he explained to the Parliamentary Select Committee in 1913:

(W)e are not suggesting large but medium sized asylums, of say 1,000 to 2,000 white patients, with the addition of a certain number of natives, according to the needs of the asylum in regard to its menial work. If one remembers that there are two sexes to be considered it leaves quite a moderate number really of each sex for classification. If a smaller number is taken than the one I have suggested, then a most important element of treatment is lost, that is the proper classification of the patients.⁵⁶

He went on to explain why classification was crucial to both treatment and administration:

With less than a certain number of patients there cannot be classification, with the result that in the same wards there are living together, taking exercise and recreation together people of a different class and of most unsuitable character to mix, to the great detriment and discomfort of them all. Many of the patients are unhappy as a result and their recovery retarded.... It is much easier to administer an asylum when one can classify. From both points of view, that of the administration and of the welfare of the patients there must be a certain number in order to obtain a proper classification and until this is achieved there is defective efficiency.⁵⁷

⁵⁴ E. Shorter, *A History of Psychiatry: A History of Psychiatry from the Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997), p. 106.

⁵⁵ Swartz, 'Colonialism and The Production of Psychiatric Knowledge at the Cape', pp. 98-99.

⁵⁶ *Select Committee, 1913*, p. 34. Evidence of Dr. J. T. Dunston, 15 April 1913.

⁵⁷ *Ibid.*

The administrative benefits of large asylums included a correspondingly larger staff complement. As he pointed out, at the smaller institutions – though this was true for the Pietermaritzburg asylum despite its relatively large numbers of patients – staff had to double up, a doctor or storekeeper or head nurse on leave of absence could cause ‘the whole place’ to become ‘disorganised’. Medical and nursing staff could also, in larger asylums, gain more varied experience. The benefits to patients were not only those that accrued from being correctly classified, but also in that there would be more staff to supervise their ‘occupations’, meaning outdoor work and recreation. Dunston added: ‘Even the concerts in a small institution are less pleasing to the patients as there is less talent to draw on.’⁵⁸ Once more, Dunston felt it necessary to reassure the Committee that his scheme did not intend to have the ‘monster asylums’ that Dodds had invoked, but that they would be of ‘medium size’. He drew, he said, on his ‘rather unique experience’ of having worked in both a small asylum and at a larger institution. In the six years that he had been at the Pretoria Asylum, the number of patients there had grown from 400 to 1,100 but at the same time ‘the comfort of the patients has increased and the administrative difficulties have greatly decreased.’ He added, however, that ‘... it will not be until the numbers of white patients are doubled that the full advantages of classification can be obtained.’⁵⁹

Dunston had already, in February 1913, submitted a Memorandum to the Secretary for the Interior on the subject of the clinical and administrative classification of patients. He identified four main ‘classes’:

1. Those who feel the onset of mental breakdown and are incipient cases.
2. Those who are suffering from acute mental disease – a recoverable illness of short duration.
3. Those who are suffering from acute mental diseases, a recoverable illness – but of more or less long duration.
4. Those who are incurable and will as long as they live require custodial treatment.⁶⁰

⁵⁸ *Select Committee, 1913*, p. 33. Evidence of Dr. J. T. Dunston, 15 April 1913.

⁵⁹ *Select Committee, 1913*, p. 37. Evidence of Dr. J. T. Dunston, 15 April 1913.

⁶⁰ The original Memorandum – and several other reports – is located at the NAR Prime Minister’s

The first category ('Class 1') included patients 'who from stress of work, worry or illness or other depressing or enervating conditions are beginning to exhibit symptoms of mental illness.' It also included those who resorted to excessive alcohol consumption to ward off an impending nervous breakdown, neurasthenics, and those exhibiting nervous exhaustion, but who did not have a 'poor hereditary condition'. If treatment were sought early enough the prognosis was good, but insufficient understanding and stigma – 'the Asylum fear' – meant that many such sufferers left it too late before they sought treatment, rendering themselves vulnerable to future attacks and breakdown. Dunston was of the firm opinion that people in this category were 'not certifiable' and that they should not be admitted to what he termed 'a mental hospital' so as to avoid the shameful taint of being confined to an asylum. Instead, he recommended that this class of patients – the nervous cases – be admitted to a specialist 'neurasthenic' ward at a local hospital.

Ideally, persons who fell under the category of 'Class 1' should also not have to come into contact with the 'Class 2 patients', who 'often suffering from errors of conduct' – such as noisiness and violence – were 'troublesome'.⁶¹ This second category of patients was certifiable, but under suitable treatment often made a quick recovery and could remain well for the rest of their lives. Avoidance of stigma was also 'very necessary' for this class of patient. A separate institution altogether, what he termed a 'special psychopathic hospital', separated from the asylum, would be more appropriate for the second broad group of patients. It was anticipated that their stay at the facility would be short-term, or that patients could be treated on an out-patient basis.

'Class 3' patients occupied something of a middle ground between those whose prognosis was hopeful and those who were incurable: characterised by acute, relapsing forms of

Office (hereafter PM) 1/1/322 184/2/1913, Public Health. Extension of Lunatic and Leper Asylums, and is reproduced as Appendix B in the Select Committee Report, published in May 1913.

⁶¹ NAR PM 1/1/322 184/2/1913, Public Health. Extension of Lunatic and Leper Asylums.

illness, Dunston identified 'hereditary and constitutional weakness' as the underlying cause of their illnesses, and stated that this rendered prolonged and repeated period of treatment necessary. With more experience and knowledge, he was hopeful that 'more and more cures can be anticipated.' He wanted them treated in 'the mental hospital of the Asylum'. This meant that each asylum would have an observation ward, where patients could be classified, treated and moved on if their prognosis seemed good. Class 1 patients should never have reached the asylum, but some who had deteriorated or relapsed, might have done so. At the Pretoria Asylum, in the section set aside as a mental hospital there, in 1913 there were 60 patients; and Dunston gave their recovery rate as 80 percent. Classification and the early allocation to the correct facility was therefore the key to successful recovery. Indeed, Dunston wanted the law altered so that 'it is possible to admit patients in mental hospitals without a certificate at all, and certificates should only be resorted to when it is necessary in the public interest.'⁶² Separation of the mental from the mad, the renaming of conditions and facilities, and the encouragement of early voluntary admission to specialist wards would, it was generally agreed, help to lessen 'the Asylum fear'.

'Class 4', the final class of patients, were deemed to be 'from the beginning incurable.' They were the imbeciles, degenerates, demented patients, those who suffered from delusional insanity, of secondary dementia following epilepsy, and general paralysis of the insane. Their prognosis was, in Dunston's view, hopeless and all that could be hoped for was custodial care to prevent them from being dangerous to themselves or to others.⁶³ Indeed, Dunston recommended that the 'administrative ideal' would be for 'Class 4' patients to live in what he termed 'working and custodial colonies. Those who are harmless and able to do some work should be living in villas and on parole. The dangerous, the

⁶² *Select Committee, 1913*, p.78. Evidence of Dr. J. T. Dunston, 18 April 1913.

⁶³ NAR PM 1/1/322 184/2/1913, Public Health. Extension of Lunatic and Leper Asylums.

helpless and the senile should be suitably cared for in closed villas and hospitals.’⁶⁴ The language of the penitentiary remained uppermost.

Dunston recognized that it was not feasible to provide wards for neurasthenics and well as specialist mental hospitals connected to the more traditional asylum in every region of South Africa, but urged that in each of the large centres of population – Cape Town, Pretoria, and Johannesburg – there should be a neurological ward at the general hospital, administered by the Provincial Administration, and with the nearest ‘mental expert’ acting as a consultant for the general medical practitioners. In these cities, there should also be a state-sponsored ‘Psychopathic Hospital’ with out-patient and research laboratory facilities. More closely allied with the local asylum, it should be administered by that institution’s Medical Superintendent. Dunston added that this combination of recuperative, curative and custodial facilities might also be contemplated at Kimberley and at Durban.⁶⁵ There was no mention of Pietermaritzburg.

This suggested overhaul of South African psychiatry could clearly not be achieved overnight. An asylum system that combined different elements of the overall scheme was therefore mooted. Based on what was termed the ‘villa’ or ‘village’ system, it had already begun to be implemented at a number of older asylums. At Pietermaritzburg, as we have seen, private patients (who were invariably white) were housed separately from non-fee paying white patients as well as African and Indian inmates. The distinction between patients was on the basis of race and class, not necessarily on clinical categories. Nonetheless, it was recognized that dangerous, manic and disruptive white patients needed to be kept apart from those whites who were quiet and more melancholic. This led to a proliferation and multiplication of wards and buildings. These were termed ‘villas’, ideally accommodating twenty to forty patients, with a number of attending staff.

⁶⁴ *Ibid*

⁶⁵ *Ibid*.

Dunston explained how the villa system could answer the needs of expanding asylum accommodation, specialist attention, and closer supervision:

There would be a mental hospital for each sex, and every patient would go through this hospital on admission. There he would be seen by the medical staff in consultation.

If the staff decide that a patient cannot recover he is drafted to a villa with other people of the same class and people with whom he will best agree. If he is quiet and harmless he will go in a villa where people of his own class stay, and where they have no chance of annoying quiet people.

You may take a very noisy patient from a villa intended for quiet patients and put him in another villa where the patients are noisy and he may then become quiet as sometimes he thinks it was no use making a lot of noise when all the other people are doing the same thing. Then if he becomes quiet again he is sent back to the villa where he previously was. A patient can be raised class by class until eventually we may be able to say to his relatives that you may take him home with you if you like to look after him yourselves.⁶⁶

In racially-mixed asylums such as Pretoria and Pietermaritzburg, African, Indian and 'coloured' patients were also to be admitted to and classified at the mental hospital section, but the villa system, as Swift made clear, would not apply to black patients. Instead, each asylum estate would comprise a mixture of villa and old block-ward accommodation.⁶⁷ Criminal lunatics would be centralized at Bloemfontein; troublesome, but not criminal, black patients would be largely housed at Fort Beaufort; and the 'chronic coloured or native cases' would be shared among the larger asylums so as to '... diminish our maintenance rate ...'⁶⁸ As Dunston acknowledged: 'Already we have more native patients than white so we have to make more provision for them. We propose in our scheme that these people should be put on big areas of ground, that they should be encouraged to work as much as they can, to grow their own mealies, raise cattle and to make these institutions as far as

⁶⁶ *Select Committee, 1913*, pp. 74-75. Evidence of Dr. J.T. Dunston, 18 April 1913.

⁶⁷ *Select Committee, 1913*, p. 32. Evidence of Dr. E. Swift, 15 April 1913.

⁶⁸ *Select Committee, 1913*, p. 75. Evidence of Dr. J.T. Dunston, 18 April 1913.

possible self-supporting.⁶⁹ He spoke of safeguarding the welfare of ‘native’ patients, but the underlying assumptions of racially-determined mental capacities, as well as attitudes that regarded blacks as being physiologically more suited to heavy outdoor labour, meant that the older ideas of the therapeutic benefits of ‘useful labour’ would permit the turning of black asylum inmates into a reserve pool of labour on the asylum estate. As financial pressures put the planned improvements and extensions to South African asylums on the state’s economic backburner during World War 1, the exploitation of black inmate labour would increase accordingly.

Dunston closed his recommendations on his scheme by explaining that: ‘These notes reflect the modern view in practice in regard to the treatment of the mentally afflicted in the States of Europe and America. They deal with the practical application of these views to the Union of South Africa, with its special difficulties of sparse population and great distances.’⁷⁰ He did not add that the proposals, too, further entrenched an asylum system that reflected the country’s racial and class cleavages. Nonetheless, it was made explicit in the Select Committee’s report, in which ‘Coloured’ meant all black people:

... there is no valid objection to the maintenance on the same Asylum Estate, and under one administration, of patients drawn from both the European and the Coloured sections of the population, provided they are housed apart and not brought into contact when undergoing treatment, or at meals or entertainments; but that, on the contrary, considerable economy can be expected inasmuch as suitable coloured patients can be employed with advantage, both to the State and to themselves, on work on such Estates, which in the ordinary way would be performed by hired Coloured labour.⁷¹

Underpinning Dunston’s scheme – the expansion of mental hospitals, the reclassifying of patients, the training of personnel – both within existing asylums and across the country, was his conviction that a new legislative framework was imperative. This was necessary

⁶⁹ *Ibid.*

⁷⁰ NAR PM 1/1/322 184/2/1913, Public Health. Extension of Lunatic and Leper Asylums.

⁷¹ *Select Committee, 1913*, p. v.

not only to provide greater protection for patients – such as against the ease with which they could be plucked off a Transvaal street and deposited in a gaol or an asylum – but also to manoeuvre the shift in professional and lay thinking away from old and outmoded notions, such as that of ‘lunacy’ itself. ‘I think’, he said ‘that the whole of the terms in the Lunacy Law must be altered – you must give up using words like lunatics and asylums.’ He did not entirely favour the term ‘mental hospital’, but said he could not think of a better one. He added: ‘we should talk about male nurses and not attendants’ and ‘mental illness and never lunacy. Our terms must be entirely revised under the new Bill, we should not retain the use of the old terms which have unpleasant associations.’⁷² A report on the Act for the Governor General in November 1916, emphasized: ‘One of the first points to be noted in this Act is that all references to lunacy or insanity, lunatics or lunatic asylums are omitted and these expressions are replaced respectively by the terms “mental disorder or defect”, “patient” and “mental hospital”.’⁷³

As Saul Dubow, Sally Swartz and Hilary Sapire, among others, have detailed, Dunston’s views were indeed highly influential in the drafting of the 1916 Mental Disorders Act, the terminology of which reflects his overall scheme for a new South African ‘mental science’ and ‘asylum system’. His central concern with what he regarded as a crucial nexus – the links between ‘the propagation of the unfit’ and an increase in the incidence of insanity – were stated as early as 1912 in a Memorandum to the Secretary for the Interior: ‘the present laws must be conducive to continuous increase in the proportion of the insane from propagation of the unfit through patients discharged as unrecovered. ... the earlier restrictions are placed ... the simpler would be the problem of housing and the less the increase in insanity as far as it is affected by the hereditary factor.’⁷⁴

⁷² *Select Committee, 1913*, p. 79. Evidence of Dr. J.T. Dunston, 18 April 1913.

