Family commitments and economies of emotions:
The family and mental illness in Natal to c. 1960[1]

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ABSTRACT

Much of the scholarship of nineteenth and early twentieth century psychiatry in Southern Africa has argued that its discourses, ideology and material practice are an example *par excellence* of imperial medicine, where mental hospitals were largely sites of state-initiated detention. Drawing on the archival records which detail the legal grounds for the committal of thousands of people to the Pietermaritzburg and Fort Napier Mental Hospitals from 1916 to 1960, it seems however, that in practice in Natal and Zululand, as in the metropole, it was often families rather than medical doctors or state officials who played a decisive role in initiating the process and determining the timing of the committal of patients. This set of records is unique for this region for they detail the committal process of persons from all social, class and ethnic backgrounds. I argue that in order to write a social history of mental illness we need to document how families imagined the role of institutional psychiatric medicine and mental hospitals and their place in the range of therapeutic or custodial options. The paper also raises questions about the changing nature of 'the family', mental illness and emotions, in South Africa in the first half of the twentieth century.

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[1] This paper is something of a bridging exercise between research already published and a new project which will return to the sources already used and also reach into the more recent past. It has not been possible to conduct as much primary research as I would have wished in time for the writing of this paper; nonetheless I have opted to retain the original - ambitious - title as an indication of my intentions to cover the period from the 1860s to the late 1950s. Earlier versions of the paper were presented at conferences at the University of Johannesburg (June 2007) and Oxford (January 2008). Thanks to Joscelyn Cumming for research assistance at the Pietermaritzburg Archives Repository in early 2009.

Introductions

Over the last several decades many scholars have convincingly demonstrated that through its discourses, ideology and material practice, psychiatry in Africa has been *par excellence* a branch of imperial medicine. Characterised by the scientific racism of the time which regarded Africans' brains as being structured differently to those of 'Europeans', Africans were commonly regarded as less intelligent, of being incapable of introspection or of depression, or of the will to commit suicide, or of feeling emotions such as melancholy and guilt. With regard to its institutional practice, many studies show that asylums constructed by the imperialists and settlers were little more than holding places for those who threatened the social order, and were soon filled by inmates whose detention had been initiated by the police or by magistrates.

Referring more specifically to South Africa, we know this to be true, too: for instance, structural racism and sexism were lent an aura of spurious scientific validity by the pronouncements of some infamous asylum doctors. Some individuals who were seen locally as divinely inspired were medically declared hysterical by state medical authorities. In 1979 the American Psychiatric Association conducted an enquiry into allegations of abuse of psychiatric practices and facilities in South Africa.[2] Although it found no instances of political detainees being incarcerated in mental hospitals as was notoriously the case in Stalin's Russia, the committee's report stated that there was "…good reason for international concern about black psychiatric patients in South Africa and that [they had] found unacceptable medical practices that resulted in needless deaths of black South Africans. Medical and psychiatric care for blacks was grossly inferior to that for whites." Furthermore, as Shula Marks has recently documented, there was frequently violent abuse by staff of patients in South African mental hospitals, private as well as state.[3] Unsurprisingly then, South African psychiatry has a justifiably poor reputation.

The majority of the histories we have of psychiatric practice have largely used the records kept by asylums - later called mental or psychiatric hospitals - to show how colonial psychiatry served as one of the ideological grounds on which South Africa's increasingly rigid racialised society was founded. Most of these studies have explored 'the first phase' of the history of psychiatry in this region, that is, up until circa 1920.[4] During this period,

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 American Psychiatric Association, 'Report of the Committee to Visit South Africa', in *American Journal of Psychiatry*, 136, 11 (November 1979), pp.1498-1506. Quotation from p. 1498..

[3] S. Marks, 'The Microphysics of Power: Mental Nursing in South Africa in the First Half of the Twentieth Century', in Sloan Mahone and Megan Vaughan eds, *Psychiatry and Empire* (Houndmills, Basingstoke: Palgrave, 2007).

[4] By psychiatric I here refer to 'western psychiatry' and not to indigenous therapeutics concerned with categorizing or healing illnesses or disturbances of the mind which might be referred to as 'folk psychiatry'.

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psychiatric practice and institutions were almost exclusively associated with asylums and their medical staff mostly came from Britain and retained strong ties with British medical associations and practice. From the 1910s and during the 1920s, a number of South African eugenicists entered into correspondence with their mental hygiene counterparts in the USA and a number of German and Central European psychiatrists and psychoanalysts came to South Africa.

Largely dependent on the kinds of sources left by these doctors and other medical professionals, our histories have reflected a relationship linking the metropoles of Europe and the USA with the urban areas of South Africa where, in the main, the mental hospitals of the nineteenth and early twentieth centuries were constructed.[5] In this history, the flow of knowledge and expertise was largely one way, from metropolitan core to imperial periphery. And within these colonial satellites, state agents such as district surgeons, magistrates and police had the authority to bring people within the ambit of disciplinary psychiatric regimes, which turned people into patients and sometimes the troublesome or dissident into the 'disordered'.

It is possible however that this power-knowledge model restricts our understanding of the multiple dynamics which lay behind the steadily increasing numbers of patients in South African psychiatric hospitals. In this paper, I build on my earlier work which charted the history of the 'first phase' of colonial psychiatry in Natal and Zululand, where I argued that until at least the First World War colonial psychiatric ideas, intentions and institutions had only limited impact in this region. For, even though colonial asylums were always bursting at the seams, only a tiny percentage of the population were kept as mental patients or legally defined as being insane.[6] In Natal and Zululand in the early 1900s this was, at the

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For the background to nineteenth and early twentieth century psychiatry as well as African therapeutics, see Julie Parle, *States of Mind: Searching for Mental Health in Natal and Zululand, 1868-1918* (Scottsville, Pietermaritzburg: UKZN Press, 2007), esp. Chapter 1. For the more recent period, see Tiffany Jones, '"Disordered States": Views about Mental Disorder and the Management of the Mad in South Africa, 1938-1989' (PhD dissertation: Queen's University, Canada: November 2004). Thanks to the author for a copy of this dissertation.

