

THE FOOLS ON THE HILL: THE NATAL GOVERNMENT ASYLUM AND THE INSTITUTIONALISATION OF INSANITY IN COLONIAL NATAL¹

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Representing one aspect of my wider research into changing perceptions and practices of mental illness and mental health in the period c.1850-1950 in the region that today is KwaZulu-Natal, this paper focuses on the colonial identification and institutionalisation of those deemed insane between the 1860s and 1909. Based on the published statistics pertaining to the Natal Government Asylum (established 1880), I sketch a social profile of those officially certified as being of unsound mind, and suggest some of the reasons why they might have been said to have been so. The paper is divided into six parts. Parts I and II outline some of the methodological difficulties of this area of research, as well as the major debates and controversies surrounding the history of western psychiatry, and the role of the asylum. In Parts III and IV I consider briefly the emergence of colonial medicine and psychiatry in southern Africa and, more particularly, in Natal, in the mid- to late-nineteenth century. The analysis of the Natal Government Asylum statistics forms Part V, while the concluding section raises questions about the influence of colonial psychiatry far beyond the asylum walls.

¹ The title of this paper 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 Sander 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. In the research for and writing of this paper, I've gained enormously from discussions with, and have been assisted by, many people. My thanks especially to Catherine Burns and the members of the KZN Women's Narratives Group, Sydwell Dlamini, Karen Flint, Michael Mahoney, and Steve Terry. This is, however, very much work-in-progress, so please do not quote.

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 A., 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 A. 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 A. 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 A.²*

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

DMJ³

² Town Hill Hospital, Pietermaritzburg. Natal Government Asylum (hereafter NGA) vol. XI (European Patient Case-Book, 1904-1919). 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 A. was admitted to the NGA on 4 September 1908 at the age of 34, and diagnosed as 'Melancholic'. I have followed convention in omitting patients' full surnames so as to protect confidentiality. Whether or not such practices mitigate or reinforce prejudice against the mentally ill remains a moot point. Discussion on the responsibilities of the historian in this regard would be interesting.

³ NGA, vol. XI. Excerpt from a much longer letter pinned to p. 379, with a further letter dated 25 May 1906. The patient, David Morrison J, had been admitted to the NGA on 2 April 1906. Aged 29, and described as a Jewish pauper, he was termed 'clearly insane'.

I.

Built in 1880 on the Town Hill, then on the outskirts of Pietermaritzburg, the capital city of the Colony of Natal, the Natal Government Asylum was southern Africa's first custom-built lunatic asylum.⁴ Until 1927, when black patients were transferred to the disused military barracks at Fort Napier, the Natal Government Asylum (NGA) remained the chief site of detainment for those - white, African and Indian, men and women - who were deemed to be insane. Today, in 1999, and now known as Town Hill Hospital, the asylum still houses nearly four hundred psychiatric patients. Once visible to and overlooking Pietermaritzburg, Town Hill Hospital is no longer on the fringes of the city, and the hospital is now obscured behind avenues of hundred year-old trees and a more recent concrete-paling perimeter fence. Almost as obscure is the history of this institution, its patients, staff, and its role in the formation of psychiatric knowledge and practice in the region, which today is KwaZulu-Natal.⁵

Quoted above are two letters written by patients - or inmates, the terminology is problematic in either case - of the NGA in the early part of this century. Such records represent a rare echo of the voices of those who were confined to asylums. They also illustrate the difficulties of attempting to interpret such writings. At first glance, the letter written by Madeline A. 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.⁶ The extract from the letter to Kitty by David Morrison J., 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 Madeline A. was still a patient in late 1919, when we lose track of her, David Morrison J. was released 'cured' after only three and a half months.

⁴ 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 Harriet Deacon (ed.) *The Island: A History of Robben Island, 1488-1990* (Cape Town and Johannesburg: Mayibuye Books and David Philip, 1996).

⁵ Short pieces about the NGA (later, the Pietermaritzburg Mental Hospital) appear in the general (and generally dated) texts on medical history in South Africa, including E. 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 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). 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).

⁶ For recent overviews of the history of western psychiatry, see Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons, Inc., 1997) and Roy Porter's chapter 'Psychiatry', in his book, *The Greatest Benefit to Mankind: A Medical History of Humanity From Antiquity to the Present* (London: HarperCollins, 1997).

Indeed, in a recent acerbic overview of the historiography of western psychiatry, Edward Shorter remarks 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.'⁷ In a spirited attempt to '...rescue the history of psychiatry from the sectarians who have made the subject a sandbox for their ideologies', and in a no-nonsense rebuttal of some of the more extreme social constructionist and Foucauldian analyses of madness and society, Shorter states that mental illness '...has a reality independent of conventions of gender and class, and this reality can be mapped, understood, and treated in a systematic and scientific way.'⁸ Representing a neo-apologist perspective that is in tune with the current moves towards (re)situating mental illness in terms - to a greater or lesser extent - of biology, genetics, and neuroscience, writers such as Shorter nonetheless concede that: '...how patients experience these conditions [of mental illness, such as schizophrenia or depression], and how society makes sense of them, are indeed subject to the influence of culture and convention.'⁹

It is with these questions, of how a society identifies the mentally ill, that I am concerned in this paper. Based on a particular set of sources, with particular questions in mind, here it is the colonial definition of insanity that will be under scrutiny. My intention is to contribute to the small but growing number of histories of western psychiatry and colonialism in southern Africa. As such, the paper follows the path set by Megan Vaughan, Harriet Deacon, Felicity Swanson, and others in basing their studies on particular asylums.¹⁰ The identification of the insane of Natal and Zululand, is, however, only one aspect of my broader study of changing concepts and practices of mental health and mental illness in this region between the mid-nineteenth and the mid-twentieth centuries. The paper will conclude by raising questions about how significant colonial psychiatric knowledge in the period may have been in the construction of racist discourses and practices beyond the asylum grounds.

⁷ Shorter, *A History of Psychiatry*, p.ix.

⁸ *Ibid.*, p.viii. I am sure that Shorter would add 'race and culture' to the categories of gender and class.

⁹ *Ibid.*

¹⁰ Megan Vaughan, 'Idioms of Madness: Zomba Lunatic Asylum, Nyasaland, in the Colonial Era' in *Journal of Southern African Studies*, 9, 2 (1983); Harriet Deacon, 'A History of the Medical Institutions on Robben Island, Cape Colony, 1846-1910' (Ph.D. dissertation, Cambridge University, 1994); Sally 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); Felicity Swanson, 'Colonial Madness: The Construction of Gender in the Grahamstown Lunatic Asylum, 1875-1905' (History Honours thesis, University of Cape Town, 1994); R. Warwick, 'Mental Health Care at Valkenberg Asylum, 1891-1909', (History Honours thesis, University of Cape Town, 1989). Also, Jonathan Sadowsky 'Imperial Bedlam: Institutions of Madness and Colonialism in Southwest Nigeria' (unpublished Ph.D. dissertation, Case Western Reserve University, 1996?).