⁷³ NAR PM 1/1/116 20/8 Report on Mental Disorders Act, 1916.

⁷⁴ NAR PM 1/1/322 184/2/1913, Public Health. Extension of Lunatic and Leper Asylums, Memorandum, Dr. J. T. Dunston to Acting Secretary for the Interior, 22 December 1912, p. 12.

Dunston was by no means alone in drawing attention to the apparent threat from the mentally defective and 'feeble-minded'. The years before World War 1 saw the beginnings of a mental hygiene movement in South Africa, with a variety of concerns, including the 'influence of heredity on families, the relationship between mental defect and social problems, and new techniques in the discovery and testing of mental defectives.'⁷⁵ Backed by prominent liberals, such as John X. Merriman, as Saul Dubow puts it: 'Notions of protection and care were genuine motivations ... but these concerns coexisted with wider anxieties about the consequences of "race deterioration" and the prevalence of social pathology within the broader body politic.'⁷⁶ Within the profession of psychiatry more especially, debates about mental hygiene and 'the problem of the feeble minded' would be aired in the *South African Medical Journal* before 1918; from the 1920s the question of sterilization would be vigorously discussed, with Dunston as one of its most fervent supporters. In the early 1930s, his views were openly challenged by his former colleague at Pretoria, Dr. Harry Egerton Brown, who, after a period of illustrious military service, had taken up the post of Medical Superintendent at the Pietermaritzburg Mental Hospital.⁷⁷

Legal historian, A. Kruger, has helpfully identified the major provisions of the 1916 Act, which was to remain virtually unaltered until 1973. It made no distinctions on grounds of race.⁷⁸ Seven categories of 'mentally disordered or defective persons' were stipulated, including: 'those who were incapable of managing himself [sic] or his affairs; those mentally infirm from age or decay of the faculties; idiots; imbeciles; feeble-minded

⁷⁵ Dubow, *Scientific Racism in Modern South Africa*, p. 145.

⁷⁶ Dubow, *Scientific Racism in Modern South Africa*, p. 146.

⁷⁷ See, for example, the differing stances taken by J.T. Dunston and H. Egerton Brown on 'The Sterilization of the Mentally Defective', in the *South African Medical Journal*, 6, 4, (February), 1932, pp. 107-117.

⁷⁸ As several scholars have pointed out, and as discussed in this dissertation, the lack of adequate hospital, including asylum, facilities for black patients had already become entrenched practice. The lack of legal discrimination did nothing to ameliorate this situation.

persons; epileptics; and a socially defective person'.⁷⁹ The bureaucratic procedures required for committal were standardized. These included the Reception Orders on which I draw in Chapter 4 of this dissertation.

These could be issued after medical certification and if a magistrate were satisfied that a person was mentally disordered or defective *and*:

- (a) that he is not under proper care, oversight or control;
- (b) that he is cruelly treated or neglected, or
- (c) that he has suicidal tendencies or is a danger to himself or others, or
- (d) that he is an inebriate, or
- (e) that the patient is in receipt of relief from public or charitable funds at the time of giving birth to an illegitimate child or during such pregnancy, or
- (f) the person having care or control of the patient consents⁸⁰

Safeguards against prolonged detention without proper certification were laid down; and police holding of persons suspected of being mentally disordered or dangerous to himself [sic] was limited to forty-eight hours. Provision was made, too, for voluntary patients at mental hospitals as well as for what was termed 'single-care' patients, meaning those certified under the Act, but 'received' in a private home or dwelling if it was deemed 'safe and convenient.' This was the type of arrangement that the attorney John Jacob Hugman sought for his ward, Florence Ethel Plowes – classified as a 'high grade imbecile' – of Durban in late 1916.⁸¹ Hugman found that the provisions of the Act had actually made it more difficult for him to place Plowes in care outside the asylum, since the Act stipulated that 'a patient cannot be received into a private dwelling except upon the authority of a reception order issued by a magistrate ... the magistrate must also examine the householder

⁷⁹ A. Kruger, *Mental Health Law in South Africa* (Durban: Butterworth, 1980), p. 22.

⁸⁰ Kruger, *Mental Health Law in South Africa*, p. 23.

⁸¹ Pietermaritzburg Archives Repository, Registrar of the Supreme Court, 1/27/2, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916, R.S.C.N (M) 37/17: Florence Ethel Plowes, of 74 Currie Road, Durban, 7 February 1917: Reception Order granted by the Chief Magistrate, Durban on 19 January 1917.

and satisfy himself that he is a fit person and that his dwelling is suitable.⁸² Such checks had become necessary, it was argued, because of the recent increase in the number of persons 'received and detained' in private dwellings, especially in the Cape.⁸³

The significance of the 1916 Mental Disorders Act was that it not only consolidated the existing laws, but, as Dubow describes, it:

represented the first systematic effort in South Africa to provide a working typology of "defective persons": the outdated and unspecific vocabulary of "lunacy" and "insanity" was therefore replaced by a new purpose-designed terminology comprising categories such as idiots, imbeciles, feeble-minded persons, moral imbeciles and epileptics. Each of these distinct categories were defined and described in terms of behavioural characteristics and degrees of congenital defectiveness – though the means to measure relative defectiveness was not elucidated.⁸⁴

Moreover, as Sally Swartz notes, the inclusion as *prima facie* evidence of mental disorder behaviours regarded as marking a person as socially defective, had important ramifications. Prior to 1916, such a person – an alcoholic, or drug addict, or mother of an illegitimate child, say – could only be compelled to be confined to an asylum if the conditions under which they were living were in some way inadequate, cruel, or neglectful (provided that person was not also dangerous to self or to others.) Now, 'particular mental or physical conditions in themselves' were reasons for committal, changing the asylum 'from a place of refuge when other resources had failed, to a specialised medical institution, providing treatment tailored to defined disorders.'⁸⁵ The power of medical officers, magistrates, and psychiatrists to police the social order was thus inscribed in law.

⁸² NAR PM 1/1/116 20/8, Report on Mental Disorders Act, 1916, p. 5. This report states that much of the terminology and definitions used in the South African 1916 Act were taken from the English Mental Deficiency Act of 1913, and from the New Zealand Act of 1911, on which 'the former is actually based.' See p. 12.

⁸³ NAR PM 1/1/116 20/8, Report on Mental Disorders Act, 1916, p. 6.

⁸⁴ Dubow, *Scientific Racism in Modern South Africa*, p. 146.

⁸⁵ Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p.83.

The 1916 Mental Disorders Act also established the office of the Commissioner of Mentally Disordered and Defective Persons. He was to visit 'any institution or other place where patients are detained, examine any patient thereat, receive reports, give directions for discharge or difference of treatment and generally supervise and review the cases of all patients.'⁸⁶ John T. Dunston was appointed Commissioner from 1916, renamed 'Commissioner of Mental Hygiene' in 1922. He possessed not inconsiderable authority in the administrative, scientific and financial running of a national South African asylum system that he had helped to bring into existence. His major concern remained always with the white population and with the feeble-minded and the threat he believed they posed to racial integrity and energy. The black insane were of, at best, secondary interest to him, believing as he did that they were 'a "mentally inferior race"'. He went on to say: 'Such an impression is further strengthened by many other facts – they are extremely childish and emotional; they lack initiative; they rarely display foresight or worry about the future.'⁸⁷ It is perhaps, then, not surprising that under Dunston's tenure as Commissioner, the Pietermaritzburg Mental Hospital would become one of the country's less high-profile institutions: its existing facilities for whites were comparatively good; the percentage of whites to total 'European' population in the region was the highest in the Union; and the anticipated area of greatest increase in intake was of African and Indian patients. This meant, as I will describe in the next section, that it would receive proportionately less funding than asylums that had been ear-marked for an anticipated increase in white patients or which lay closer to the Rand, the nerve-centre of the modernizing South African state, and from where Dunston closely controlled the country's asylum administration.

⁸⁶ NAR PM 1/1/116 20/8, Report on Mental Disorders Act, 1916, p. 6.

⁸⁷ J. T. Dunston, 'The Problem of the Feeble-Minded in South Africa', *Journal of Mental Science*, 46, 1921, pp. 449-58, quoted in Edgar and Sapire, '*African Apocalypse*', p. 120.

This national context goes some way to explaining a measure of marginalisation of Natal's psychiatrists and facilities after 1910. Nonetheless, local factors – including the role played by individuals concerned with the running of the Pietermaritzburg Mental Hospital – also contributed to what might be regarded as a decline in status. For, from being southern Africa's first custom-built lunatic asylum, a late-nineteenth century 'Model Asylum for the Insane'⁸⁸ and showpiece of colonial liberalism, those who came after the energetic and charismatic James Hyslop found, by the 1920s, themselves struggling to persuade Dunston to allocate the finances, the staff and the rank that would keep the Pietermaritzburg Mental Hospital a 'first grade' institution.

The 'A-Z of Mental Disease and Asylum Administration': the Pietermaritzburg Mental Hospital, 1910-1918.

By 1911, Dr. A. D. Pringle had served at the NGA as Hyslop's Assistant for seven years. In that time, and more especially since the South African War, Hyslop's military commitments had continued – he was a Lieutenant Colonel in the Natal Medical Corps – and on several occasions Pringle had been left for extended periods in charge of more than 600 patients at what was then South Africa's second largest asylum. In 1909, for instance, Hyslop had more than three months' leave of absence; in 1911, he was away for 53 days (during which time, he married, for a second time, in Scotland); in 1912 he took six weeks' paid leave to accompany the troops comprising the Natal Coronation Contingent on their voyage to England, in addition to the time he spent in militia training.⁸⁹ Hyslop was again absent from Natal for much of the first half of 1913 – as we have noted – and in the

⁸⁸ *Natal Blue Book, 1879*. Lunatic Asylum Return. Charles Ward was Acting District Surgeon for Pietermaritzburg in that year.

⁸⁹ NAR CS 994 20795, Dr. J. Hyslop, Health. Medical Superintendent, NGA, Natal. Hyslop had married Clementina Brown in 1882. Hyslop's second wife was Lady Barbara Joanna Steel, who had been an active member of the Liberal Party and the W.S.P.U. She was president of the Women's Enfranchisement League of the Union of South Africa until 1930. See *The South African Women's Who's Who* (Johannesburg: Biographies Pty Ltd., 1937) 'Lady Barbara Joanna Steel'. There were no children from either marriage.

following year, he resigned from the Pietermaritzburg Mental Hospital. The asylum was said, by the time of his retirement, to be 'one of the show places of the town' and he one of the most eminent scientists in South Africa. He continued to remain active for some time, as first Assistant Director and then Deputy Director of Natal Medical Services during the first years of World War I until, 'owing to the strain of overwork, his constitution gave way, and he was consequently released from military service in August, 1917, an invalid.'⁹⁰ He died in October 1917.

On Hyslop's retirement in 1914, Dr. Harry Egerton Brown was temporarily appointed in his place, and then, from August 1915, Dr. Robert Sinclair Black, was promoted from Valkenberg to the post of Physician Superintendent at Pietermaritzburg. In 1903 – as Sally Swartz recounts – Black had been demoted from Senior Medical Officer because of drunkenness. He was to have been sent to Fort Beaufort as a *locum tenens*, but this was cancelled when he arrived there in an inebriated state.⁹¹ After this, he seems to have had an exemplary career and received considerable support from Dodds. Black died unexpectedly at the end of September 1919, and was succeeded as by Brown who had headed up the Fort Beaufort Asylum for the previous four years.⁹² Brown held the Pietermaritzburg post until 1931.⁹³

From October 1909, a Second Assistant Medical Officer, Dr. Herbert William Glashan, worked with Pringle. While Pringle went on to further his career at the Pretoria Asylum, Glashan remained until the early 1920s. After the War, Glashan was promoted to the post

⁹⁰ Obituary, *South African Journal of Science*, 14, 1917-1918, pp. 311-314.

⁹¹ Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p. 38.

⁹² NAR Executive Council (hereafter URU) 244 1649, Promotion of Drs R.S. Black and H.E. Brown', November 1919.

⁹³ NAR Department of Health (GES) 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown.

of Senior Physician, but then was offered the post of Physician Superintendent at Fort Beaufort.⁹⁴ He remained there from 1921 to 1931, and then returned once more to Pietermaritzburg.

These details are more than a mere chronicle of the various appointments to the positions of medical and administrative authority at the Pietermaritzburg Mental Hospital, they are indicative of Dunston's new asylum scheme at work. Before 1910, it had been the norm for an individual Medical Superintendent to hold a position of not inconsiderable influence for many years, if not decades. This had had its drawbacks: Pringle, for example, felt that Hyslop's long tenure had blocked his own opportunities for advancement. In August 1911, Pringle wrote to H. B. Shawe, the Under Secretary for the Interior, sounding him out about the possibilities of professional promotion in the new Union. His letter reveals that he was alert to the fact that Hyslop's patronage would now be of limited influence since 'Medical Superintendents' posts under Union [are] now going by seniority, [and this] has affected my prospects very materially.' Pringle added: 'Had Dr. Hyslop retired a year or 2 years ago, I should almost certainly have succeeded him here. He indicated this to me verbally a few years back.'⁹⁵

By drawing attention to the fact that he had, *de facto*, run the asylum for some time, as well as to the experience that he had gained with acute and chronic cases of patients of all classes and colours, Pringle tried to convince Shawe that he was the best person to replace Hyslop.