[5] Tiffany Jones states that the majority of South African mental hospitals were in "remote rural areas" [page 89]. This may have been so in the mid to late twentieth century, but this was not the case in the late 1800s and early 1900s where the major institutions were to be found in the country's largest urban areas or provincial capitals, including on the Rand, in Cape Town, Bloemfontein and in Pietermaritzburg. The creation of a 'new asylum system' which proposed large scale hospitals of more than 1,000 patients was mooted in 1913 by Dr J T Dunston who was South Africa's first Commissioner of Mentally Disordered and Defective Persons. These 'monster asylums' were anathema to an older generation of Physician Superintendents. See Parle, *States of Mind*, Chapter 6.

[6] The reasons for this increase have usually been located in increasing urbanization as well as in growing intolerance for people 'in the wrong place', whether defined as such because of capitalism or racist ideologies. See, for example, Bob Edgar and Hilary Sapire's *African Apocalypse* for the link between prisons and asylums

most, 0.05 percent of the population of the region. Even of those recorded in the Census as being insane, most were not actually in asylums. By the late 1960s just fewer than 30,000 people were housed in South African state psychiatric hospitals.[7] From that time onwards, the state sub-contracted the institutional accommodation of state patients to a private contractor, Smith Mitchell, which by the mid-1980s provided an additional 12,000 'beds' (more usually mats for the majority of patients, who were black).[8]

As charted elsewhere, however, these institutions were only one —and usually the very last —option utilised by those seeking to have a mentally ill person cured or at least protected from further harm to themselves or to others. Committal came most usually after a search in the popular and folk sectors of healing for a cure, and not infrequently after several strategies for care and containment had been tried, usually firstly through custodial or nursing care within the family, or through paid private nursing homes and sanatoria for the middle classes, an expense that had to borne by relatives. Moreover, and as much recent international literature has shown, it was often families rather than state or biomedical officials who initiated the process and the timing of committal of a family member as a mental patient. Indeed, families sometimes remained important actors in the lives of those who were committed as mental patients and even if the stigma of having madness in the family remained (as it still does) the incarcerated insane were not necessarily abandoned.[9] Especially in the case of the middle class mad, families contributed financially to their upkeep in the psychiatric hospital; they visited patients and took or sent special foods; paid for additional private nursing; arranged furlough or trial leave for patients considered advanced in their recovery; and on occasion, families energetically petitioned for the release of patients whom, they believed, could be better cared for (or whose labour might be well utilised) at home rather than in a state mental hospital.

This history has not yet been explored in the South African context, and a country in which whites were in a minority may offer an interesting comparative study to those

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in South Africa; and Lynette Jackson's *Surfacing Up* for the labeling as insane of African women in the then Rhodesia who strayed out of their economic, geographic and socially-allotted place. To my knowledge, less well documented than socio-economic, ideological or political reasons for the swelling numbers of hospitalized patients are biological or medical reasons. For instance, in several countries the Great 'Flu Pandemic of 1919 was thought to have been followed by an increase in suicide rates. Late nineteenth and early twentieth century psychiatry held that insanity could follow febrile infections such as influenza. This is still a matter of scientific debate.

[7] From a total population of around 17 million, though it is unclear whether this includes the later homelamds/ Bantustans.

[8] Jones, 'Dis-ordered States', p. 212.

[9] For a succinct and helpful overview of this literature, see the Introduction in D. Wright and J. Moran (eds) *Mental Health and Canadian Society: Historical Perspectives* (Montreal & Kingston: McGill-Queen's University Press, 2006).

pioneering works which have investigated the role of families in the management of madness in North America, Canada, Australia and New Zealand which had much larger immigrant communities.[10] In addition, there is also evidence to suggest that by the 1920s while police and state officials still formed the main conduits through which black patients were brought to the Pietermaritzburg Mental Hospital (formerly, the Natal Government Asylum) or Fort Napier Hospital, some Africans and Indians were initiating the committal of family members who were violent (to themselves as well as to others) as a consequence of mental illness.

Family commitments

It is the role of families in managing madness which I wish to explore in more detail here and in future work. I do so as a way of asking two sets of questions. The first relates to that already described above which concerns the place of mental hospitals within the range of options available (and considered appropriate) for the treatment and control of the insane. The second - as yet more tentative and exploratory - turns the focus away from institutions, medicine and social control exercised from above and instead raises questions about the changing nature of 'the family' in South Africa during the momentous decades of the twentieth century that saw the increasing but uneven grip of industrial and rural capitalism, urbanisation, migrant labour, segregation, apartheid, re-workings of gender roles, and of intense pressures on and within families.

Under what conditions did families decide when a disruptive or dangerous person should be certified and restrained as a mentally disordered or defective person? What were the boundaries of the family's capacity to care for or restrain such a person? Can we glimpse what contestations - perhaps across generation and/or gender - occurred within families in making such decisions? What did families imagine the role of the mental hospital and psychiatric medicine to be: was it hoped that the mentally ill could be cured, or only that they be kept from harming themselves or others? And, perhaps most intriguing of all, what can such questions tell us about the ways in which definitions of privacy, shame,

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[10] Some examples of this literature include: Akihito Suzuki, *Madness at Home: The Psychiatrist, the Patient and the Family in England, 1820-1860* (Los Angeles: University of California Press; 2006); Catharine Coleborne, 'Families, Patients and Emotions: Asylums for the Insane in Colonial Australia and New Zealand, c. 1880-1910', *Social History of Medicine* 19, 3, (2006), pp. 425-442; and a number of chapters in the Wright and Moran volume cited above. Tiffany Jones's unpublished PhD also touches on some aspects of the role of the family - though usually in terms of trying to effect patient discharges - in her Chapter 5, '"Patient Accounts: Challenging Exile, 1939-1960'.

stigma and of what Catharine Coleborne has called 'emotional culture' were reconstituted in the first half of the twentieth century?[11]