II. Asylums and Alienists

From uncritical histories of scientific progress and dawning enlightenment in the treatment of the insane, through exposes of gothic horror and inhumane treatment, to an agent of social control and repression, the asylum¹¹ has been the focus of considerable attention.¹² As 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. New categories of mental disease were identified, new causes of insanity proposed, and a range of new treatment regimes explored. After the 'madhouses' of the Middle Ages came 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.'¹³

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.¹⁴

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, Robert 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:

¹¹ Terminology was fluid throughout the nineteenth and early twentieth centuries. In Natal, the NGA was, for a short time, known as the Natal Government Lunatic Asylum. As definitions and descriptions of mental illness underwent discursive shifts as the result of both developments in psychiatric study and wider social factors - such as Social Darwinism and the articulation of scientific racism - so too did the names given to institutions. After World War I 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 aetiology of mental disease. In the NGA records, medical personnel initially used the term 'insane', while the later records also refer to 'mental disorder'.

¹² It is not possible here to provide a fuller account or bibliography of the now extensive literature on the history of asylums and psychiatry. Shorter's *A History of Psychiatry*, Chapters 1 and 2, and Porter's *The Greatest Benefit*, Chapter XVI are both good broad surveys. Sally Swartz's 'Colonialism and the Production of Psychiatric Knowledge in the Cape' has a thorough review of the literature.

¹³ Porter, *The Greatest Benefit*, p. 494.

¹⁴ See Shorter, *A History of Psychiatry*, Chapters 1 and 2.

...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 process¹⁵

From the 1970s, feminist analyses of psychiatry added further fuel to the funeral pyre of legitimacy for asylums,¹⁶ 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.

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. Of enormous significance to the more recent studies of the social history of medicine - and to questions about psychology more generally - is the issue of culture and mental health/illness.¹⁷

The question of defining and identifying mental illness is likely to remain unresolved and contested: 'hostage to the mind-body problem', as Roy Porter recently put it, 'buffeted back and forth between psychological and physical definitions of its object and its techniques.'¹⁸ However, 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?

¹⁵ Porter, *The Greatest Benefit to Mankind*, p.522.

¹⁶ For example, Phyllis Chesler, *Women and Madness* (New York: Doubleday, 1975); Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (London: The Women's Press, 1979); Elaine Showalter, *The Female Malady: Women, Madness, And English Culture, 1830-1980* (New York: Pantheon Books, 1985).

¹⁷ Leslie Swartz's *Culture and Mental Health: A southern African View* (Cape Town: Oxford University Press, 1998) is an excellent introduction to this immense and complicated debate.

¹⁸ Porter, *The Greatest Benefit*, p.523.

III. Asylums in Africa: The Creation of a Colonial Psychiatry

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?'¹⁹ 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.²⁰ 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'.²¹ 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 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'.²²

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.²³

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

¹⁹ Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, California: Stanford University Press, 1991), p.8.

²⁰ *Ibid.*, p.ix.

²¹ *Ibid.* There have been few attempts by historians to examine the ways in which Africans or other colonial subjects in southern Africa defined and treated mental illness. The few studies of which I am aware are by anthropologists who, while considering the maintenance of mental health as a central part of a holistic therapeutic system, have rarely attempted to trace the ways in which these definitions have changed over time. This will be an important part of my dissertation. The focus of this paper is, however, on colonial/western psychiatry.

²² *Ibid.*, p.10.

²³ *Ibid.*, p.11.

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 intense interest and concern to professional and lay-persons alike.²⁴ 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 southern Africa, in the late nineteenth and early twentieth centuries such beliefs became grist to the mill of segregationist discourses and practices.

But, back to asylums: In his recent *Anatomy of Power: European Constructions of the African Body*, a genealogical study of the texts and discourses that 'produced the African mind and body', Alexander 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 From the 1880s, the first specialists in mental illness arrived from Britain - the majority of who 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 contributed 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

²⁴ 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 Saul Dubow, *Illicit Union: 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.

²⁵ Alexander 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. It is also not clear why Butchart claims (p.112) that this 'first glimpse' took place at Town Hill Hospital [sic] at Pietermaritzburg' in 1875. Sticking - like superglue - to a Foucauldian analysis, Butchart holds that: 'To search any earlier for signs of the African psyche is to 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 Lunacy Law 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 - reshapings of western views about medicine, psychiatry, mind, or body. Such discourse analyses are interesting and important, but seldom require the author to enquire about the closeness of the fit of the analysis to the fragments of life and experience that we have available to us through arduous archival and documentary research.

Valkenberg Asylum in Cape Town in the period between 1891 and 1920.²⁶ 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'.²⁷ Further, she describes how a distinct form of psychiatric knowledge developed in the Cape. She argues that:

(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.²⁸

Section V of this paper - which relies heavily on the methodology used by Swartz, and which will refer to her findings for the purposes of comparison - will outline a social profile of those deemed insane in Natal in the period between c.1868 and 1909. In this way, it may be possible to highlight the commonalities as well as the regional differences in asylum practice and in the social conditions which played a part in both the experience of, and the production of knowledge about, mental illness in late nineteenth and early twentieth century southern Africa.

IV. Madness, medicine, and the state in Colonial Natal

If, as Butchart maintains, 'the African psyche' did not - and could not - exist before the 1870s²⁹, the inhabitants and lawmakers of Natal were nonetheless troubled by the mad in their midst much earlier than this. As early as 1855 the Pietermaritzburg Town Council agreed to grant fifty acres of land on Town Hill to the colonial government '...for the sole purpose of establishing a Public Lunatic Asylum'.³⁰ Then, as now, delivery took some time and it was not until 1873 that the Deed of Transfer was signed.

²⁶ See footnote 10. 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).

²⁷ *Ibid.*, p.5.

²⁸ 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. Swartz, (p.8) argues that 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.

²⁹ Butchart, *The Anatomy of Power*, p.112. I have commented on this in footnote 25.

³⁰ G. Fouché, 'Mental Health in Colonial Pietermaritzburg', p.186.

Natal was, in the early 1870s, only just beginning to emerge from a severe economic depression, and it took until 1876 for the Colonial Secretary to authorise the expenditure of £20,000.00 for the construction of a lunatic asylum based on 'the latest and most approved design.'³¹ The Natal Government Asylum was opened in February 1880.