Naturally when one has done arduous work in such an institution as this, one becomes attached to both the place and the patients; I have acted as Medical Superintendent on many occasions and for long periods ... I do sincerely hope that, even if the exigencies of Union do not permit of my getting this post in the near

⁹⁴ NAR GES 3050 S12/145, Dr H.W. Glashan, 1988-1944. Glashan retired in either 1939 or 1940, but came out of retirement during the Second World War.

⁹⁵ NAR CS 986 20397, Dr A. D. Pringle, NGA. Dr A. D. Pringle to Acting Under Secretary, Department of the Interior, 14 August 1911. Emphasis in original.

future, that there may eventually be a chance of my returning to the senior post in this place ... There is ... a vast difference in administering a small Asylum with chronic patients only, and a large place like this (640 patients) containing European, Indian and Native chronic and acute cases; it is the latter which make a medical man (keen on curing these unfortunate people (recent acute cases) full of anxiety year in and year out....⁹⁶

It was at Pietermaritzburg, he explained, that he had ‘learned mental disease and asylum administration from A to Z.’ His chances for promotion in Natal were, however, he recognized limited. He went on to add: ‘when one looks ahead, realizing what a small service the Asylum branch (Medical) is, the prospect of older men remaining many, many years with us makes the road to promotion for younger men appear a very long one – and Hope deferred makes the heart very sick indeed’. He acknowledged that Dr. Sinclair Black had seniority over him, but was careful to remind Shawe that his appointment to Natal in 1904 had preceded that of Brown to Pretoria in 1905.⁹⁷ He expressed himself willing to serve as a replacement for the Physician Superintendents of Bloemfontein, Grahamstown, Port Alfred or Fort Beaufort should a *locum tenens* be required, saying ‘I speak both Dutch and Kafir.’

In June 1912, almost a year after he approached Shawe, Pringle was confidentially asked if he would be prepared to move to Robben Island to change places with Sinclair Black, whose health required him to move away from the island. Pringle declined, saying that Hyslop’s frequent absences meant it was imperative that ‘... this Asylum is now such a large one (630-640 patients) ... that it is very necessary that the Senior Assistant should be absolutely familiar with the methods of administration, staff, etc, and also one who has had considerable experience. He closed with thanks for the offer and by saying ‘Dr. Hyslop ...

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*

completes 30 years' service on 2nd July. I often wonder how many of us will be lucky enough to last as long.'⁹⁸

Some time after this - between 1915 and 1916, the exact date is unclear – Pringle was transferred to Pretoria. In the meantime, he and Brown had, for a short three month stint, swapped jobs. This, the Department of the Interior explained, was because the 'Government has definitely decided to adopt the principle of interchanging Medical Officers employed in the Asylum Service with a view to all Medical Officers becoming acquainted with the method of administration and treatment adopted in the various institutions.'⁹⁹ It was shortly after this that Brown was drafted and served with distinction, holding the rank of Major. Something of a tussle between the Departments of Defence and of the Interior occurred over who could lay most claim to his services. In responding to a request from the Secretary for the Interior in June 1915 for Brown to be released from military service because of a shortage of senior staff in the asylum service, the Secretary of Defence demurred, explaining that 'Major Brown has been especially in charge and dealt almost exclusively with the question of invaliding members of the Union Defence Forces, granting them sick leave, discharging them as medically unfit and granting compensation for permanent disablement, whole or partial.'¹⁰⁰ His post was described as an administrative one. It is not clear whether it was his judgement as a physician or as a psychiatrist that was called on, however. If the latter, then this 'combination of military and mental matters' was of a fundamentally different nature to that of Hyslop, whose role in the Natal military had

⁹⁸NAR CS 986 20397, Dr A. D. Pringle, NGA. Dr A. D. Pringle to Acting Under Secretary, Department of the Interior, 26 June 1912.

⁹⁹ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown. Under Secretary for the Interior to Medical Superintendent, Bloemfontein Asylum, 14 October 1914.

¹⁰⁰ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown. Secretary for Defence to Secretary for the Interior, 29 June 1915. I hope to pursue the history of the early engagement of Egerton Brown and other South African psychiatrists in the military in future research.

been medical and not mental. The importance of Brown's war work was acknowledged in February 1919, when he was awarded an O.B.E.

Sally Swartz has noted that the transfer of asylum staff was common practice in the Cape from the 1890s onwards and that 'this undoubtedly contributed to the establishment of some degree of shared institutional culture with respect to the management of the insane.'¹⁰¹ For Natal, until 1910, however, the major influences, whether in terms of recruited staff or of ideas of asylum management – forged through Hyslop – had usually been with Britain. After Union, Natal was brought more firmly within the ambit of a wider South African network and institutional culture that increasingly harked to its experiences of managing the mad in a racially fragmented society. To illustrate this point: by the time he was appointed as Physician Superintendent of the Pietermaritzburg Mental Hospital in November 1919, Brown had occupied positions at several of the Union's major institutions – at Pretoria Lunatic Asylum and the Pretoria Leper Institution; as a replacement officer on Robben Island; as an Assistant Medical Officer at Bloemfontein and Pietermaritzburg Asylums, and as Physician Superintendent at Fort Beaufort. Robert Sinclair Black, whose early death brought Brown to Pietermaritzburg, had previously held offices on Robben Island and Valkenberg. Pietermaritzburg was not Brown's preferred choice, however, and it is perhaps worth looking briefly at the first few years of his tenure there – although, strictly speaking, they lie outside the time parameters set for this dissertation – as they give insights into the experiences of South Africa's professional psychiatrists in the years immediately following World War I.

When, in October 1919, Brown received news that he was to be transferred and promoted from Fort Beaufort to Pietermaritzburg, he wrote to the Colonel Shawe, the officer in the Department of the Interior responsible for much of the administration of the asylum system, that he was reluctant to take up the posting since, if he did so he 'might not get the chance of ever receiving promotion to Valkenberg which I understand is the same grade as

¹⁰¹ Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p. 27.

Maritzburg and which I consider will be, one day, the premier Mental Hospital of the Union and one of which I have always desired to be Physician Superintendent.’¹⁰² Like Pringle, Brown was concerned for his personal prospects, but his letter suggests too that the future of Pietermaritzburg for an ambitious psychiatrist was already in doubt. In this, both showed some prescience, for Shawe’s reply to Brown could not have been entirely reassuring. He wrote that he was: ‘quite prepared to give you an assurance that if it [Valkenberg] is still of the same grade as Maritzburg at the date of retirement of Dr. Cassidy, the department will be prepared to agree to your transfer thereto.’¹⁰³

Pringle was also right to be concerned about the small numbers of qualified and experienced professionals in the country’s asylum service. If Southern Africa had been, to use Anne Digby’s phrase, a ‘medical El Dorado’ after the South African War, it was not so after World War 1, at least not for psychiatrists, and the government attempted, without short term success, to recruit suitable doctors from Britain.¹⁰⁴ The South African psychiatric profession was, in the post-War years, stretched. When one senior staff member took leave, a replacement had to be found from a limited pool. Requests for leave were often turned down: in May 1920, for example, Brown applied for relief medical officers since both he and Glashan were, he said, in need of leave for reasons of health. He was told to stay at his post, since Swift of Bloemfontein was shortly due to leave for England, Cowper of Grahamstown was on sick leave, Croly of Pretoria was leaving for England ‘for serious

¹⁰² NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown. H.E. Brown, Physician Superintendent, Mental Hospital, Fort Beaufort, to Colonel Shawe, Department of the Interior, 14 October 1919.

¹⁰³ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown. Colonel Shawe to Dr. H.E. Brown, 18 October 1919. Cassidy had replaced Dodds at Valkenberg. Swartz gives the date of the retirement of Dodds as 1913, Burrows as 1914.

¹⁰⁴ A. Digby, “‘A Medical El Dorado’? Colonial Medical Incomes and Practice at the Cape”, *Social History of Medicine*, 8, 3 (1995); and NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Staff file of Dr. H.E. Brown. Secretary for the Interior to Major H.E. Brown, Physician Superintendent, Mental Hospital, Pietermaritzburg, 10 May 1920.

reasons of health ... None of the other Institutions can possibly spare a medical officer.’¹⁰⁵ He proposed that a local doctor be appointed to assist him in Glashan’s absence and this was approved by the Secretary for the Interior, since he recognized that the ‘Pietermaritzburg Mental Hospital is a large and important Institution and it is quite impossible for the work there to be properly performed in the absence of either of the two Physicians ...’¹⁰⁶ The Treasury admitted that the institution was short staffed, but it refused to fund a temporary post, arguing that better plans should have been made and that Brown simply had to delay his leave.

The correspondence between the latter and the Secretary for the Interior gives something of an idea of the strain under which he and Glashan – and others in similar posts elsewhere in the country – had been working for some time: Brown wrote, for instance, that Glashan had septic sores on his fingers, that he himself had had very little leave in ten years of continuous service, and that ‘as I do not desire to risk a breakdown, which, has already occurred to one Physician Superintendent, I beg to request that your decision may be reconsidered, and that I be allowed to proceed on leave as desired...’ One of the tasks that had apparently been onerous, had been the bringing up to date of the Case Books and Reports and the transferral of patient records to the loose leaf folder format. He closed by dryly requesting ‘that you reply to this Minute by wire, the cost of same to be collected [the original term was ‘deducted’, but this was crossed out] from me, if you so desire.’¹⁰⁷ He was finally granted leave in August, after the Treasury had been told that:

At the present time the position of the Mental Hospital service owing to the shortage of medical staff is most acute and it is impossible to grant much needed

¹⁰⁵ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Secretary for the Interior to Major H.E. Brown, Physician Superintendent, Mental Hospital, Pietermaritzburg, 10 May 1920.

¹⁰⁶ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923, Secretary for the Interior to Secretary for Finance, 17 May 1920.

¹⁰⁷ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Dr. H. E. Brown to Secretary for the Interior, 29 May 1920.

rest to the medical officers who are being called upon to perform extra duty ... Several medical officers have broken down in health completely owing to overstrain and been compelled to take long leave in order to recuperate.¹⁰⁸

This was not before a major rift had occurred between Brown and the Department of the Interior, and Dunston in particular. They had been on a collision course for some time. For instance, in 1919, before leaving Fort Beaufort, Brown had told Shawe that ‘if Drs Dunston and Cassidy will be relieved of their present positions ... the chief source of my discontent, from my own point of view and all the Assistant Physicians, would be removed.’¹⁰⁹ He did not go into details as to the source of his discontent, but he apparently confided in Shawe on a visit to Pretoria in 1920. No doubt one of his grievances stemmed from the apparent downgrading of the Pietermaritzburg Mental Hospital – and his own status and salary – to a second-class institution, with Valkenberg, Bloemfontein and Pretoria Asylums (and their Physician Superintendents) being placed on the top tier. He wrote a personal letter to Shawe, arguing that ‘this means that we drop from the same grade as the two latter to the level of Grahamstown and Fort Beaufort’ and that this was unfair because

as regards patients we come second to Pretoria and that our admission rate is the third highest. Probably Valkenberg and Bloemfontein have greater accommodation but our admission rate is practically the same as theirs, and the responsibility of catering for those without adequate accommodation is greater than where more accommodation exists; further increased accommodation must be extensive here in the near future if we are to be able to cope with the admissions. I hope that the above will influence you in this matter as I feel very strongly that this Institution should certainly rank with Valkenberg and Bloemfontein and not with Fort Beaufort and Grahamstown.¹¹⁰

In response, Shawe motivated to have Brown’s salary pegged at the highest grade, but made no comment on the status of the mental hospital at Pietermaritzburg.

¹⁰⁸ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Secretary for the Interior to Secretary for Finance, 23 August 1920.

¹⁰⁹ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923. Dr. H.E. Brown to Colonel Shawe, 14 October 1919.

¹¹⁰ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923, Dr. H.E. Brown to Colonel Shawe, 3 March 1920.

The reduction in grade would, presumably, have very materially affected the financial status of institutions as well as their prestige more generally. The state's exact motivations here are unclear. Since other mental hospitals, most notably Pretoria, had large numbers of African patients, there was no uncomplicated linkage between the moves to downgrade Pietermaritzburg and the racial profile of inmates. More local factors had, however – as we shall see – raised doubts in the minds of Dunston and at the Department of the Interior as to the wisdom of future expansion of the Pietermaritzburg Mental Hospital on the Town Hill.

Brown's frustrations with the lack of support staff and mounting workload had been forcefully expressed in his Annual Report for 1920, which he presented to the Mental Hospital Board – made up of local doctors and officials – before submitting it to Dunston. In it Brown pointed out that the number of patients had risen steeply in the preceding fifteen years – from 499 in 1905 to 829 – but that the number of medical staff remained the same: three – a Physician Superintendent and two Assistant Physicians.¹¹¹ In fact, as he noted, one Assistantship stood vacant. Not only had clinical responsibilities expanded enormously, he added, but so too had the paperwork, especially because of the various forms required under the Mental Disorders Act of 1916. He was of the opinion that 'these could be much simplified and the form of the Report required by the English Commissioners would amply suit the purpose.'