Whereas Coleborne was able to draw on correspondence from families to and from asylum doctors and family members who were mental patients, unfortunately very little such correspondence has survived in the records from this region especially for the period after 1919, when the last of two surviving (European) Patient Case-Books was closed and patient records were moved to loose leaf folders. These records appear to have been destroyed. Instead, my sources are the archived Reception Orders that, following the Mental Disorders Act of 1916, document the grounds upon which applications were made to have a person declared mentally disordered or defective and thereafter detained in a mental hospital.[12]

Complied in the month after the first detention of the person said to be insane these included certificates by two medical practitioners; a report by the resident magistrate; and a brief report of observation by the Physician Superintendent of the Mental Hospital.[13] There is a complete run of these records from 1916 through to 1959, and they make for a unique set of medico-legal records not only in terms of the long stretch of time that they cover, but also given South Africa's history of racially-determined record-keeping, that they document the grounds for committal of persons of all legally-determined racial and ethnic designations.[14] Indeed, they are the *only* archival sources which document the grounds on which the legal detention of thousands of people of all social and economic backgrounds was argued and justified.

[11] Coleborne, 'Families, Patients and Emotions'. The term 'emotional cultures' appears on p. 427.

[12] Documentation pertaining to the medical and legal grounds for the admission of mental patients after the passage of the Mental Disorders Act of 1916 has been preserved at the Pietermaritzburg Archives Repository, in the Registrar of the Supreme Court collection. For further discussion of the Reception Orders and committal process see Sally Swartz, S. Swartz, 'Colonialism and the Production of Psychiatric Knowledge in the Cape, 1891-1920' (Ph.D. thesis, University of Cape Town, 1996), pp. 82-83 and Jones, '"Dis-Ordered States"', pp. 90-95. There were few voluntary committals, although as early as 1913 Dunston and others had hoped that 'higher class' patients would submit themselves for treatment or seclusion. See UG, SC. 14-'13, *Select Committee, 1913*, Evidence of Dr. J. T. Dunston, 18 April 1913 and passim. Out-patient treatment only became available on a significant scale in the 1960s.

[13] One if no second medical practitioner were available. As Jones points out on pp.92-93, in the case of 'ordinary' patients, "As medical practitioners were not always readily available, especially in the rural areas, an individual could be institutionalized on the say-so of the original applicant and a single medical practitioner. In the first instance, a magistrate could admit individuals for 6 weeks. Once they were admitted and examined, those whose 'illness' was confirmed came back to the magistrates who had the discretion to order indefinite detention, subject to periodic review, annually for the first 3 years and every 5 years after that". 'Urgent applications/cases' could be committed via a direct application to the medical superintendent of a mental hospital who within ten days, had to forward the application for reception to a magistrate'

[14] I have in mind here the contrast with the way that statistics about suicide were kept or not. See *States of Mind*, Chapter 5,

That the committal forms remained substantially the same over a 42 year period enables us to have a relatively consistent set of data for comparison. On the other hand, a close reading of the small adjustments made to the forms also indicates changing state definitions of and attitudes toward the family and its responsibility for the mentally ill. For instance, in 1915 a magistrate ruled that the brothers of a man detained by the police in Zululand and subsequently admitted to the Pietermaritzburg Mental Hospital did not have to sign security for his maintenance costs. But soon after, the relatives of African and Indian patients were being pressed to meet these costs. Moreover, in some instances they were *offering* to do so as can be seen in the papers of Gomase Sibiya from near Stanger whose husband Nyokana Mtetwa although described as "In poor circumstances six children and monthly paid labourer [sic]" was in 1925 recorded by the Magistrate as offer[ing] "to pay an amount of ten shillings a month" towards his wife's "cost of maintenance".[15]

Sibiya had been detained on the grounds of "General behaviour", for being "Dirty in habits" and for starting cane fires because she was cold but "had not the sense to control them". She was identified by her husband as having exhibited this dangerous behaviour for two years. What prompted her arrest this time is not known, but this was not this family's first acquaintance with state care or control of the mentally ill. Mtetwa — presumably it was he as neither the two medical doctors nor the magistrate who signed her forms claimed any prior knowledge of her — also noted that she had had a sister who had been "sent to the asylum and treated." At the time of appearing before the district magistrate he added that in his opinion Gomase was, "now quite sane". From this distance of time, it is impossible to assess Nyokana Mtetwa's motivations, but it seems likely that he anticipated a return of Gomase's affliction. It is also possible that the cost of ten shillings a month would have been less burdensome to the cost to Nyonka of paying for local remedies and consultations with healers or for claims from his neighbours or local landowner to damaged property.

Indication that from the 1920s the state was now requiring the family —formerly loosely defined as "friends and relatives"— to shoulder the burden of financial expenditure for state mental patients can be seen in new provisions in the one of the bundle of forms which were required for the completion of the committal, the 'Mental S.10 Report of Magistrate'. This form now, in addition to the questions which had appeared on the original forms (Whether friends and relatives are able to pay for maintenance, and, if so, to what extent? Has patient any movable property? Has patient any immovable property?) included several new sections, the responses to which were intended to identify more precisely which family members could be held accountable for the costs of maintenance. Hence the Magistrate now had to provide details of the patient's "Domicile and Environment (Urban, Rural or Unknown) and Economic Condition (Dependent, Marginal or Comfortable)."

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[15] PAR RSC 1/27/31 R. 166/1925, Committal and Further Detention Papers of Gomase Sibiya alias Niozize or Odeseas Ndabazita, of New Guelderland, near Stanger, 8 September 1925.

Interestingly, it was now required that officials furnish details as to the "Sex, age, occupation, and circumstances of children, if any" and to state the "Names, address, occupation, and circumstance of parents."