In the meantime, 'lunatics, epileptics and idiotics' were accommodated, firstly, at gaols and hospitals around the colony, and, after 1875, at a temporary asylum in Pietermaritzburg. Right from the start, male inmates outnumbered females. In 1874, for example, the temporary asylum accommodated five women and twenty-nine men.³² Until the late 1890s, the numbers of 'European' and 'Native' men were roughly equal, while only a handful of Indian men and women were admitted during this period.³³ We have little information about these people, and the circumstances surrounding their confinement are obscure. That they were a source of concern, however, seems clear. Arising from contemporary anxieties about the abuse of patients in asylums and following British precedent, a Board of Management was appointed. Consisting of the Colonial Secretary, the Mayor of Pietermaritzburg, and a 'private citizen', the Board was entrusted with 'the proper running' of the temporary asylum.³⁴ John Smithwick - formerly a sergeant in the 75th Regiment - was appointed as Natal's first 'Keeper of Lunatics' - thus reinforcing the notion of the custodial, rather than the therapeutic, role played by asylums at this time.

For reasons that I have not yet been able to pin down, legislation in Natal authorising the detention of 'lunatics' was passed at what seems to be a relatively early date. Certainly, 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' was promulgated well in advance of most other health-related legislation in the colony. In fact, this law predated similar Cape legislation by eleven years. In a discussion of the history of mental health law in South Africa, Kruger points out that:

³¹ Ibid.

³² Natal Blue Book (NBB), 1896: Hospital and Asylum Returns. Natal Government Asylum, Medical Superintendent's Report and Statistical Tables. 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.

³³ Ibid. The NGA records and the published Blue Book Statistical Tables use the then current terminology of 'Europeans', 'Natives', and 'Indians'. Not until 1918 was the category 'Coloured' 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 is not intended to be offensive. This is also the case with such terms as 'epileptic', 'paralytic', 'idiot', and so on.

³⁴ Fouché, 'Mental Health in Colonial Pietermaritzburg', p.186.

... 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.³⁵

In the mid- and late 1860s trade stagnation and economic recession led to an increase in poverty, crime, drunkenness, and other forms of socially disruptive behaviour in Natal, particularly in the towns of Pietermaritzburg and Durban. 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.³⁶ 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 Act firmly entrenched colonial legal and medical practitioners as the authorities who had the knowledge and power required to define and detain lunatics. Both entry to and exit from the asylum were conditional upon the issuing of medical certificates. Section 1 required that '... if a person is discovered under circumstances denoting derangement of the mind, and a purpose of committing suicide or a crime for which he could be indicted...³⁷, the resident magistrate call upon two medical practitioners to assist him. If they were satisfied that the person was a 'dangerous lunatic or dangerous idiot', the magistrate could issue a warrant for the committal of that person to a gaol or public hospital. Release could be granted by a Supreme Court judge, or the Lieutenant Governor could effect a transfer to a lunatic asylum. Several safeguards, against maltreatment and of the unlawful detention of sane persons, were built into the Act.

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. Further sections allowed for the Lieutenant Governor to order the examination of a person's mental condition on the request of a relative, and for insane persons to be released into the care of their next of kin. It is interesting to note that, while the Cape Act No. 20 of 1879 was almost a verbatim copy of the earlier Natal Act, the former omitted Section 7. This stated that if the patient had no relative or guardian easily accessible such an

³⁵ A. Kruger, *Mental Health Law in South Africa* (Durban: Butterworth, 1980), pp.16 and 17 (footnote 58). This Act remained in force until 1916, when it was superseded by the Mental Disorders Act. The only modification to the 1868 Act came with the short Act (Law 8) of 1891, which clarified responsibility for the costs of maintenance of lunatics in asylums. The 1916 Mental Disorders Act remained in force, with a number of amendments until the passing of the Mental Health Act in 1973. Kruger, p.21.

³⁶ For a fuller discussion, see Julie Parle, *The Impact of the Depression Upon Pietermaritzburg During the 1860s* (unpublished M.A. thesis, University of Natal, Pietermaritzburg, 1988).

³⁷ Kruger, *Mental Health Law in South Africa*, p.17.

application could be made by '... any person or society under whose protection or care such insane person shall actually be for the time being...'.³⁸ In the case of Indian inmates, it was not infrequent that this application was brought by their employers in Natal. The Act did not attempt to define lunacy or insanity, and the mechanisms for detaining and committing 'ordinary lunatics' were inadequate, probably technically illegal.³⁹

While private patients were admitted to the NGA - and usually brought in a not insignificant source of income - it seems accurate to say that from the 1860s colonial medicine and the state combined in extending their influence over those who crossed the borders between sanity and insanity, normality and abnormality, individual eccentricity and threat to the social order. From the 1880s the alliance between Natal's emergent medical establishment and the colonial state was strengthened through the person and activities of James Hyslop, M.B., C.M., (Edinburgh). Appointed as first Resident Surgeon of the NGA on 21 June 1882, and licensed for practice in Natal in August of the same year, Hyslop headed the NGA until his retirement in 1914. 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'⁴⁰, 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 Natal 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.⁴¹

³⁸ Pietermaritzburg Archives Repository (PAR), Natal Colonial Publications (NCP) 5/2/3-5/2/10. Law No. 1, 1868. Section 7.

³⁹ 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.

⁴⁰ Obituary, *South African Journal of Science* (hereafter *SAJS*), 14 (1917-1918), p. 312.

⁴¹ 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*, vol. II. (Cape Town and Johannesburg: Tafelberg-Uitgewer Ltd., 1972), p.325; and Obituary in the *SAJS*, 14 (1917-1918), pp.312-314;

Indeed, Hyslop became 'a Natalian through and through'.⁴² 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 as a gentleman should'.⁴³ More than this, he was described as being '*persona grata* in Government circles'.⁴⁴ 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. 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 1917.⁴⁵

These positions, this combination of 'mental and military work',⁴⁶ as well as his reputation as a 'specialist in mental diseases', made it likely that Hyslop received considerable respect, and that his views on a variety of subjects would be influential in colonial society. It is difficult to know, however, exactly *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. Unlike his counterparts at the Cape - many of who shared his social and medical background - Hyslop did not publish widely in the medical journals.⁴⁷ His only published paper - which I have not yet been able to locate - was titled: 'An Investigation into the Anatomy of the Central Nervous System'.⁴⁸ Hyslop's apparent interest in the organic origins of mental disease may well have been a legacy of the time he spent in Germany and Austria. Writing of the differences between British and German strands of psychiatry in the mid-to-late nineteenth century, Roy Porter notes that the latter tended towards attempts to establish 'scientific understanding of psychiatric disorders through systematic observation, experimentation and dissection'.⁴⁹ Porter adds that this focus on the somatic origins of mental disease

⁴² Burrows, *A History of Medicine in South Africa*, p.219.

⁴³ Obituary, *SAJS*, 14 (1917-1918), p.313.

⁴⁴ *Ibid.*, p.314.

⁴⁵ *Ibid.*, pp.312-314.

⁴⁶ *Ibid.*, p.312.

⁴⁷ 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.

⁴⁸ Obituary, *SAJS*, 14 (1917-1918), p.313.