While Hyslop seems – as noted in Chapter 2 – to have secured the loyalty and long service of a number of senior staff, most asylums and hospitals around the country found it very difficult, especially during and immediately after World War, 1 to retain qualified

¹¹¹ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923, Extract from Brown's Annual Report, 1920. A copy of only one sheet – page 2 on 'Staff Matters' - of this report appears to have survived.

nursing staff. Brown's 1920 Report detailed that there had been '19 female and 29 male resignations during the year'; moreover, at least five male nurses had been absent for a number of years, on military service. Brown made clear his opinion that his institution could not function without more staff and, what is more, he laid the blame for the shortfall squarely at the feet of Dunston: 'For this Hospital to be efficiently and scientifically conducted there should be at least three Assistant Physicians. The appointment of a third Assistant Physician has been applied for but, on the advice of the Commissioner for Mental Disorders, this has been deleted from the Estimates for 1920-21.'¹¹²

He went on to say that this had implications for the well-being of the patients: 'I must point out that the more the Medical Staff are able to enter into the general life of the patients and to devote their time to the clinical side of their cases the greater is the recovery rate and economy is thus effected.' He then cited statistics from across the Union that demonstrated, or so he argued, that the 'Recovery Rate is in the proportion to the number of Medical Officers employed', and that there had been a significant drop in the recovery of patients in 1917 because of the increased clerical work required since the passage of the 1916 Mental Disorders Act.¹¹³ Brown's report gained him the sympathetic support of the local Board, but it brought the extreme opprobrium of Shawe and Dunston.

Dunston wrote to Shawe, with nine indictments against Brown. Unfortunately, we do not have the full Annual Report – it was not published – only Dunston's rebuttal. In it, he said that Brown's statistics on the relationship between patient recovery rates and medical appointments were 'untrue', 'absurd' and 'amusing', 'illogical ... ill-considered and casual, and hence false and ridiculous.'¹¹⁴ He objected to the Board having seen the

¹¹² *Ibid.*

¹¹³ *Ibid.*

¹¹⁴ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923, Confidential letter from Dr. J. T. Dunston to Colonel Shawe, 1 June 1920.

Report before it was submitted to his Department, and claimed that they had been misled, and ‘used as a foil’ by Brown. There were further epithets. Brown’s Report, Dunston said, was ‘blatantly stupid and could not be made by a responsible officer’. He added the comment that ‘I do not hesitate to say that if he ... shews such impaired judgment as to make it doubtful whether he be fit to occupy his position.’ Dunston rejected the accusation that he had blocked the appointment of a second Assistant Physician and alluded to a much longer fractious relationship between himself and Brown: ‘If it be not his opinion, but only stated for personal reasons and with ulterior motives, as I fear is the case, then it is deliberate falsehood – unworthy, reprehensible and insulting to the intelligence of the Department.’¹¹⁵ Dunston’s letter contained further damning judgements on Brown’s loyalty, capability and integrity, describing him as ‘unreliable’, ‘reprehensible’, ‘rude’ and ‘resentful’. Without showing a shred of sympathy for the heavily burdened – though undoubtedly difficult – Brown, Dunston reduced his former colleague’s complaints to the level of a personal vendetta. He told Shawe that ‘we are driven to the conclusion that the Physician Superintendent wishes to attack the Department by any means ...I can only guess at the motives of the attack, as will appear, but I do know that the issue is insincere and that the conduct of the Physician Superintendent in the matter is dishonourable and disloyal to the Department.’ He pulled rank, too: ‘Moreover, it is contrary to the Public Service Regulations...’¹¹⁶ He accused Brown, like a junior officer, of ‘insubordination’.

The ‘conduct’ to which Dunston referred was an ‘Attempt to induce the Assistant Physicians to petition against the decision and policy of the Department’. Again, unfortunately, scant details of the exact grievances being aired amongst the Union’s psychiatric service personnel are given in the surviving correspondence between Dunston, Shawe and Brown, but at least one was the fact that Dunston held the joint

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*

appointment of Commissioner for Mental Disorders and Physician Superintendent at the Pretoria Mental Hospital. Another was that Dr. Cassidy had not retired from Valkenberg as had been expected – or at least, as Brown had anticipated – and that this meant that there were further obstacles in the way of promotion for several Assistant Physicians who had been hoping for professional advancement for some time.¹¹⁷ As a result of the brouhaha, the undertaking that Shawe had earlier given Brown that he would be transferred to Valkenberg on Cassidy's retirement was withdrawn. Dunston expressed himself as 'very glad' to know this, and urged Shawe to bring Brown to heel, and that every Physician Superintendent be made to recognise that 'the service comes first, and that he has not claim on any particular place, and that even if appointed he may, if the Department thinks his services will be more useful elsewhere, be moved at any time.' He suggested, but did not insist, that Brown be demoted.

The extent of Dunston's influence and authority over South Africa's asylum service, whether through his scheme to reorganize its conceptual and material basis or his intolerance of dissent by professionals within it, are clearly shown in these responses to Brown's complaints of being overworked, short-staffed and undermined by his own superiors. Brown was made to withdraw the offending portions of his Report, and was sternly reprimanded by Shawe. Stung by Shawe's lack of support, he could only retreat, saying that 'I would respectfully draw your attention to the difficulties and worries that I have had in taking over an Institution which has been severely handicapped by the long illness of its late superintendent...'¹¹⁸ His long-awaited leave was finally granted in August, the month after his retraction.

¹¹⁷ *Ibid.*

¹¹⁸ NAR GES 3040 S12/300, Mental Hospital, Pietermaritzburg, 1912-1923, Dr. H.E. Brown to Colonel Shawe, 14 June 1920.

Brown escaped demotion and remained at Pietermaritzburg until 1931, but to cross Dunston was to risk being marginalised within what was still a very small profession. Cassidy eventually did retire, in 1923, and was replaced by Eric Swift, who had been so supportive of Dunston's proposals at the Select Committee hearings in 1913. In the meantime, Brown and Dunston would disagree professionally in the pages of the *South African Medical Journal* on the matter of the 'sterilization of the unfit'. Whether the antipathy between these two psychiatrists materially affected the allocation of funding and staff to the Pietermaritzburg Mental Hospital in the 1920s and 1930s cannot be known with certainty, but Brown's concerns that it was being downgraded in importance, in comparison to Valkenberg, Bloemfontein, and Pretoria, were perhaps not without foundation. By 1926, Pietermaritzburg had, in terms of numbers, the fourth highest patient population (978); its medical staff complement had been increased to five – putting it on a par with Bloemfontein (which had 1,088 patients) – but below Valkenberg and Pretoria (1,539 and 1,804 patients respectively); and the amount of money spent annually on patients at Pietermaritzburg, was less than that spent on patients at the higher prestige institutions, and closer to the maintenance rates expended on the predominantly or black-only institutions.¹¹⁹

A more systematic analysis of the reports of the Commissioner for Mental Hygiene in the 1920s and 1930s could reveal the differences between institutions more clearly. It does seem however, that the position of prestige that the Natal Government Asylum had occupied on Union had diminished somewhat by the end of World War I, and even more so decade or so later. Although the national context was important in determining the broad policies and practices of the Pietermaritzburg Mental Hospital in this period, more local factors were also influential in placing limits on the extent to which it could become a site for the future expansion. For, by World War I, some citizens of the city of Pietermaritzburg were voicing their objection to the continued existence of the mental

¹¹⁹ UG 25-'29, *Report of the Commissioner for Mental Hygiene: Statistical Tables for 1926 and 1927* (Pretoria: The Government Printer, 1929).

hospital, which no longer stood on the outskirts of the town, but had been encircled by elite suburbs. As a 1918 petition to the City Council made clear, Pietermaritzburg was no longer quite so willing to accommodate the mad in its midst.

‘The Night Long Song of a Hundred Mad Natives’¹²⁰: The mad in the midst of Pietermaritzburg

From the 1860s and 1870s when the colonial government of Natal and the Pietermaritzburg Town Council first began to consider the desirability of different sites for the proposed lunatic asylum, the people of the city had had somewhat mixed feelings about the permanent presence of madmen in the borough. An early proposal had been for the public asylum to be situated near the base of the garrison at Fort Napier, on land where the Railway Station – which has become famous for its association with Gandhi – stands today. This proposal met, as we saw in Chapter 2, with resistance from some of the burgesses and 115 petitioners persuaded the Town Council to withdraw its offer to donate this piece of land to the government, and to find an alternative site outside the city. In 1873, the Council was able to offer a site of fifty acres, on the Town Hill, then a mile and more beyond the city. This early ambivalence with which the citizens of Pietermaritzburg regarded the Natal Government Asylum and its patients would prove to be a common theme in the future, and there have been – since the 1880s – at least two occasions on which unease with the institution grew into outright opposition, with petitions and motivations being presented to the Council to have the expansion of the asylum restricted, and perhaps to move the institution altogether. These calls have coincided not only with the actual expansion of the asylum grounds and number of inmates, but with times of both

¹²⁰ NAR GES 2767 4/78, Land for Natal Mental Hospital . Minutes of the Meeting of Finance and General Purposes Committee, Held on Thursday, 26 September, 1918, at 2:30 pm. 877/18. ‘Grant of Land to Mental Hospital.’ See below for the context of this phrase.

economic strain and of economic boom. They have also shown how fears about race, gender and insanity could be fused and focused at times of social strain.

When building of the NGA first began in the late 1870s, the site of fifty acres on the Town Hill was somewhat remote from the city, though its elevated position on a bare hill made it visible for some miles around. Until the extension of the railway up the Town Hill in the early twentieth century, many of the staff travelled to and from town on horseback and, later, by rickshaw. Hyslop's merging of his passion for horticulture and the regimes of purposeful – preferably outdoor – work by patients meant that, by the 1890s, the grounds were well planted with trees and shrubs. A farm was established; there was also a quarry. The asylum grounds came to represent a country estate, both reassuring and desirable for a city that sought to establish its colonial credentials. The opening of the Main Building, in 1891, added substantially to the image of the NGA as a monument to the civilizing influence of British culture and bourgeois values. The racial geography of the estate, however, as we have seen, soon reflected that of the city and the country in which it was rooted: African and Indian patients were housed separately from white inmates, and their accommodation was always inferior. Nonetheless, it was only from the late 1890s that black patients outnumbered whites at the NGA.

In the decades that bracketed the turn of the twentieth century, the NGA was often referred to in approving terms. No doubt Hyslop's character, his deep involvement in the colonial military, the town's civic affairs and social life, helped to alleviate any elite suspicions of the institution he so dominated. The sentiment expressed by the Wragg Commission of 1887 is typical of the time:

The Lunatic Asylum at Pietermaritzburg, to which insane persons are sent from all parts of the Colony, is a fine, brick building situated on a hill about one mile north-west of the city, in well-kept grounds, 50 acres in extent, commanding a beautiful view of the city and its suburbs. Female patients are housed in a separate block. ... We carefully inspected all the arrangements of the institution, and we now record, with great satisfaction, that under the care of Dr. Hyslop, who

assumed charge in 1882, the comfort and welfare of the inflicted inmates are sought to be secured by all means which ability and experience can suggest.¹²¹

In 1906, the glossy publication, *Twentieth Century Impressions of Natal*, devoted some space to both the NGA and to Hyslop. The tributes paid to Hyslop on his death also made frequent mention of the manner in which the asylum grounds added to the aesthetic and architectural appeal and prestige of the city.

By 1914, however, when Hyslop retired, the newly renamed Pietermaritzburg Mental Hospital was no longer on the outer boundaries of the city. Its patient numbers had increased vastly more than the hundred originally envisaged some thirty years earlier, and the majority of these had, for some time, been African or Indian. Keeping pace with the expanding asylum population – with the attendant need for staff, room for recreation, as well as, increasingly, for land upon which to grow food for the patients – Hyslop had gradually expanded the grounds. By purchasing lands adjoining the original grant, by 1913, the asylum grounds were 140 acres in extent. Hyslop, however, expressed the view that this was not enough. Receiving the backing of the Department of the Interior and J.T. Dunston, after Union, a more concerted effort was made to acquire a number of properties abutting the asylum lands. During the years of World War I this became even more important as the country's mental hospitals were urged to make themselves as self-sufficient as possible.

In the first decade of the twentieth century Hyslop had complained that he had been under great pressure from the colonial government to reduce expenditure on the asylum. Nonetheless, in 1909, he had managed to persuade the state to alienate thirty-six acres from land that had been set aside as a public park, and in the following year, building began there on a separate building for fee-paying private patients. This was completed in

¹²¹ Natal Government Gazette XXXIX No. 2262 Tuesday, September 20 1887, Government Notice No. 430, 1887, *Report of the Commission appointed to inquire into and report upon the Indian Immigration Laws and Regulations of the Colony, and on the general condition of the Indian population of Natal*, Chapter XXVIII, p. 59.

September 1911.¹²² Thus, even before Dunston's scheme was presented at the Select Committee hearings in 1913, an effective 'villa' system had been established at Pietermaritzburg. Since before Hyslop's retirement, he and Pringle were engaged in negotiations to expand the grounds and patient accommodation by purchasing existing properties, including houses, from adjacent landowners. The names of the properties were retained for the wards or separate facilities that were established on them: Sandringham, Dulwich – in 1914 - and Kingsbury, an estate of over 47 acres and two 'tumble-down cottages', in 1917. One of these cottages had already been rented by the hospital for some years. Money needed to be spent on all these, and on occasion, costs were met by pruning the approved expenditure for black staff accommodation.¹²³

In 1915, in accordance with the recommendations put forward in the Select Committee Report, part of one of the older buildings, known as Berea, was converted into an admission ward for the reception of 'acute cases', and it was put under the charge of female nurses. This, Dr. Black would later comment, 'was the first real attempt in Natal at Hospital treatment for the Mentally Disordered, and though it was make shift [sic] it was a very great advance and improvement on previous conditions.'¹²⁴

Work on further accommodation for black patients began in 1917, but was considerably delayed because of materials shortages experienced during the War: new quarters for

¹²² U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 25. 'History of Institution' by Dr. R.S. Sinclair Black, Physician-Superintendent of Pietermaritzburg Mental Hospital.

¹²³ See NAR PWD 1815 16/6572 Pietermaritzburg Mental Hospital, Alterations, Sandringham, 1917-1920. Acting Secretary for the Department of the Interior to Secretary for Public Works, 18 December 1917.