While I have yet to establish the precise motivation for these new stipulations, it is likely that in part they reflect the growing financial independence of and distance between individuals and 'the family' as sons and daughters moved away from homes and kinship communities where resources had formerly been more directly controlled by parents, particularly fathers. There is of course no fixed identity of 'the family' much less a pre-determined trajectory for its changing productive, reproductive and social identities and roles in 'Africa' or anywhere. Nonetheless, as Shula Marks and Richard Rathbone observed as far back as 1983 in their Introduction to a collection of articles on the African family a general trend towards the "undermining of the authority of family heads and chiefs and a fall in the size of settlement groups" can be discerned.[16] They note however that:

> This should not lead us to seek out the emergence of the archetypical nuclear family. As Jack Goody has pointed out, the change from the pre-industrial to the industrial family in Africa, as elsewhere, does not centre upon the emergence of the 'elementary family' out of kin groups, for small domestic groups [within larger settlement groups] are virtually universal. [The changes] concern the disappearance of many of the functions of the wider ties of kinship, especially those centring on kin groups such as clans, lineages and kindreds... It is the process whereby kinship relations shrink largely but not entirely to the compass of man's family of birth and family of marriage. This 'shrinkage' has had profound repercussions for socialization practices and the support networks performed by wider kin.[17]

It would be easy to regard the definitions in the committal papers of who comprised family members responsible for the mental hospital maintenance costs as merely reflecting western notions of the nuclear family (a social formation itself in process), but this may not be entirely accurate and may in part have reflected the ways that people defined their own relationship to the mentally ill person - though again it is impossible to know whether people who self-identified for the purposes of bureaucratic record-keeping as 'uncle' or 'father' were direct biological relatives. If however the 'shrinkage' in extended family responsibilities suggested above was indeed marked in the first half of the twentieth century, then the family commitment to ongoing economic and emotional involvement with ill and absent family members was indeed a component of a newly imagined set of social relations.

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[16] Shula Marks and Richard Rathbone, 'The History of the Family in Africa: Introduction ', in *The Journal of African History*, vol. 24, no. 2 (1983), pp. 145-161.

[17] Marks and Rathbone, 'The History of the Family in Africa', p. 158.

Marks and Rathbone noted that the studies of the African family included in the 1983 collection had been dominated by considerations of political economy. But over the past twenty five years or so, it is not only changes in family size, distribution, productive and reproductive roles that have received attention from Africanist scholars but also gender and generational relations and the socialisation of youth, particularly as regards sexuality. Recently, some have also begun to address the problems of researching the processes by which the private sphere - or spheres, perhaps - formed over the last century or so. For instance, by using letters and petitions as sources, it has been possible to answer in the strong affirmative that there was an "African private sphere in South Africa prior to the rise of the apartheid state", and that the "literary technology of the colonial state [was adopted and used] to construct a new individualized and affective domain".[18] Even more recently, the wonderful collection *Love in Africa* addresses the history of one emotion in historical context, exploring how its "affective practices and discourses emerge out of the particular convergence of political, economic, and cultural processes."[19] They add that "…emotions are embedded in historically situated words, cultural practices, and material conditions that constitute certain kinds of subjects and enable particular kinds of relationships."[20]

Emotions such as love, hate, fear, anger, pride, and shame must thus be studied with a regard for the tension between universal human expressions of affect and historically constituted relationships. Similarly, given that it has long been accepted that definitions of insanity have been differently defined across time and place I would like to see if the committal papers with which I am now working and which legally inscribed a person's mental status may give us one way of researching emotions and power relations within families. Important to consider will be which family members were committed, and by whom, at which point of their mental illness, and for reason (or perhaps lack of reason) as reported to the police, magistrates, district surgeons, or other state authorities, and whether these changed across time. In this, the decision to initiate the drastic process of committal was often prompted by economic considerations, but these considerations were not rooted in material factors alone.

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[18] K. Breckenridge, 'Of Love Letters and Amanuenses: Beginning the Cultural History of the Working Class Private Sphere in Southern Africa, 1900-1933' *Journal of Southern African Studies*, 26, 2 (June 2000), p.348; C. Burns, 'Censorship and Affection: South African Women's Letters During World War Two', paper presented to the History and African Studies Seminar, University of Natal, Durban (now Howard College, UKZN), April 2000, and available at http://www.history.humsci.ukzn.ac.za. Last accessed 11 June 2007; and chapters by Breckenridge, Catherine Burns and Vukile Khumalo in Karin Barber (ed.) *Africa's Hidden Histories: Everyday Literacy and Making the Self* (Bloomington: Indiana University Press, 2006).

[19] Jennifer Cole and Lynn M. Thomas, 'Introduction: Thinking Through Love in Africa'; in their collection *Love in Africa* (Chicago and London: University of Chicago Press, 2009). The quotation is from page 29.

[20] Cole and Thomas, 'Introduction', *Love in Africa*, p. 3.

Economies of Emotions

By recognizing that families were often the crucial agents in determining whether a family member should be detained on grounds of mental instability, thus bringing the issue of insanity into the public domain, we can illuminate aspects of the social history of madness in the nineteenth and twentieth centuries. But, we might ask, how might the history of mental illness shed light on the social history of the world of the family? This question has recently been explored by Catherine Coleborne in a fascinating article which analyses the ways in which asylum records, especially patient case-notes and correspondence between asylum doctors and patients' families, from Australia and New Zealand in the late 1800s and early 1900s chart the emotional lives of both mental patients and their families. She reminds us that this was a "critical period in the development of asylum management, [which] was also shaped by an emerging discourse of modernity expressed through new prescriptions for family roles."[21]

Drawing on the path-breaking work on the history of 'emotionology' by the Stearnses, which insisted that "…aspects of emotional experience are legitimate subjects for historical inquiry" and "might help us to push social history in new directions", Coleborne goes on to argue that "… perhaps more than any other theme explored in this field, it is this focus on families that has the potential to open up discussion about past emotional cultures as evidenced through the asylum and its sources."[22] For, if final mental breakdown beyond the point of containment was signalled by the limits of a family's endurance or tolerance, it was by the expression or enactment of emotions thought to be 'inappropriate' that this point was determined. It was then the intention of the asylum doctors and their moral management regimes to "restore inmates to an appropriate state of emotional balance".[23]

Sadly, without extant correspondence that would have been kept in the now-destroyed patient files, it will be difficult to pursue the ways, as Coleborne's work suggests, in which mental hospitals become "theatres of emotions" for the public display of affection and performance of gender roles as well as the negotiations between family members and

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[21] Coleborne, 'Families, Patients and Emotions', p. 425. As Barbara H. Rosenwein explains in her article 'Worrying about Emotions in History, *The American Historical Review*, 107, 3 (June 2002), found at http://www.historycooperative.org/journals/ahr/107.3/ah0302000821.html and last accessed on 1 November 2009 explains, 'emotionology' refers to the "attitudes or standards that a society, or a definable group within a society, maintains towards basic emotions and their appropriate expression [and] ways that institutions reflect and encourage these attitudes in human conduct". It is not so much concerned with how people feel or how they represent their feelings, but what people thought about such matters as crying in public, getting angry, or showing anger physically. It assumes that what people *think* about feelings they will eventually actually feel."