⁴⁹ Porter, *The Greatest Benefit*, p.509.

meant that German psychiatrists tended to be less therapeutic in orientation than their British counterparts. Hyslop himself frequently bemoaned the lack of dissection facilities at the NGA, 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...⁵⁰

A belief that mental disease or disorder had an organic basis did not mean that treatment had to take a biological or chemical form. Hyslop appears to have been strongly convinced of the benefits of 'moral therapy'. First elaborated in the early nineteenth century, moral treatment required that patients be taught to control their 'passions' through routine and meaningful employment. Immediately inhibiting physical restraints were removed, and instead inmates were subject to staff surveillance and to the discipline of a strong father figure in the form of the Superintendent, and expected to conform to a 'family' atmosphere.

As soon as he took over at the NGA, Hyslop began to employ these - at the time modern - methods. All patients were encouraged to become involved in the gardens and fieldwork - over two thousand trees were planted - or in the laundry, or on the asylum farm. From the start, however, 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 coerce African women inmates to 'employ themselves usefully'. His eventual solution must, however, raise serious questions about the extent to which Hyslop's commitment to 'moral treatment' was compromised by racist and sexist convictions. 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 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.⁵¹

⁵⁰ NBB, 1893-1894: Asylum Return and Statistical Tables, Medical Superintendent's Report. In his 1898 Report, he again asked for a post-mortem room for such examinations 'to which so much importance is attached in the Home Asylums', and called for the colonial government to create a post for a pathologist in Natal.

⁵¹ NBB, 1887. Lunatic Asylum Returns, Report By Resident Surgeon, Lunatic Asylum.

It is perhaps wise at this point to recall to Shorter's injunctions against selective quotation. I also do not wish to put forward a straight-forward 'doctors-as-agents-of-empire' argument, for, 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 conscious intent of sinister doctors ... 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.⁵²

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 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.⁵³ 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?

Unfortunately, I do not have space here to explore fully the history of the NGA under Hyslop. Instead, I wish to return to the questions raised earlier about the patients themselves: who were they, and why were they there? What can we know about the ways in which insanity was defined in colonial Natal?

⁵² Sadowsky, 'Imperial Bedlam', p.8. Vaughan and Swartz also caution against an over-simplification of the view of western medicine and doctors as agents of empire.

⁵³ 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.

V. The Fools on the Hill

i. The Sources

In trying to answer these questions, we are faced, paradoxically, 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 these statistical tables which I attempt to interpret below. 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, 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 patients was kept at the NGA itself. Sometime after 1910 these documents were transferred to loose-leaf folders. These have been lost or destroyed.

We also have precious little clinical information: until around 1904, Hyslop and his later deputies, Drs Aitken, Glashan, and Egerton Brown, entered clinical information in large leather-bound Case-Books. Several of these Case-Books survived at Town Hill Hospital until about 1980, but only one remains today.⁵⁴ 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 - initially a whites-only institution - separate books were kept for men and women. In her finely-nuanced study of the Valkenberg series (248 patient folders from the period 1891-1920), Sally Swartz reads the statistical tables and other surviving documentation as texts that reveal in complex ways how

⁵⁴ 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. The loss, theft or destruction of the other volumes highlights the disturbing and distressing rate at which such valuable documentation is disappearing, the result of indifference as well as intention.

psychiatric knowledge was constructed at the Cape.⁵⁵ In short, an analysis of the forms and tables provided physicians with guidelines for describing forms of insanity, and for stripping 'lunatics' of their individual identity, transforming them from people to 'cases'. This was doubly so in the case of black patients. In fact, 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. For this reason - and because only one such source has survived anyway - it seems unlikely that it is possible to (re)construct a psychiatric profile of the NGA patients. 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.

ii. Race and Gender in the Admissions, 1864-1909

On 31st December 1909, on the eve of Union, Madeline A. 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.⁵⁶ 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. The Natal census of 1904 showed the following figures: whites 50,321; Indians 59,776; and 'Natives' 554,744.⁵⁷ 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.'⁵⁸ Later, fears about rising rates of insanity and feeble-mindedness amongst whites would feed more directly into eugenicist discourses and practices both in Natal and in South Africa as a whole.

Figure 1 shows the total annual admissions to the NGA between 1880 and 1909.⁵⁹ Increases in patient

⁵⁵ 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 'Colonialism and the Production of Psychiatric Knowledge in the Cape'.

⁵⁶ 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.

⁵⁷ Figures quoted in *Twentieth Century Impressions of Natal: Its People, Commerce, Industries, and Resources* (Natal: Lloyd's Greater British Publishing Company, 1906), p.64.

⁵⁸ NBB, 1897. Asylum Returns. Medical Superintendent's Report.

⁵⁹ 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

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. 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.

FIGURE 1: NGA, 1880-1909: Annual Admissions

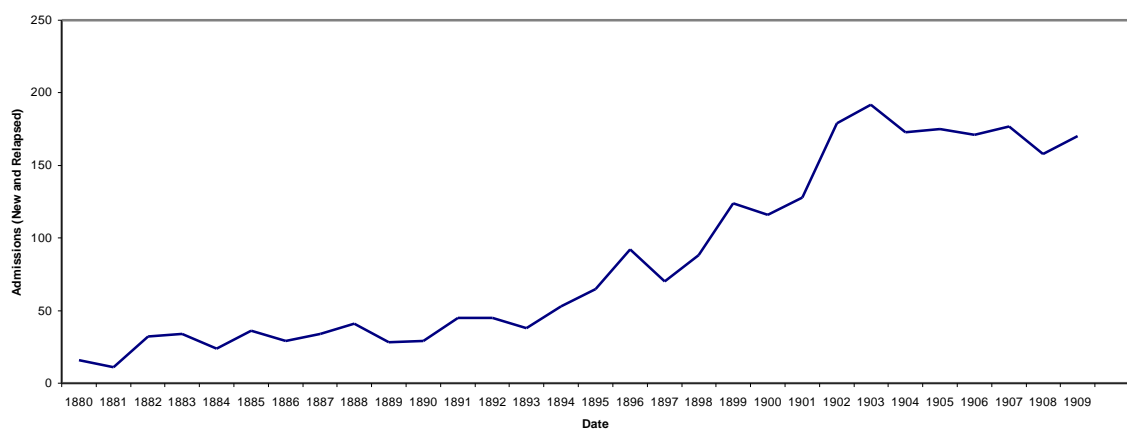
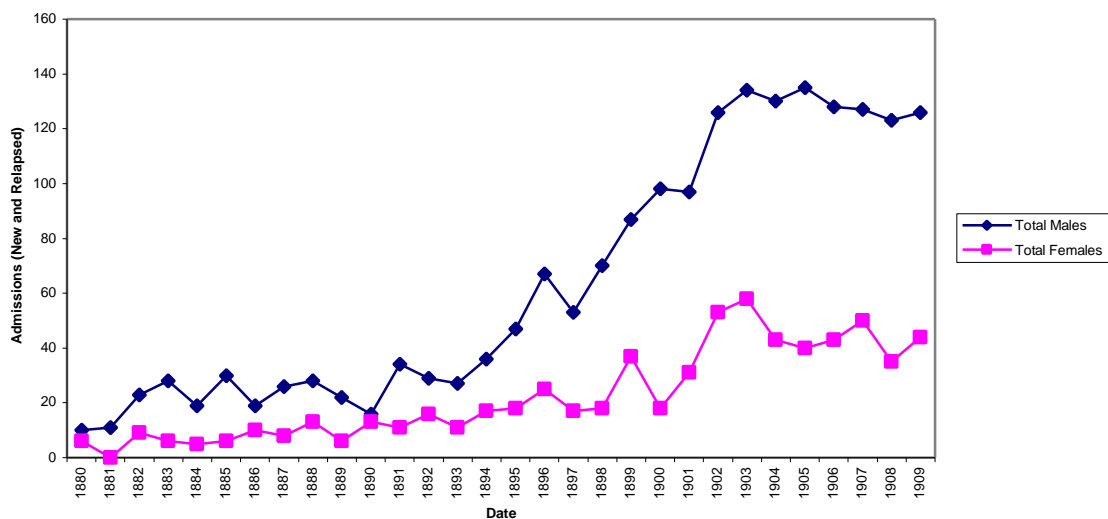