¹²⁴ U.G. 31-'20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 25. 'History of Institution' by Dr. R.S. Sinclair Black, Physician-Superintendent of Pietermaritzburg Mental Hospital.

black men were opened in 1918, though not before the ‘overcrowding’ there had accounted for a high death toll following the Spanish ‘Flu epidemic of that year.’¹²⁵ In late 1918, work commenced on ‘New Female Native Quarters’. This was finished in 1919. For these constructions, all the labour was performed by patients. While some white inmates did join the work gangs, it was mostly African and Indian patients who were engaged in the heavy work of tilling, digging, and building. Moreover, the accommodation given to black patients was of an inferior standard to that for whites. This had been firmly established in 1913 when the vast discrepancy between the officially calculated rates providing for the facilities of white and black mental patients was clearly stated: Gorges had told the Select Committee, ‘(w)e have made provision on the basis of £250 a bed for Europeans and £75 a bed for natives.’¹²⁶ Given that the state’s commitment to expand the accommodation at Pietermaritzburg was primarily for black patients, Natal received less than those hospitals where the greatest need was perceived to be for better facilities for whites, especially at Valkenberg and Pretoria. Pressure for segregated facilities within the hospital complex came not only from administrators, state officials and psychiatrists, however, but also from the families of patients, including on occasion, some who would later be officially classified as being ‘not European’. In 1920, for instance, ‘Coloured’ voters in Pietermaritzburg petitioned the state for a greater measure of racial segregation within the mental hospital, asking that their relatives who were patients should not be housed with African inmates, and stating that they, the families, were prepared to pay substantially towards the maintenance costs of these ‘Coloured’ patients.¹²⁷

¹²⁵ U.G. 31-‘20, *Report of the Commissioner of Mentally Disordered and Defective Persons*, p. 27. ‘History of Institution’.

¹²⁶ *Select Committee, 1913*, p. 140. Evidence of Mr. E.H.L. Gorges, 25 April 1913.

¹²⁷ NAR Department of the Treasury (hereafter TES) 4009 F21/53, *Asylums: Coloured People at the Mental Hospital, Pmb, Accommodation, Mr. Benjamin, 376 Greyling Street, Pietermaritzburg to Private Secretary, 4 May 1920*. The petitioner was told that accommodation for ‘Coloureds’ would, in the future, be provided at Valkenberg.

Along with the growing number of patients came the need for more staff, and the needs of private patients made it even more necessary that suitable accommodation be provided for staff who were sometimes paid for directly by the patient's family. As with patients, this was provided on a differential basis according to sex and race. While white men and women staff were referred to as 'nurses', African and Indian staff were called 'attendants'. Substantial housing for the former was provided from 1911, when Male Nurses occupied their own quarters, and 1913 when a Nurses' Home was completed. This provided for about twenty female nurses in single rooms, as well as a Matron. Once this building had been completed, white women patients were moved across from the wood and iron structures that they had been occupying for some years. Pringle told the Secretary for the Interior, they were 'unbearably hot and stifling in the summer' and that Hyslop had 'repeatedly condemned them as unfit for human habitation.'¹²⁸

The upgrading of nursing and attending staff at the country's mental hospitals had been one of Dunston's recommendations in 1913. By 1918, the Pietermaritzburg Mental Hospital had a total of 143 staff, medical, clerical, and nursing. At that date there were 25 male and 32 female nurses who were 'Europeans', as well as 23 male nurses and 6 female, said to be 'coloured'.¹²⁹ It was apparently not easy to attract, or keep, trained, skilled or dedicated staff: in 1915, for example, only five candidates had presented themselves to the Natal Medical Council to sit the 'Mental Nurses Examination'. In an effort to recruit more, that Council recommended that the examination fee be lowered since the candidates were 'as a rule not too well off.'¹³⁰ The Secretary for the Interior, Gorges, was also keen that the professionalization of – white – medical and nursing staff be centralized at one of the

¹²⁸ NAR Public Works Department (hereafter PWD) 1815 15/6572, Natal Asylum, Nurses' Home, 1914. Dr. A.D. Pringle to Secretary for the Interior, 8 July 1911.

¹²⁹ U.G. 31-'20 *Report of the Commissioner of Mentally Disordered and Defective Persons*, Statement Showing Staff Employed at 31 December, 1918, p. 47.

¹³⁰ NAR TES 732 F4/29, Department of the Interior, Natal, Fee for Mental Nurses' Examination, 1915. Secretary for the Department of the Interior to the Secretary for Finance, 5 February 1915.

‘larger asylums in the Union’. This, he added, should become a ‘training institution for all medical officers who enter the asylum service, and that they should spend some time there and be trained both in regard to the study of mental diseases and their treatment ... and also trained in the administration of asylums, which is also specialised and somewhat difficult.’¹³¹

Gorges had told the Select Committee that ‘(w)e have trained boys at Pretoria to look after native patients under the supervision of white male nurses, and they are more satisfactory in my opinion than white male nurses would be, and I think you ought to extend the principle throughout the country.’¹³² He favoured, too, the use of ‘Coloured’ female nurses, especially since it would be ‘a very great economy.’ Far more black ‘other employees’ – 45 (38 males) - were employed at Pietermaritzburg than anywhere else in the country, reflecting the low status of many of the institution’s patients as well as attending staff. Their accommodation was separate from that of the white staff; and, plans from 1919 show that although Indian, African and Coloured patients shared the same wards (though these were segregated by sex) Indian and African attendants or staff were housed separately.¹³³

¹³¹ *Select Committee, 1913*, p. 140. Evidence of Mr. E.H.L. Gorges, 25 April 1913. Space precludes me from further discussing the professionalisation of psychiatric nursing in South Africa, though given the proximity of nursing staff and especially ‘attendants’ to patients on a more regular and personal level than that of the senior medical staff, this is a most important topic. Late in my research, I serendipitously came across – included in NAR TES 4263 F21/57 Asylums: Potchefstroom Mental Hospital – an annotated copy of the 1914 publication by the Department of the Interior, *Regulations for the Management of Hospitals for the Treatment of Mental Disease and Defect* (Pretoria: Government Printer, 1914) which carefully and exactly lays out the appropriate roles and responsibilities in the asylum medical and nursing hierarchy. This warrants further attention. For recent histories of nursing in South Africa, see C. Burns, ‘“A man is a clumsy thing who does not know how to handle the sick”: Male Nurses in South Africa: A History of Absence’ *Journal of Southern African Studies*, 24, 4 (December) 1998 and S. Marks, *Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession* (Johannesburg: University of the Witwatersrand Press, 1994). Also, Swartz, ‘The Production of Psychiatric Knowledge at the Cape’, pp. 38-40.

¹³² *Select Committee, 1913*, pp. 80-81. Evidence of Dr. J. T. Dunston, 18 April 1913.

¹³³ NAR PWD 1815 16/6572 Pietermaritzburg Mental Hospital, Alterations, Physician Superintendent’s Quarters. Physician Superintendent, Pietermaritzburg Mental Hospital to Acting Secretary for the Interior, 26 April 1919.

Later that year, additional ‘quarters’ were constructed for Indian employees, which comprised ‘two married quarters and a block of three single rooms and a kitchen.’

These 1919 plans are interesting in a number of ways: not only do they make clear the way that asylum architecture and ground layout reflected racial and class distinctions, but they also illustrate the number of what might be termed ‘support staff’ that were required to keep the hospital and the estate functioning. The plans detail, for instance, residences for a storeman, an electrician, a gardener, and a clerk of works. There was also a smithy, workshops, a mortuary, stables and coach house, and laundry. Sandringham and Kingsbury were described as ‘villas’, and the ‘Berea Hospital’ was now the subject of detailed discussions for its further expansion and remodelling as a ‘Receiving Block’. What Black wanted, he said, was a ‘Receiving Block with 42 beds (32 dormitory and 10 private rooms)’ That this facility was primarily intended for white patients is clear: ‘My experience is’ Black added, ‘that ample accommodation of private rooms is indispensable in a Receiving Hospital, especially when a considerable proportion of the patients are of the better class as is the case here.’¹³⁴ The designs were sent to Dunston for approval.

All this meant for a sizeable community of people – patients, medical and nursing staff, attendants, gardeners and workmen – who were permanently resident at the Pietermaritzburg Mental Hospital. In 1910, there were 619 patients; in 1914, 643; and then, in the next four years, there came a large jump to 797, of whom only 355 were classified as Europeans. In 1918, as we have noted, there were also more than 140 staff, many of whom were black. By the time of Union, the ambivalence towards the asylum shown in the 1870s by the white citizens of Pietermaritzburg, was turning to antipathy, if not hostility. For not only had the asylum expanded far further than had originally been anticipated, it was also

¹³⁴ NAR PWD 1815 16/6572 Pietermaritzburg Mental Hospital, Alterations, Physician Superintendent’s Quarters. Physician Superintendent, Pietermaritzburg Mental Hospital to Acting Secretary for the Interior, 26 April 1919.

increasingly anomalous as an institution housing large numbers of blacks in the midst of what were now predominantly white suburbs.

Although, as social geographer Trevor Wills has shown, the boom in the development of the suburbs which lie above the Town Hill – Wembley, Athlone and Clarendon – occurred mostly after World War 2, by World War 1 several substantial properties had been established in the immediately surrounding vicinity of the asylum.¹³⁵ This had the effect of increasing the value of the land around the hospital grounds; and when word got out that the Union government was in the market for more land for the hospital, their owners were attracted by the high prices they might be able to secure. Some tried to lever a higher price for themselves because of the proximity of the asylum and its inmates. Just before his retirement, Hyslop, for example, engaged lawyers to approach Mr. T. F. Dixon with a view to buying his property, Dulwich. Dixon, it appears, tried to hold out for a good price, beyond the value of what Hyslop believed the land was actually worth. His lawyers told him that while Dixon was ‘beginning to feel the proximity of the Asylum inmates a nuisance, he is most obdurate and would not agree to accepting a penny less than £2,000 for his property.’¹³⁶ Hyslop thought its worth at £1,750, and attempted a counter manoeuvre: by offering to purchase a property adjoining Dixon’s, the latter would find himself ‘bounded on all three sides by Asylum property... and it would in all probability make Dixon more willing to part with his property...’¹³⁷ Dulwich went up for public

¹³⁵ T. Wills, ‘The Segregated City’, in J.P.C. Laband and R. Haswell (eds.) *Pietermaritzburg: A New History of an African City* (Pietermaritzburg: University of Natal Press and Shooter and Shuter, 1988), p. 39. Also, T. Wills, ‘Segregation, separation and desegregation: Pietermaritzburg since 1910’, in B. Guest and J. Sellers (eds.) *Receded Tides of Empire: Aspects of the Economic and Social History of Natal and Zululand since 1910* (Pietermaritzburg: University of Natal Press, 1994), pp. 283–309.

¹³⁶ NAR GES 2767 4/78, Land for Natal Mental Hospital. Duff, Mitchell and Eadie, 288 Church Street, Pietermaritzburg to Dr. Hyslop, NGA, 15 January 1914.

¹³⁷ NAR GES 2767 4/78, Land for Natal Mental Hospital, Dr. J. Hyslop, NGA to the Secretary for the Interior, 19 January 1914.

auction a few days later and was secured for the hospital, but at what price was not recorded.

Other landowners in the vicinity expressed increasing concern about the asylum's presence in their backyard. Opposition to the asylum coincided with its expansion during the years of World War I. It also took place at a time when the city of Pietermaritzburg was characterised by growing numbers of African workers, Indian traders and artisans, and an expanding, though still relatively small, community of 'Coloureds'. Suburban settlement was also accelerating, and competition for the most economically favourable land was closely tied to racial politics. Wills has described this as a period in which Pietermaritzburg was '... transformed by suburban developments and attempts to control a burgeoning "non-white" population whose plight (along with that of many white families) was exacerbated by long years of economic depression.'¹³⁸ While the major impetus towards the *de facto* racial segregation of the city had been well underway by the early twentieth century, '... this process was enhanced by the increasing concentration of the City's white population in suburbs flanking the old town core'.¹³⁹ These suburbs included the Town Hill, and the plans to extend the asylum ignited a flash of protest in which concerns about class, race and gender were given an extra edge by the prospect of the presence of the insane in the midst of a white residential area.

The first signs of organized protest came in November 1916, when some twenty-four petitioners - 'and others', who did not sign their names – submitted a memorial to the Pietermaritzburg City Council in which they objected to an impending grant of a section of the town lands, at the back of the Mental Hospital, alongside the Howick Road. The petitioners' initial objections were to the enlargement of the hospital grounds *per se*, as they '...beg[ged] to protest against the sale or hiring of the said piece of ground to

¹³⁸ Wills, 'The Segregated City', p. 38.

¹³⁹ *Ibid.*

Government Asylum Authorities for any purpose whatsoever.’¹⁴⁰ They added that, in their view, ‘it would be extremely detrimental to all properties surrounding, and would also militate against any buildings being erected in the proximity.’ They asked that ‘...all inmates and buildings of this description should be kept as far as possible from the High roads.’

Two of the petitioners wrote separately to various government officials, explaining the reasons for their objections. C. Webbe, for instance, wrote to the Surveyor-General that ‘... the owners and tenants in the neighbourhood protest most strongly ... The Asylum is too near now, and we are often troubled with the cries of the inmates. We, of course, understand this cannot be helped, but the institution or inmates need not be brought nearer.’¹⁴¹ The Surveyor-General was sympathetic, writing to the Secretary for Lands in Pretoria that ‘... it would not be very nice to Asylum patients just across the road every time the front door is opened.’¹⁴² The Council, as it had done forty years before, bowed to the pressure of its rate-paying constituents, and passed a resolution refusing to enter into further negotiations on the matter with the government.