[22] Coleborne, 'Families, Patients and Emotions', p. 428.

[23] Coleborne, 'Families, Patients and Emotions', p. 432.

mental specialists as to whom had the authority to decide what constituted madness or mere eccentricity.[24] As yet, and unsurprisingly, what little evidence I do have is largely by and about white patients and their families in the late nineteenth and early twentieth centuries. These fragmentary accounts do however point very clearly to the affective as well as the economic dimensions of settler family life. For instance, I have already written of Emma Lovett and her husband's and daughters' devotion to her. This comes through powerfully and movingly in the sustained campaign they mounted for nearly nine years to have her released from the asylum in Pietermaritzburg. In 1896, the illiterate Henry Lovett had submitted on his behalf a request for Emma's release, saying " … she feels so much at her confinement which parts her from me (her husband) and her children, that I am afraid if that released, she will continue to fret so, that her life will not be very long. … [she] … has always been a good wife and fond mother."'[25] This appeal to the ideal of familial closeness and emphasis on Emma's otherwise 'unblemished' character and motherly devotion failed however. Three years later, Henry once more informed the authorities that he believe[d] "… that the prolonged confinement is telling on her health and consequently on her spirits… [He added] I would now request that the matter of my wife's release under the circumstances I have mentioned may be taken into consideration as the present state of affairs is very hard both for her and for myself."[26]

> After a number of legalistically-worded Petitions had failed, in a letter sent directly to James Hyslop, the Physician Superintendent, in December 1901, Jessie Cecelia Lovett drew attention to the family's feelings of loss, love and duty, saying:

> Just a few lines to ask you If you really cant [sic] grant mothers release, as we feel it so very hard to be separated from our mother so long. We promise you we will look after her and do everything for her comfort. It seems so hard doctor to have a mother and have to be parted from her especially now her family have grown up and are quite able to look after her and we know it is our duty to do so also as mother is getting an aged woman, we feel it is so hard on her to be there.…[27]

Nearly two years earlier, in her own Petition for Release to the Governor General Emma Lovett had sought to establish remorse and a proper understanding of her guilt as grounds

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[24] See Coleborne, 'Families, Patients and Emotions', pp. 437-9. One further set of questions that can be considered using the Reception Orders is that of the very stuff of nightmares, for the hallucinations, fears, dreads and feelings of persecution which tormented many were recorded as evidence of insanity itself once they had grown 'out of proportion'.

[25] Pietermaritzburg Archives Repository, Minister of Justice and Public Works (hereafter MJPW) 137 JPW 1732/1908, 'Allison and Hime: Forward a Petition by Emma Lovett Praying for her Release from the Asylum, 1900-1908', Petition of Henry Lovett to Attorney General, 25th July 1896.

[26] MJPW 137, Henry Debney Lovett, Verulam, to Principal Under Secretary, 9th February 1899, 8383/98.

[27] MJPW 137, Letter to Dr James Hyslop from J.C. Lovett, 42 Carlisle Street, [Durban], 8 December 1901.

for convincing the state of her suitability for release into the care of her family. In that Petition, she stated that she had "suffered terribly for her unfortunate failing and offence" and that she was "… almost heart-broken over the sad affair, as she dearly loved her child."[28] She drew attention too to the nightmares she had been victim to over "the past twenty six years" but pointed out that she was now suffering to an even greater extent. She attributed these nightmares -- which others described as "nocturnal fits" -- as being the consequence of her "… peculiar surroundings and the continual worry and anxiety about her husband who is now a cripple, and her children…"[29]

The underlying arguments being made here and the sentiments being appealed to were that Emma Lovett's family, by reason of their emotional closeness and family bonds were better able to judge her state of mind than either the medico-psychiatric expert Hyslop, or the legal state bureaucrats who did not know their family history or its emotional intimacies. What they believed was that the bout of insanity Emma Lovett had experienced in 1894 had been a deeply tragic but transient episode; that without Emma as wife and mother the family was incomplete; and that she would be both safer and saner within her own home than in the Asylum. Tragically, this was not so.

If the Lovett family based their appeals for Emma's release into their care on the grounds of the well-being of the family unit, others could make a similar argument for keeping errant and difficult family members <u>away,</u> as the following letter shows. Written in 1907 from London to Walter Payne, a patient at the Natal Government Asylum, it is worth quoting in full.

London, 15/11/1907
To Walter J.C. Payne. NGA.

Dear Walter,

When you are well + about again I wish you to clearly understand that mother + father are far from well + not able to look after any of us, they want looking after themselves. I know they have worried a long time about you + the only way to lessen that worry is for you to make the best of

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[28] MJPW 137, Petition of Emma Lovett, wife of Henry Lovett, at present an inmate of the Natal Government Asylum at Pietermaritzburg, in the Colony of Natal. Sworn under oath on 17th January, 1900.

[29] MJPW 137, Petition of Emma Lovett, wife of Henry Lovett, at present an inmate of the Natal Government Asylum at Pietermaritzburg, in the Colony of Natal. Sworn under oath on 17th January, 1900.

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things + get on your feet once more in Sth Africa. Should you come home you will very materially add to their worries for should you stay in the house with them mother has to look after you when her own health demands that she should be looked after instead. They, the old people, would also wonder what would become of you when they were gone. If in spite of what I have stated you decide to come home, you will take a deal of responsibility on your shoulders as to how long father + mother live. Father is a present slowly recovering from a "shock" + mother is under orders to go into the Muldnay Park Hospital with a badly congested kidney – we think it was the probability of an operation on mother that brought on father's stroke. From the enclosed letter from Harry you will note that brother father + mother are as well as can be expected.