FIGURE 2: NGA, 1880-1909: Annual Admissions (Male and Female)



some of the relevant figures for these years. It is not clear why these years should be missing from the published record.

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.⁶⁰ 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%⁶¹ 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 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.

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.

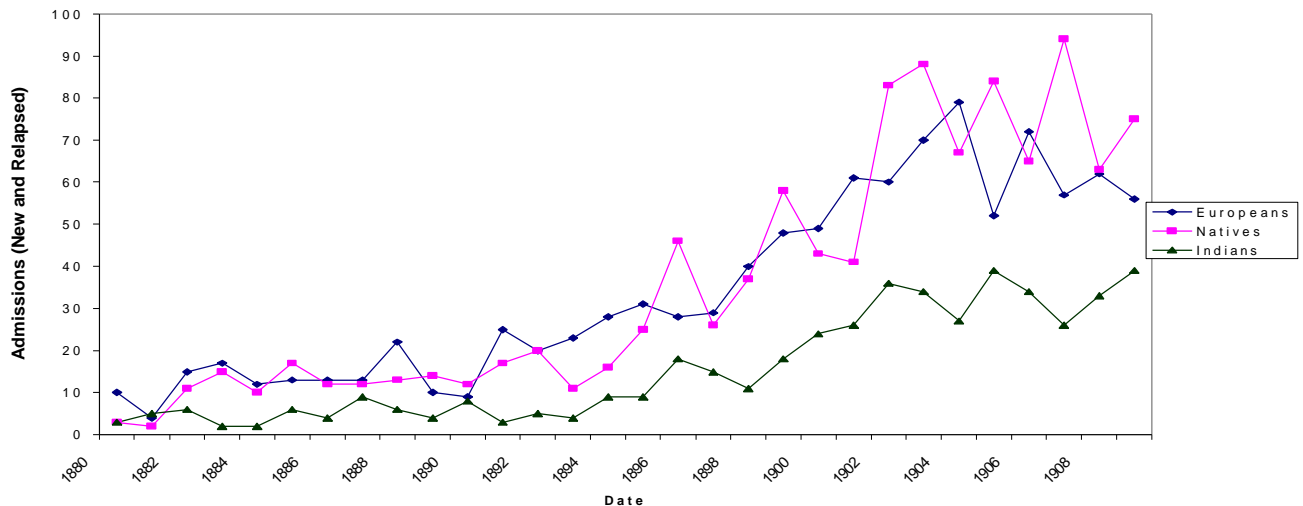
The late 1890s, as many have attested, were a time of great economic and social hardship and upheaval for many of Natal and Zululand's Africans. Political turmoil was accompanied by a devastating series of natural disasters - plagues of locusts, drought, famine, and an epidemic of rinderpest - which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

⁶⁰ *Twentieth Century Impressions of Natal*, p.65.

⁶¹ *Ibid.* This refers to both Natal and Zululand.

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.⁶²

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



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.'⁶³

The vast majority of inmates - of all races and of both sexes - were between the ages of 25 and 45 on admittance.⁶⁴ 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'. Hyslop was never comfortable with their presence, 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

⁶² See John 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 Jeff Guy, 'Gender oppression in southern Africa's precapitalist societies' and Cherryl Walker, 'Gender and the development of the migrant labour system c.1850-1930', in Cherryl Walker (ed.) *Women and Gender in Southern Africa to 1945* (Cape Town: David Philip, 1990).

⁶³ NBB, 1900. Report of the Medical Superintendent, Natal Government Asylum, For the Year 1900.

⁶⁴ The pattern was similar at Valkenberg, where approximately two-thirds of admissions were aged between 25 and 44.

of a little 'teaching...under the care of specially trained nurses' - but that their presence was disruptive for the older patients.⁶⁵ His hope that these children would be catered for elsewhere was not realised, and by 1909 there were thirteen patients aged between fifteen and twenty; however, there were only two between the ages of ten and fifteen.

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 '...while marriage significantly improves the likelihood of men avoiding hospitalisation for mental illness, it may increase the likelihood for women.'⁶⁶ 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.⁶⁷ 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

⁶⁵ NBB, 1898: Report of the Medical Superintendent, Natal Government Asylum, For The Year 1898.

⁶⁶ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p.42.

⁶⁷ 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 Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), pp.110-117.

kept occupied by 'household and domestic duties'. White women had a slightly greater range of 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'.⁶⁸ No such enquiry was held. I hope that further archival research into the collections of the Indian Immigration Office will throw further light on the histories of these persons.

iii. Prognosis: Recoveries, Discharges and Deaths

What does seem surprising, at first glance, is that Indian inmates had a higher recovery rate than any other identified category of patients. In terms of conditions of accommodation and diet, patients were - from the earliest days - segregated by race and sex. Sexist and racist assumptions permeated psychiatry at this time, and served to justify differential diagnoses and treatment. 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 of each year.⁶⁹ 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