This brought Dunston to Pietermaritzburg early in 1917. There he met the Mayor, and then the whole of the Council, whom he addressed. He reported to Shawe that he felt ‘most of the members were sympathetic when they were fully acquainted with the facts. The objectors were extremely angry and wanted to know from the Council why the question

¹⁴⁰ NAR GES 2767 4/78, Land for Natal Mental Hospital. ‘Address to The Mayor and Council, Pietermaritzburg signed by twenty-four petitioners and others’, 29 November 1916. Of the signatories, all appear to have been white.

¹⁴¹ NAR GES 2767 4/78, Land for Natal Mental Hospital. C. Webbe to Surveyor-General, Natal. 4 December 1916.

¹⁴² NAR GES 2767 4/78, Land for Natal Mental Hospital. F.J. Lewis, Surveyor-General, Natal to the Secretary for Lands, Pretoria. 7 December 1916.

had been reopened ..¹⁴³ Dunston then, along with the Council went to visit the site and there they met a ‘Committee of the objectors.’ They were persuaded to withdraw their objections, but only after Dunston had been forced to accept a number of conditions. These were that ‘... the Government should (1) plant a belt of trees fenced on the inner side between the property of the objectors and the Mental Hospital, and (2) that no accommodation for patients would be erected on the site adjoining the Howick Road.’¹⁴⁴ These were agreed to, and an application was put to the Council for the grant of several portions of lands to ‘round off’ the estate and to enable it to double its patient accommodation.¹⁴⁵ This was acceded to in September 1917.

The Town Council may have been mollified, but the residents of the Town Hill were not. Over the next year and more, opposition to the extension to the hospital grounds became if anything more virulent and the demands for safeguards more specific. Furthermore, whereas the earlier objections had been to the asylum and its inmates in general, now the attempts to highlight the grievances of the residents became couched in overtly racialised terms that stressed the ‘dangerousness’ that ‘mad Natives’ posed to ‘innocent’ and ‘peaceful’ whites, especially women and children.

In June 1918, a petition was sent to the Provincial Secretary ‘... by certain people who are interested in the matter and who strongly object to the transfer agreed upon by the Corporation.’¹⁴⁶ This was followed, on 27 August, by a meeting between ‘A Deputation of Town Hill Residents’, the Mayor and the Administrator and Provincial Executive. Dunston

¹⁴³ NAR GES 2767 4/78, Land for Natal Mental Hospital. Dr. J. T. Dunston to Acting Secretary for the Interior, 31 January 1917.

¹⁴⁴ *Ibid.*

¹⁴⁵ NAR GES 2767 4/78, Land for Natal Mental Hospital. Town Clerk, Pietermaritzburg to The Surveyor General, Pietermaritzburg, 5 September 1917.

¹⁴⁶ NAR GES 2767 4/78, Land for Natal Mental Hospital. Acting Secretary for the Interior to The Provincial Secretary, Pietermaritzburg, 22 August 1918.

said that he thought that the matter had gone beyond that of directly affected parties only and that ‘people who have little or no interest in the matter are being dragged in.’¹⁴⁷ In response, the Secretary for the Interior proposed that there be a strip of ‘neutral ground’ between the residential properties and the hospital. He noted that this was as much in the interests of the patients as the petitioners. In the meantime, matters in Pietermaritzburg came to a head in September and October 1918. On 26 September, the Deputation – as they styled themselves – addressed a meeting of the Municipal Finance and General Purpose Committee. Dr. Sinclair Black was present, at his own request. The spokesperson for the residents was Mr. W. S. Bigby. He said that the six delegates present represented the ‘moderates’ of a much larger group. He spoke of ‘the strength of the opposition to the grant of land in the midst of a popular residential area to the Mental Hospital’ and of their fears that the suburb would soon become ‘a total wreck’.¹⁴⁸ He pointed out that the number of patients at the Mental Hospital had originally been ‘comparatively small’ but that:

with the present growth with patients brought from other Provinces – the Cape and the Free State – the residents’ disabilities and disadvantages had become very marked. Mr. Bigby pointed out that the number of natives is on the increase and that it would be readily admitted that no one desired a Native Location in the neighbourhood. The residents were being saddled with a growing Native location in which the Natives are mad and while the night-long song of a 100 mad Natives is not too agreeable, the nuisance becomes far more than ten times as bad when the number is increased to 1,000. The same applies to the risk of escape.¹⁴⁹

Combining white fears of black men making unprovoked sexual attacks on white women and popular stereotypes of mental patients as being dangerous, Bigby told the Committee that the Deputation ‘had thought out certain conditions (a) to secure protection and a sense of security for ladies and children living or having occasion to use the road in the vicinity

¹⁴⁷ NAR GES 2767 4/78, Land for Natal Mental Hospital . ‘Extract from Dr. Dunston’s Report on a Visit to PmBurg Mental Hospital’, 26 June 1918.

¹⁴⁸ NAR GES 2767 4/78, Land for Natal Mental Hospital . Minutes of the Meeting of Finance and General Purposes Committee, Held on Thursday, 26 September, 1918, at 2:30 pm. 877/18. ‘Grant of Land to Mental Hospital.’

¹⁴⁹ *Ibid.*

and (b) to call a halt to the “peaceful penetration” and so preserve the suburb as a residential area.¹⁵⁰ These conditions now included not only a screen of trees but in addition that ‘the Government shall erect and maintain in good repair a double fence along the whole of the boundaries’, the outer fence to be constructed of wire and the inner, a “Pale” unclimbable [sic] steel fence.’ The two were to be ‘no less than 100 feet apart, and the belt of ornamental trees should be planted between them. Nor was there to be any new entrance to the Mental Hospital on the new grant of land, which was in any case only to be used for grazing purposes. Furthermore, no patients – unless ‘under strict observation’ while engaged in agricultural labour – were to be allowed on the land. These patients would, by and large, have been African and Indian. Finally, the government was not to seek to acquire any further land for the hospital on the Howick Road or in the remaining lands that approached the city.¹⁵¹ As a further threat, one of the petitioners – a Miss Henderson – threatened to take the whole matter to court. Dr Sinclair Black was asked if he wished to comment, but he replied that the matter ‘would have to be dealt with by the authorities in Pretoria’. In November 1918, the Department of the Interior agreed to the conditions requested by the Deputation.¹⁵²

The limits to any significant future expansion of the Mental Hospital in the midst of the city were thus established by 1918. In the next decade, a solution to the perennial overcrowding of patients that had characterised the asylum on the Town Hill almost since its inception in 1880, was sought by converting the former military barracks at Fort Napier into a mental hospital. The first patients were moved to this most unsatisfactory facility in 1928.¹⁵³

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

¹⁵² NAR GES 2767 4/78, Land for Natal Mental Hospital. Acting Secretary for the Interior to Secretary for Lands, 16 November 1918.

¹⁵³ See G. Fouché, 'Mental Health in Colonial Pietermaritzburg', in Laband and Haswell (eds.) *Pietermaritzburg: A New History of an African City*, p. 188.

The city's ambivalent attitude towards the accommodation of the mad, especially of those at the old Natal Government Asylum, did not disappear, however. Indeed, in the 1960s, by which time most of the patients at Town Hill Hospital were white, the Pietermaritzburg City Council again bowed to pressure from local ratepayers to approach the government to 'release' the 305 acres that the hospital then occupied. Arguments put forward ostensibly prioritised the needs of the patients for more 'modern' facilities, as well as the desire to run the city's two psychiatric hospitals on a more 'efficient' basis.¹⁵⁴ In a submission made in Parliament on 20 September 1966, Mr. Bill Sutton, the M.P. for Mooi River (whose constituency included Town Hill), gave voice to the concerns of the white citizens of Pietermaritzburg that can be seen as continuing to reflect the same motivations that had prompted the petitioners of the 1870s and of 1918. Sutton asked whether it was the government's intention to move some of the African mental patients from the city since 'both Town Hill and Fort Napier were now in the centre of Pietermaritzburg.'¹⁵⁵ Racial segregation of psychiatric patients was not sufficient however, and he pointed out that Town Hill occupied prime city land, which could be developed for residential purposes. There is an irony in the insane of Natal and Zululand occupying land that came to be highly desired by the citizens of the city. There is perhaps another irony in that it was the *apartheid* Minister of Health, Albert Hertzog, who rejected the request to close down Town Hill Hospital, saying that 'The plea for the hospital to be moved resulted from "glittering eyes on that ground."¹⁵⁶

¹⁵⁴ *Natal Witness*, 'Council Gets MP Support Over Hospital', 18 June 1966.

¹⁵⁵ *Natal Witness*, 'Minister Rejects Town Hill Plea', 21 September 1966.

¹⁵⁶ *Ibid.*

Conclusions: Professionals and the positioning of South African psychiatry, 1910–1918

In 1910, psychiatry in South Africa was almost exclusively associated with the asylums that had been established by colonial governments, and with a handful of doctors who, based at these institutions, were acknowledged as being specialists in mental diseases. With the possible exception of the Pretoria Asylum, the asylums inherited by the Union Government of South Africa were overcrowded and in urgent need of upgrading. This was acknowledged by James Hyslop, who had presided over the Natal Government Asylum for more than three decades. He hoped for a more favourable material dispensation under the new state.

Since the 1890s, the NGA had shared the reputation of being the region's most pre-eminent asylum with Valkenberg Asylum at the Cape. At the Select Committee hearings on the treatment of lunacy of 1913, Hyslop and Dodds had been acknowledged as the country's leading experts in their field, but within a year they were both to retire and a new generation of psychiatrists would set about restructuring the legislative basis for the definition and confinement of those who were now termed 'mentally disordered or defective', as well as the institutions that were designed to accommodate them. The most important of these was Dr. John T. Dunston. At the hearings in 1913, Dunston made public his plans: these amounted to the creation of a national asylum system. It was national in that patients were to be allocated to different facilities across the country, on the basis of race and class. It was national in that the psychiatric professionals – the Physician and Assistant Physician Superintendents – were to be rotated around the country in accordance with the decisions of the Commissioner of Mentally Disordered and Defective Persons. The first incumbent of this post was Dunston himself. It was national in that funding to the different institutions was largely determined by Dunston, and his authority extended to the approval of plans and designs for the extensions and alterations that were to be carried out at all the country's mental hospitals. If a problem arose – such as it did in Pietermaritzburg in 1916-1918 – it was Dunston who was the trouble-shooter. One could also add that the system was a nationally South African one, in that the differential allocation of asylum facilities as well as

the use of black patients as estate labour that had begun in the colonial era was expanded and institutionalised to an even greater degree in the twentieth century. As a corollary, far greater resources were dedicated to white patients. The facilities that accommodated greater numbers of black patients therefore stood at something of a disadvantage.

The creation of this asylum system was well under way by 1918. It was not without its problems, however. Few qualified psychiatrists were attracted to South Africa, a situation that was exacerbated by the War. Some South African professionals – such as Dr. Harry Egerton Brown and many nursing staff – served in the Union Defence Forces. Those who remained were overworked and there were reports of several nervous breakdowns amongst the psychiatrists themselves. Moreover, Dunston himself was resented by some and, as shown in his interactions with Brown in 1919 and 1920, was not always sympathetic to the conditions under which some were obliged to work.

In the decade between 1910 and 1920, the Pietermaritzburg Mental Hospital slipped from being seen as a leading psychiatric institution to one that was – in terms of both funding and prestige – ranked more closely with those at Grahamstown (which was relatively small) and at Port Alfred and Fort Beaufort, the latter was for African patients only. This lack of status can in part be explained by the massive shift in the country's economic and demographic gravity to the Rand, but it is also possible – and ironic – that Hyslop's relative success in keeping the NGA facilities for whites fairly up-to-date as well as the significant numbers of black patients at Natal meant that there was less official concern with the Pietermaritzburg Mental Hospital. Animosity from the town's citizens in the years of the War as well as a number of overworked and often ill Physician Superintendents who came after Hyslop, all combined to weaken the institution's image. The relationship between Brown and Dunston – characterized by friction and bitterness – only served to further isolate Natal.

As well as overhauling the country's asylum administration, Dunston was preoccupied with the wholesale reorganization of South African mental science, too. His greatest concern was

with whites, and he devoted more and more of his energies to the identification of, and provision of facilities for, the white feeble-minded and mentally degenerate and disordered. This preoccupation with eugenics was of course by no means unusual for the time, but it did lead to a neglect of the country's mental hospital inmates, the majority of whom were black. Dunston did not go uncontested; again Brown played a role here, but these developments lie largely in the 1920s and 1930s, beyond the scope of this dissertation.

If these decades were marked by a relative lack of professional psychiatric interest in black persons already certified as mad, however, and as others have shown, attempts to know and understand 'the native mind' followed several new trajectories. While biological determinist views continued well into the 1950s in the work and writings of people such as J.C. Carothers in East Africa,¹⁵⁷ the '... psychopathology of the African became increasingly dependent on a representation of something called 'African culture.'¹⁵⁸ Historians, anthropologists, and ethnographers commonly assumed the language of the 'psychological sciences' in seeking to explain the 'essence of primitive mentality.'¹⁵⁹

From the 1920s, these were infused with Freudian terminology as studies sought to explain apparent differences between black and white in terms of weaning practices or local manifestations of the Oedipal complex. For instance, stereotypes of 'the Zulu' were frequently couched in terms of a particular mind-set or attitude. The most notable examples

¹⁵⁷ Carothers believed that Africans' frontal lobes were underdeveloped and, therefore, that they had suffered a 'natural lobotomy'. Ludicrous as this might seem to us now, Carothers' work was highly regarded at the time. In the 1950s, Carothers was employed by the Kenyan colonial government to 're-educate' Mau Mau detainees. M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, California: Stanford University Press, 1991), pp.111-114. Also, J. McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995).

¹⁵⁸ Vaughan, *Curing Their Ills*, p.111.