You have always fought well against you long run of bad luck + I feel sure you will continue to fight fortune in Sth Africa. It is a long long lane that has no turning + both Sth Africa + your own affairs must improve very shortly now.

Yours affectionately,
Steve[30]

The emotions uppermost here are "the worry" that Walter and Steve's parents have experienced about Walter and the increased burden that his return would bring for them, though clearly Mrs Payne would attempt to undertake care of Walter if he were physically present. Of course, we do not know for certain what Steve Payne's motivations in writing this letter actually were. Perhaps he had ulterior material motives for keeping Walter away from their parents; perhaps he had nothing but genuine concern for both them and his brother. Either way, his urging that: "If in spite of what I have stated you decide to come home, you will take a deal of responsibility on your shoulders as to how long father + mother live" could hardly have been any comfort to Walter. Steve Payne also appears to have seen no conflict between the burden of putative guilt with which he warns his brother to stay in South Africa, and far from his natal family, and his parting sentences wishing Walter well and signing off "Yours affectionately".

Settler society in Natal had always been stratified and snobbish and became ever more so. In this, social distance was important and needed to be policed. Indeed, this was necessary to distinguish the emerging elite not only from the indigenous Africans and working class Indians, but also from a wealthy but small Indian merchant class and, from the growing numbers of 'Poor Whites', most of whom were Afrikaans and of whom it was

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[30] Natal Government Asylum (European) Patient Case Patient Book XI, Patient 2339, Walter Thomas Payne. Memos/correspondence pinned to p. 179. Payne had been admitted on 26 September 1907 and was discharged in February 1909. On admittance, he was described as a 34 year old pauper; a widower; and he had been in the Colony of Natal for eleven years. His diagnosis was "Epileptic Mania". No deceased estate papers for him are evident via NAAIRS.

believed were of 'degenerate stock' posing a danger to 'white civilisation'. As described by Coleborne for Victorian Australian and New Zealand, in Natal in the early twentieth century, settler family politics (in the broad sense of apportioning and controlling resources) increasingly required a calculus of propriety which included emotional continence on the one hand (no excessive displays of passion or inappropriately timed behaviours), deep affection, and privacy.[31]

The popular conception supposedly backed by mental science, that whites were more sensitive, more prone to nervous strain and collapse, fed into and off bourgeois sensitivities of race, class and gender. As the century progressed, some forms of mental illness were gradually medicalised and their stigma very gradually began to diminish. Local mental hospitals became viewed as a (barely) more acceptable alternative to having a having a mentally disturbed, deranged or eccentric family member detained in a gaol or sent away, as had been the case in the mid-nineteenth century.[32] Nonetheless, it remained a matter of shame and embarrassment to have such a family member. Formal psychiatry and mental hospitals thus continued to occupy a profoundly ambiguous position in family strategies of managing madness. When, we need to know, did a family decide to initiate committal? At what point did considerations of disruption to the family economy or to material resources because of the removal of a mentally ill family member mean that committal was the preferable option? And, at what point did class and *the family's imagining of itself rather than material factors* suggest this? These are the kinds of questions I am interested in exploring not only for settler families but also for Africans and Indians to look at the commonalities and differences between how, say, settlers from Europe or from Asia in the mid-nineteenth century (re)constituted their individual and familial private spheres.[33]

Thus far, I have only random snippets of evidence, but cumulatively they suggest that we should pay greater attention to the agency of <u>families</u> in determining patterns of admissions to psychiatric hospitals and should read the Reception Orders with an ear to hearing subaltern voices as well as those of officials and medical officers. Take for instance

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  Coleborne, 'Families, Patients and Emotions', p. 427.

[32] Intriguing work has also been done by David Goodhew whose article on working class respectability in the Western Areas of Johannesburg promises parallels with my own, concerned as he is with values, norms and attitudes. See his 'Working-Class Respectability: The Example of the Western Areas of Johannesburg, 1930-55', *The Journal of African History*, 41, 2 (2000), pp. 241-266.

[33] There are, it should be cautioned, dangers in posing the question in this way, for it implies that there are separate strands - coinciding with something called race or culture or ethnic identity - which fit all too neatly into what sociologist Gerhard Maré calls 'race-thinking'. Indeed, it seems clear that regardless of social background, violence remained the primary stated reason for committal and that class and gender were important factors in influencing whether or not a family took the decision to approach an authority - legal or medical - to have one of their own certified as insane.

the situation of Lloyd Kuluse, from Ndwedwe in the Lower Tugela region. Identified in 1944 committal papers as a "General Labourer" of 48 years of age, Lloyd nonetheless had what at the time was a high level of education (Standard 7) and was described as a Methodist.[34] A member of a *kholwa* family, the Application for Kuluse's detention as a Mental Patient was brought by his brother, Clement. To the Resident Magistrate, Clement [or a second brother, Adam, the records are unclear] described the grounds on which he brought the application: "He is not under proper care or control, bursts into song for no reason at all." He also provided the information that their "Father [had been] in a Mental Hospital for some time."

I find this short and formulaic set of records interesting for a number of reasons. Firstly, Lloyd apparently was not the first generation of a *kholwa* family to be placed in a Mental Hospital and it was his family who brought him to the attention of the relevant authorities. This was not an isolated instance. Secondly, they did so for an apparently frivolous reason: that he "burst into song for no reason at all." While closer scrutiny of the documents does show that he troubled his family for other reasons too, he had tried "to break articles in a house"; that he "wander[ed] away frequently … has tried to break down a wall … points out all imaginary figures flying through the air etc.", it is nonetheless Lloyd's inappropriately timed bursts of song which are most insistently cited by his brothers as being evidence of his insanity and the need for him to be certified as insane. What does this signify about notions of social conduct? Thirdly, and in what my research so far is beginning to reveal as a pattern, the two medical certificates echo - if not repeat - the evidence put forward by Clement Kuluse. It is *his* reportage of his brother's apparent insanity which persuades the medical doctors to sign the documentation which has Lloyd sent to the Mental Hospital in Pietermaritzburg.