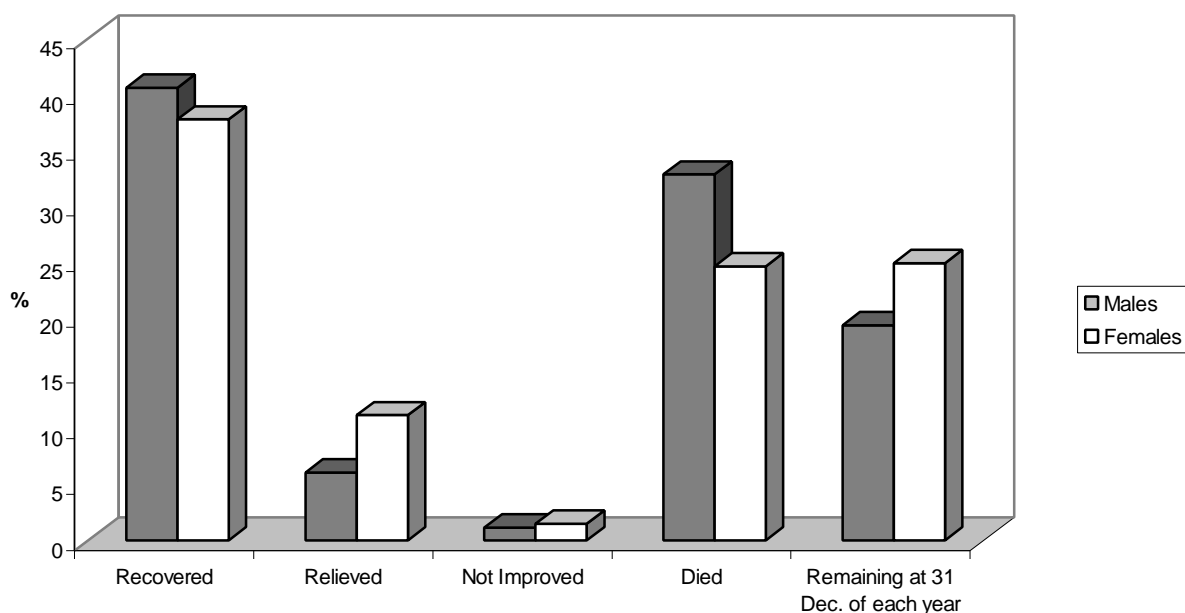
⁶⁸ *Indian Opinion*, 4 June 1904, quoted in Surendra Bhana and Bridglal Pachai (eds.) *A Documentary History of Indian South Africans* (Cape Town and Stanford: David Philip and Hoover Institution Press, 1984), p.20.

⁶⁹ 'Patients Discharged' was further divided into patients discharged as 'relieved', as 'recovered', or as 'not improved'. Discharge, therefore, does not necessarily indicate full recovery.

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 1891-1920.⁷⁰ 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'.⁷¹ 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 relatively high.

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

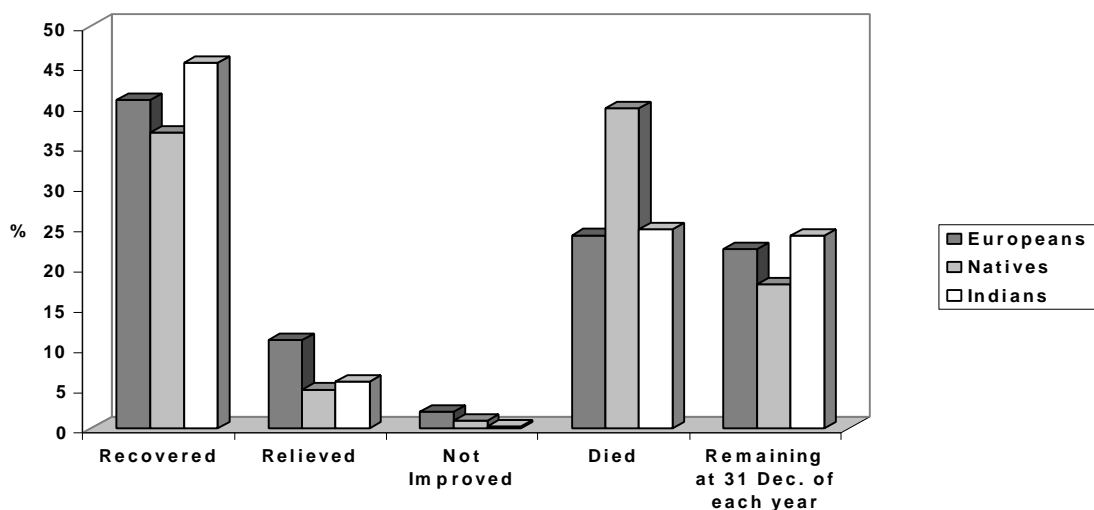
⁷⁰ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p.46.

⁷¹ Ibid., Appendix 2, Table 7a.

of long-term chronic patients. The same pattern has been discerned in a wide variety of studies of asylum populations around the world.⁷² 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 or 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.

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. 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.⁷³ This would appear to support the proposition that African people at this time would only seek admission to facilities such as asylums for

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



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 stipulated diet scales, might well have further lowered black inmates' resistance to disease. Writing in 1988, Fouché

⁷² For example, see Richard W. Fox's pioneering statistical and cultural study, *So Far Disordered in Mind: Insanity in California, 1870-1930*, pp.104-135.

⁷³ NBB, 1897. Asylum Returns: Medical Superintendent's Report.

commented: '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.'⁷⁴ 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' 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%.⁷⁵

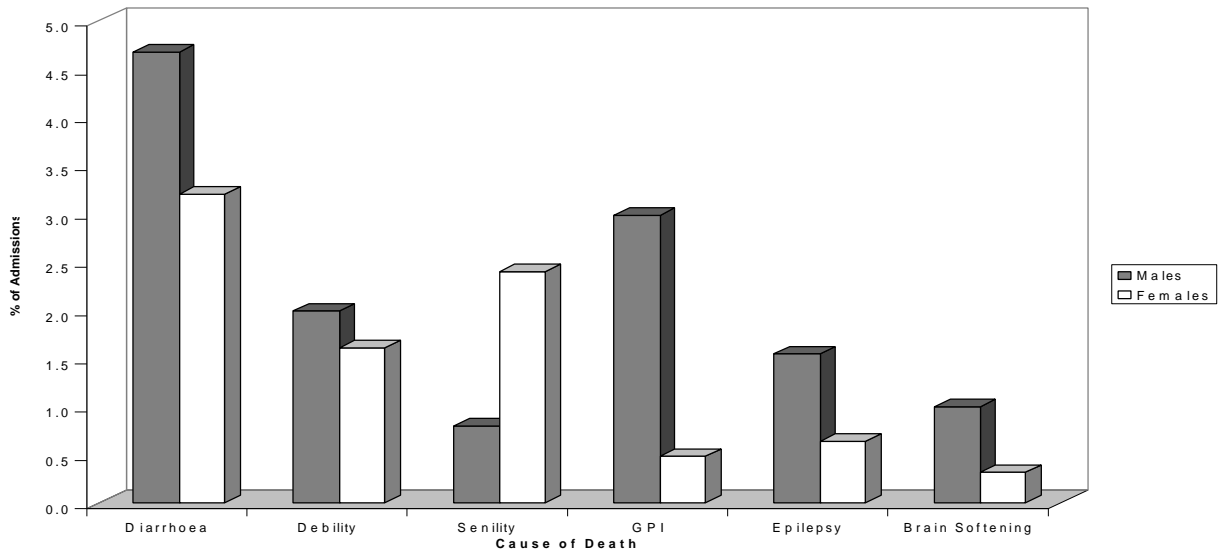
From 1870 onwards the Annual Reports recorded causes of male and female patient deaths in increasingly detailed Obituary Tables. By the 1900s, these tables listed more than twenty causes of death under four major headings (viz. Cerebral and Spinal Diseases, Thoracic Diseases, Abdominal Diseases, and 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 6.⁷⁶ 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.