¹⁵⁹ This phrase is used by Dubow – *Scientific Racism in Modern South Africa* - p.202 - in referring to the works of Dudley Kidd in the early years of the twentieth century, viz. *The Essential Kafir* (London: 1904); *Savage Childhood: A Study of Kafir Children* (London: 1906); and *Kafir Socialism and the Dawn of Individualism* (London: 1908).

of these are the works which characterise Shaka as motivated by a psycho-sexual complex, and as being capable of extreme, even sadistic, cruelty.¹⁶⁰ In similar vein, 'the Zulu' were portrayed in 1932, as practising 'natural eugenics by killing off the weak'.¹⁶¹ Zulu 'nature' was therefore cast in terms of the pathological. There were other frames of reference for portrayals of the Zulu mind, too. As early as 1917, an article by A.T. Bryant, an influential figure in the formation of views about the Zulu, on the 'Mental Development of the South African Native' appeared in the journal *Eugenics Review*.¹⁶²

Also dating from this time was the intelligence testing movement, which 'promised to provide immediate and reliable assessment of intellectual abilities and aptitudes ... (resting) on the claim that they were scientific and objective'.¹⁶³ One of the earliest attempts to use intelligence tests to compare blacks and whites was conducted at the Amanzimtoti Institute and the Adams Practising School. The results of the study - 'Binet-Simon Tests on Zulus' - were published in the *South African Journal of Science* in 1917.¹⁶⁴ By the late 1920s, Natal was regularly used as a data hunting-ground for educationalists and policy-makers interested in establishing the relative mental capacities of whites, Africans and Indians so as to determine and justify the separate and unequal provision of education to different 'races'.¹⁶⁵ In the 1950s, on the other hand, 'Zulu intelligence' was no longer the main interest of

¹⁶⁰ Carolyn Hamilton covers the major representations of Shaka and 'Zuluness' in *Terrific Majesty: The Powers of Shaka Zulu and the Limits of Historical Invention* (Cape Town: David Philip, 1998).

¹⁶¹ S.K. Woods, 'Practical Eugenics in Zululand', 'Notes and Memoranda', *Eugenics Review*, 24, 1 (1932), quoted by Dubow, *Scientific Racism in Modern South Africa*, p. 168.

¹⁶² A.T. Bryant, 'Mental Development of the South African Native', *Eugenics Review*, 9, 1 (1917).

¹⁶³ Dubow, *Scientific Racism in Modern South Africa*, p.209. See, also, Rich, 'Race, Science, and the Legitimization of White Supremacy in South Africa, 1902–1940'.

¹⁶⁴ S.G. Rich, 'Binet-Simon Tests on Zulus', *South African Journal of Science (SAJS)*, 14 (1917).

¹⁶⁵ See M.L. Fick, 'Intelligence Test Results of Poor White, Native (Zulu), Coloured and Indian School Children and the Educational and Social Implications', *SAJS*, 26 (December) 1929.

psychiatrists, psychologists and others, instead papers appeared on subjects such as Zulu mothers' weaning practices and the social context of 'Zulu dreams'.¹⁶⁶

To follow such professional concerns and the discourses of difference that they spun leads us away once more from the experiences of those who were closely identified with the mad of their times: the psychiatrists who diagnosed them and who oversaw the institutions in which they were confined; the staff and the attendants who were responsible for (or who neglected) their day-to-day welfare; the families who sought to have them committed or, alternatively, to have them released. It does even less to tell us about how those who themselves experienced mental illness responded to the institutions of insanity in twentieth century South Africa.

And yet, the formation of the profession of psychiatry in early twentieth century South Africa remains significant in that it helped to foster the growing importance of that sector of medicine in the lives of many. Much as it can be criticised, the Mental Disorders Act of 1916, for instance, and the psychiatric framework it established, did provide for the provision of a series of stages of mental hospital care that could be utilized by those who voluntarily sought to alleviate psychological distress through Western psychiatry. That most of these were white and middle class has been, in part, a consequence of the interests of the profession that had, since the mid-nineteenth century, gradually gained greater influence. However, one of the major themes of this dissertation has been to show the limits of psychiatry in this region in the period up to the end of World War I, and it is important to recall that the professional sector has never achieved a monopoly in claims to healing disturbed states of mind, least of all in South Africa.

¹⁶⁶ R.C. Albino and V.J. Thompson, 'The Effects of Sudden Weaning on Zulu Children', in *The British Journal of Medical Psychology*, 29, 3 & 4 (1956), and S.G. Lee, 'Social Influences in Zulu Dreaming', in *Journal of Social Psychology*, 47 (1958).

Conclusions

Southern Africa today stands in enormous need of mental health services that are both relevant and accessible to the majority of the region's peoples. World Health Organization (WHO) surveys consistently reveal that, around the world, mental health issues are placing increasing demands on public health services.¹ In developing countries, the need is perhaps even more pressing, as the WHO predicts that within a decade or two, 'the biggest disease burden' will be depression and other forms of mental illness. The ravages of the AIDS pandemic in southern Africa have intensified the already crushing pressures on communities, families, and individuals, buckling from decades of political alienation, dispossession, violence, disease and, for many, dire poverty. Nor are existing and mental health services equipped to respond to this alarming situation. Under-staffed and insufficiently funded, there are simply not enough trained and qualified mental health practitioners or social welfare workers to cope with increasing demands.²

In the face of such a bleak outlook, however, since 1994 at least, there has been a widespread – and welcome – public acknowledgement that matters of psychological well-being are essential to overall health, and to healing. This was perhaps most strikingly conveyed through the powerful imagery of the traumatised victims of *apartheid* being supported and comforted as they spoke out at the hearings of the Truth and Reconciliation Commission (TRC), about past atrocities, their anger, and ongoing pain. In addition, and although it may be argued that the South African government needs to pay more than lip service to the benefits of pre- and post-test counselling for those undergoing HIV tests, because of AIDS, counselling, both professional and lay, has

¹ See http://www.who.int/mental_health. Accessed 25 January 2004.

² For the early 1990s, Leslie Swartz gives a ratio of one psychiatrist to 130,500 people in South Africa. If we expand the category of mental health professionals to include psychologists (both clinical and industrial), psychiatric nurses and social workers, the figures are 1:15,200; 1:5,400; and 1:5,200 respectively. Leslie Swartz, *Culture and Mental Health: A southern African View* (Cape Town: Oxford University Press, 1998), p. 79.

acquired a new legitimacy. To be sure, much of the counselling of AIDS-patients falls to voluntary workers who receive only basic training, and on whom the burdens of maintaining confidentiality and of absorbing the anguish of their clients, weigh heavily, but there is now a recognition that the provision of counselling must be an integral part of state-sponsored AIDS-treatment programmes. Mental health issues can no longer be seen as separate from those of individual bodily health, or of being the exclusive province of highly-qualified specialists, particularly psychiatrists, psychologists, and psychotherapists.³

Even were there numerically sufficient numbers of such specialists, it is doubtful however, that professional mental health practitioners would be able to answer the needs of the country's growing numbers of people seeking help for what, broadly speaking, can be termed mental health problems. There are historical reasons for this. Looking to the recent past, and as the TRC Health Sector Hearings on human rights violations revealed, the formalized professions of psychiatry and psychology in South Africa had, during the *apartheid* era failed to broaden their base to include significant numbers of black practitioners; and the academic training of psychiatrists and psychologists discriminated against black students, who had often had to take up post-graduate specialist training at institutions outside South Africa. Nor were some of its practitioners politically neutral: some had been complicit in some appalling instances of abuse – direct or otherwise – of

³ Of course, and as this dissertation has sought to demonstrate, this separation was itself a historically and culturally specific construct that was never embraced by most societies, including many of those of southern Africa. My intention here is to highlight the way in which professional, state-sponsored mental health services are, in some ways, beginning to reflect the break down of this 'Western' construction of the mind/body and mental illness/health dichotomies. That mental health issues associated with the trauma of the AIDS epidemic and post-apartheid socio-economic pressures are expressed in other ways – such as through the idioms of witchcraft – is also significant. For eloquent illustrations of this, see Adam Ashforth, *Madumo: A Man Bewitched* (Cape Town: David Philip, 2000), and 'An Epidemic of Witchcraft? The Implications of AIDS for the post-apartheid State', *African Studies* (Special Edition: AIDS in Context), 61, 1 (2002).

both black and white prisoners and detainees, and of some white troops.⁴ Thus, the establishment of a post-1994 South African psychiatry requires the enlargement of its personnel, and the repudiation of a discredited, political alliance with the former state.

Concerns about the linkages between the South African state and psychiatry had been expressed long before the TRC hearings. In 1979, the American Psychiatric Association conducted an enquiry into allegations of the abuse of psychiatric practices and facilities in South Africa. The committee's report stated that there was '... good reason for international concern about black psychiatric patients in South Africa' and that:

We found unacceptable medical practices that resulted in needless deaths of black South Africans. Medical and psychiatric care for blacks was grossly inferior to that for whites. We found that apartheid has a destructive impact on the families, social institutions, and the mental health of black South Africans. We believe that these findings substantiate allegations of social and political abuse of psychiatry in South Africa.⁵

It found accusations that *apartheid* dissidents were being confined in psychiatric facilities to be unfounded, however, and was '... heartened to discover concern about and criticism of these abusive *apartheid* practices among psychiatrists, physicians, medical students, and nurses in South Africa.'⁶ It noted, too, that white psychiatrists had also been negatively affected by *apartheid*; that most of the distinguished leaders in the field had emigrated, or were about to; and, overall, that 'South African psychiatry, never a

⁴ See Truth and Reconciliation Commission: Human Rights Violations, Health Sector Hearings, Cape Town 17 and 18 June 1997: Available at <http://www.doj.gov.za/trc/special/specialhealth.htm> Accessed 24 January 2004.

⁵ American Psychiatric Association, 'Report of the Committee to Visit South Africa', in *American Journal of Psychiatry*, 136, 11 (November 1979), pp.1498-1506. Quotation from p. 1498.

⁶ Dr. K.G. Fisser, Medical Superintendent of Town Hill and Fort Napier Hospitals in Pietermaritzburg between 1976 and 1983, stated that he and his administration had never been approached by South African government to hospitalize political detainees or prisoners. Interview with Dr. Ken Fisser, Pietermaritzburg, 3 August 2002.

numerically strong specialty, seems dispirited, and it is estimated that only 150 qualified psychiatrists remain to serve a population of 25 million people.⁷

Given the limited number of practitioners, and an association with an oppressive state machinery, it is small wonder, then, that formal, Western-based psychiatry has been of limited relevance to the majority of those South Africans who have sought a remedy for disturbed, distressed or destructive states of mind. Moreover, and as several important studies have shown, a relationship between state ideologies and many aspects of psychiatric practice in this region stretches back much further than the apartheid era, to the foundational years of the discipline and its institutional base – in asylums – in the colonial period.

Focusing on Natal and Zululand between the 1860s and the end of World War 1, this study has charted what might be termed the ‘first phase’ of the practice Western-based psychiatric theory and practice in southern Africa. It has, however, not been concerned only with the interests, discourses and influence of a tiny number of professionals who, from the mid- to late-nineteenth century, introduced then modern asylum practices and facilities to the region. Indeed, in researching these, it is not so much the power of colonial psychiatry that became evident, but its effective limitations.

These were the consequence of a number of related factors: The relatively small number of people actually certified and confined as lunatics during this period; the enormous areas, even amongst ‘specialists in mental and nervous diseases’, of ignorance about the causes of mental maladies and disorders; and the limited extent to which medicine, including psychiatry, reached into areas of human concern and ‘conditions’ that only some time later would come to be regarded as the legitimate concern of psychiatrists rather than of lawyers, judges or gaolers.

⁷ American Psychiatric Association, ‘Report of the Committee to Visit South Africa’, pp. 1498-9.

These areas of ignorance, sometimes due to colonial arrogance, but also rooted in fundamentally disparate cosmologies and epistemologies of illness and health, are most clearly demonstrated in colonial responses to African and Indian idioms of psychological suffering as expressed through spirit possession, such as *indiki* or *ufufunyane*. They could also, as in the case of Nontetha Nkwenkwe in the eastern Cape, be manipulated by state officials who sought, as Edgar and Sapire put it, 'the imprimatur of expert psychiatric opinion'⁸ for the confinement of those who had the potential for stirring anti-state agitation. How typical was such a situation, is, however, impossible to gauge accurately.

Moreover, there were other situations where a *lack* of psychiatric concern had, arguably, tragic implications. Colonial psychiatry, for instance, showed no interest in or inclination to become involved in a court case that had eleven women – the *amandiki* – tried for witchcraft. That they were let off with only a stern warning – though subsequently, some women were punished – owed more to nineteenth century confusions about women, witchcraft and hysteria than it did any humanitarian concern with the *amandiki's* state of mind. I have also argued that, until the early twentieth century, psychiatry remained aloof from understanding suicide as a consequence of mental – or psychological – suffering (and therefore within its ambit) rather than as a moral failing, due to individual weakness. This meant that high rates of self-destruction amongst indentured Indian workers in Natal were not regarded as a psycho-medical problem. Suicide – and alcoholism – did begin to be medicalized towards the late 1800s, but in Natal at least, this occurred firstly for whites. For Africans, psychiatric disinterest combined with the state's restricted surveillance capacity to create a picture of suicide as almost unheard of, a 'taboo surrounded by silence'.

Even by 1910, the majority of persons in Natal – and in South Africa as a whole – of all racial, gender and ethnic backgrounds who were acknowledged in census returns to be

⁸ R. Edgar and H. Sapire, *African Apocalypse: The Story of Nontetha Nkwenkwe, a Twentieth-Century South African Prophet* (Johannesburg: Witwatersrand University Press, 2000), pp. 125-126.