The definition of such people as being ill rather than merely criminal began before they came within the ambit of medical professionals and could be strongly influenced by their families or kin networks. This can be seen from the records of Lloyd Kuluse. In another example from the same year - 1944 - Enos Tshabalala from Bergville brought an application for the detention of his brother, Msiwe (41 years old). According to Enos, the grounds for his belief that Msiwe should be certified insane were "…that he interferes with the property of other people for no apparent reason. He runs about at night, refuses to eat, and talks nonsense."[35] It is no great leap from these words to those of the District Surgeon of Bergville: "He is irrational in his speech, has periods of exaltation and depression, delusions of persecutions."

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[34] PAR, RSC 1/27/131, M. 310/44, Lloyd Kuluse, S. 9 Dated 3 October 1944. Application brought by Adam [?] Kuluse on 30 September 1944.

[35] RSC 1/27/131 (1944), M. 339/1944, 'Msiwe Tshabalala', Reception Order, 14 November 1944.

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The records also conclusively confirm an earlier argument that suicidal acts were not at all uncommon for African people. In approaching the authorities to have self-destructive sons, daughters, brothers, sisters and spouses (though seldom parents) detained as psychiatric patients (rather than as prisoners - recall that attempted suicide was a criminal act until the 1960s) families thus played a part in situating the urge to self-killing as a medical rather than felonious matter.

Nevertheless, the choice of committal to a mental hospital of the demented and disruptive remained one of last resort when all else had failed. Even as some destructive states of mind such as being suicidal were medicalised, families continued to shield the mentally afflicted within the home for as long as they could. General medical doctors and psychiatrists in private practice would, it seems, assist in this. In the case of Queenie Vivian Peter, the thirty-two year old daughter of a well-to-do Durban produce merchant, in 1944 this extended to bringing psychiatric medicine into the home where Queenie had been given no fewer than three Phrenazol (Cardiazol) convulsive shock treatments.[36] Queenie was withdrawn and laughed without reason; she would not be left alone, heard voices and was "exceedingly scared of the dark." She had a history of psychiatric interventions sought by her parents (she consulted a Dr Meyerstein of 380 Essenwood Road in September, October and November as well as the Johannesburg-based Dr Morris Joshua Cohen, twice in the space of three weeks) and interestingly among the reasons given for her committal were that she "…Accuses servants of criminal acts when this is not so"; "… accuses the native kitchen boy of spreading rumours about her in the neighbourhood". Even the best treatment Queenie would have received at the Pietermaritzburg Mental Hospital however would not have differed greatly from that she had already undergone through private practice, as in the 1940s and 1950s the most frequently used therapies (now of debated if not highly dubious efficacy) were electro-convulsive and insulin coma treatments.

Class remained important and it is possible that middle class women like Queenie Peter who is not described as violent and whose labour was not significant for family survival were committed only once their behaviours had either exhausted the family's emotional and physical stores or were severely disruptive to the internal arrangements of the home or were so socially out-of-bounds that their continued presence within the home was perceived as unfitting, embarrassing or even inappropriate for a caring family. (Tellingly, Queenie is described as being single, but as having a two-year old son: the family were Roman Catholics). By the 1950s and 1960s it was not uncommon for metropolitan physicians, psychiatrists and social workers to advocate for the institutionalisation of mentally and physically disabled children, the elderly and the unstable for "the good of the family".

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[36] RSC 1/27/131 (1944), M. 379/44, Queenie Vivian Peter, Reception Order granted 11 December 1944.

Another set of questions might ask under what circumstances and how quickly or slowly were women committed to an asylum by family members? Women inmates were never the majority of patients in Southern African mental hospitals. This was especially true for African and Indian women in Natal and Zululand, of whom only small numbers were committed during this period. White men also outnumbered their female counterparts. This should not surprise us for 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 likely to be admitted to asylums more quickly. Perhaps the realm of emotions which could be tolerated, including extreme emotions, was wider for women than it was for men?

The continued trend of lower numbers of African and Indian women in psychiatric institutions was a reflection of the fact that their labour remained crucial to the survival of the household economy.[37] Especially for rural peasant households and urban working families, there was a delicate balance between the need for family labour and the threat to the material well-being of the family once the afflicted could no longer work and/or their actions were threatening property, either that of the family or of neighbours. Generally speaking, only when evidencing marked emotional disturbance or extreme violence, were women committed as mental patients. Because women's household and agricultural labour was of such importance to the family economy, a wider range of behaviours and disturbances of affect were tolerated amongst women than amongst men.[38] Only once they became too disruptive or alternatively too withdrawn to contribute to the family economy were they removed to the Mental Hospital. In an example of the latter, Ellen Moweni, aged 25, and described as a "Native Cook", came to the Pietermaritzburg Mental Hospital in October 1925 after her husband, Seth, reported to a Medical Officer that she had " … on 3rd June appeared to go mad.[39] Started to walk and shout non-sense.… After two days of this she lay still in the home, not talking at all, refusing food. Now she has to be fed by hand and with difficulty is forced to take some food". Seth stresses the loss of Ellen's labour: "… she used to be a very good housewife but now does not work … is very sleepy and talks very little but what she says is sensible […] that she refuses to eat food and has gone thin…" But

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[37] Number of Patients in PMB Mental Hospitals, 1929 by race and gender. (Source: Annual Report of the Commissioner for Mentally Defective and Disordered Persons.)
Pietermaritzburg Mental Hospital   Fort Napier Hospital
MFMFEuropeans207163Europeans184153Natives291124Natives463-Coloured1329Coloured23-Asiatics8431Asiatics6-TOTAL943TOTAL829

[38] See R.W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978) and Parle, *States of Mind*, Chapter 1.