⁷⁴ Fouché, 'Mental Health in Colonial Pietermaritzburg', p.186.

⁷⁵ *Twentieth Century Impressions of Natal*, p.66. Unfortunately, this source does not give mortality rates for Africans and Indians in the urban areas.

⁷⁶ 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. 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.

iv. Aetiologies of Mental Illness, 1895-1909

On 21 May 1906, Frank S., 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'⁷⁷. 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.'

⁷⁷ NGA, vol.XI, European Patient Case-Book, pp.433-435.

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.⁷⁸

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 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.⁷⁹

The notes kept on Frank S. 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'.

⁷⁸ Ibid., Carbon copy of 'Confidential Report', pinned to p.434, and signed by P.S., Durban, 19th June 1906.

⁷⁹ Ibid.

Frank S.'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 developments in Europe after the late eighteenth century, 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.⁸⁰ 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.⁸¹

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.'⁸² 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.⁸³

⁸⁰ 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.

⁸¹ NBB 1905, Report of the Medical Superintendent, Natal Government Asylum, for the Year 1905.

⁸² *Ibid.*

⁸³ Both Shula Marks's *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) and McCord's *The Calling*, describe the efforts of families of mentally disturbed people to negotiate between African and western forms of therapy. In both instances, eventual confinement in an asylum was the result.

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 disorder.'⁸⁴ 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 S., in colonial Natal, possibly suffered from both.⁸⁵ Unfortunately, the histories of the spread of syphilis and of alcohol production, distribution and consumption in this region have not yet been written, but we know that they were on the increase in the late nineteenth and early twentieth centuries. Although I have not made a systematic record, the Resident Magistrate's Reports frequently mention syphilis. It is clear that alcoholism was a chronic problem in Pietermaritzburg, especially amongst white men,⁸⁶ and a recent study of the Lower Tugela region shows that, during this time, new patterns of alcohol consumption amongst Africans were emerging. *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.'⁸⁷

Table 1, on p.31, 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

⁸⁴ Shorter, *A History of Psychiatry*, p.53.

⁸⁵ 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.

⁸⁶ 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.

⁸⁷ Michael 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 '*isiShimiyana*', or treacle-mead drinkers, of Natal. These extreme effects were said to be unknown amongst *utshwala* drinkers.

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.⁸⁸ 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.'⁸⁹

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.'⁹⁰ 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 enormous concern for both psychiatrists and for the colonial state. These fears served as a rationalisation for segregation.⁹¹ 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. Clearly, I need to investigate this issue further.

⁸⁸ 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.

⁸⁹ NBB, 1904. Report of the Medical Superintendent, Natal Government Asylum For the Year 1904.

⁹⁰ *Ibid.*, p.108.

⁹¹ S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', pp.113-116, and Dubow, *Illicit Union*.

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	
Veneral 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	

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 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 high recovery 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.

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 in the '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 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'.⁹² 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 best, 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.

⁹² Butchart, *The Anatomy of Power*, p.112.

v. Diagnoses, 1870-1909: Wild Women and Melancholic Men?

Throughout the nineteenth century, psychiatrists developed new nosological categories,⁹³ and these changing forms of diagnosis are mirrored in the NGA statistical tables after 1894. Until this date, the 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'.⁹⁴ 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. In any case, the figures require further interrogation.

Figure 7: Diagnoses, 1870-1894

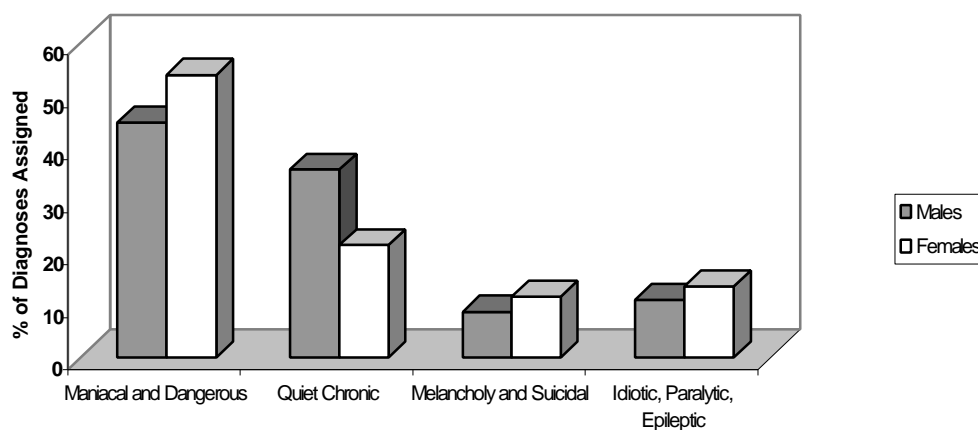


Table 2 gives some idea as to the way in which diagnostic categories became considerably more complex over time. The dates in brackets indicate the category's first appearance in the NGA

⁹³ See Shorter, *A History of Psychiatry*, pp.99-112.

⁹⁴ T. Duncan Greenlees, 'Insanity Among the Natives of South Africa', *Journal of Mental Science*, 41 (January 1895), p72.

nosological tables. The over-arching framework of mania, melancholia and dementia remained in place for some time.⁹⁵ Mania, 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 category⁹⁶. 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.⁹⁷ 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. The reasons for Natal's unusual pattern of diagnosis are, as yet, unclear.

This analysis of the NGA statistics illustrates many of the methodological and theoretical problems surrounding the study of asylums and of the institutionalisation of insanity raised in the opening sections of this paper. 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. I can only raise here the question of why this might have been so. 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. Similarly, a study

⁹⁵ 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 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.

⁹⁶ 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.

⁹⁷ *Ibid.*, p.103.

such as this that focuses on people-as-statistics both highlights and obscures the lived experiences of those whom it discusses. In the case of the vast majority of those admitted to the NGA, however, these statistics are all that remain.