‘insane’ remained outside the direct concern of professional psychiatry and its asylums.⁹ This recognition serves brings us once more to the question of the overall impact of – to use Leslie Swartz’s terminology – the formal, professional, sector of mental health care in South Africa in the period before World War 1. For, what is clear, is that healing strategies and specialists that were located in what have been termed the ‘popular’ and the ‘folk’ sectors continued – as they do today – to be the primary means by which mental illness was treated. Significant, too, is the recognition that not only did the overwhelming majority of Africans and Indians living in Natal and Zululand continue to conceive of, and attempt to alleviate, mental illness in terms of existing therapeutic traditions, but that for whites in the region, nineteenth and early twentieth century psychiatry also represented only one weapon in the armoury against madness, and one that was often only taken as a last resort.

This is not to imply that deny that the experience of institutionalized care and control of those who found themselves within the ambit of Western-based psychiatry in South Africa was in any way insignificant. Clearly, to be identified as insane and confined to an asylum (or, later, mental or psychiatric hospital or ward) on grounds of insanity, idiocy or criminal lunacy – or their later labels – was to undergo an experience that was profoundly shaped by psychiatric theories and practices that were themselves both a part and a product of this region’s history of colonialism, economic exploitation, and intense concern with racial – and other forms of – difference.

As several studies have shown, the history of psychiatry in southern Africa bears the imprint of a legacy in which the unequal provision of facilities, including food, accommodation, and medico-psychiatric attention, was an integral part of the experience of the institutionalization of insanity from the date of its origin in this region, in the nineteenth century. Such practices were, however, initially, not an inescapable

⁹ SC. 14-'13, *Report of the Select Committee on Treatment of Lunatics, May 1913* (Cape Town: Cape Times Limited, Government Printers, 1913), p. xix. Appendices: Tables G ‘Showing Proportion of Registered Population and Total Insane to Total Population, Europeans’, and H ‘Showing Proportion of Registered Population and Total Insane to Total Population, Coloureds’. These figures reflect the 1911 census.

consequence of medical, scientific or constitutional principles: indeed, mid–nineteenth century liberal humanitarianism was responsible for the establishment, in the colonial states, of asylums that, in name at least, were to be the hallmarks of civilized care of the mentally ill. Their genesis was to be ‘consistent with humanity itself.’¹⁰

It was against this background that the Natal Government Asylum (NGA) at Pietermaritzburg in the Colony of Natal, was built. After the accommodation of what were then termed ‘lunatics’ at gaols and hospitals and then in a series of temporary asylums, from the late 1870s, the legally–defined and detained mad of Natal and Zululand were accommodated on the Town Hill, a mile or so outside the city. Construction on what was southern Africa’s first purpose–designed lunatic asylum began in the late 1870s and the NGA opened its doors in 1880. Natal had also preceded the Cape Colony and the Boer Republics in passing, in 1868, legislation providing for ‘the safe custody of persons dangerously insane, and also for the care and maintenance of persons who are insane, but not dangerously so’.¹¹ This legislation stood until the 1916 Mental Disorders Act of the Union of South Africa, which considerably expanded the definition of those considered to be suitable for, or in need of, psychiatric care.

While the history of asylum practice in Natal follows closely that of other comparable institutions – such as Grahamstown and Valkenberg asylums in the Cape – there were some significant differences, too. The NGA, although custom–built as an asylum was not, as Valkenberg was initially, in intention reserved for white patients only. A product of an earlier era of liberalism, the NGA continued to accommodate the mentally ill of the region – African, Indian, and white; men and women – on the same grounds, and overseen by the same senior staff, for more than a century. More notable, perhaps, was the absence of the elaboration of a distinct theoretical basis, predicated upon scientific racist and Social Darwinist understandings of human nature, for distinguishing between

¹⁰ Pietermaritzburg Archives Repository (PAR) Government House 359, Circular Despatch from Secretary of State for the Colonies, 6 April 1864.

¹¹ (Natal) Law No. 1, 1868, ‘The Custody of Lunatics Law’.

the character traits and mental capacities of different 'races'. The person most closely associated with the founding decades in the history of the NGA – which was the seat of colonial psychiatry in Natal – Dr. James Hyslop, was of a tradition of scientific universalism, and under his direction the therapeutic benefits of the asylum were thought to be activated through moral treatment, especially outdoor work on the asylum estate.

In the thirty-two years in which Hyslop headed the NGA, its patient numbers expanded – as was the case everywhere where asylums were found – greatly. In debates about the causes of such an apparent rapid rise in madness, Foucauldian and social constructionist-inspired arguments have focused on the role of a professionalizing branch of medicine, in tandem with a disciplining state, in policing and detaining the socially marginal or those who threatened the borderlines of a patriarchal capitalist order. As a counter-charge, neo-apologists such as Edward Shorter have attempted to demonstrate that there was, in the nineteenth and early twentieth centuries, an increase in some of the material causes of madness; for instance, in neuro-syphilis, and in alcoholism that could result in *delirium tremens* and death. The sections of this dissertation that look at the social profile of the patients admitted to the NGA attempt to locate the inmates, as far as possible, within the socio-economic context of Natal and Zululand. It would appear that material factors did play a role in bringing the insane to the attention of colonial authorities, and perhaps – as, for example, war and troops spread venereal syphilis through the region, and as new, more potent brews of alcohol interacted with a collapse of social drinking taboos amongst Africans to increase alcohol consumption – to lead to an escalation in some illnesses that manifested ultimately in madness.

Another factor in rising asylum inmate populations was the redistribution of the mentally ill: in colonial Natal and Zululand, many settler families lacked a reliable network of relatives possessed of sufficient resources to cope with the mentally unstable, especially if they had become physically threatening. In times of economic hardship, such as in the economic depression of the 1860s and then in the wake of migration to the diamond and gold fields, the colony's lack of social welfare for indigent or needy whites became visible. Under such circumstances, mental insecurity was both exacerbated, and required

institutional responses – the NGA and Grey’s Hospital in Pietermaritzburg often took in persons who were not strictly–speaking in need of institutionalization. Sometimes, admission to an asylum was a temporary measure only, until either the afflicted person improved or family circumstances allowed for an application to be made for the person to be ‘released’ into their care.

This use of the asylum by families as an option, albeit a reluctantly utilized one, in the management of madness has been described in a number of studies of the social histories of madness in Western countries.¹² The practice is, then, not particularly surprising in the context of settlers in Natal, either: more intriguing is the role played by Africans in initiating the process of committal to an asylum. In testimony before a 1913 Parliamentary Select Committee, James Hyslop indicated that, in some cases, it was at the behest of Africans themselves that some inmates had been certified as lunatics and confined as such at the NGA.¹³ From ‘Reception Orders’ dating from 1916, there is some corroborating evidence for this: the case of Bennie Mkize being perhaps the clearest example.¹⁴ The asylum as part of African strategies in restraining the insane, especially the dangerously so, is one that, I would argue, needs to be taken into consideration.

That Indians were so underrepresented in patient numbers at the NGA may have been in part a reflection of both their rejection of Western biomedicine – of which they had some justification to be wary – and a lack of ‘push’ from families seeking to have the state take responsibility for the care and control of Indians who exhibited crazy behaviours. Of course, significant here too was the state’s active repatriation of mentally and physically

¹² See my discussion in Chapter 4, and various essays in P. Bartlett and D. Wright, ‘Community Care and its Antecedents’, in P. Bartlett and D. Wright (eds.) *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (London and New Brunswick, NJ: The Athlone Press, 1999).

¹³ *Select Committee, 1913*, p. 52. Evidence of Dr. J. Hyslop, 16 April 1913.

¹⁴ PAR Registrar Supreme Court (RSC) 1/27 /1, Attorney General to Registrar of Supreme Court, Minute RSCN (M) Mental Disorders Act, No. 38, 1916 (M) 8/16, Bennie Mkize of Rasmani’s Location, Umzimkulu. 21st December 1916. See Chapters 1 and 4.

ill Indians as well as the taking, by several hundred Indians, of a drastic solution to psychological suffering in their own hands, by killing themselves.

If families played an important part in deciding when committal was desirable or no longer avoidable, there are very many instances where this was delayed as long as possible, or where alternatives to the asylum were sought. African concepts of and remedies for illness proved both resilient and highly flexible, taking on board aspects of Western biomedicine and Indian herbal treatments, as well as reworking older ways of naming and describing ailments: understanding the specificities of *indiki* and *ufufunyane* at particular times and places can, for example, or so I have argued, help us to gain insights into the ways in which idioms of psychological distress were expressed. The paths taken to banish the causes of such dis-ease embraced older forms of therapy, as well as newer healing strategies, including Christian prayer, and self-administered medicines and concoctions. The range of these that were available to purchase expanded, especially from the early twentieth century, and whites as well as blacks provided a ready market for healing entrepreneurs of all kinds.

By 1918, the variety of options for those searching for solace from mental illness – or engaged in the quest for a greater degree of mental health – was perhaps at its widest, representing professional biomedical treatment at the NGA (though, in practice, this often amounted to little more than custodial control); popular sector nostrums, potions, dietary regimes, mail-order remedies, love medicines and the like; faith healers, spiritualists, African and Indian *izangoma* and *izinyanga*; and other ‘folk’ healers who promoted their cures. Several states of mind that had not been within the purview of medicine were also becoming more accepted as psychiatric disorders. In an attempt to break down the stigma attached to insanity, and to certification as a lunatic, Hyslop – like his counterparts elsewhere in the country – had endeavoured to diminish the taint of madness by providing facilities at the NGA that were deemed to be appropriate for middle class whites.

This occurred against the background of two important factors: firstly, biomedical doctors sought to raise the status of their profession by claiming exclusivity in legitimacy, in other words, by moving to exclude rival claimants. This process acquired momentum after World War 1, but the Mental Disorders Act of 1916 had already, in the area of mental health, begun to establish with greater precision the persons who could legally, through state and biomedical authorities, be detained on the grounds of being mentally disordered or defective. Secondly, by this time, professional – and state – concern was not so much with the confinement of those who had already exhibited behaviours that could be classified as mad, but with the prevention of the mental and moral ‘degeneration’ of whites. There was, then, less of a focus on asylums – the majority of whose inmates were black – than with the protection and advancement of the ‘mental hygiene’ of whites.

South African psychiatry in its national form after 1910, and more especially after 1918, might be said to represent a ‘second phase’ of its professional history. The fate of individual mental hospitals, including the Pietermaritzburg Mental Hospital, becomes harder to trace, owing in part to the lack of surviving documentation. Dr. J. T. Dunston, Commissioner for Mentally Disordered and Defective Persons from 1916, inaugurated a period of determined expansion of psychiatric facilities, based at the existing asylums, including on the Town Hill at Pietermaritzburg, but war and economic depression combined with racial resentment and economic tensions to ignite a protest against the expansion of the asylum buildings or grounds by white rate-payers. From 1927, a second mental hospital in the city was provided at the old garrison at Fort Napier. It was close to this site that the original location of the NGA had been planned in the early 1870s, but petitioners from the city’s white burgesses had caused the Town Council to reconsider and then to offer the lands on the Town Hill.

Fort Napier was never a satisfactory mental hospital. No substantial improvements were implemented and ‘... the temporary wood and iron structures built to accommodate German internees during the War were retained as wards.’ Fouché notes that World War

2 interfered once more with building reconstruction, and that it was not until the 1950s that these were undertaken.¹⁵ When he took over as Senior Medical Superintendent in 1976, Dr. K. G. Fismer found the therapeutic regimes of the mental hospitals at Town Hill and Fort Napier to be virtually non-existent, and that the wards accommodated many people whose states of mind, had they but received care and treatment, could have improved significantly.¹⁶

Today, Town Hill and Fort Napier continue to be regarded with some ambivalence by the citizens of Pietermaritzburg, and a series of recent tragedies and scandals involving patients has revived public concern about the potential for abuse that exists in psychiatric hospitals.¹⁷ Considerably reduced in extent from the more than 300 acres of grounds that it occupied in the 1960s, Town Hill Hospital is now bounded by the 'new' Grey's Hospital, an upmarket retirement complex, an exclusive hotel and restaurant – on the site of Hyslop's former residence – and a busy road that borders on a burgeoning commercial and light-industrial area. The 400 or so patients who are still accommodated at Town Hill are thus both more in the midst of the city than ever before, and as removed from it as they were in the past.

It is to be hoped that, in the twenty-first century, South African psychiatry is entering a third phase, one that is characterized by a profession that is both supported by the state and independent of it. And yet, once more, it is perhaps not in its institutional setting that the quest for the alleviation of psychological suffering remains the most significant for the majority of South Africans. Western biomedicine occupies an important – but limited

¹⁵ G. Fouché, 'Mental Health in Colonial Pietermaritzburg', in J.P.C. Laband and R. Haswell (eds.) *Pietermaritzburg: A New History of an African City* (Pietermaritzburg: University of Natal Press and Shooter and Shuter, 1988), p. 188.

¹⁶ Interview with Dr. K. G. Fismer, Pietermaritzburg, 3 August 2002.

¹⁷ See, for example, 'A Conspiracy of Silence: A little boy was murdered at Fort Napier and no official is taking the rap', *Natal Witness*, 13 February 1999, and 'When patients come last', *Natal Witness*, 13 April 2002.

– niche in the contemporary panoply of healing strategies. Minds that are out of order or out of control still seek solace from the popular and folk sectors, which continue to offer old and new remedies and solutions. That these have, to a greater extent than ever before, adopted some of the concepts and techniques of more recent developments in ‘professional’ psychology and psychiatry – such as the recognition of the lasting consequences of trauma, of the value of counselling, and of the importance of the interplay between the biological and the social – serves the growing need for ways of achieving mental health that are both accessible and attainable.

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VII. INTERVIEWS

Dr. K.G. Fisser, Pietermaritzburg, 3 August 2002.