[39] RSC 1/27/31 (1925), M. 194/5 'Ellen Moweni of Malvern, Durban', Reception Order granted on 30 October 1925. Application brought by her husband, Seth (or Zetha) Moweni.

it was not only her labour which had been withdrawn, so too had her emotional engagement with Seth and their three children. In the medical reports, we are told that Ellen "takes no interest in her surroundings. Her apathy is quite abnormal." It seems too that by the 1920s, aspirant middle class women were expected to possess (or at least express) certain feelings about their roles as wives, mothers and house-keepers for it was noted that "From being a cheerful girl Ellen has become very depressed and she refuses to talk and adopts an attitude of passive resistance."

Withdrawal, apathy and being emotionally 'blunted' were not uniquely problematic in women however. Lack of affect or a refusal of social engagement or of meaningful employment also appeared with more frequency in the applications for committal: Robert Allen Sim was so remote with "no interest in the surroundings … does very little to occupy his time … appears emotionally blunted" - that he was committed as a patient in 1944.[40] Then in his early forties, Sim had been voluntary boarder (or patient) and we can surmise that his condition had been noticeable for some time.[41]

While emotional absence was disturbing to the ideal of the middle class family and when combined with physical dependency could lead to increased care-giving burdens for family members (or require expensive nursing care or an increase in the number of domestic servants) the tipping point remained violence. "Danger to self or others" posed by the insane remained a common thread in the reasons given for initiating committals, both by the state and by families. Indeed, I have not so far found a single instance of a committal of a black person that was not justified in part on the grounds of violence - real or implied. But such violent or destructive acts were not always the only grounds given by family members for their application for a reception order. Usually, it was common to add details of one or more further aberrant behaviours. For instance, one of the reasons noted by Enos Tshabalala in his application emphasized that his brother, Msiwe, "talks nonsense".[42] In December 1949 Jovu Hlongwane sought to have his son, Mzombi (aged about twenty-four) admitted because he had been "mentally deranged for a period of two months and wants to fight and hit everybody at the kraal".[43] Apparently, he threw a stone at his father and attacked his sisters. If these acts of violence were not sufficient to convince the magistrate that Mzombi was crazy and not just a nuisance, Jovu added that "he undresses himself and goes around naked."

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[40] RSC 1/27/131, M. 345/44, Robert Allen Sim.

[41] For many other patients, the reports by the Physician Superintendents suggest that quiescence and detachment followed rather than preceded the first committal: making the task - should anyone try it - of retrospective diagnosis very difficult indeed and reminding us once more of the multiple difficulties of working with these kinds of sources.

[42] RSC 1/27/131 (1944), M. 339/1944, 'Msiwe Tshabalala', Reception Order, 14 November 1944.

[43] RSC 1/27/151 (1950), M5/50, 'Jalimane Hlatswayo', Reception Order applied for by Elias Hlatswayo (father) on 13 December 1949 and granted 17 December 1949.

Failure to recognize one's own lack of rationality was also often cited as proof of insanity: Charlie Chetty, brother-in-law of Vengetas [no surname given] of Springfield, Durban, detailed how Vengetas would threaten violence and when the doctor came to "take him to the Hospital … run away".[44] But the threats of violence often became more subdued by the time that the person was medically examined and the medical reports as well as those by the receiving Physician Superintendent at Town Hill or Fort Napier frequently recorded very different or additional behaviours. Examining Vengetas, Dr Dawood Salleh Mall for instance recorded his delusions: "Chain smokes, talks and laughs to himself, is untidy and dishevelled. He says 'Ghandi is praying'. 'We must stay like God.' He knows many dames in India, America, Basra, England. Would not admit to an examination, resisted all attempts and treatment. Ran away from the car taking him to Hospital."

Certainly, by the 1940s and 1950s, a greater range of inappropriate and disturbing behaviours and emotional states were being reported. These especially included the non-performance of labour; inexplicable quietness or withdrawal from interaction with others; inappropriate nakedness, especially in front of children; the excessive beating of spouses, parents and children; and extreme emotionality.[45] This suggests to me that working class families were able to draw on a changing or widening set of notions of what were acceptable and desirable familial norms. I am tempted too to hypothesize that the emphasis on violence in reportage to resident magistrates, district surgeons and general doctors might have been at least in part a strategy employed by those who brought the applications. Stressing violence would make their application stronger than, for instance, accounts of strangely timed singing, laughter and silence.

Conclusions

The archived reception orders are both bountiful and bounded as the information they give about the interior worlds of those legally committed to mental hospitals and their families is fragmentary at best and often can only be glimpsed by reading against the grain of official formulations and medicalised terminologies. Yet, they offer us some insight into the emotions identified by both families and officials as being extreme or inappropriate. The sheer number of committal papers is daunting and overall patterns -- if patterns there be -- as yet indistinct. Nonetheless it seems safe to conclude that psychiatry and its institutions were not simply tools of social or political control by the state, and that families could

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[44] RSC 1/27/151 (1950), M1/50, 'Vengetas', Reception Order applied for by Charlie Chetty on 20 December 1949 and granted 20 December 1949.

[45] RSC 1/27/151 (1950), M5/50, 'Jalimane Hlatswayo'.. Constable Cloete described Jalimane as follows "Unreasonable temper. Unmanageable at home. Very emotional."

provide a significant 'push' factor in initiating the committal process or in bringing relatives to the attention of magistrates and district surgeons. In many cases families decided on the timing of committal and thus their role could be as, if not more important, than that of authorities.

In order to write the history of mental illness we therefore need to consider how it was that families imagined both themselves and the role of institutional psychiatric medicine and mental hospitals in the difficult task of caring for or controlling the mentally ill. In this, the ability of families to absorb disruptive or threatening behaviours and to sustain the withdrawal of labour and material contributions comprises an aspect of an economy of emotions. Additionally, the family's capacity to constitute or continue to perceive itself as a familial network committed to its members through social roles experienced and performed through emotions such as pride, duty, love, guilt, deference, pity, obligation and other values needs to be considered. Not to do so is to diminish the agency and very often the anguish experienced by many people in initiating the committal process as well as to overplay the hand of the state and the institutions of psychiatry in the social history of mental illness.