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

VI. Epilogue and Conclusion

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. Between 1876 and 1895, lunatic asylums - many of which are still in use today - were established in all four of the future provinces.⁹⁸ This period also saw the creation, in both theory and practice, of a psychiatry that was profoundly shaped by its colonial context, making clear distinctions between people, not only on the basis of sanity and insanity, normality and abnormality, but also on the grounds of race and sex. The story of the Natal Government Asylum as a focal point in the creation of psychiatric knowledge and practice in this region is only just beginning to be told.

After 1909, however, it becomes more difficult to trace the history of this particular institution. While mental matters were a matter of enormous and pressing concern to the new state, the statistics that are reproduced in the reports of the Commissioner of Mentally Disordered and Defective Persons (as he was termed from 1916, and from the 1920s, Commissioner of Mental Hygiene) 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.⁹⁹ 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 in Natal when, in 1927, black patients were moved to Fort Napier. 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.

In contrast to personal narratives, however, the measuring, categorizing, enumerating, labelling and compartmentalizing of those now termed 'mentally disordered or defective' assumed almost crazed - and I use the term on purpose - proportions. The 1929 Report of the Commissioner for Mental Hygiene, for example, has dozens of tables stretching across its 118 pages.¹⁰⁰ What were they for? As Swartz explains, they had several purposes and audiences:

⁹⁸ Lea and Foster, *Perspectives on Mental Handicap in South Africa*, p.28.

⁹⁹ Barbara 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. I've searched long and hard for clinical information from Natal: little seems to have survived. An empty folder (NAR: ARH vol.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.

¹⁰⁰ U.G.25 '29. Report of the Commissioner of Mental Hygiene, 1926-1928.

The statistical tables performed discursively the translation of the ambiguous and fluid phenomena of insanity into categories, and then into numbers. Diagnostic classification allowed prediction of outcome, and to some degree guided treatment in the asylum. [However],... classification had another function apart from guiding patient management. They were a display of knowledge, in which numbers had a central role to play. By erasing ambiguity, they enacted the ability of asylum doctors to identify and count the insane, and also to trace insanity's origin. Classification was therefore the discursive tool used to construct insanity as knowable, a means through which to control anxiety about a perceived increase in degenerative, savage and poorly understood disease.¹⁰¹

And these anxieties appeared to many, in the years up to the late 1930s, to be based on very real grounds. In Europe and North America, so too in South Africa, doctors, psychiatrists and law-makers shifted away from focussing 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.¹⁰²

Meanwhile, 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,¹⁰³ the '... psychopathology of the African became increasingly dependent on a representation of something called 'African culture.'¹⁰⁴ Historians, anthropologists, and ethnographers commonly assumed the language of the 'psychological sciences' in seeking to explain the 'essence of primitive mentality.'¹⁰⁵ 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. 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.'¹⁰⁶ The ways in which these forms of 'knowledge' about 'the African' were constructed and employed in Natal and Zululand in the late nineteenth and early twentieth centuries will be an important area of my future research.

¹⁰¹ Swartz, 'Colonialism and the Production of Psychiatric Knowledge at the Cape', p.110.

¹⁰² This, of course, is an important and wide area of study in itself, and the Natal context will be examined in another chapter of my dissertation. 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 chapters 4 and 5 of Saul Dubow's *Illicit Union*.

¹⁰³ 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. Vaughan, *Curing Their Ills*, pp.111-114. Also, Jock McCulloch, *Colonial Psychiatry and 'the African Mind'* (Cambridge: Cambridge University Press, 1995).

¹⁰⁴ Vaughan, *Curing Their Ills*, p.111.

¹⁰⁵ This phrase is used by Dubow - *Illicit Union*, 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).

¹⁰⁶ Dubow, *Illicit Union*, p.209.

What I am especially interested in is how the concepts and language of psychiatry and psychology infiltrated both the professional and the common-sense notions held by blacks as well as whites of who and what constituted 'the African', 'the Indian' and 'the whites' in this region. I wish to explore, for example, how stereotypes of 'the Zulu' were couched in terms of a particular mind-set or attitude. The most notable instance of this, of course, are the works which characterise Shaka as motivated by a psycho-sexual complex, and as being capable of extreme, even sadistic, cruelty.¹⁰⁷ In similar vein, 'the Zulu' were portrayed in 1932, as practising 'natural eugenics by killing off the weak'.¹⁰⁸ '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*.¹⁰⁹ At the same time, 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 1917.¹¹⁰ 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'.¹¹¹ In the 1950s, on the other hand, Zulu intelligence was no longer the main interest of psychologists and others, instead papers appeared on subjects such as 'Zulu mothers' weaning practices and the social context of 'Zulu dreams'.¹¹²

These are all examples of professional discourses that employ psychological concepts as part of their explanatory tools. Less easy to pin down, although one has a sense that they were (are?) ubiquitous, are every-day, common-sense invocations of the nature of the 'Other' expressed in terms of the mind, the character, or the personality. I believe that these concepts - hardly ever self-interrogated and yet (or because of?) having a smack of scientific validity - were extremely important in the formation of racial stereotypes. For now one example will have to suffice. In 'Belinda's Book for Colonial Housewives', published, I'm guessing, around 1930, in between tips on making pineapple preserve and the merits of plain coloured flannel bloomers for young children, the anonymous author provides the following observations on 'Native Servants':

¹⁰⁷ 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).

¹⁰⁸ S.K. Woods, 'Practical Eugenics in Zululand', 'Notes and Memoranda', *Eugenics Review*, 24, 1 (1932), quoted by Dubow, *Illicit Union*, p.168.

¹⁰⁹ *Eugenics Review*, 9, 1 (1917).

¹¹⁰ S.G. Rich, 'Binet-Simon Tests on Zulus', *SAJS*, 14 (1917).

¹¹¹ For example, 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).

¹¹² 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).

Native girls are frequently attacked with a peculiar kind of hysteria, and many a white mistress has been frightened nearly out of her wits. ... A sympathetic friend - the sufferer is usually attended by several such friends - will vouch the information that the afflicted one is bewitched. ... The attack usually subsides in violence if the sympathetic audience are summarily dismissed.¹¹³

But, I'm getting ahead of myself in describing my research agenda, and we seem to have come a long way from the mad and the asylums of Natal. Yet, this is the point that I would like to make: while colonial psychiatry played an important role in the construction of racial science in southern Africa with all that that entailed, in its institutional setting it was only one source for the creation of knowledge about both blacks and whites in this region. Perhaps of greater significance is an exploration of the ways in which its concepts and language came to permeate other forms of expression about 'the Other' beyond the asylum walls. And more than this, we need an understanding of how western ideas about the mind - both normal and abnormal - were accepted, rejected, or reshaped by the people whom they were said to describe.

¹¹³ My thanks to Dorothy and Dave Gallagher for lending me their copy of 'Belinda's Book for Colonial Housewives'. Unfortunately, the covers and publication details have been lost.